



> LISTEN > LOOK > RESOLVE



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**OFFICE OF THE
HEALTH SERVICES COMMISSIONER
(OHSC) STAFF AT 30 JUNE 2004**

Position	Staff Member(s)	Responsibilities
Manager, Executive Services	Michael McDonald	Manages the operations of the Health Records Act 2001 (HRA) and corporate support services.
Manager, Assessment & Investigation	Lynn Griffin	Manages the assessment, acceptance, resolution and referral of all new complaints.
Chief Conciliator	Teresa Punshon	Manages the conciliation unit.
Senior Conciliators	Keith Jackson Kath Kelsey Orysia Ckuj	Supervise conciliators in their casework and conciliate the more complex cases.
Conciliators	Christine Lalor Koula Louras Lynn Buchanan Mark McPherson	Assist parties with a complaint to reach a resolution in a confidential and privileged setting.
Aboriginal Liaison Officer	Melanie Fraser	Liases and conducts outreach work with Aboriginal and Torres Strait Islander communities in Victoria. Performs conciliation functions and responds to inquiries on matter involving these communities.
Conciliation Administration Officer	Julie-Anne Balash	Maintains the conciliation waiting list and provides administrative support to the conciliation team.
Registrar	Shiranee Sinnathamby	Liases with the professional Registration Boards and assists the Manager, Assessment & Investigations.
Assessment Officers	Heather Andrew Jill Aitken Anna Boulton Piotr Nyczek	Receive inquiry calls, case manage and assist resolution of complaints and provide advice to health service users and providers.
Legal & Policy Officer	Angela Palombo	Provides legal advice to the Commissioner and oversees Freedom of Information requests and takes a key role in the educating and training health service providers and holders of health information about the HRA.
Project Officer	Susan Joseph	Educates and trains health service providers and holders of health information about the HRA.
Corporate Services Officer	Philip Punshon	Provides corporate support services and supervises the Information Technology (IT) function.
Information Services Officer	Colin McKnight	Provides IT support and assistance to staff and hospitals.
Executive Assistant	Kate Kennedy (from 21/6/2004) Susan Herbert (until 18/6/2004)	Provides executive, administrative and keyboard support to the Commissioner.
Receptionist	Joe Barczak	Sandra Popovski (Mental Health Review Board) provided support receptionist duties for the office in the 2003/2004 financial year.

COMMISSIONER'S SUMMARY

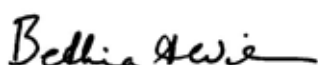
The Office of the Health Services Commissioner (OHSC) has completed another busy year. Complaint numbers have increased and requests to provide training, presentations, and participation in giving policy advice are frequent. Requests for information about health privacy issues are also frequent and come from consumers and holders of health information. This year we intentionally focused on people from culturally and linguistically diverse backgrounds through our Outreach Program in partnership with Privacy Victoria and also on older persons through presentations to groups such as Probus, Lions and Rotary. This has been an enjoyable part of the years work.

The OHSC continues to enjoy a constructive relationship with all twelve health disciplinary Boards, most contacts being with the larger Boards such as the Medical Practitioners Board of Victoria, the Nurses Board, the Dentists Board and the Psychologists Registration Board. The relationship helps to ensure appropriate complaint handling and in finding creative ways to improve the quality of the services. Quality improvement continues to be an important aspiration of people who bring their issues to the OHSC and are also a priority for the Commission. We continue to participate in important initiatives of the Victorian Quality Council and the Australian Safety and Quality Council, as well as with individual health services, consumer and provider organisations.

I am particularly grateful to the health professionals who continue to provide us with expertise, opinions and advice. Without this assistance our success rate in complaint handling would not be nearly as positive. It also demonstrates confidence on the part of providers in the way the OHSC carries out its work.

As in previous years the Commission has continued to support the important work carried out by the complaints liaison officers and their umbrella organisation the Health Services Liaison Officers Association. We continue to generate the interest of complaints officers for our training and orientation programs, which they say are extremely helpful.

I take this opportunity to thank the hard working staff of the OHSC and acknowledge the expertise that they bring to health complaint handling. The support of the Health Services Review Council under the presidency of Michael Gorton continues to be forthcoming and extremely valuable. I and the staff of the Commission extend our warmest congratulations to Michael Gorton on his appointment as a Member of the Order of Australia in the Australia Day Honours in January 2004.



Beth Wilson
Health Services Commissioner (HSC)

HEALTH SERVICES REVIEW COUNCIL PRESIDENT'S REPORT 2003/2004

This year has been most active for the Council, with a number of issues and activities, and particularly continuation of the Council's major project - developing Guidelines for Complaint Handling in Healthcare Services.

The Council has worked closely with the Health Services Commissioner on a range of issues, much of which is detailed in the Commissioner's Report and later in this Report.

The Council

Under the Health Services (Conciliation and Review) Act 1987, the Council has the following functions:

1. To advise the Minister on the health complaints system and the operation of the Commissioner;
2. To provide expertise, guidance and advice to the Commissioner;
3. To promote the Commissioner, the operations of the Commissioner and the guiding principles in the Act;
4. To advise the Minister and Commissioner on issues referred to the Council by the Commissioner;
5. With the Minister's approval, to refer matters relating to health service complaints to the Commissioner for inquiry.

Membership

During the relevant period the Council comprised:

Michael Gorton AM

Michael is a partner with Russell Kennedy, Solicitors, with experience in corporate and commercial law, and a special interest in Health Law. He has qualifications in Law and Commerce, and has an extensive background in the community sector. Michael was awarded Honorary Fellowships by the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists. He was, until 1999, Victoria's first permanent male Commissioner with the Victorian Equal Opportunity Commission, and is Deputy Chairperson of the Infertility Treatment Authority and Chair of the Victorian Biotechnology Ethics Advisory Committee. Michael is a former National President of Greening Australia; former Victorian President of the United Nations Association of Australia; and former Co-Chair of Reconciliation Victoria Inc.

Dr Paul Nisselle AM

Paul has been a provider representative on the Health Services Review Council since 1994. He was in general practice in Elwood for 18 years before entering the medical indemnity industry in 1989. He is now Senior Advisor, Risk Management for the Medical Defence Association of Victoria. He is a Past-President, Past Chairman and Past Federal Councillor of AMA Victoria and has served on the Medical Practitioners Board of Victoria. Thinly disguised as "Dr Paul", he has, since 1982, discussed a wide range of medical topics, in a fortnightly segment on ABC Radio, principally through 774 ABC Melbourne.

Pamela Barrand

Pamela is a lawyer with the Youth Legal Service of Victoria Legal Aid. She is a Board Member of the Eastern Health Network, a member of the Mental Health Review Board and participates in a number of community working groups including City of Whitehorse Youth Issues Working Group, Refugee Youth and Justice Working Group and the Court Network Consultative Group of the Children's Court.

Marcia Coleman

Marcia has had extensive high level experience in the health sector spanning the last 27 years. Her experience has been heavily oriented to the identification and management of risk and key issues, change management, corporate governance, communication and consultation. She is

presently Chairman of Australians Donate, the peak body for organ and tissue donation for transplantation in Australia.

Susan Bunting

Susan is currently an independent consultant for the Australian Council on Healthcare Standards, a member of the Data Review Committee of the Australian Childrens' Cancer Study Group Research Protocol 8 and a consumer advocate in healthcare.

She is also a lawyer, policy analyst and applied bio-ethicist with over 20 years experience.

David Brous

David is the Principal of the Impact Consulting Group, a Melbourne based public body and program evaluation practice. He is a former member of the Victorian Public Records Advisory Council and a former Senior Vice-President of the Victorian Branch of the Institute of Public Administration Australia. He has a strong interest in the provision of culturally appropriate health care services.

Lou Tehan

Lou has a professional background in health and welfare (Division 1 Registered Nurse) in the primary and acute care sector in both management and direct service provision. She is rurally based and currently employed by Grampians Community Health Centre. Her working philosophy is grounded in the social model of health. Lou also has a masters degree in Creative Arts Therapy (RMIT) and as such works primarily with people who have Acquired Brain Injury and children with problems. Her private practice encompasses professional development and an educative aspect. Her work is underpinned by the belief that given appropriate guidance people are able to find their own solutions through realising their own potential. Lou is a member of the Australian Creative Arts Therapy Association and Australian Health Professionals Association

Kathy Wilson

Kathy has Postgraduate qualifications in health services administration and completed Undergraduate studies in community development. She was CEO of Inner South Community Health Service for 10 years and has been involved in the development of a broad range of public sector initiatives including refuge programs for women, public sector co-operative housing and the Victorian Women's Health Program. In 2001 she was awarded the Victorian Health Care Associations True Professionals Award for leadership excellence and contribution to the health sector. Kathy currently provides consultancy services to the public health and community sectors.

Catherine Dean

Catherine is a social worker who has worked in women's health for over 20 years. She has undertaken a range of roles, which have included direct services to women, policy development and program management in both acute and primary health settings. Through her extensive experience in the sexual assault field, Catherine has a particular commitment to working towards the elimination of violence against women and children. She coordinated the development and publication of national standards of practice for sexual assault services throughout Australia. Catherine currently works as part of the Quality and Safety team at the Royal Women's Hospital and has a Post Graduate Diploma in Dispute Resolution.

Jamie Gardiner

Jamie is a human rights advocate. He has long been on the executive of Liberty Victoria, of which he is now a Vice-President. Since 2000 he has been a part-time Equal Opportunity Commissioner, and a Member of the Mental Health Review Board. As a gay activist Jamie has been campaigning for an end to discrimination, both in the law and under the law, for over 30 years. He was a founding member of the Victorian AIDS Council, and took part in the mostly successful campaign in the 1980s to have a health policy for HIV/AIDS that respected human rights, in a public health model.

Robyne Schwarz

Robyne joined the Council in 2003 as a community representative. She has both Physiotherapy and Social Work qualifications and was senior practitioner at the Royal Children's Hospital (RCH)

for 15 years. Her main focus at RCH was on service innovation, clinical governance and consumer and community participation.

Robyne established a new statewide system of home and community based care for children with ongoing and complex medical conditions. Robyne has been a National Director and State President of the Australian Association of Social Workers and has lectured in Social Work at the University of Melbourne. She is currently Vice-President of Jewish Care which is a large aged and community services organization.

Robyne brings to the Council experience as a health services practitioner, along with knowledge of and commitment to quality management, community participation in healthcare and clinical governance system development. The Council members are representatives of providers, users and independent people in relation to the health system. The Council includes a representative with experience in matters affecting the privacy of individuals in relation to health information, representing both interests of organisations that handle information as well as consumers.

Health Records Act 2001 (HRA)

The Council has been kept informed by the Commissioner in relation to the first full year of operation of the HRA. The Commissioner's Report details the level of complaints now being received in relation to issues of access to information, ensuring that information is accurate and dealing with allegations of improper disclosure of confidential information.

Council Project - "Guide to Complaint Handling in Health Care Services"

The Council is now finalising its major project to develop Guidelines for Complaint Handling in Health Institutions. Much preliminary work and training was undertaken during prior periods. During this year that material has been piloted through a number of hospitals. The Project is funded through the Department of Human Services.

We are grateful to the Hepburn Hospital, Ararat Hospital and Western Hospital for their participation in the pilot exercise.

The Project is also monitored through consultation with key stakeholders and a stakeholders reference group. We appreciate the work of those involved in the Project Committees, representing medical and nursing staff, and representatives of health institutions, safety committees, complaints liaison officers and consumers.

Our original project officer, Diane Spartels completed her role in October 2003. The work since that time has been ably carried out by Teresa Punshon, Lynn Buchanan and Mark McPherson. We are grateful for their assistance in their work on this project.

