Waitematā
District Health Board

Best Care for Everyone

Chief Medical Officer
Private Bag 93-503
Takapuna
Auckland 0740
Telephone: 09 442 7203
Facsimile: 09 486 8924

24 June 2019

[redacted]

[redacted]

Re: Official Information Act request – complaints concerning clinical staff

Dear [redacted]

Thank you for your Official Information Act request received by Waitematā District Health Board (DHB) on 27 May 2019. Your specific questions and our responses are provided below and, as per your request, are for the financial year 2017-2018 and 2018 up till the end of April 2019.

Waitematā DHB cares for the largest resident population of any DHB in New Zealand, currently standing at more than 630,000 people. In addition to caring for our own population, we provide forensic psychiatry services and child disability services for the entire Northern Region. Waitematā DHB is also the metro Auckland provider of child community dental services and community alcohol and drug services.

Our services manage more than 200,000 patient interactions per year and the rate of complaints is very low within this context, although each is taken seriously and robustly investigated.

Complaints

It should be noted that in 2018, Waitematā DHB improved the way we collect data about complaints, recording named individual staff, and, where practicable, recording this data retrospectively. This may result in the impression of an increase in the number of complaints about clinical staff. However, please be aware that this is likely due to improved record-keeping rather than an increase in the actual rate of complaints. There has also been a slight increase in the number of complaints received by Waitematā DHB when comparing 2017–2018 and 2018–end of April 2019.

1. Total number of complaints (non-HDC) received concerning clinical staff

Please note that we have interpreted the term "concerning clinical staff" as covering those complaints where a member of our clinical workforce has been mentioned in a complaint. The data provided below, therefore, should not be read as the number of complaints specifically focusing on clinical staff.

For the financial year (July–June) 2017-2018, 49 complaints were received where individual named clinicians were referenced. For the period 2018 up till the end of April 2019, 96 complaints were received where individual named clinical staff members were referenced.

2. Total number of complaints (HDC) received by DHBs concerning clinical staff

The following include complaints made to the Health and Disability Commissioner that are either referred back to Waitematā DHB to be responded to locally under section 34(1)(d) of the Health and Disability Commissioner Act 1994, or referred to the Nationwide Health and Disability Advocacy Service.

For the financial year 2017-2018, 10 complaints were received concerning individual named clinicians. For the period 2018 up till the end of April 2019, 16 complaints were received concerning individual named clinicians.

3. Average time taken for closing complaints

The average time to close non-HDC complaints in 2017-2018 was 13 days, and for 2018 – April 2019 this was 15 days. This is among the very best complaint response times by any DHB in New Zealand.

4. The top 10 longest times and shortest times for closing

Please note that various factors influence the time taken to be able to close a complaint, such as information required from others or the scheduling of meetings suitable to all parties involved.

The top 10 longest times for closing in 2017-2018 were: 99, 118, 123, 132, 157, 163, 164, 193, 196, and 200 days.

The top 10 longest times for closing from 2018 – April 2019 were: 91, 94, 103, 104, 106, 108, 114, 179, 218, and 254 days.

The top 10 shortest closing times for both periods were zero days.

Adverse Events

Waitematā DHB reports possible adverse events to the Health Quality and Safety Commission (HQSC) prior to an investigation having been completed. Once Waitematā DHB has completed an adverse event investigation, the investigation report is approved by our Adverse Events Committee and the event is then confirmed with the HQSC. Sometimes, the investigation will identify that the adverse event was not as serious as first suspected and does not meet the criteria of a serious adverse event that is reportable to the HQSC (using an agreed HQSC rating matrix). The numbers below are the number of possible adverse events reported to the HQSC for the relevant period.

5. [The number of] Serious Adverse events reported

For the financial year 2017-2018, a total of 103 (plus 23 from the previous year 2016-17) possible serious adverse events were reported to the HQSC. This is in addition to 22 incidents that fall within the Behaviour (e.g. intended self-harm, aggression, assault, dangerous behaviour) event code. For the period 2018 up till the end of April 2019, 30 possible serious

adverse events were reported to the HQSC, plus 14 incidents that fall within the Behaviour event code.

6. Number of beds within DHB

The number of beds within any district health board will flex up and down as demand dictates. The bed figures provided reflect the average of how many beds were available/open for the period 2017-2018, which was 1084, and 2018 to end April 2019, which was 1075.

I trust that this information meets your requirements. Waitematā DHB, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare.

This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider this.

Yours sincerely,

Dr Andrew Brant
Chief Medical Officer & Deputy CEO
WAITEMATĀ DISTRICT HEALTH BOARD