Act and Code Review – Supporting better and equitable resolution for all communities

Background paper to support discussion

Disclaimer: This working paper is to get feedback and help develop thinking in the early stages of policy development for the Act and Code review. It does not necessarily represent the views of HDC.

Context

Purpose and scope of review

The Health and Disability Commissioner (HDC) has a statutory requirement to regularly review the Health and Disability Commissioner Act 1994 (the Act) Act and the Health and Disability Services Consumers' Code of Rights (the Code) and make recommendations to the Minister of Health.

These reviews are an opportunity to make sure the Act and Code are effective in protecting and promoting the rights of all people using health and disability services. The issues we are giving focus to in this review are:

1. Supporting better and equitable complaints resolution for all communities
2. Making the Act and Code effective for, and responsive to Māori
3. Making the Act and Code work better for tāngata whaikaha | disabled people
4. Considering the options for a right of appeal for HDC decisions.

We are not considering options to expand the scope of HDC or additional Codes for any matter.

Purpose and approach

We are holding this workshop with key stakeholders to understand what is working well, and what could be improved across the spectrum of complaints resolution.

While our focus in this review is on legislative change to support improvement, we recognise that culture and practice change are vital contributors to improving outcomes. We will be capturing feedback for non-legislative improvements to be considered by our quality improvement and leadership teams and to be shared with relevant agencies.

While this workshop will have a particular focus on the right to appeal HDC decisions (*pages 10-14*), we also invite any feedback on the following:

- The principles of complaints resolution

- The right to complain (Right 10)
- Advocacy services
- HDC processes

Your insights will help shape a public consultation document seeking feedback on how we can improve the Act and Code, which we are planning to release in March next year and be open for submissions through to July. We will report to the Minister of Health with our findings and recommendations in December 2024.

Principles of complaints resolution

The Act requires complaints resolution to be fair, simple, speedy and efficient, and provides a range of resolution pathways to best balance those principles depending on the context.

- Fair means that resolution should follow the principles of natural justice, including to be impartial and fair to both parties, transparent and consistent. In the context of upholding consumer rights, fair also means ensuring equitable access to complaint resolution that considers the inherent power and resource imbalance between providers and consumers, appropriate accountability of health and disability providers, and action needed for system learning and improvement.
- Simple means the process for making and resolving a complaint should be accessible and easy to understand and issues should be resolved at the lowest appropriate level across the complaints system.
- Speedy means timely resolution that avoids undue delays and reflects the urgency of the situation.
- Efficient means limited resources are allocated in a fair and effective way and people's time and energy are respected.

'Fair, simple, speedy and efficient' balances two diverse aims. On the one hand, facilitating resolution of suitable complaints directly with the service provider. On the other, ensuring quality services for the public, and proper accountability of providers by providing for an independent investigation of complaints by the HDC, and for legal proceedings in the most serious cases.

The HDC is charged with ensuring that the purpose of the Act is met in its entirety and that this balance of interests is appropriately managed.

There has been an increased focus, in recent years, on the need for complaints resolution processes to enhance people's mana and to be more people-centred and trauma-informed. People have also highlighted the importance of equitable and culturally responsive approaches to complaints.

Including a requirement to enhance people's mana as a principle of complaint resolution has been suggested as a way to incorporate the essence of resolution from a te ao Māori perspective and encourage the use of hohou te rongo (dispute resolution from a te ao Māori perspective) and restorative practices where appropriate. An example of a requirement in legislation to enhance people's mana is the Substance Addiction (Compulsory Assessment and Treatment) Act 2017, which includes as a purpose of the Act to "protect and enhance [the person receiving compulsory treatment's] mana and dignity…". The implementation of this legislation was supported by guidance and training in relation to providing mana enhancing care.

Consideration of the use of kupu Māori (Māori words) in the Act and Code to facilitate interpretation and application from a te ao Māori perspective, as well as the protections needed to ensure the ongoing integrity of interpretation and application of those kupu is explored further in the issue of Giving practical effect to Te Tiriti o Waitangi in the Act and Code.

Questions:

- Are the four principles for complaints resolution "fair, simple, speedy and efficient" still fit for purpose? Why / Why not?
- Should a requirement to 'uphold mana' be included as a principle for complaints resolution? Why / why not?
- Are there any other principles we should consider? Why?

Right to complain (Right 10)

Right 10 provides for the right to complain. It sets out that every consumer has the right to complain and that every provider must facilitate the fair, simple, speedy and efficient resolution of complaints. Appendix 1 sets out Right 10 in full.

Barriers to making complaints

We have heard that there may be barriers to making a complaint because of an ongoing relationship the consumer may have with a provider, and concern that making a complaint might negatively affect that relationship. This is particularly the case where people are reliant on the care provided for example, disabled or older people in residential facilities, people who are reliant on home carer support (including where the carer may also be a family member), and those who require strictly controlled medications such as for opioid substitution treatment.

One option to support people to feel safe to complain is to include a non-retaliation clause in Right 10. Currently Right 10 does not explicitly protect consumers from retaliation from providers and this may be a barrier for some consumers to make a complaint. However, the right to complain (Right 10) continues to apply after a

complaint has been made, and the Code provides for other rights that would protect against retaliation where a complaint has been made, including the right to be treated with respect (Right 1), to freedom from discrimination and coercion (Right 2), and to services of an appropriate standard (Right 4). An example of a non-retaliation clause in legislation is the Protected Disclosures (Protection of Whistleblowers) Act 2022. This Act prevents a person (A) from treating, or threatening to treat, another person (B) less favourably because of a protected disclosure (see section 22 No victimisation).

Questions:

- Do you think Right 10 should explicitly provide for protection against retaliation?
- What other changes could be made to remove barriers and support people to feel safe to complain?