The Guidelines will be launched later in 2004. They have been developed in an endeavour to assist health care services deal with complaints and adverse events. More timely intervention and more sensitive handling can significantly reduce the cost and delays, incurred when complaints are allowed to become protracted and where antagonism is entrenched. Better resolution of complaints will produce a better result for both health care services and consumers alike.

Review of the Regulation of Health Professionals

The Council prepared a major submission to the Review of the Regulation of the Health Professions in Victoria. The Department of Human Services is currently undergoing a review of the various pieces of legislation and regulations affecting health professionals and their professional standards. Council's detailed submission welcomed changes that would increase transparency of decision making and standards, consistency of approach between the various professional Boards and Tribunals, and recommended greater cooperation and possible co-location of the professional Boards and Tribunals.

"Guthrie Cards"

During the year a number of media reports highlighted issues in relation to the collection and storage of the so called "Guthrie Cards" - blood testing cards arising from genetic screening of infants for various diseases in Victoria. This major and important public health program has been operating for over 30 years. The records used are currently held by Genetic Health

Services Victoria, with a service contract with the Department of Human Services. Issues of privacy and use and access to records have arisen. The Council played a major facilitation role in bringing stakeholders together including the Health Services Commissioner, Privacy Commissioner, Department of Human Services, Victorian Law Reform Commission, Genetic Health Services Victoria and a range of legal and ethical experts, to discuss these various issues. As a result of the facilitation exercise by the Council, a Working Group was formed to address the various issues raised.

The Council is grateful for the cooperation of the representatives at the stakeholders meeting, and for those involved in the Working Group.

It is important, given the publicity and public interest in the matter, that these records be held securely and that access to the records (potentially containing genetic information for a large number of Victorians) is appropriately handled. Transparent guidelines for access, use and research must be developed.

Review of Complaint Data

One of the roles of the Council is to review the data maintained by the Commissioner in relation to health complaints received through her office. The Council receives and reviews this material regularly and discusses trends and issues with the Commissioner.

Working with the Health Services Commissioner

Council discussed a range of other issues which arose during the year with the Commissioner.

In particular Council was kept advised of issues in relation to an application before the Magistrates Court of Victoria by the Medical Practitioners Board of Victoria for access to the health records of a woman involved in a termination of pregnancy. Issues of privacy, consent and confidentiality were considered in this process. Concern was expressed at release of information by the Coroner's Office in the course of dealing with these issues. The Court decision in this case will have wide ramifications for privacy and health records legislation and policy.

The Council also worked with the Commissioner in the development of a review of the procedures adopted by the Commissioner in the "Royal Melbourne Hospital Inquiry", conducted by the Commissioner and reported in the previous year. The Council welcomed the research undertaken through the Commissioner's office looking at the style of investigation, the approach undertaken and the lessons to be learned for future inquiries of this nature. The research undertaken is valuable and will better inform these processes in the future. The Commissioner was also involved during the year in follow up processes in relation to her recommendations arising from her Inquiry Report.

Council provided advice to the Commissioner and the Minister in relation to proposals by the Commonwealth Government to legislate for access to the medical health records of children under the age of 16. The Council viewed this legislation with concern. We note that the Commonwealth Government did not proceed with the proposed legislation.

The Council values the strong and close working relationship with the Commissioner, Beth Wilson and her staff.

The education and training program undertaken by the Commissioner is substantial, and Beth's personal contribution to community awareness programs is enormous. Her ability to communicate important messages, and reach all sectors of the community, industry and key stakeholders is well recognised.

Beth's lifelong commitment to community education was recognised during the year with the award of an Honorary Doctorate in Education by the RMIT University. We add our congratulations.

Thanks

The Council appreciates the continuing support of the Minister and her personal interest in the work of the Council.

The Council functions with the great support of Beth Wilson and her staff, during this year particularly Susan Herbert, Kate Kennedy and Michael McDonald. Since our last report both Julie Rolfe and Meredith Carter have left the Council to pursue other interests. We thank them for their contribution. We have welcomed Susan Bunting, Jamie Gardiner and Robyne Schwarz to the Council, all of whom have contributed greatly over the last year.

Finally I congratulate and thank my fellow Council members for work on the Council's project which, in particular, has required a substantial commitment. We are pleased that the project is producing great results, and will be finalised in the near future.

I am also grateful for the support received from Council and others on appointment as a Member of the Order of Australia in the Australia Day Honours in January 2004.

The Council remains committed to its objectives, in monitoring the health complaints system in Victoria. We note increased emphasis in the health system generally on quality and safety in healthcare, and the adoption of risk management practices. The work of the Council and the Commissioner contributes to that cause.



Michael Gorton AM
President – Health Services Review Council

STATUTORY FUNCTIONS

The Role of the Commissioner

The OHSC was established in Victoria in 1988. The Commissioner's role is to receive, investigate and resolve complaints from users of health services, to support health care services in providing quality health care and to assist them in resolving complaints. The legislation also requires that information gained from complaints should be used to improve the standards of health care and prevent breaches of these standards.

The *Health Services (Conciliation & Review) Act 1987* states that the Commissioner is to:

- a) deal with users' complaints; and
- b) ways in which the guiding principles may be carried out and help service providers to the quality of health care.

The purposes of the Act include:

- a) to provide an independent and accessible review mechanism for users of health services; and
- b) to provide a means for reviewing and improving the quality of health service provision.

Guiding Principles

The guiding principles of the *Health Services (Conciliation & Review) Act 1987* promote:

- a) quality health care given as promptly as circumstances permit; and
- b) considerate health care; and
- c) respect for privacy and dignity of persons being given health care; and

- d) the provision of adequate information on services provided or treatment available in terms which are understandable; and
- e) participation in decision making affecting individual health care; and
- f) an environment of informed choice in accepting or refusing treatment or participation in education or research programs.

Expectations and Standards

The guiding principles establish the range of responsibilities for health services and the basis upon which a person might complain that a breach of these responsibilities has occurred. They establish a framework for the HSC to become involved in improving health services and reporting on the problems identified and the improvements made.

HRA

The HSC is also responsible for the administration of the legislation dealing with privacy of an individual's health information. The HRA commenced on 1 July 2002. The purpose of the Act is to promote fair and responsible handling of health information by:

- a) protecting the privacy of an individual's health information that is held in the public and private sectors; and
- b) providing individuals with a right of access to their health information; and
- c) providing an accessible framework for the resolution of complaints regarding the handling of health information.

From 1 July 2002 organisations holding health information must manage the health information which relates to individuals, in accordance with the Health Privacy Principles in the HRA, subject to any specific provisions about the management of health information in any other Act.

Individuals are now able to seek access to information about them held by any person or organisation in the private sector. The Freedom of Information Act 1982 (FOI) continues to provide a mechanism for individuals to seek access to their health information held by public sector organisations. However, in the event of a refusal of access to health information under the FOI Act, the HRA also provides an avenue for these refusals to be conciliated in certain circumstances.

Complaints can be made to the HSC by individuals about an interference with their privacy because their health information has not been managed in accordance with the HRA, or who have experienced difficulties accessing health information about them. The HSC assesses complaints and, if a complaint is accepted, it may be conciliated, investigated or dismissed. Where a complaint is dismissed, the individual has the right to take action at the Victorian Civil Appeals Tribunal (VCAT).

Other Statutory Roles

The HSC provides training to a wide range of health service users, providers and organisations that hold health information. This is in accordance with our functions as outlined in section 9 of the Act. A supportive working relationship exists between the HSC and the complaints liaison officers at public hospitals and many other health services in Victoria. Dialogue continues between the HSC, consumer representatives including the Health Issues Centre and health service providers and their associations.

Liaison, Training and Promotion

The OHSC consults regularly with the 12 professional Registration Boards about complaint handling in accordance with section 19(6) of the Act. Regular meetings between the OHSC and the Boards are held to determine the most effective and efficient ways of handling complaints about registered practitioners. This process avoids double handling and ensures the legislative requirements are met. The HSC also discusses relevant issues with the Ombudsman, the Mental Health Review Board, the Intellectual Disability Review Panel, the Office of the Public Advocate, the Coroner, the Privacy Commissioner, the Commissioner for Equal Opportunity, the Infertility

Treatment Authority and other relevant authorities. These links assist our work, especially where the management of complaints involves more than one Office.

The Commissioner places strong emphasis on promotion and training to improve accessibility of the OHSC to the public and health service providers. During the year under review the HSC has been represented at many conferences and venues to promote the work of the Office. The Commissioner conducted 65 presentations, 9 lectures, 6 launches and participated in 9 conferences and 4 hypotheticals in the 2003/04 financial year. Consumers of health services from the non metropolitan regions, children and adolescents, indigenous Australians and people from non English speaking backgrounds have been under represented as complainants and an outreach program has been introduced to make the service accessible to them. The OHSC brochure has been produced in 15 languages. The employment of a full-time Aboriginal Liaison Officer has assisted in reaching indigenous communities. A summary of her work appears in the Aboriginal Liaison Officer's section of this Report.

This year the Commissioner has continued to concentrate on taking the message to older people through PROBUS clubs and other relevant organisations. These have been particularly enjoyable encounters. In May 2004 the Commissioner was awarded a Doctorate in Education Honoris Causa from RMIT University for her contribution to community education.

PUBLIC INTEREST ISSUES

Complaints can indicate trends within the health care system that have implications for the general public. Public interest is defined by the following criteria:

1. The circumstances outlined in the complaint are likely to affect a significant number of people, or
2. These circumstances impact on certain population groups, or
3. The complaint is indicative of a systematic flaw or the result of a deficiency in policy or procedures, or
4. The complaint raises an issue that is individual in nature but that occurs unreasonably often, suggesting a systemic problem exists.

These criteria have been used to highlight complaints as they move through the system so the public interest issue may be given appropriate attention in conjunction with the individual's complaint. A review of complaints so labelled has highlighted a number of issues.

Optical Dispensing

The activities of a firm of optical dispensers were the subject of a story in *The Age* by Tom Noble on 6 April, 2004.

Dissatisfaction within the community has been created by their reluctance to rectify or replace glasses that do not meet the needs or expectations of their clients. It is good business practice to adopt a responsive and conciliatory manner in addressing the complaints made by customers and a large number of dissatisfied clients is not in the best interests of the public nor the business.

The Commissioner continues to work with Consumer Affairs and the Australian Competition and Consumer Commission in assisting consumers who have complaints.

Release and Transfer of Medical Records

Numerous concerns were raised this year about the overall handling and release of medical records from a five doctor medical clinic in a regional town. The property's freehold owner left the practice to move to another town and a second doctor was due to move a short time later. The remaining three doctors had arranged to stay in the building for a few more months. Most patient records were left with these three doctors. The clinic, which is now closed, was thrown into disarray when one month after the owner's departure, due to unforeseen circumstances, these arrangements changed. The remaining doctors all left the practice suddenly and the practice manager became unwell and unfit for work. The building was vacated and many of the patients' records were left behind. A day was arranged for the building to be open and records to be collected but not all patients could make it on that

day. Various attempts were made to provide patients with the records but these were somewhat informal and complaints were made against the doctor who was the owner of the building. Eventually all the problems were resolved but this story underlines the importance and the necessity of careful planning for transfer of records when a practice closes.

Victorian Civil And Administrative Tribunal (VCAT) Civil List - Referrals

When a person is dissatisfied with the costs associated with the provision of a health service and these issues cannot be resolved through the OHSC, the complainant can apply for the matter to be heard through VCAT's Civil List. This is a relatively simple and affordable option for complainants in situations where the service provider is not agreeable to resolving the complaint through HSC processes.

Research and Policy Projects

The Unusually Persistent Complainant

In conjunction with Professor Paul Mullen and Dr Grant Lester of Forensicare, research was conducted into the responses of complaints officers to unusually persistent complainants. Experience had shown that a small number of complainants would persist with their complaints for much longer than might be expected, sometimes at great personal costs to themselves and their families. The first part of the research is completed and was published in the British Journal of Psychiatry in April 2004.

Rural Consumer's Complaints about Health Services

This research involves collaboration between the OHSC and Professor John Humphreys and Judith Jones of the Monash University School of Rural Health at Bendigo. A de-identified database of 23,866 HSC complaints files was analysed to determine rural-urban differences based on the remote and metropolitan classification. Important differences between rural and metropolitan consumers were noted, with rural consumers being significantly under-represented. The findings were presented at the National Rural Health Conference in Hobart in March 2004. Funding from the Department of Human Services Rural and Regional Health Division will allow expansion of this research in the new financial year. The researchers have also received an Australian Research Council grant to explore the issues identified in the first study.

Open Disclosure Project (Southern Health, Victoria)

The OHSC has been a member of the Reference Group for this research in best practice in communicating with patients and families after adverse events. The OHSC has also assisted with obtaining a volunteer comparison sample of subjects from former complainants, who agreed to assist the research by speaking of their own experiences.

Complex Clients Project

The Commissioner was a member of the Working Group on Complex Clients, convened by DHS to respond to people with multiple and complex needs. The Phase One Report and a Client Profile Data and Case Studies Report were completed during the previous year and launched in July 2004 by the Minister. One of the outcomes of the group was the establishment of the Multiple and Complex Needs Panel. The Commissioner is pleased the panel is located in the same building as the OHSC which will enable our positive working relationships to develop further.

Quality of Care Reports

This is the third year the HSC has been involved in the judging of the Quality of Care Reports. The standard of reports indicates hospitals take the project seriously and have a genuine commitment to developing a better understanding of and consultation with communities. In particular an emphasis is shown in communicating with diverse communities, such as the Culturally and Linguistically Diverse, in a complex setting.

Pregnancy Disorder Study

The University of Melbourne/Royal Women's Hospital are conducting research into the experiences of women with disorders of pregnancy such as pre-eclampsia and placenta praevia. The OHSC assisted the project by providing de-identified case summaries of issues around the management of pregnancy disorders.

CALM Project

The Central Highlands Division of GPs began a pilot project on complaints management entitled CALM (Conflict and Litigation Management). The OHSC assisted by participating in the evaluation committee and the steering committee.

Respecting Patient Choices

The Austin Hospital is leading a project to develop effective means to enable patients and their families to document their wishes for managing end of life experiences. The OHSC has participated in the reference group for this project.

Regulation of the Health Professions

During the year the Department of Human Services conducted a wide-ranging review into the system of registration and regulation of health professionals. The HSC participated in the steering group for this project.

Student Projects

The OHSC is happy to talk to students and teachers about the possibility of student placements within the Office. Mutually beneficial projects are developed to meet the interests of the students as well as the Office.

Wendy Kimpton, a graduate in Psychology from Swinburne University has finalised a "road map" of the Health Services Commissioner's Inquiry into the Royal Melbourne Hospital.

Emma Beattie and Alison Froumis, third year Health Information Management students from La Trobe University, each completed a 6 week placement with the OHSC. The students were instrumental in updating the OHSC contacts database as well as increasing their knowledge and awareness of the OHSC.

Heike Holtz, a work experience student from Germany, spent 8 weeks working on a project involving evaluation of prisoner complaints.

ANALYSIS OF COMPLAINT TRENDS

Throughout this Annual Report anecdotal information has been used to illustrate the types of complaints received. Details have been altered to protect confidentiality and, wherever possible, actions taken or resolutions achieved have been indicated. Outcomes cannot be indicated where the matter is still in progress.

2003/2004 Summary

In the twelve months under review the Office received 2450 new complaints comprising 1080 single contact complaints, where the complainant did not continue with the complaint after the initial contact and 1370 complaints (accepted cases), which were confirmed in writing. It is not certain why so many people do not confirm complaints, but this pattern has been noted in other complaints agencies and it may be that the opportunity to be heard is all that is wanted in some cases.

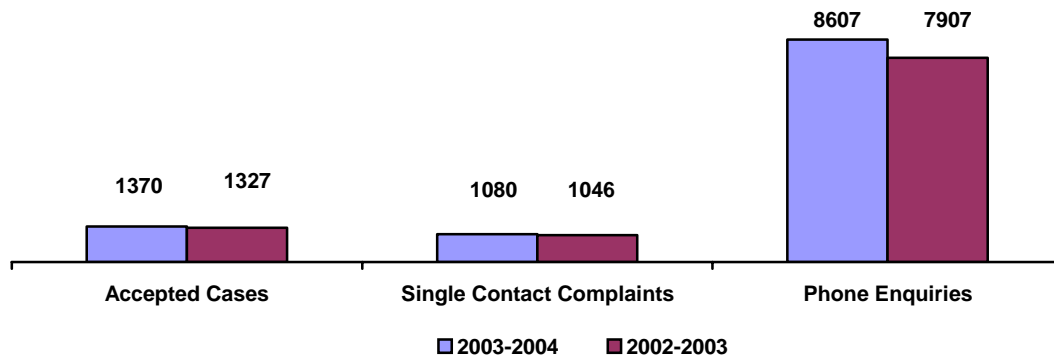
Complaint numbers were up slightly this year with 43 more accepted than last year and 34 more single contact complaints. Telephone inquiries increased with an additional 700 this year, many of which were about the HRA. The OHSC continues to play an important role in referring callers to relevant services as public awareness of the HSC increases many people use the service to assist them in navigating their way through the health system. Some radio announcers refer any callers with health related queries the OHSC. We are happy to provide this service, as it can be. The majority of callers, both consumers and providers, enquiring to difficult for people to locate the agencies they need.

Table 1 below shows the complaints and enquiries received by the OHSC during 2003/2004 and Figure 1 shows a comparison with last year's figures.

Table 1: New Complaints and Enquiries

Complaints				
	Enquires byTelephone	Single Contact	Accepted Cases	Total
HSC	6095	979	1226	8300
HRA	2512	101	144	2757
Total	8607	1080	1370	11057

Figure 1: Complaints and Enquiries – July 2003 to June 2004



Enquiries

Explained in introduction

Table 2: Enquiry types

HRA Issues		HSC Issues	
Access to records	32%	Access to records	2%
Referred to Federal Privacy Commissioner	0%	Fees	11%
Privacy information	52%	Food & environmental health	10%
Referred to State Privacy Commissioner	0%	Health insurance	2%
Referred to FOI Act	5%	Hospital waiting list	1%
Fees	7%	Other	33%
Request for brochure	4%	Referred elsewhere	39%
		Request for brochure	2%
	100%		100%

The majority of callers, both consumers and providers, enquiring about the HRA were asking about privacy rights and obligations. The second largest group were enquiring about access to records. Seventy two percent of calls other than HRA enquiries were redirected or given general advice and assistance.

Seriousness

Complaints often raise more than one issue and it is only the primary issue, which is reported here.

Seriousness Rating

1. Low: a phone call, letter or an explanation should easily resolve the problem. Included are complaints that are frivolous, vexatious, obviously misconceived or where an investigation is unwarranted.
2. Medium: there has been a misunderstanding; issues frequently involve access to records, disputes about costs, discourtesy, diagnostic or treatment errors without serious sequelae.
3. High: there are significant quality assurance implications, changes in practice are needed to avoid a recurrence or there is a need for policy development. These also include complaints associated with personal injury, professional misconduct, unlawful or unethical acts, lack of informed consent with serious adverse outcomes.

Table 3: Seriousness by Issue at Closure

HRA	2003 - 2004					2002 - 2003				
	Low	Medium	High	Total	%	Low	Medium	High	Total	%
Access & Correction	65	35	5	105	4%	34	14	0	48	3%
Anonymity	1	0	0	1	0%	2	0	0	2	0%
Collection	2	0	0	2	0%	4	3	0	7	0%
Data Quality	12	7	2	21	1%	2	1	0	3	0%
Identifiers	1	0	0	1	0%	0	0	0	0	0%
Info Available to another HSP	4	2	0	6	0%	3	0	0	3	0%
Openness	1	0	0	1	0%	1	1	0	2	0%
Transborder Data Flows	0	1	0	1	0%	0	0	0	0	0%
Transfer/Closure of HSP	3	3	0	6	0%	2	1	0	3	0%
Use & Disclosure	34	41	4	79	3%	26	17	1	44	2%
None	2	0	0	2	0%	0	0	0	0	0%
Total	125	89	11	225	9%	74	37	1	112	5%
<hr/>										
HSC	Low	Medium	High	Total	%	Low	Medium	High	Total	%
Access	127	69	15	211	8%	164	65	6	235	10%
Administration	34	15	1	50	2%	48	10	0	58	2%
Communication	164	86	24	274	11%	180	72	8	260	11%
Cost	111	43	2	156	6%	98	20	1	119	5%
Not Specified	65	70	6	141	5%	159	35	10	204	9%
Rights	98	77	14	189	7%	74	48	17	139	6%
Treatment	520	615	206	1341	52%	475	584	182	1241	52%
Total	1119	975	268	2362	91%	1198	834	224	2256	95%
<hr/>										
Grand Total	1244	1064	379	2587	100%	1272	871	225	2368	100%
	48%	41%	11%	100%		54%	36%	10%	100%	

The number of complaints classed as serious rose by 144 over the previous year however this equated to only a 1% increase as the number of files closed in this reporting year also increased, by 219. The majority of complaints continue to be within the low and medium ratings (48% and 41% respectively). These variations are slight and do not reflect any significant change in patterns for this year.

Who Complained?

A complainant is defined as the person who makes the complaint. This is most often the patient or consumer of the health service.

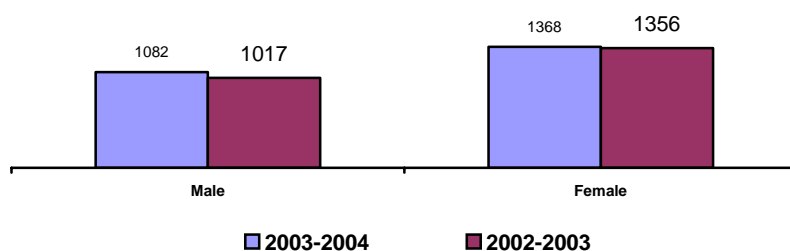
This year 44% of consumers were male and 56% were female. Women complained and were nominated as the consumer in complaints more often than men and while it is not known why this occurs, it may be because they also tend to be the carers of people using health services.

The age group with the majority of complaints was the 35 to 54 group compared with the 25 to 34 group last financial year.

Table 4: Consumer Profile

Age Range	Female	Male	Total
0 to 01	15	9	24
01 to 04	7	15	22
05 to 14	9	29	38
15 to 24	42	23	65
25 to 34	107	51	158
35 to 44	113	75	188
45 to 54	110	78	188
55 to 64	85	78	163
65 to 74	39	42	81
75 +	69	50	119
Unknown	772	632	1404
Total	1368	1082	2450

Figure 2: Consumer Gender



HOW COMPLAINTS ARE MANAGED

The OHSC is structured into three distinct teams (*see Organisation Chart in the Executive Services section*) with the Assessment and Conciliation teams responsible for managing the complaints received in the Office.

The enquiry telephone line operates from 9am to 5pm, five days a week. At other times messages may be left on the answering machine. Assessment Officers are usually the first point of contact for members of the public and have a broad knowledge of health issues and, where appropriate, provide referrals to other agencies if the enquiry does not come within the jurisdiction of the HSC.