Barriers to simple, timely responses from providers

We have heard from both people making complaints and providers that the processes and timeframes for providers to respond to complaints set out in Right 10 are overly prescriptive and confusing. The provisions in Right 10 do not have flexibility to allow for a range of complexity. This can result in multiple extensions to the set timeframes. Feedback so far indicates that while people like having some timeframes in the Code, principle-based direction within Right 10 could enable more clarity and responsiveness.

We've also heard that provider complaint processes can be hard to find and follow and have wide variation nationally. While providers display the Code of Rights poster, which includes processes for complaining to the advocacy service and HDC, they often do not display information about their own complaints processes. This encourages people to bypass the provider to complain directly to HDC, even where the provider may be best placed to resolve the issue.

We note some complaints bodies in New Zealand such as the Privacy Commissioner and health complaint resolution bodies overseas have a requirement for an attempt at resolution directly with the provider before coming to them. While such a requirement would encourage early resolution, it could also create a barrier to people making complaints, and therefore reduce access to justice, as well as the opportunity for public health and safety concerns to be transparently and adequately considered.

Questions:

- What is your experience of how well provider complaint processes (as set out in the Code) are working?
- What options should we consider to improve provider complaint processes?
- Should the complaint processes for providers in Right 10 be less prescriptive and more principle-based? What could that look like?
- Should people be required to attempt resolution with the provider (with or without the support of advocacy services) before lodging a complaint with the HDC? If yes, in what circumstances and what safeguards should be considered?

Advocacy services

The Act provides for HDC to appoint an independent Director of Advocacy, who oversees and contracts independent advocacy services to assist in the early resolution of complaints at source, and to assist in redressing the inherent power and knowledge imbalance between consumers and providers, as well as helping to restore relationships. The Act also provides for HDC to make guidelines to direct how advocacy services should operate. The role of advocacy services set out in the Act includes to promote the Code and resolution options for complaints; to help consumers with informed consent; and to help consumers make complaints and to seek resolution with providers.

We want to hear from you what opportunities there are to strengthen the role of the advocacy service to better meet the needs of people and communities and support a seamless interface between an independent advocacy service that empowers people making complaints, and the HDC which resolves complaints independently from people and providers.

The provisions relating to advocacy services are set out in Appendix 2. The Act sets out the functions of advocates, allows for a range of advocacy models to be contracted, and for HDC to prepare guidance for how advocacy services should operate. Currently HDC contracts a single national provider to provide advocacy services across the country. In the 2022/23 year, 27 advocates dealt with 2857 complaints and over 21,000 enquiries. Due to funding constraints, the number of advocates is fewer than when the service was first established.

Currently there are also no specialist advocates to meet the needs of Māori, tāngata whaikaha | disabled consumers and others (although there have been dedicated advocates in the past e.g. Deaf advocates).

We also note that the functions of advocates in the Act includes providing assistance to health consumers to ensure informed consent (section 30(d)). To the best of our knowledge the advocacy service has never undertaken this function.

Despite these constraints, both people accessing advocacy services and providers report satisfaction with the advocacy service and they have high resolution rates.

Questions:

- What is your experience of how well the advocacy service is working for people and providers to resolve complaints?
- What does an advocacy service need to look like to uphold the rights of all people, including to meet the needs of Māori, tāngata whaikaha | disabled people and others?

Options for strengthening advocacy services

Most of the options for strengthening the advocacy service are operational (including contract models for advocacy services, number and skills of advocates), however, legislative provisions in the Act which could support a strengthened advocacy service include to:

- Clarify that the responsibility of the Director of Advocacy to the HDC includes promoting the purpose of the Act to support alignment towards shared goals (section 24(1) states the responsibilities are for the "efficient, effective, and economical management of the Director of Advocacy").
- Expand on what should be included in advocacy guidelines in section 28, including to provide for processes that specifically meet the needs of whānau Māori and disabled consumers and their whānau | family and those who support them.
- Include a requirement to consult with Māori on the preparation of advocacy guidelines.

Feedback provided in this review will contribute to any future consideration of changes to the advocacy guidelines and advocacy service contracts.

Questions:

- What do you think are the most important changes that could be made to strengthen advocacy services? Why?
- What, if any, changes should be made to the Act to strengthen advocacy services? Why?

HDC decision-making processes

The Act sets out the processes HDC must follow and the options HDC has for complaint resolution (see Appendix 3). HDC has a range of option to address the breadth of issues complained about. Complaints can range from relatively minor issues such as food quality or minor miscommunications through to more serious and urgent issues that may raise risk of harm, public health and safety or professional conduct concerns.

On receiving a complaint, HDC must undertake a preliminary assessment to decide on the most appropriate complaint resolution pathway. Depending on the nature of the complaint the preliminary assessment may involve gathering and assessing information from different sources before making a decision. This can include: asking the provider to respond to the complaint and the concerns raised; seeking independent clinical advice about the standard of care; and asking the complainant and provider to comment on any information gathered. The HDC will also consider the provider's history of complaints and may seek information from other agencies such as the Ministry of Health or the Accident Compensation Corporation.

Following preliminary assessment there are different resolution pathways. HDC can:

- **Refer the complaint to the Advocacy Service, or to the provider** for direct resolution between the parties. Resolution between parties is one our most common resolution methods and can be particularly useful where there is an on-going relationship between provider and consumer that needs to be maintained or in cases where the resolution outcome can be directly met by the provider at the point of service (e.g. booking an appointment). Currently HDC contracts a single national provider to provide advocacy services across the country. Both the Advocacy Service and providers are required to report back to HDC on the outcome of these referrals, so HDC can ensure that people's concerns have been addressed appropriately.
- **Refer the complaint to other agencies** where the issues raised are more appropriately dealt with by that agency – for example, issues related to a registered provider's fitness to practice are often more appropriately dealt with by their regulatory authority who can assess and, if necessary, restrict their ability to practice (which HDC cannot do).
- **Call a hui/mediation** involving the parties in the complaint. This resolution pathway has historically been used infrequently. However, HDC recently established a small cultural team led by a Director Māori who provides cultural oversight of complaints and the option of hui ā-whānau. Hui ā-whānau brings a te ao Māori approach to complaints resolution, and assists whānau in feeling heard, validates their lived experience, provides a space for whānau to determine what resolution is for them, as well as improves the cultural response of providers.