When enquiries are received by telephone, an Assessment Officer listens and assesses the issue/s the caller is presenting. The legislation anticipates that consumers will attempt to resolve issues themselves wherever possible and staff advise complainants, where appropriate, to make direct contact with the service provider. It is hoped that many of the unconfirmed complaints are resolved in this way.

If the complaint is about a health service provider (HSP), and the complainant is unable to resolve the matter directly, a complaint form is sent out. The caller is asked to complete the form, sign an authorisation and give details of the complaint. The Act requires that complaints made on the telephone or in person must be confirmed in writing. Staff are able to assist in this process.

Assessment Officers record all potential complaints on the database as cases. If a complaint is not confirmed in writing, the matter is closed although complaints identified as serious may be followed up.

If a complaint is from a person from a non-English speaking background the enquiry officer may access interpreter services and assist the complainant in lodging the complaint. Assessment Officers also interview prospective complainants when they present in person.

Confirmed complaints are entered on the database in detail, including a summary of the complaint. A hard copy file is made up and an acknowledgment letter sent to the complainant.

The complaint is sent to the health service provider who is asked to respond within 28 days. A response may be in writing directly to the complainant or sent via the OHSC depending upon the circumstances. The majority of complaints are resolved at this stage.

A clear explanation from the HSP complained about and, where appropriate, an apology continues to be the most effective means of resolving complaints.

The maximum time a complaint may stay in the assessment stage is 84 days. If a case is not resolved within this time the Commissioner formally refers the case to conciliation. This referral can occur earlier if the case is assessed as being more likely to be resolved in conciliation.

The conciliation process is quarantined from all other processes within the OHSC and its aim is to encourage settlement of the complaint by arranging informal, confidential discussions between the parties.

Within two weeks of receiving the referral the conciliator writes to the parties giving details of the arrangements for the discussions. These proceedings are privileged and nothing said or disclosed during the conciliation may be admitted in any court action. The process is entirely voluntary; at any stage in the negotiations either party can decide not to proceed any further and this ends the matter in conciliation.

Generally complaints in conciliation fall into two categories. One is the desire for an explanation as to what happened and why. The other is the claim for damages, compensation or remedial treatment. Often they involve elements of both. A claim for compensation is usually negotiated between the parties and their advisors, with the conciliator as the link, without a meeting.

When there is a dispute about a health service provider's liability for a claim then with the agreement of the parties, an independent expert opinion is sought. The conciliator organises this from an expert in the relevant field. Copies of this opinion go to the parties who use it as a basis for further negotiations.

If a conciliation results in the payment of damages or compensation then normal legal conventions, that is, release documents are prepared.

How Were the Complaints Resolved?

In the year 2003/2004, 2587 cases were closed by the HSC.

The number of files closed varies from the number of files received within any given year, as there are always carry over files at each stage. A more detailed explanation of outcomes is in the following reports.

Table 5: Resolution Stages

Stage of Complaint Process	HRA	HSC	Total	%
Closed in Enquiry (Single Contact Complaints)	93	996	1089	42%
Closed in Assessment	102	998	1100	43%
Closed in Conciliation	30	363	393	15%
Closed in Investigation	0	5	5	0%
Total Cases Closed	225	2362	2587	100%

Assessment Report

The Assessment Team is the intake area for all complaints to the OHSC under the *Health Services Conciliation & Review Act 1987* and the HRA. In addition to the management of these complaints, the team also provide the help line telephone service to the community. The help line receives potential complaints and also refers callers to other services such as the Environment Protection Authority and the Aged Care Complaints Resolution Service.

Each Assessment Officer manages a caseload of complaints, which they assess to see how the issues may be resolved. The majority are resolved informally through the provision of explanations, apologies, refunds, further services or procedural changes. If the cases are not resolved in the statutory time limit of 12 weeks the Assessment Officer will then recommend the case be closed, referred internally to conciliation or investigation or externally to another agency.

The HRA has been associated with an increased number of enquiry phone calls and a growing number of complaints. While most health service providers are now aware of the HRA and its implications, there are some complex situations that need to be resolved with the assistance of the OHSC. These complaints generate a great deal of work requiring assistance from the OHSC's Legal Officer as previously uncharted territory is explored.

Where there is an inconsistency between the HRA and another Act the specific overrides the HRA. So while a complainant may believe they have a right of access to their health records under the HRA, it may be their access is prohibited or constrained by the terms of another Act. The OHSC has been generally pleased at the open approach to access demonstrated by the vast majority of providers.

Table 6 shows the broad resolution categories for complaints resolved in the assessment stage.

Table 6: Resolution in Assessment

Assessment	2003/04	2002/03
Apology	2%	3%
Concern registered	2%	5%
Costs refunded	5%	2%
Declined	22%	19%
Explanation offered	51%	56%
Objective Not Obtained	3%	2%
Procedural change	0%	1%
Referred elsewhere	12%	7%
Service obtained	2%	4%
Withdrawn by user	1%	1%
	100%	100%

Changes to Tort Law came into effect in Victoria in October 2003 and part of these changes gave indemnity to apologies made to patients after adverse events. Nevertheless, apologies are still the most difficult outcome to achieve trailing behind refunds of costs. An apology for an unintended outcome, even where no blame is attributed, can be a very healing process and may prevent complaints being made.

The majority of complaints are found to be the result of misunderstandings and this is why most are resolved by the provision of further explanations, sometimes from the service provider and sometimes with the assistance of other health professionals.

Conciliation Report

Unresolved complaints are assessed by the Assessment Team to recommend to the Commissioner the most appropriate avenue which may achieve the complainant's sought outcome. There is a maximum statutory period of 84 days during which a decision is made. Complaints that are considered to be suitable for conciliation must be referred. The types of complaints referred to conciliation vary widely. These may include matters which are awaiting a response from health service providers who have taken longer than the statutory period allows and the complainant seeks an explanation. Alternatively, the complainant may have received an explanation but is unhappy with the response and seeks to explore the issues raised further. Other matters may involve substantial disputes with possible legal consequences.

A man complained that he sustained nerve damage to his arm during an unrelated surgical procedure, which prevented him from working in his current employment. The parties agreed to negotiate a settlement

The complaint was settled following the exchange of a release document and a cheque. The requirements of the Health and Other Services (Compensation) Act 1995 were satisfied.

The impact of the introduction of the *Wrongs and Limitation of Actions Acts (Insurance Reform) Act 2003* which received Royal Assent on 16 June 2003, has begun to be felt. The Act applies to persons who were injured on or after 21 May 2003. For people injured before that date, it was necessary to issue proceedings before 1 October 2003, or the new laws will apply to them. Therefore after 1 October 2003, the Act applies to everyone who wishes to bring a civil claim, (unless one of the limited exceptions apply).

A man complained, following a fall in August 2003 in which he injured his right arm, the hospital did not accurately diagnose the fracture he sustained until nine days after x-rays were taken. He believed the failure to diagnose the fracture in a timely manner, delayed appropriate treatment, causing him undue pain and suffering.

The complaint was resolved following a second opinion obtained in conciliation. Under the new laws which applied in this case, his claim for pain and suffering was not successful because his injury did not meet the greater than 5% permanent physical and/or greater than 10% permanent psychological impairment threshold according to the AMA's "4th Edition Guide to the Evaluation of Permanent Impairment". He did however receive his out-of-pocket costs that included a component for loss of wages, as his sick leave had been exhausted.

A woman complained her dentist misdiagnosed the cause of pain and swelling in her mouth. She said only after she sought a second opinion, was the problem able to be treated successfully.

The original dentist explained the treatment provided was appropriate at the time and that he had not missed the problem. A second opinion was obtained for conciliation purposes which exonerated the dentist's choice of management.

Feedback from various plaintiff and defendant firms suggests they view the HSC as a useful "safety valve" for people who can no longer litigate successfully or for whom it's not economical. To that end, it is expected the workload for the HSC and her Conciliation team is likely to grow exponentially.

Complaints referred to conciliation are prioritised as follows:

- HRA complaints are allocated immediately because most are about failure to provide access to records within the statutory time frame stipulated under the Act.
- Other complaints are dealt with according to date of referral to conciliation (oldest file in the Office is dealt with first) unless the state of health of the complainant and/or provider dictates otherwise or there is a time problem due to the *Limitation of Actions Act 1958* and subsequent amendments made by the *Wrongs and Limitation of Actions Acts (Insurance Reform) Act 2003*.

Currently we aim to action files within two weeks of referral to conciliation, depending on workload. The majority of conciliation files as always raise issues of a complex nature, which require in depth analysis, research, consultation and management.

Where the conciliation process identifies systemic issues within the Victorian health service industry, and/or deals with matters of public interest, the conciliation team adopts a very proactive role, in cooperation with the participants, to address these issues effectively to achieve long-term change management.

A man complained that his 36 weeks pregnant wife, presented, at the request of the treating obstetrician, at the obstetrics department of a hospital with flu like symptoms. In the next hour she became very distressed experiencing difficulty breathing. Although the woman's blood pressure was at a similar level to pre-pregnancy, her ability to walk around the labour ward and the heart reading on the CTG monitor were falsely reassuring. Despite the woman being obviously out of breath, her husband had to ask for oxygen, whereas he believes it should have been provided as a matter of routine. In addition, the hospital staff did not insert an IV and commence fluids even though the woman's condition was deteriorating. When the obstetrician (who was unavoidably delayed) saw the woman, he arranged for her to be transferred to the emergency department of a nearby hospital. The woman and baby died the following day from meningococcal septicaemia.

As part of the resolution between the complainant and the health service provider of this complaint, it was agreed that after the conciliation process concluded, key stakeholders would be contacted to convey and negotiate suggestions for addressing the important issues raised. It was noted that many obstetric units in Victoria are "stand alone" from an emergency department and either do not provide 24 hour medical cover or are not affiliated with an emergency department. Given the tragic circumstances, even though it is possible the outcome may not have been different even with the best available emergency care, the parties to the conciliation felt it was important to alert key stakeholders to the need for obstetric units to plan for the care and treatment of patients who are sick and unstable and to put arrangements in place for the transfer of such patients to an emergency department.

HRA

Whilst the majority of HRA complaints referred to conciliation are about failure to gain access to records, the next largest group complained about the use and disclosure of information.

The parents of a three-year-old child complained that the child's privacy was breached when his health information was discussed in a parents' meeting.

Discussions led to the parties agreeing to negotiate a settlement. The complaint was resolved to the satisfaction of all concerned.

In a small number of situations, complaints are deemed to be non-conciliable. This may occur due to a range of circumstances. As participation in the conciliation process under the principal Act is voluntary, in such circumstances, the conciliation cannot continue.

A young woman complained that after numerous attempts by her surgeon to correct problems with her existing breast implants, she remained dissatisfied with the end result.

The surgeon believed there was nothing more that could be done and decided not to participate in any further discussions on the subject. The woman is considering taking legal action.

Conciliation continues to be regarded by health service consumers and providers as a successful mechanism for the resolution of complaints, including matters that might otherwise be dealt with in litigation. The level of co-operation of parties with the conciliation process continues to be high and there is considerable recognition that the processes are

impartial and fair. Many health services consumers continue to express a preference for conciliation even though they have the option of formal litigation. They view conciliation as a "gentler" or more therapeutic form of jurisprudence than the more adversarial approach.

Three hundred and ninety three complaints were closed in conciliation in the period under review, 66 more than in the previous year. Ninety percent were resolved, and the remaining 10% were unable to be conciliated.

The Koori Outreach Programme (which is part of the conciliation team's brief) continues to be dynamic, reaching many remote communities in country Victoria (see Report below) The Programme recognises the Koori Community's reluctance to complain formally, requiring immediate handling of matters that arise in a culturally sensitive manner. The Aboriginal Liaison Officer is also involved in broad education outreach programmes relating to the HSC and HRA legislation.

Table 7: Resolution in Conciliation

Type of Resolution	2003/04	2002/03
Apology given	6%	7%
Change in procedure/policy	1%	1%
Compensation	17%	17%
Explanation/Information provided	66%	65%
Total resolved	90%	90%
Referred to Board	0%	1%
Non-conciliable	10%	9%
Total	100%	100%

Aboriginal Liaison Officer's Report

The Aboriginal Liaison Officer (ALO) has a diverse role that involves:

- Liaising and creating networks with Aboriginal and Torres Strait Islander communities;
- Increasing the awareness of the Office within those communities;
- Providing policy advice to the Commissioner on matters pertaining to indigenous Australians; and
- Attending to and conciliating complaints and enquiries involving Aboriginal and Torres Strait Islander parties.

Complaints

The ALO is able to deal with issues in a manner appropriate to indigenous communities, which enables a number of them being resolved informally. Not having the ALO position was previously a barrier to many indigenous people pursuing complaints through the Office. The resolution of indigenous complaints involve active participation on behalf of the ALO who:

- Assists complainants to formulate their complaints;
- Seeks responses from health providers to those complaints;
- Facilitates conciliation meetings between consumers and health providers;
- Seeks medical records, reports and opinions where appropriate; and
- Negotiates agreements between parties.

The number of written complaints from Aboriginals and Torres Strait Islanders rose from 36 last year to 54 this year, with the common themes continuing to relate to issues of treatment, access, communication and discrimination.

An Aboriginal woman was referred to a specialist for a back problem she was experiencing. She found the man's manner and speech abrupt and rude and that he handled her roughly. She got the distinct impression she was being treated less favourably on the basis of her Aboriginality. Rather than continue, the woman told the specialist she wanted to end the consultation and asked him to return her documents to her general practitioner. When she got up to leave the room, she says the specialist became angry, pushed the documents at her and tried to manhandle her out of the room. The woman complained with the intention of bringing her concerns about his behaviour to his attention and requested that the matter be referred to the relevant registration board.

Outreach and Privacy Issues

The ALO continued to visit communities across the State and liaise with key stakeholders. A large part of that work involved responding to requests for information about the HRA. Outreach highlighted the following health privacy issues for Aboriginal and Torres Strait Islander people in Victoria:

- How to access records;
- Who can access records of a deceased person when several family members are seeking access;
- The impact of fees on indigenous families in accessing health records;
- Privacy implications for health workers in Aboriginal organisations who have the unique situation of providing health services to close relatives and/or friends.

The result of issues highlighted by these communities have been included in a publication aimed at Aboriginal and Torres Strait Islander communities entitled "Health Privacy - It's Our Business." This document will be published and distributed early in the next financial year.

An Aboriginal man made an application to his general practitioner to have access to his medical records created after 1 July 2002. The doctor initially refused access and then advised the man he would have to bear the costs of the doctor creating a policy, establishing processes for accessing records in addition to paying for her time to set up these processes. The reason given was that this was the first request she had received for access to medical records and someone would have to cover her costs. The man contacted the Aboriginal Liaison Officer who contacted the doctor the same day to inform her we had received a verbal complaint. The doctor subsequently sought advice from the AMA and her medical defence and agreed that her understanding was wrong. The following day the man's request for access was granted, an apology given and fees were waived.

Prison Visits

To increase awareness of the Office amongst the Aboriginal and Torres Strait Islander prisoner population, the Aboriginal Liaison Officer commenced visiting prisons across the state and by the end of the financial year had visited all prisons at least once. A definite need to maintain these visits was identified and this will continue to be a core part of her work in the next financial year.

Table 8 shows ATSI complaints and enquiries made to the Office during the year.

Table 8: ATSI Complaints and Enquiries

Nature of Enquiry/Referral	
Request for brochures & reports	42
Speaking engagements	18
Food, environmental health enquiries	1
Health Insurance enquiries	4
Referral to Federal Privacy Commissioner	0
Referral to State Privacy Commissioner	7
Referral to Aboriginal Legal Service	9
Referral to other dispute settlement service	7
Referred elsewhere	20
Other enquiries	107
	215

Nature of Complaint	
HRA Issue	
Use & Disclosure	1
HSC Issue	
Access	16
Communication	6
Cost	1
Rights	8
Treatment	20
Not specified	2
	53
	54

Registrar's Report

The past year saw an increase in the number of meetings during which complaint information was shared between the Registration Boards and the OHSC. The number of complaints discussed was greater than in the last couple of years. The excellent relationship the HSC enjoys with the 12 health registration boards continued and the co-operation of the Registrars and other staff of all the Boards is greatly appreciated.

Regular meetings between the OHSC Registrar and the Registrar of the relevant officer of the Registration Board are for the purpose of discussing all complaints against registered health service providers. These discussions allow input by the Board and the OHSC about the management of the complaint. Those complaints received by Boards, which are suitable for conciliation by the OHSC, are referred to the Commissioner and complaints received by the Commissioner which relate to unprofessional conduct are referred by the Commissioner to the relevant Registration Board without delay. After the Board's processes the complainant is able to request the Commissioner to re-open a file for considering any compensable issues.

Apart from these one on one meetings, networking meetings are conducted half yearly between Boards' complaint handling staff and OHSC assessment and conciliation staff. These group interactions are valuable and result in policy development, education and training.

During the past year a total of 1078 complaints were discussed with the Registration Boards. Of this total, 655 complaints were received by the Boards and 423 by the OHSC. A total of 650 complaints were about medical practitioners, 165 about dentists and 78 were complaints about pharmacists, with the remaining 185 being health service providers belonging to the nine other disciplines. Of the 423 OHSC complaints discussed, 80 were formally referred to the Boards for consideration. This was a marginal increase on the number referred last year. Of these referrals, 57 were to the Medical Practitioners Board of Victoria.

The Registrar attends regular meetings between Registrars of all Boards to exchange ideas and network. During the past year the HSC commenced a program to provide training in communication and complaint handling to any practitioner who may wish to avail themselves of the opportunity.

The role of the Registrar includes the approval and assessment of new complaints and providing advice and support as a member of the Assessment Team as well as managing the FOI function. Ten FOI requests were received during the year. Eight of these were processed whilst 2 were deemed invalid.

Table 9: Dealings with Registration Boards

Organisation	HSC Complaints discussed with Boards	Board Complaints discussed with HSC	HSC Complaints Formally referred to Boards	Board Complaints formally referred to HSC
Chinese Medicine Registration Board	2	12	1	1
Chiropractors Registration Board of Victoria	3	11	1	0
Dental Practice Board of Victoria	44	121	4	2
Medical Practitioners Board of Victoria	302	348	57	12
Medical Radiation Technologists Board of Victoria	1	1	0	0
Nurses Board of Victoria	2	31	0	0
Optometrists Registration Board of Victoria	42	1	2	0
Osteopaths Registration Board of Victoria	1	1	0	0
Pharmacy Board of Victoria	14	64	8	4
Physiotherapists Registration Board of Victoria	4	11	3	0
Podiatrists Registration Board of Victoria	2	9	0	2
Psychologists Registration Board of Victoria	7	46	4	2
	424	656	80	23

Prisoner Complaints

Prisoner complaint numbers have continued to rise from 215 last year to 226 this year. Visits to metropolitan and regional prisons have continued to make the OHSC accessible to prisoners.

Eight metropolitan, assessment and country prisons were visited during the year. Wherever possible, attempts are made to resolve prisoner's verbal complaints on the day of the visit.

In May and June 2004, a work experience student Heike Holtz assisted in an evaluation of prisoner complaints. This was done at the request of the Commissioner who wanted to ascertain the numbers, types and outcomes of prisoner complaints. The outcome of the evaluation will be available soon.

Generally, issues of complaint remain the same. Medication issues remain a dominant cause of complaint with prisoners continuing to want access to antipsychotics, benzodiazepam and pain killing medication.

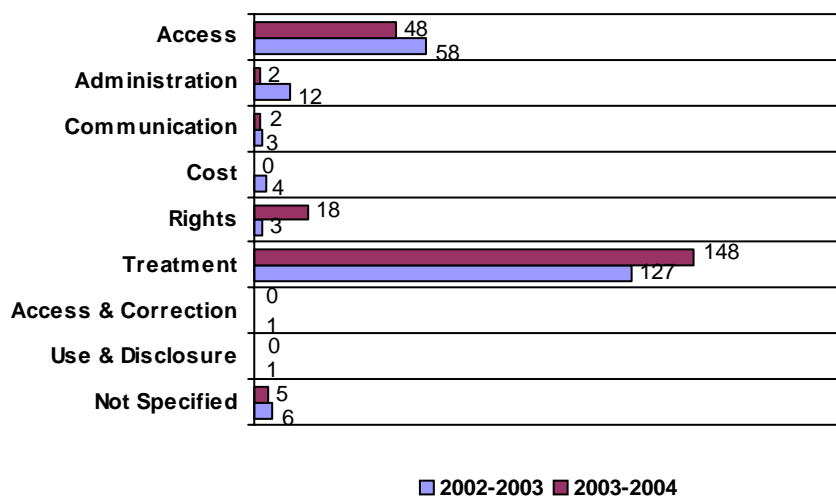
Prisoners suffering mental health problems form a large proportion of complaints to the Office in one way or another. There is always a high demand on psychiatric services. Anecdotal evidence to the Office would suggest a need for more psychiatric services to be provided to prisoners suffering mental health illnesses. Demand on acute beds at the Thomas Embling Hospital and the Acute Assessment Unit at the Melbourne Assessment Prison is always extremely high, thus leaving those prisoners with mental health illnesses to be

treated by the limited services within their individual prison. Victoria is fortunate in having a world-class purpose built facility, the Thomas Embling Hospital, which is a 100 bed acute psychiatric facility, and opened in 2000. However, demand for these services has continued to rise.

A prisoner complains he is being coerced to take psychiatric medication. He says if he doesn't take it he is intimidated and placed in an isolation cell.

The provider responded to the complaint detailing the difficulties in managing the prisoner his non-compliance with psychiatric medication and behavioural difficulties. As prisoners cannot be compelled to take medication against their will, opinions were sought from senior psychiatrists about his management in a correctional setting. He was then transferred to another prison where he attempted suicide. He was eventually transferred to a specialist hospital for prisoners with psychiatric illnesses.

Figure 3: Prisoner Complaints



REASONS FOR COMPLAINTS

Complaints received by the Commissioner are classified according to their underlying issues. The broad categories are as follows:

HSC Issue Categories

Access

refers to availability of services in terms of location, waiting times and other constraints that limit use of the service;

Treatment

refers to diagnosis, testing, medication and other therapies provided;

Communication

refers to manner of communication such as rudeness, disinterest, quality and quantity of information provided about treatment, risks, outcomes and prognosis;

Cost

refers to information about costs and fees, discrepancies between advertised and actual costs, charges and rebates;

Rights

refers to rights to privacy and dignity, consent to treatment, reasonable access to records; and

Administration

refers to support services for providers such as reception, waiting lists, cleaning services, etc.