HDC continues to explore the broader application of hui ā-whānau and mediation in complaints resolution and how we can use this function to greater effect and embed its use more fully within our processes.

- **Take no further action** on a complaint where the preliminary assessment indicates that a formal investigation is not warranted. The HDC has wide discretion to take no further action on a complaint. For example no further action may be taken where the care was appropriate, or where matters are being addressed through other appropriate processes. This pathway can be accompanied by educational comments or recommendations to improve the quality of care or facilitate resolution of the complaint.
- **Conduct a formal investigation** which can result in the provider being found in breach of the Code, as well as recommendations. Under the Act, the Commissioner may also undertake an investigation on her own initiative, in the absence of a complaint, into any aspect of care that, on the face of it, appears to breach consumer rights.
- **Refer a provider to the Director of Proceedings (DP)** where the Commissioner has determined the Code has been breached. The DP can prosecute when providers are referred to them by the HDC and there is public interest in doing so.

When undertaking an assessment of a person's care, the HDC engages in a quasi-judicial but inquisitorial process. The HDC assesses every side of the argument, weighs up evidence, reaches conclusions on the facts, applies the law (the Code), and makes an impartial decision.

Significantly increasing complaint numbers is having an impact on the time it takes for the HDC to assess and resolve complaints. This can have a negative impact on consumers and providers and lessen the impact of our recommendations and the interventions of other agencies we may refer to.

We are hearing that:

- the way complaint resolution pathways are described in the Act, particularly in relation to 'no further action' and investigations, can be confusing
- our complaint processes can be hard to understand and follow
- our processes are too paper-based and often do not enhance people's mana or address the outcomes people are seeking from laying a complaint.

Research suggests there are a range of outcomes people are seeking when they make a complaint. People want to: be heard; understand what happened and why; receive an apology; improve services and prevent what happened to them happening to others; seek restoration; and hold people and providers accountable.[1]

[1] Jo Manning [2018 NZLR] 618.

There are calls for our complaints resolution processes to be more transparent and people-centred to improve people's experience and facilitate equitable and culturally responsive approaches that include a focus on preserving and restoring relationships where appropriate alongside considerations of public safety, accountability, and service improvement.

We want to hear how well the complaint resolution pathways are working and what could be changed to support better and equitable resolution for all communities.

Question

- *What is your experience of how well HDC's complaints resolution processes support better and equitable resolution for all communities?*

Options for supporting better and equitable resolution for all communities

Legislative options to support better and equitable resolution for all communities include:

- Reviewing the wording of the complaint resolution pathway to take 'no action' or 'no further action' to better reflect the process and outcome of the decision.
- Expanding the application of a 'mediation conference' in section 61 of the Act and broadening the wording to reflect a wider application. The term 'mediation' in the Act is also broader than the ordinary usage of the term and it may be helpful to use different language such as 'facilitated resolution' or 'conciliation'[2] and explicitly recognise and provide for tikanga led resolution practices such as hohou te rongo and hui ā-whānau.

HDC can also undertake operational changes to support better and equitable resolution for all communities. Improvements we have recently put in place include:

- strengthening our cultural responsiveness through the establishment of our Director Māori role and supporting his team to provide cultural oversight of complaints and cultural advice as a routine part of the triage of complaints, and to provide a hui-ā-whānau option for Māori whānau who make complaints.
- introducing a new multidisciplinary triage system with senior resource to review new complaints. This has allowed for better and earlier identification of systemic issues and more strategic use of HDC's levers, including better communication of emerging concerns with external parties.

[2] Processes of 'conciliation' feature in legislation for several comparable Australian agencies including, for example, the State of Victoria's Health Complaints Commissioner (HCC), and the Northern Territory's Health and Community Services Complaints Commission. While definitions of conciliation, and the conciliation process vary slightly between jurisdictions and agencies, the process is typically flexible, designed to suit the circumstances in each matter, and allows the consumer and provider the opportunity to identify the issues in dispute, develop options, consider alternatives and endeavour to reach an agreement and resolution. The HCC also allows conciliation for the whole, or part of the complaint.

- a renewed focus on supporting early resolution between the parties. Where appropriate, we support people and providers to try to resolve complaints together first before intervening as we know that generally, this is the most effective and timely way to resolve concerns.
- introducing complainant and provider experience surveys to measure the impacts of change on the people we engage with and to prioritise our improvement work.
- introducing clinical navigators to help talk people through our findings, and explain why sometimes when bad things have happened, it doesn't mean their rights have been breached.

Question:

- What legislative and non-legislative changes do you think are most important to support better and equitable complaints resolution for all communities? What impact (positive and negative) do you think these changes would have?

Options for a right of appeal of HDC decisions

The Legislative Design Advisory Committee (LDAC) advises that where an agency such as the HDC makes a decision affecting a person's rights or interests, *"that person should generally be able to have the decision reviewed in some way. The ability to review or appeal a decision helps to ensure that those decisions are in accordance with the law. Also, the prospect of scrutiny encourages first-instance decision makers to produce decisions of the highest possible quality."*[3]

The pathways for review of HDC decisions if a person who complains or a provider who is complained about is unsatisfied with the outcome are as follows:

- Ask the HDC to review the decision. The decision to review a closed file is at the discretion of the HDC. Recent processes have been put in place to make the HDC's consideration of review more transparent;
- Lodge a complaint with the Ombudsman. The Ombudsman's review will focus on procedural fairness (whether the decision was reasonable and made in accordance with the law). While the Ombudsman is not legally precluded from looking into the substantial fairness or reasons for the decision, the Ombudsman would not substitute a fresh decision or remake findings of fact or law. However, they can make recommendations to the HDC for reconsideration of the matter; and/or
- Seek judicial review in the High Court. Similar to an Ombudsman review, in a judicial review a judge will look at whether the way the decision was made was in accordance with the law. The judge won't usually decide whether the decision was the 'right' decision.

[3] https://www.ldac.org.nz/assets/documents/Chapter-28-Creating-a-system-of-appeal-review-and-complaint-2020-06-25.pdf, page 130

Additionally, where a matter has been investigated by the HDC and results in a breach decision, then:

- the HDC can refer the matter to the Director of Proceedings for prosecution in the Health Practitioners Disciplinary Tribunal (HPDT) and/or the Human Rights Review Tribunal (HRRT).
    - The HPDT hears and makes decisions on disciplinary proceedings brought against registered health practitioners. Disciplinary proceedings against a health practitioner can only be brought before the HPDT by either the Director of Proceedings or a Professional Conduct Committee.
    - The HRRT hears claims relating to breaches of the Code as well as breaches of the Human Rights Act 1993 and the Privacy Act 2020. The HRRT considers the matter afresh and has the power to award damages, including punitive damages, but not compensatory damages where they are barred by the Accident Compensation Corporation Act 2001;
- if the HDC does not refer the matter to the Director of Proceedings, where there has been a breach finding the complainant can take the matter themselves to the HRRT.

A recent petition to the Health Select Committee has argued that there are limited options for substantive review (considering the matter afresh or whether the 'right' decision was made) of HDC decisions. The petitioner was of the view that introducing a right of appeal would "provide assurance that HDC decisions are fair and transparent. It would also lead to improvements in the protection of consumers' rights, the identification of patterns of harm, and standards of care."[4]

We want to hear from you whether a right of appeal of HDC decisions is needed to strengthen the promotion and protection of the rights of people accessing health and disability services, and if so, what that right of appeal should look like.

The LDAC advises that *"the value of an appeal must be balanced in the particular circumstances against a consideration of the potential costs, implications of delay, significance of the subject matter, competence and expertise of the decision-maker in the first instance, and the need for finality. However, concerns about cost and delay should usually be dealt with by limiting the right of appeal, rather than denying it altogether."*[5]

[4] Petition of Renate Schutte: A right to appeal decisions made by the Health and Disability Commissioner (selectcommittees.parliament.nz)
[5] https://www.ldac.org.nz/assets/documents/Chapter-28-Creating-a-system-of-appeal-review-and-complaint-2020-06-25.pdf, page 131

Questions:

- Do you think the current pathways to challenge an HDC decision are adequate? Why? / Why not?

Options

Legislative options to challenge HDC decisions include:

- Introducing a right to appeal HDC decisions to the Courts of general jurisdiction (District Court, High Court, Court of Appeal, Supreme Court) and / or
- Introducing a statutory requirement for internal review process; and / or
- A lowering of threshold for access to the Human Rights Review Tribunal (HRRT) – currently a complaint must be investigated and the provider found in breach for access to the HRRT by a complainant.

There are also a number of non-legislative actions that HDC has taken to address some of the concerns raised by the petition, and in relation to a recent review by the Ombudsman, which are set out below. We also want to hear from you whether you think our internal processes for reviewing HDC decisions are adequate and how they can be improved.

Introducing a right to appeal HDC decisions to the Courts of general jurisdiction

The LDAC guidance suggests that where there is a specialist statutory office holder such as the HDC empowered to investigate complaints relating to a particular field, they "*should be relied on rather than creating new jurisdictions, unless there are good reasons not to… [including] that the body lacks the necessary powers, independence, or governance arrangements to properly address the issues."*

Questions:

- What reasons, if any, do you think would support a right of appeal to the Courts of general jurisdiction?

Introducing a statutory requirement for internal HDC review processes

Currently the HDC has discretion to undertake internal reviews of decisions if requested. An option to challenge HDC decisions would be to include a statutory requirement for HDC to review decisions if requested, and publicise this requirement. This right could be similar to the provision in the Health Care Complaints Commission Act 1993 (NSW) which requires that "The Commission must review a decision made under section 39 [action taken after an investigation] if asked to do so by the complainant" (section 41(3)).

The threshold for accessing HRRT

The HRRT is a special jurisdiction tribunal that can hear claims relating to breaches of the Human Rights Act 1993, the Privacy Act 2020 and our Act. Unlike the HDC, the HRRT will usually hold public hearings, and can award damages for losses suffered, including injury to feelings, humiliation and loss of dignity. The HRRT's decision may be appealed to the High Court.

To access the HRRT under our Act, the HDC must have both investigated the complaint and made a breach decision. This is a higher threshold than the Privacy Act and Human Rights Act. For access to the HRRT:

- the Human Rights Act only requires that a complaint is first made to the Human Rights Commission and the Commission closes that complaint.
- the Privacy Act requires that the Privacy Commissioner must first have investigated the complaint. The Privacy Commissioner does not have to conclude that there was substance to the complaint (that is, that 'interference with the privacy of the individual has occurred').

This is in contrast to our Act where a person can only bring proceedings if the HDC, having found a breach of the Code on the part of the person to whom that section applies, has not referred the person to the Director of Proceedings under section 45(2)(f); or the Director of Proceedings declines or fails to take proceedings.

The petitioners submitted that the threshold for access to the HRRT to appeal HDC decisions should be lowered to allow a complainant access to the HRRT at their own initiative without the HDC having determined there was a breach of the Code.