HRA Issue Categories

Access and Correction

refers to the right of individuals to access and correct health information held about them, subject to certain criteria;

Anonymity

refers to the right of an individual to not identify themselves when it is lawful and practicable;

Collection

refers to how and when health information is collected;

Data Quality

refers to how accurate, complete, up to date and relevant the health information is, having regard to the purpose for which it is held;

Identifiers

refers to the unnecessary use of identifiers, for example the use of a public sector identifier by a private sector organisation can only occur with the individual's consent or if it is required by law;

Information Available to Another HSP

refers to one HSP making information available to another;

Openness

refers to organisations policies on the management of health information and steps an individual must take to access their health information;

Transborder Data Flows

refers to the transfer of an individual's health information outside Victoria;

Transfer/Closure of a HSP Practice

refers to the process to be followed when a practice or business of a health service provider is sold or closed; and

Use and Disclosure

refers to how an organisation has used or disclosed an individual's health information.

Most complaints identify only one of these as an issue but approximately one in three raises concerns about more than one issue.

Primary Issues in Complaints 2003/2004

Health Services Conciliation & Review Act 1987

In 139 (6%) complaints an issue was not specified and it is likely that these complaints were not confirmed in writing.

As in previous years, treatment issues (56% up from 49%) were the major component of complaints with inadequate treatment, negligent treatment and inadequate diagnosis being the most frequently cited.

Table 10: Treatment

Treatment	56%
Inadequate treatment	461
Negligent treatment	212
Inadequate diagnosis	185
Medication	141
Unskilful/incompetent treatment	109
Rough treatment	64
Wrong diagnosis	28
Wrong treatment	15
Other	13
Total Treatment	1228

A man with a past history of cancer consulted his GP because of increasing pain and tiredness. The doctor sent him for blood tests and an xray but these were all reported to be normal. The doctor told his patient that he was just getting old and should learn to accept it. After several months of continued pain, the man decided to see a new GP who became concerned on hearing about the history and sent him to a specialist. A scan showed advanced metastasised cancer.

A subsequent review of the earlier tests showed errors in the readings of these. The GP acknowledged he should have referred the man when the pain did not resolve. The case was referred to conciliation where it was resolved.

A woman took her child's prescription to a pharmacy where she was given an unfamiliar package. When she questioned this she was told it was the same medication from another company. The child became quite unwell and was taken to her doctor who asked to see her medication. It was not the prescribed medication nor was it a reasonable substitute. The medication was ceased and the child soon recovered with no permanent harm.

The complaint was referred to the Pharmacy Board because the issues appeared to be matters of professional conduct. The pharmacist was required to undertake further training.

Table 11: Communication

Communication	11%
Poor attitude/discourtesy	82
Inconsiderate/undignified service	56
Wrong/misleading information	43
Absence of caring	35
Failure to consult	29
Other	4
Total Communication	249

Table 11 shows issues where communication has been identified as the primary issue in a complaint, however experience shows communication is a feature of all complaints. It is disappointing to note poor attitude and discourtesy account for 82 complaints and 56 involved inconsiderate or undignified service.

A man complained that when he had attended the Emergency Department of a public hospital because of severe abdominal pains, the doctor reading his records had told him to leave because of his history of psychiatric care at the hospital. This had been said in a rude and uncaring manner. The man took himself by taxi to a second hospital where he was diagnosed and treated for a bowel obstruction.

The Hospital apologised to the man and advised him the doctor had been counselled over his error and his rudeness. The doctor acknowledged he had been judgemental and expressed regret to the complainant.

A family complained they had been advised their father had lung cancer and did not have long to live. The man and his wife had sold their home and taken an overseas trip so he could enjoy his last days. On his return to Australia he attended the outpatient clinic where the diagnosis had been given and was told he may not have cancer, he needed a biopsy to establish a final diagnosis. The biopsy was conducted and was found to be clear

In assessment it was found the man had refused an interpreter but had not clearly understood what he was being told. It was conceded that perhaps the information could have been communicated more clearly and accompanied by written advice. The family were satisfied that procedures would be improved in the future.

Table 12 below shows the types of complaints made in relation to rights.

Table 12: Rights issues

Rights	9%
Other	74
Unprofessional conduct	34
Privacy/confidentiality	21
No/insufficient consent	17
Discrimination	13
Assault	11
Access to records	10
Refusal to treat	6
Accuracy of records	4
Total Rights	190

A small number of complaints about access to or correction of records or privacy/confidentiality were managed under the *Health Services (Conciliation & Review) Act 1987* because the records in question predated the commencement of the HRA. A person is only entitled to a summary of private health records created prior to 1 July 2002 although the HSC encourages holders of health information to be as open as possible with all information. If there is no reason why the record shouldn't be released then holders of health information are encouraged to do so.

Where complaints are received about the unprofessional conduct of a registered service provider these are referred to the relevant registration board. The HSC investigates such allegations against unregistered providers.

A woman complained she had felt dismayed when a masseur had kissed her during treatment. She had wanted to protest but felt unable to do so through embarrassment and shock.

It was found the masseur had no formal qualifications and no professional affiliations. He explained he had kissed the patient only to reassure her, as she had seemed tense. The Commissioner advised him his behaviour was unacceptable and he should undertake formal training and join a professional association before resuming practice. He agreed to do this.

Table 13 below sets out access issues raised in complaints

Table 13: Access Issues

Access	9%
No/Inadequate service	75
Delay in treatment	44
Discharge arrangements	22
Communication breakdown	20
Delay in admission	17
Non attendance	6
Refused admission	5
Waiting list	5
Transport	3
Total Access	197

A research study conducted by Monash University showed that access issues were more frequent in rural areas where services are more limited than in the metropolitan area and larger rural cities. Waiting lists continue to impact on the numbers of people awaiting surgery in the public system. Complaints are made where appointments for surgery have been confirmed then are repeatedly cancelled due to unforeseen emergencies, shortage of ICU beds and so forth. Waiting times for access to public dental services is also a frequent concern expressed by callers to the HSC.

A family living in an isolated area drove their mother several kilometres to the nearest hospital after she had fallen and was in pain. The nurse on duty at the Hospital called the doctor on duty and after some discussion advised the family to take the woman home and come to see him in his rooms the next day. The family were unhappy with this advice and drove her to the next hospital, more than an hour away where she was x-rayed and admitted for observation. Although there were no fractures to be treated the family felt let down by the doctor who had chosen not to attend.

He apologised for the distress and the matter was resolved amicably

Table 14 below sets out the cost issues raised in complaints.

Table 14: Cost Issues

Cost	7%
Billing practices	59
Amount charged	45
Information on costs	35
Over-servicing	6
Fraud	5
Health insurance	1
Other	1
Unnecessary treatment	1
Total Cost	153

Many callers to the HSC express concern about the costs of attending medical consultations. They often ask if doctors are "allowed" to charge what they perceive to be unreasonably high fees. The Officer taking the call explains that medical fees are not regulated in Australia, however there is an expectation that service users will be given sufficient information, including likely costs in order to decide whether they wish to proceed with the treatment. The discussion of costs prior to treatment still seems to be a rare occurrence.

Twenty three percent (35) of cost issues complaints identified information on costs as the primary issue.

A man attended a dentist because his tooth had fractured although he was not experiencing any pain. The dentist tested the tooth, took an x-ray and advised the man that the tooth had died. He explained the options, which were extraction with or without a prosthetic replacement tooth or root canal therapy and, possibly, a crown. The man opted for the root canal therapy at a cost of \$800 but was very upset to learn afterwards that the cost for the crown was an additional \$1000. He said that if he had known this he would have had the tooth extracted.

The dentist said he was sorry the miscommunication had occurred and offered to prepare the crown for the man for the cost of materials only. This was gratefully accepted and the matter resolved.

Table 15 shows the administration issues in complaints.

Table 15: Administrative Issues

Administration	2%
Management Practices	13
Failure to provide certificate	8
No/inadequate response	8
Hygiene	7
Other	5
Policy	3
Quackery/legality	3
Advertising	2
Total Administration	49

From time to time people complain about the administrative staff and policies of a health service. They might say they found the receptionist rude and uncaring, or that their messages are not passed to the health professionals in a timely manner. It is pleasing to note the number of these complaints dropped from 60 last year to 49.

A woman telephoned her doctor because she had some questions about her newly prescribed medication and was concerned she may have overdosed herself. The receptionist said the doctor could not come to the phone and she would pass the message to her when she was free. After several hours when the doctor had still not called her back the woman called the clinic again but there was no answer. She was then able to contact the doctor on her mobile phone and was given advice and reassurance about her medication.

The doctor said she had not been given the message and had told her staff that it was appropriate to ask her to take calls from patients worried about their treatment.

HRA

The number of complaints received under the HRA increased from 164 in 2002/03 to 245 in this reporting year. The majority of these (44%) continue to be the refusal of access by individuals to private health records about them. The increase in complaints received under this legislation is as expected as the education campaign conducted by the OHSC takes effect, and individuals become aware of their rights.

A source of irritation to complainants and this office is when organisations refuse access to or disclosure of information and cite 'because of the privacy act' (BOTPA) as the reason for being unable to do so. BOTPA is a term coined by New Zealand's first Privacy Commissioner and is the incorrect citing of privacy laws as an excuse for withholding information. This is usually done through a misunderstanding of the legislation and undermines credibility when, invariably, the person discovers the facts.

In attempting to address the BOTPA issue the OHSC continues its communications strategy to educate health service providers and holders of health information about their responsibilities and the rights of individuals under the HRA.

The HSC received a call from a man in a remote location in outback Australia. He was concerned about his son after he was informed by a third party the boy had been admitted to an emergency department after being bashed. The man managed to contact a nurse at the hospital who advised him privacy laws prevented her from providing him with any information about his son including whether or not he was admitted.

The worried father contacted the HSC who in turn contacted the hospital's privacy officer pointing out privacy legislation does allow the disclosure of information for compassionate reasons.

A man who had been sent to a specialist for a workcover claim asked the specialist for a copy of the report. The specialist responded that she had written the report for the insurer and the man should ask them for a copy of the report. The insurer had also refused.

After the man made a complaint to the HSC it was agreed by negotiation that the insurer would provide the man with a copy of all his records including the report.

A woman complained that her employer had discussed her workcover claim and her injury with her colleagues at a staff meeting. The employer said she had done this but it was necessary to do so in order to ensure there was adequate coverage during her absence. The woman disagreed that this was necessary saying it was a matter for the human resources unit to address and it was not necessary for all her colleagues to know about her health problems.

The employer apologised to the woman and undertook to be more circumspect with personal information in the future.

Table 16: HRA Issues

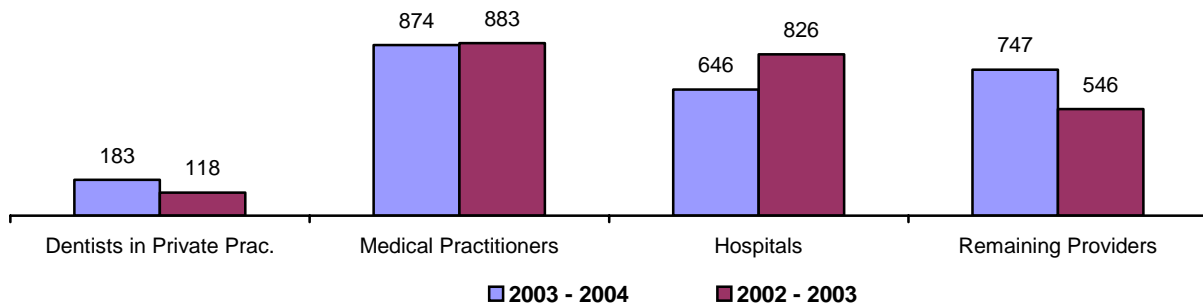
Access & Correction	44%	Info available to another HSP	3%
Access Refused	102	Unreasonable time in delivery	5
Amended statement not appended	1	Information refused	1
Correction refused	1	Excessive fee	1
No written reason for refusal	3		7
	107		
Anonymity	0%	Openness	0%
Refusal of anonymity	0	Insufficient details given	1
Collection	4%	Use & Disclosure	35%
Breach of in-confidence details	6	Disclosure – inadequate consent	62
Unlawful/Intrusive collection	2	Disclosure – inadequate disclosure	19
Inadequate collection statement	1	Use – Insufficient information	4
	9		85
Data Quality	9%	Transborder Data Flows	0%
Data inaccurate, incomplete or out of date	11	Unauthorised transborder transfer	1
Unsatisfactory protection	9		
Destruction of information of non HSP	1		
Transferred without notation	1		
	22		
Identifiers	1%	Transfer/Closure of HSP	3%
Misuse	2	Inadequate notification	5
		Unsafe storage of records	2
			7
		None (1%)	4
		Total	245

CATEGORIES OF COMPLAINTS AGAINST HEALTH SERVICE PROVIDERS

Doctors and Hospitals were the largest group of respondents to complaints about health services. This is the same as in previous years and is to be expected given the large numbers of health services provided by these within one year.