Questions:

- Do you think the threshold for a complainant to access the Human Rights Review Tribunal should be lowered? Why?
- If yes, what threshold do you consider to be most appropriate (eg following the closure of a complaint, following an investigation regardless of whether a breach has been found)?
- How might a lower threshold affect the fair, simple, speedy and efficient resolution of complaints, including any considerations of equitable access to justice?

Non-legislative changes to strengthen transparency and review of HDC decisions

Over the last few years, the HDC has made changes to strengthen the transparency of our decision-making and review processes. These include changes following recommendations from the Ombudsman as a result of complaints about our processes. We have:

- Reviewed and improved our 'closed file review' / internal review process.
- Reviewed the preliminary assessment process to determine the most appropriate resolution pathway to ensure that steps taken do not become overly protracted. As part of this, we have reviewed and clarified decision-making guidance around the interplay between taking no further action and notifying an investigation. This guidance can be found here.

Questions:

- What changes would you like to see to HDC's internal review processes?
- What other legislative and non-legislative options should we consider to make our processes more transparent and bring an appropriate level of challenge to HDC decisions?

Appendix 1

Right 10: Right to complain

1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

(2) Every consumer may make a complaint to—

(a) the individual or individuals who provided the services complained of; and

(b) any person authorised to receive complaints about that provider; and

(c) any other appropriate person, including—

(i) an independent advocate provided under the Health and Disability Commissioner Act 1994; and

(ii) the Health and Disability Commissioner.

(3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

(4) Every provider must inform a consumer about progress on the consumer's complaint at intervals of not more than 1 month.

(5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.

(6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that—

(a) the complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and

(b) the consumer is informed of any relevant internal and external complaints procedures, including the availability of—

(i) independent advocates provided under the Health and Disability Commissioner Act 1994; and

(ii) the Health and Disability Commissioner; and

(c) the consumer's complaint and the actions of the provider regarding that complaint are documented; and

(d) the consumer receives all information held by the provider that is or may be relevant to the complaint.

(7) Within 10 working days of giving written acknowledgement of a complaint, the provider must,—

(a) decide whether the provider—

(i) accepts that the complaint is justified; or

(ii) does not accept that the complaint is justified; or

(b) if it decides that more time is needed to investigate the complaint,—

(i) determine how much additional time is needed; and

(ii) if that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.

(8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of—

(a) the reasons for the decision; and

(b) any actions the provider proposes to take; and

(c) any appeal procedure the provider has in place.

Appendix 2

Part 3 of the Act – Health and Disability Services Consumer Advocacy Service

24 Director of Health and Disability Services Consumer Advocacy

(1) For the purposes of this Act, the Commissioner shall from time to time designate one of its employees as the Director of Health and Disability Services Consumer Advocacy.

(2) In exercising or performing the powers, duties, and functions of the Director of Advocacy under this Act, the person for the time being designated under subsection (1) shall not be responsible to the Commissioner but shall act independently.

(3) Nothing in subsection (2) limits the responsibility of the Director of Advocacy to the Commissioner for the efficient, effective, and economical management of the activities of the Director of Advocacy.

25 Functions of Director of Advocacy

The functions of the Director of Advocacy are as follows:

(a) to administer advocacy services agreements:

(b) to promote, by education and publicity, advocacy services:

(c) to oversee the training of advocates:

(d) to monitor the operation of advocacy services, and to report to the Minister from time to time on the results of that monitoring.

26 Advocacy services to operate independently

Subject to this Act, advocacy services shall operate independently of the Commissioner, the Ministry, purchasers, health care providers, and disability services providers.

27 Purchase of consumer advocacy services

(1) Subject to this Act, the Director of Advocacy shall from time to time, in the name and on behalf of the Crown,—

(a) negotiate and enter into advocacy services agreements containing such terms and conditions as may be agreed; and

(b) monitor the performance of each advocacy services agreement.

(2) Every advocacy services agreement shall impose on the person that agrees to provide, or arrange for the provision of, advocacy services pursuant to the agreement the duty to ensure that any guidelines for the time being in force pursuant to section 28 are followed in the provision of those services.

(3) Nothing in this section limits—

(a) any other enactment; or

(b) any powers that the Minister or the Crown has under any enactment or rule of law.

28 Guidelines for operation of advocacy services

(1) The Commissioner may from time to time, and shall if directed to do so by the Minister, issue guidelines relating to the operation of advocacy services.

(2) Without limiting subsection (1), any guidelines issued pursuant to subsection (1) shall include provisions relating to the procedures to be followed by advocates in carrying out their functions, including any special procedures to be followed when advocates are dealing with any particular persons or classes of persons.

(3) The Commissioner may from time to time, and shall if directed to do so by the Minister, issue an amendment or revocation of any guidelines issued pursuant to this section.

(4) The Commissioner may not issue any guidelines, or any amendment to or revocation of those guidelines, under this

section unless the Minister has approved the proposed guidelines or the proposed amendment or revocation.

(5) The following are secondary legislation (*see* Part 3 of the Legislation Act 2019 for publication requirements):

(a) the guidelines:

(b) an amendment to or revocation of those guidelines.

29 Consultation on preparation of guidelines

Without limiting section 14(2), the Commissioner shall, before issuing any guidelines or amendments to guidelines pursuant to subsection (1) or subsection (3) of section 28, consult with, and invite representations from, such persons, bodies, organisations, and agencies, including representatives of health consumers, disability services consumers, health care providers, and disability services providers, as the Commissioner considers necessary to ensure that a wide range of views is available to the Commissioner to assist in the preparation of those guidelines or amendments.