Please refer to Appendix 1 for a list of providers by type.

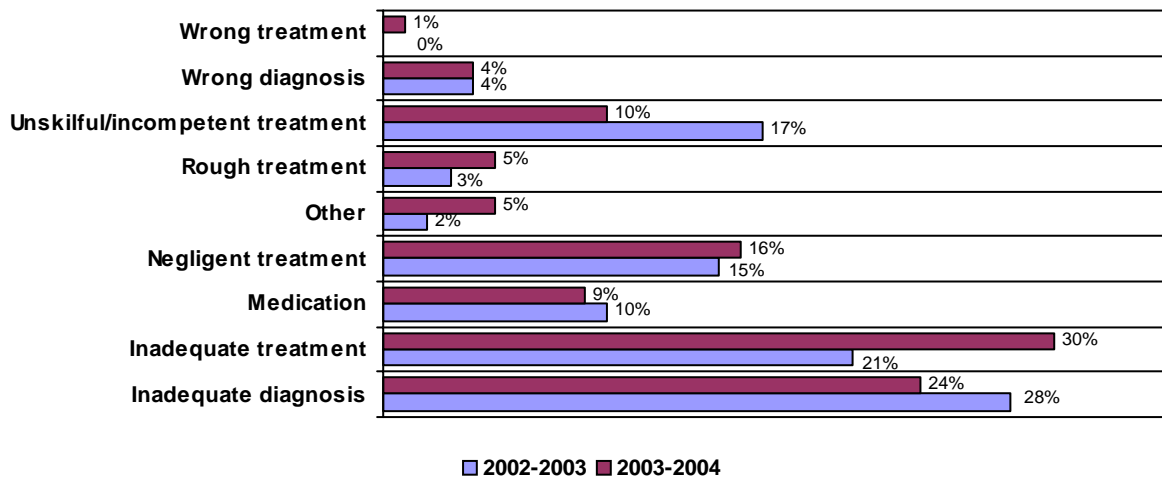
Figure 4. Categories of complaints against health service providers.



Medical Practitioners

The category Medical Practitioners includes all doctors whether in specialist service provision or general practice. Appendix 2 lists the number of complaints about individual medical specialities. The percentage of complaints about unskilful or incompetent treatment fell from 17% or 38 last year to 10% or 41 this year, however complaints about negligent treatment or inadequate treatment increased. This highlights that the issues recorded are those raised by the complainant and reflects their perceptions. The number of cases that were substantiated as negligence or incompetence is likely to be much lower.

Figure 5: Treatment Issues – Medical Practitioners



A woman had been attending her general practitioner for a few years as she had many risk factors for developing diabetes. She had routine blood tests to check this and was given advice about lifestyle. Over three consecutive visits she complained to her doctor about increased shortness of breath. She was advised again to lose weight but sent for an ECG. The report came back advising further tests while the doctor was on leave but was overlooked on his return. There was no follow up. The woman suffered a cardiac arrest and made a complaint to the HSC about the doctor.

She was very unwell and died soon after and her family asked for the complaint to be referred to the Medical Practitioners Board of Victoria.

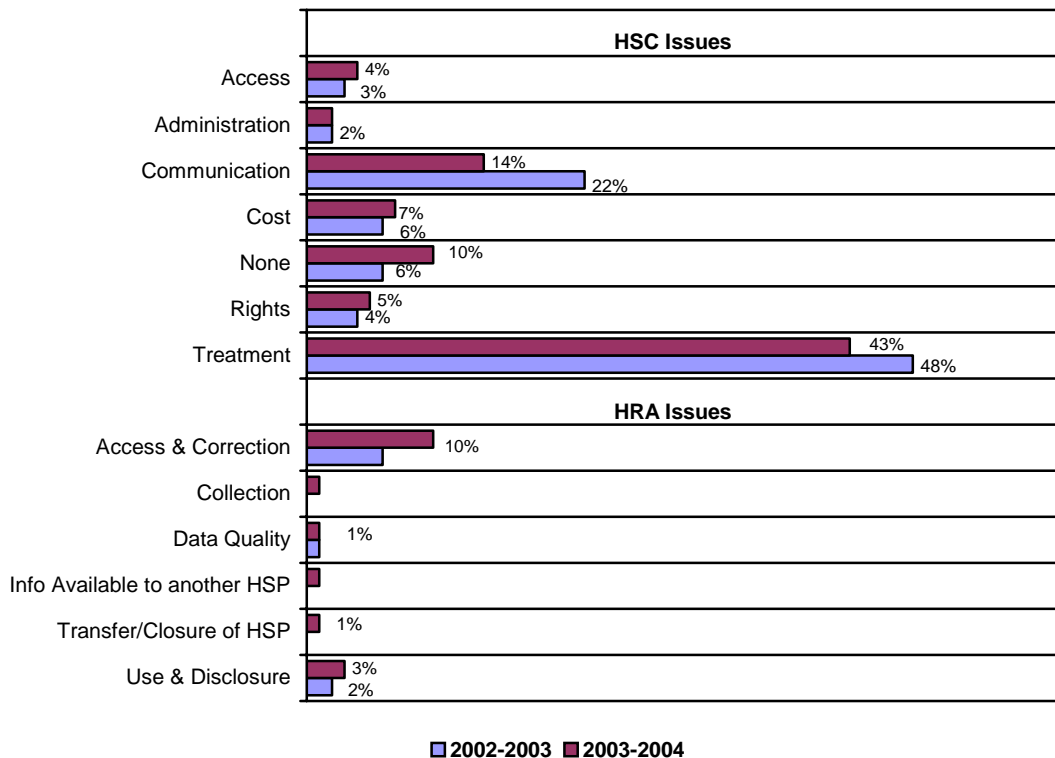
General Practitioners

Treatment issues continue to be the main focus of complaints about GPs with the next major issue being communication. Communication failure by both sides is a contributor in treatment errors and misunderstandings. The ability to listen to patients, to give them adequate time to explain their perspective and providing clear and adequate explanation for diagnoses and treatment should be an integral part of good clinical practice.

A doctor saw a small child with her parents who were very worried that she had a deep cough and was having trouble sleeping. The doctor said the problem was viral and to keep her well hydrated and to come back to see him in 24 hours or take her to hospital if she did not get better. The family were dissatisfied as they had heard a lot about meningitis and were fearful she may have been infected. They did not tell the doctor of these concerns so he did not have the opportunity to discuss the symptoms or reassure the parents. They took the child to the Emergency Department of the nearby public hospital and waited for her to be seen. After some time the child was diagnosed with croup and admitted for observation overnight and she soon recovered. The family believed the doctor had missed a serious illness and had failed to send her to hospital immediately.

Better communication about their fears and options to address these would have reduced the fears of the parents.

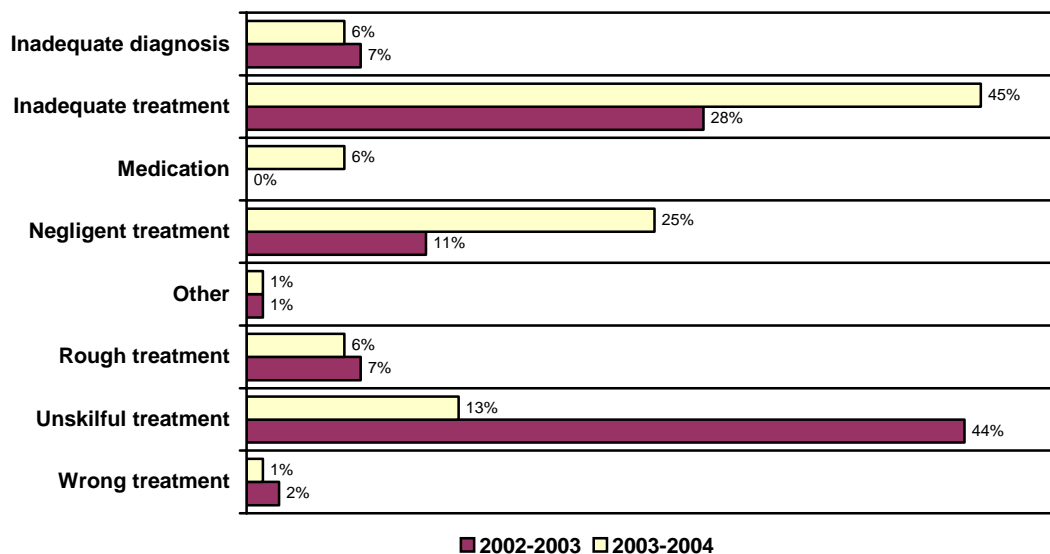
Figure 6: Issues in GP Complaints



Dentists

There were 183 complaints about dentists this year, 65 more than last year. Fifteen of these were complaints lodged under the HRA. Of the 168 remaining, 108 were treatment issues as shown below in Figure 7.

Figure 7: Treatment Issues Dentists



A family complained that orthodontic work for their 14 year old daughter was unsatisfactory as the device was uncomfortable to wear and did not seem to be addressing all her problems. On the advice of a neighbour they then took the girl to a specialist who stated he would not have used this method on the girl and would only treat her if all the original dentist's work was removed. The family believe the original dentist should refund all fees paid to him and pay for the costs of the new treatment.

The dentist agreed to refund part of the fees but felt it was unreasonable to ask him to pay for future orthodontic care, as he had not created the girls problems. The specialist told the family this offer was reasonable and the matter resolved.

Dental Prosthetist

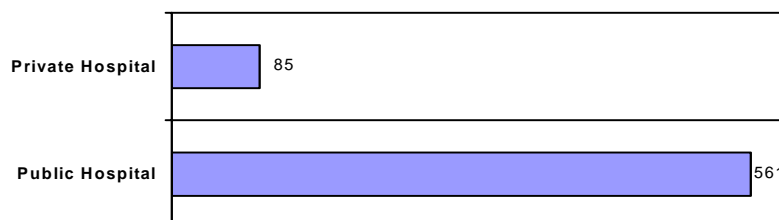
There were six complaints against dental prosthetists in 2003-2004, one less than last year.

Hospitals

Complaints made to the HSC about hospitals

There were a total of 646 complaints received about hospitals. This reflects a 9% decrease in terms of hospital representation in the overall number of complaints received by the OHSC. This may reflect improved complaint handling procedures by hospitals. The majority of these were against public hospitals, however this may be somewhat misleading as most complaints originating from care in a private hospital will be recorded against the admitting doctor.