30 Functions of advocates

An advocate shall have the following functions:

(a) to act as an advocate for health consumers and disability services consumers:

(b) to use his or her best endeavours to ensure that—

(i) health consumers on or in respect of whom any health care procedure is carried out, or is proposed to be carried out, by a health care provider; and

(ii) disability services consumers to whom disability services are provided, or are proposed to be provided, by a disability services provider—

are made aware of the provisions of the Code:

(c) having regard to the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, to provide information and assistance to health consumers, disability services consumers, and members of the public for the purposes of—

(i) promoting awareness of the rights of health consumers and of disability services consumers:

(ii) promoting awareness of the procedures available for the resolution of complaints involving a possible breach of the Code:

(d) to provide to health consumers or, where applicable, persons entitled to consent on a health consumer's behalf such assistance as may be necessary to ensure—

(i) that the health consumer's or, as the case may be, that person's consent to the carrying out of health care procedures is obtained; and

(ii) that that consent is informed consent:

(e) to promote, by education and publicity, an understanding of, and compliance with, the principle that, except where any enactment or any provision of the Code otherwise provides, no health care procedure shall be carried out without informed consent:

(f) in respect of health care providers and disability services providers in the area that the advocate serves,—

(i) to provide information on the rights of health consumers and disability services consumers:

(ii) to promote awareness of advocacy services:

(iii) to provide advice on the establishment and maintenance of procedures for providing proper information to health consumers in

relation to health care procedures and for the obtaining of consent to such health care procedures:

(iv) to provide advice on the establishment and maintenance of procedures to ensure the protection of the rights of health consumers and of disability services consumers, including monitoring procedures and complaints procedures:

(g) to receive complaints alleging that any action of any health care provider or disability services provider is or appears to be in breach of the Code:

(h) in respect of a complaint of the kind referred to in paragraph (g), to represent or assist the person alleged to be aggrieved for the purposes of endeavouring to resolve the complaint by agreement between the parties concerned:

(i) to provide assistance to persons who wish—

(i) to pursue a complaint of the kind referred to in paragraph (g) through any formal or informal procedures (including proceedings before an authority) that exist for resolving that complaint:

(ii) to make a representation to the Commissioner or any other body or person in respect of any matter that is or appears to be in breach of the Code:

(j) to report regularly to the Director of Advocacy on the operation of advocacy services in the area served by the advocate:

(k) to report to the Commissioner from time to time on any matter relating to the rights of health consumers or disability services consumers or both (whether in relation to a particular health consumer or disability services consumer, or a group of health consumers or disability services consumers, or in relation to health consumers or disability services consumers generally) that, in the advocate's opinion, should be drawn to the attention of the Commissioner:

(l) to exercise and perform such other functions, powers, and duties as are conferred or imposed on advocates by or under this Act or any other enactment.

Appendix 3

Part 4 of the Act – Complaints and investigations sections 31 – 46

Receipt of complaints

31 General right to make complaints

(1) Any person may complain orally or in writing to an advocate or to the Commissioner alleging that any action of a health care provider or a disability services provider is or appears to be in breach of the Code.

(2) Any person may complain orally or in writing to an advocate or to the Commissioner about any action of a health practitioner that was taken at any time before 1 July 1996, if it is alleged or it appears that the action—

(a) affected a health consumer; and

(b) was, at the time that it was taken, a ground for bringing disciplinary proceedings against the health practitioner under a former health registration enactment; but

(c) was not referred to the body that, under that enactment, had jurisdiction to consider it.

(3) If a complaint is made under this section to an advocate and the advocate is unable to resolve the complaint, the advocate must—

(a) refer the complaint to the Commissioner; and

(b) inform the parties concerned of that referral and the reasons for it.

32 Complaints referred to Commissioner

For the purposes of this Part, a complaint that is referred to the Commissioner under section 31(3) of this Act or section 64(1) of the Health Practitioners Competence Assurance Act 2003 must be treated as if it had been made to the Commissioner.

33 Preliminary assessment

(1) As soon as reasonably practicable after receiving a complaint, the Commissioner must make a preliminary assessment of the complaint to decide—

(a) whether to take 1 or more of the following courses of action:

(i) to refer the complaint to an agency or person in accordance with section 34 or section 36:

(ii) to refer the complaint to an advocate:

(iii) to call a conference, under section 61, of the parties concerned:

(iv) to investigate the complaint himself or herself; or

(b) whether to take no action on the complaint.

(2) The Commissioner must promptly notify the complainant and the health care provider or the disability services provider to whom the complaint relates of the Commissioner's preliminary assessment.

(3) This section does not preclude the Commissioner from revising a preliminary assessment and from subsequently exercising 1 or more of his or her other powers in relation to the complaint concerned.

(4) If the Commissioner revises a preliminary assessment, the Commissioner must promptly notify the following persons and agencies of the revised assessment:

(a) the complainant:

(b) the health care provider or the disability services provider to whom the complaint relates:

(c) any agency or any person to whom the complaint has, in accordance

with section 34 or section 36, been referred:

(d) any advocate to whom the complaint has been referred.

Referral of complaints to agencies, persons, statutory officers, or advocates

34 Referral of complaint to agencies or persons involved in health or disability sector

(1) At any time after completing a preliminary assessment of a complaint, the Commissioner may refer the complaint, in whole or in part,—

(a) to the appropriate authority if it appears from the complaint that the competence of a health practitioner or his or her fitness to practise or the appropriateness of his or her conduct may be in doubt; or

(b) to the Accident Compensation Corporation if it appears from the complaint that the aggrieved person may be entitled to cover under the Accident Compensation Act 2001; or

(c) to the Director-General of Health if it appears from the complaint that failures or inadequacies in the systems or practices of the health care provider or the disability services provider concerned may harm the health or safety of members of the public; or

(d) to the health care provider or the disability services provider to whom a complaint relates if the complaint does not raise questions about the health or safety of members of the public and can, in the Commissioner's opinion, be appropriately resolved by the provider.

(2) At any time before or after referring a complaint, in whole or in part, to an agency or person mentioned in subsection (1), the Commissioner may consult with that agency or person as to the most appropriate means of dealing with the complaint.

(3) After referring a complaint, in whole or in part, to an agency or person mentioned in subsection (1), the Commissioner must notify the complainant and the health care provider or the disability services provider to whom the complaint relates of the action that has been taken.

(4) The Commissioner may refer a complaint, in whole or in part, to more than 1 agency or person mentioned in subsection (1), as long as each referral is authorised by a paragraph of that subsection.

(5) A reference of a complaint under subsection (1) does not preclude the Commissioner from taking action on the complaint himself or herself.

35 Agencies or persons to keep Commissioner informed about referred complaints

Each agency or person to whom a complaint is referred under section 34 must—

(a) promptly acknowledge receipt of the complaint; and

(b) promptly advise the Commissioner of any significant step taken in its consideration or examination of the complaint; and

(c) promptly advise the Commissioner of the outcome of its consideration or examination of the complaint.

36 Referrals of complaints to certain statutory officers

(1) If, at any time after completing a preliminary assessment of a complaint, the Commissioner considers that the complaint relates, in whole or in part, to a matter that is more properly within the scope of the functions of one of the statutory officers specified in subsection (4), the Commissioner must promptly consult with that officer in order to determine the appropriate means of dealing with the complaint.

(2) As soon as reasonably practicable after consulting with the officer concerned, the Commissioner must determine whether the complaint should be dealt with, in whole or in part, under this Act.

(3) If the Commissioner determines that the complaint should be dealt with, in whole or in part, by one of the officers specified in subsection (4), the Commissioner must promptly—

(a) refer the complaint or, as the case requires, the appropriate part of the complaint to that officer; and

(b) notify the complainant and the health care provider or the disability services provider to whom the complaint relates of the action that has been taken.

(4) The statutory officers referred to in subsection (1) are—

(a) the Chief Commissioner under the Human Rights Act 1993:

(b) the Chief Ombudsman:

(c) the Privacy Commissioner.

37 Commissioner may refer complaint to advocate

(1) At any time after completing a preliminary assessment of a complaint (whether or not the Commissioner is investigating, or continuing to investigate, the complaint himself or herself), the Commissioner may refer the complaint to an advocate for the purpose of resolving the matter by agreement between the parties concerned.

(2) On a referral of a complaint, under subsection (1), the advocate must—

(a) use his or her best endeavours to resolve the complaint by agreement between the parties concerned; and

(b) report the results of those endeavours to the Commissioner.

(3) Every report made under subsection (2)(b) must record—

(a) the terms of any agreement reached between the parties concerned; and

(b) if agreement is not reached on all matters, those matters on which agreement is reached and those matters on which no agreement is reached; and

(c) any other matters that the advocate thinks fit.

(4) A copy of every report made under subsection (2)(b) must, on request, be made available by the Commissioner to each of the parties concerned.

Decision to take no action

38Commissioner may decide to take no action or no further action on complaint

(1) At any time after completing a preliminary assessment of a complaint (whether or not the Commissioner is investigating, or continuing to investigate, the complaint himself or herself), the Commissioner may, at his or her discretion, decide to take no action or, as the case may require, no further action on the complaint if the Commissioner considers that, having regard to all the circumstances of the case, any action or further action is unnecessary or inappropriate.

(2) The Commissioner's consideration under subsection (1) may, in particular, take into account any of the following matters:

(a) the length of time that has elapsed between the date when the subject matter of the complaint arose and the date when the complaint was made:

(b) whether the subject matter of the complaint is trivial:

(c) whether the complaint is frivolous or vexatious or is not made in good faith:

(d) whether the person alleged to be aggrieved does not want any action

taken or, as the case may be, continued:

(e) whether there is in all the circumstances an adequate remedy or right of appeal, other than the right to petition the House of Representatives or to make a complaint to an Ombudsman, that it would be reasonable for the person alleged to be aggrieved to exercise.

(3) Subsection (2) does not detract from the generality of subsection (1).

(4) In any case where the Commissioner decides to take no action, or no further action, on a complaint, the Commissioner must inform the following persons and agencies of that decision and the reasons for it:

(a) the complainant:

(b) the health care provider or the disability services provider to whom the complaint relates:

(c) any agency or any person to whom the complaint has, in accordance with section 34 or section 36, been referred:

(d) any advocate to whom the complaint has been referred.

Commissioner required to share certain information

39 Commissioner to inform agencies of certain risks

(1) Whenever the Commissioner has reason to believe that the practice of a health practitioner may pose a risk of harm to the public, the Commissioner must promptly notify the appropriate authority of that belief and the reasons for it.

(2) Whenever the Commissioner has reason to believe that failures or inadequacies in the systems or practices of a health care provider or a disability services provider are harming or are likely to harm the health or safety of members of the public, the Commissioner must promptly notify the Director-General of Health of that belief and the reasons for it.

(3) If, during or after an investigation, the Commissioner is of the opinion that there is evidence of a significant breach of duty or misconduct on the part of a health care provider or disability services provider or an officer or employee or member of a health care provider or disability services provider, the Commissioner must promptly refer the matter to the appropriate person or agency.

Investigations by Commissioner

40 Commissioner may investigate breaches

(1) The Commissioner may decide to investigate any action of a health care provider or a disability services provider if the action is, or appears to the Commissioner to be, in breach of the Code.

(2) The Commissioner may investigate any action of a health practitioner that was taken at any time before 1 July 1996, if it appears that the action affected a health consumer and was, at the time that it was taken, a ground for bringing disciplinary proceedings against the health practitioner under a former health registration enactment.

(3) The Commissioner may investigate an action under this section either on complaint or on the Commissioner's own initiative.

41Complainant and provider to be notified of investigation

(1) Before proceeding to investigate a matter under this Part, the Commissioner—

(a) must, by written notice, inform the complainant (if any), the health care provider or the disability services provider to whom the investigation relates, and any person alleged to be aggrieved (if not the complainant) of the

Commissioner's intention to make the investigation; and

(b) must, by written notice, inform the health care provider or the disability services provider to whom the investigation relates of—

(i) the details of the complaint (if any) or, as the case may be, the subject matter of the investigation; and

(ii) the right of that person to submit to the Commissioner, within 15 working days of the date of the notice, a written response in relation to the complaint or, as the case may be, the subject matter of the investigation.

(2) The Commissioner may, at his or her discretion, extend the deadline of 15 working days set by a notice given under subsection (1)(b), and may do so before or after the deadline.

42 On notification of investigation authority not to take disciplinary action until further notice

(1) In any case where, after deciding to investigate the action of a health care provider or a disability services provider, it appears to the Commissioner that the investigation directly concerns a health practitioner, the Commissioner must promptly give notice of the investigation to the appropriate authority.

(2) Once the authority has received the notice, no disciplinary action under the Health Practitioners Competence Assurance Act 2003 may be taken in relation to any subject matter of the investigation until—

(a) the Commissioner notifies the authority—

(i) that the matter is not to be investigated, or investigated further, under this Act; or

(ii) that the complaint or matter has been resolved; or

(iii) that the matter is not to be referred to the Director of Proceedings under section 45(2)(f); or

(b) the Director of Proceedings notifies the authority of his or her decision under section 49 not to institute disciplinary proceedings in relation to the matter.

(3) This section does not prevent any action under the Health Practitioners Competence Assurance Act 2003—

(a) under any of sections 36 to 42, 45 to 51, or 69 of that Act; or

(b) in bringing and completing disciplinary proceedings initiated by a charge laid by the Director of Proceedings.

43 Information about result of investigation

(1) As soon as reasonably practicable after the Commissioner completes an investigation, the Commissioner must advise the persons specified in subsection (2)—

(a) of the results of the investigation; and

(b) of any further action that the Commissioner proposes to take or that the Commissioner proposes to take no further action.

(2) The persons referred to in subsection (1) are—

(a) any complainant whose complaint led to the investigation:

(b) any person alleged to be aggrieved (if not the complainant):

(c) the health care provider or the disability services provider whose action was the subject of the investigation:

(d) if the investigation directly concerns a health practitioner, the appropriate authority.

44 Consultation required before matter referred to Director of Proceedings

(1) The Commissioner may not, under section 45(2)(f), refer 1 or more health care providers or disability services providers to the Director of Proceedings for a decision as to whether proceedings should be instituted or action taken in respect of a person unless the Commissioner has given that person an opportunity to comment on that proposed referral.

(2) The Commissioner must have regard to any relevant factors of the kind specified in subsection (3) when the Commissioner considers whether or not to refer, under section 45(2)(f), 1 or more health care providers or disability services providers to the Director of Proceedings for a decision as to whether proceedings should be instituted or any action taken.

(3) The kinds of factors referred to in subsection (2) are—

(a) the wishes of the complainant (if any) and the aggrieved person (if not the complainant) in relation to the matter; and

(b) any comments made under subsection (1) in relation to the matter; and

(c) the need to ensure that appropriate proceedings are instituted in any case where the public interest (whether for reasons of public health or public safety or for any other reason) so requires.

45 Procedure after investigation

(1) This section applies if, after making an investigation under this Part, the Commissioner is of the opinion that any action that was the subject matter of the investigation—

(a) was in breach of the Code; or

(b) in the case of an action of a health practitioner that was taken at a time before 1 July 1996, affected a health consumer and was, at the time that it was taken, a ground for bringing disciplinary proceedings against the health practitioner under a former health registration enactment.

(2) If this section applies, the Commissioner may do all or any of the following:

(a) report the Commissioner's opinion, with reasons, to any health care provider or disability services provider whose action was the subject matter of the investigation, and may make any recommendations as the Commissioner thinks fit:

(b) report the Commissioner's opinion, with reasons, together with any recommendations that the Commissioner thinks fit, to all or any of the following:

(i) any authority or professional body:

(ii) the Accident Compensation Corporation:

(iii) any other person that the Commissioner considers appropriate:

(c) make any report to the Minister that the Commissioner thinks fit:

(d) make a complaint to any authority in respect of any person:

(e) if any person wishes to make such a complaint, assist that person to do so:

(f) refer 1 or more health care providers or disability services providers to the Director of Proceedings for the purpose of deciding whether any 1 or more of the following actions should be taken in relation to those providers:

(i) any of the actions contemplated by section 47:

(ii) the institution of proceedings under section 50:

(iii) the institution of disciplinary proceedings.

(3) On referring 1 or more health care providers or disability services providers to the Director of Proceedings under subsection (2)(f), the Commissioner must advise the Director of Proceedings of any relevant factors of the kind specified in section 44(3).

(4) Subsection (2)(f)(ii) does not apply if this section applies because of subsection (1)(b).

46 Implementation of recommendations of Commissioner

(1) Where, in accordance with section 45(2)(a) or (b), the Commissioner makes any recommendation to any person, the Commissioner may request that person to notify the Commissioner, within a specified time, of the steps (if any) that the person proposes to take to give effect to that recommendation.

(2) If, within a reasonable time after a recommendation is made, no action is taken which seems to the Commissioner to be adequate and appropriate, the Commissioner—

(a) shall, after considering the comments (if any) of the person concerned, inform the complainant (if any) of the Commissioner's recommendations and may make such comments on the matter as the Commissioner thinks fit; and

(b) may, where the Commissioner considers it appropriate, transmit to the Minister such report on the matter as the Commissioner thinks fit.