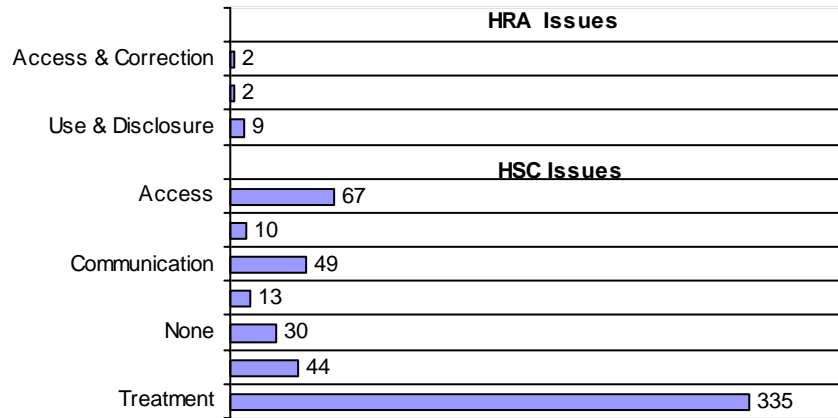
Figure 8: Public/Private Hospital Comparisons



Public Hospital Issues

The majority of complaints about public hospitals are in relation to treatment issues. Complaints about emergency departments are frequently about lack of treatment or inadequate diagnosis and care while inpatients complain about less than optimal outcomes of treatments or unexpected outcomes.

Figure 9: Public Hospital Complaints



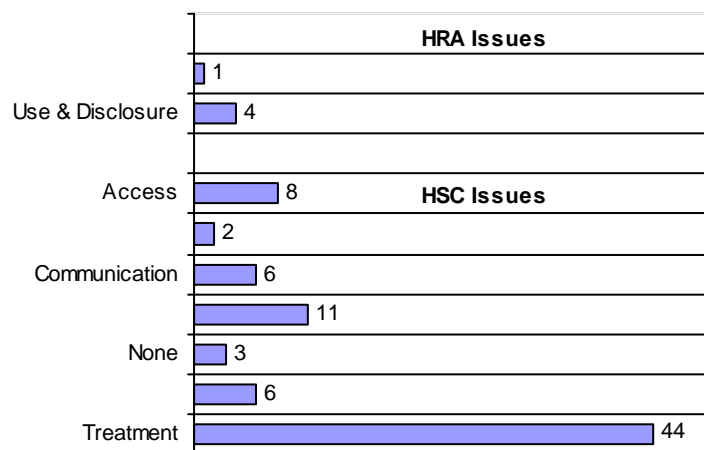
A family of a man who had died in a public hospital complained he had been neglected in the hospital but the doctors had refused to allow him to be transferred or to go home. The man had suffered a lot of pain prior to his death and the family could not understand why this had not been managed better.

The hospital explained when they met with the family that it had been very difficult to manage the man's pain as he had an adverse response to most analgesics and the side effects were worse than the pain. Many experts had been consulted but regrettably they had not been able to provide the palliative care to the extent it was needed.

Private Hospital Issues

The numbers of complaints against private hospitals are comparatively few as any complaints about treatment decisions and outcomes would usually be made against the admitting doctor rather than the hospital. The exception might be where a nurse has failed to carry out the doctor's instructions.

Figure 10: Private Hospital Issues



Treatment issues also dominate in complaints about private hospitals. There is still a lack of understanding in the community that many private hospitals do not have their own doctors, and medication and treatment can only be authorised by the patient's admitting doctor who is not available at all hours within the hospital. Patients will sometimes need to be transferred if the private hospital does not have the facilities to provide specialist treatment.

A woman who had been admitted to a private hospital for surgery experienced some post operative complications and needed to be transferred to a public hospital where she could receive intensive care after further surgery. She was angry that she had been "turfed out" of the more comfortable private hospital to a four bed ward at the public hospital and that her former surgeon had transferred her to another doctor and did not come to see her every day, although he had made a visit to her to try to explain what had occurred.

When the complaint was received the hospital and the surgeon were able to explain why she needed to be transferred and why the surgeon could not continue to treat her in the public hospital. The matter was resolved by this explanation.

Psychiatric Services

There were 27 more complaints received this year about psychiatric services compared to last year. The majority of complaints about psychiatric services involve psychiatric hospitals.

Figure 11: Psychiatric Services Complaints

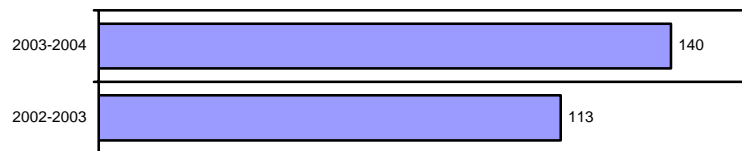
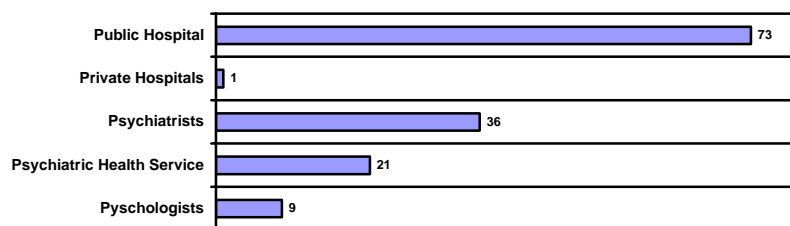


Figure 12 below shows the numbers of complaints made against each type of service.

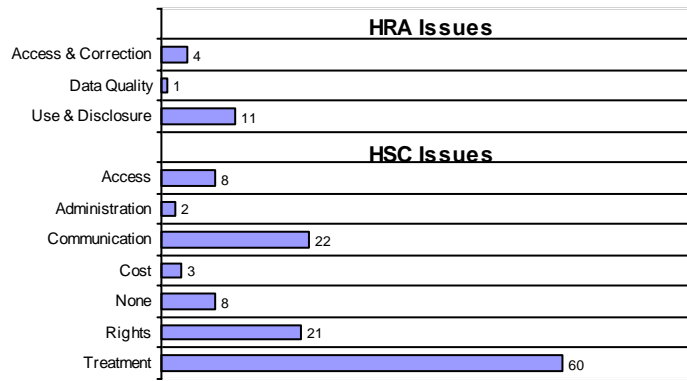
Figure 12: Types of Service



Issues in Psychiatric Service Complaints

The types of complaints against psychiatric services are similar to previous years. There are a number of complaints from people who believe they should not be classified as involuntary patients and are being detained illegally (these are referred to the Mental Health Review Board) and a similar number from people who believe hospitals are failing to admit and treat seriously unwell people who should not be in the community. The OHSC heard some serious concerns from people in relation to the subsequent suicide of patients turned away or discharged from inpatient psychiatric care. Complaints have also been received that patients with mental illness are being kept far too long in emergency departments because of the lack of psychiatric beds.

Figure 13: Issues in Psychiatric Complaints



Patients continue to complain about the use of seclusion and what they perceive as the unnecessary use of force in the treatment of people with mental illness. This year some of these complaints were addressed in conciliation.

HOSPITAL COMPLAINTS DATA

Complaints Made at Public Hospitals

Information contained in this section has been compiled from complaints lodged directly with the Complaint Liaison Officers (CLO) (or patient representative) of public hospitals and provided by them to the HSC. They utilise the Health Complaints Information Program (HCIP) to record and monitor complaints handled locally within the hospital. These complaints are separate to those lodged directly with the HSC.

The following trends comprise data provided by 52 public hospitals over the reporting period.

Who Complained and How?

Forty-seven percent of complainants were female and 42% male. As expected, public patients comprised the largest group (94%).

The majority of complaints were made via telephone call (46%) or letter (30%), 18% by personal visit and 6% by other means.

The age and gender profile of consumers is shown in Table 17 and Figure 14.

Consumer Profile

Table 17: HCIP – Age Analysis

Age	Total
Under 1	121
1 – 4	59
5 – 14	126
15 – 24	243
25 – 34	695
35 – 44	570
45 – 54	396
55 – 64	337
65 – 74	320
75+	486
Not Specified	1279
Total	4632

Figure 14: HCIP - Gender

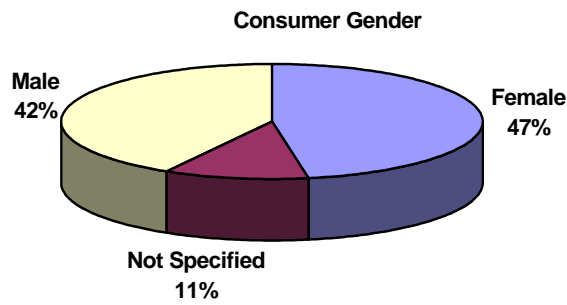


Table 18: HCIP – Patient Type

Public Patient	4370
Private Patient	221
Dept of Vet Affairs	28
Not Specified	6
TAC	3
Ineligible Patient	2
WorkCover	2
Total	4632

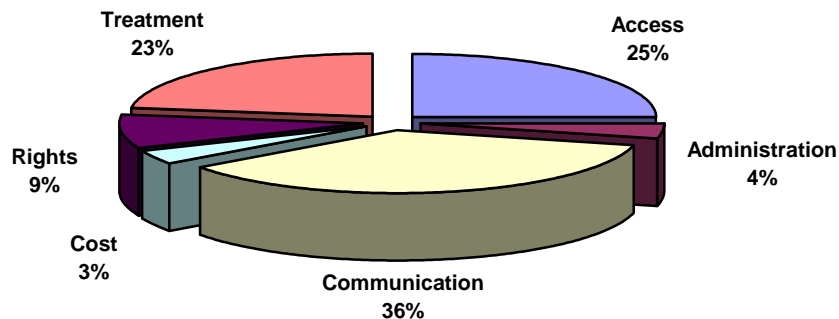
What Was the Complaint About?

During the period under review the reporting hospitals' CLO received, and dealt with, 4632 complaints. A complaint may be multi-faceted, for example be concerned with not only poor communication but also inadequate treatment, however the analysis in this report is based on the primary issue. The diagram below shows the primary issues in complaints.

Thirty six percent of complaints concerned communication issues. This is an 11 % increase on last years figures. Treatment issues decreased from 34% last year to 23% this year. Access issues of 25% remained the same. There was 1 % increase in rights issues from 8% last year to 9% this year and administration 4% this year and 3% last year. Cost issues had decreased from 5% last year to 3% this year.

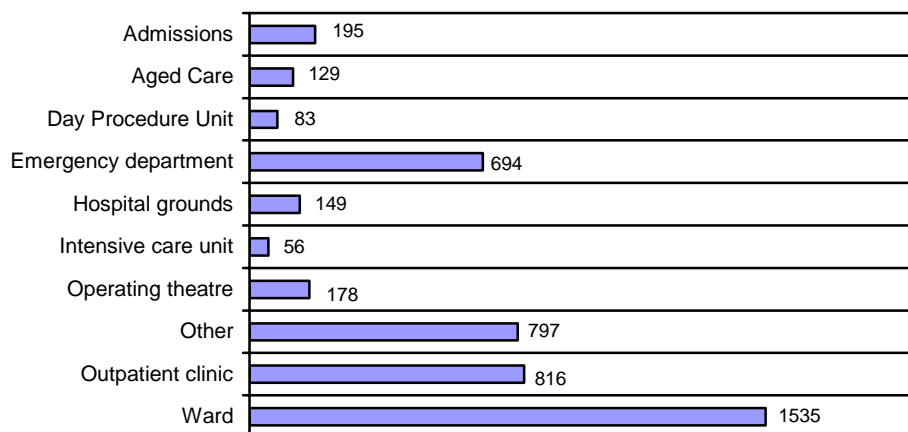
A more specific analysis of issues forms appendix 3.

Figure 15: HCIP – Issues



Site and Service at Time of Complaint

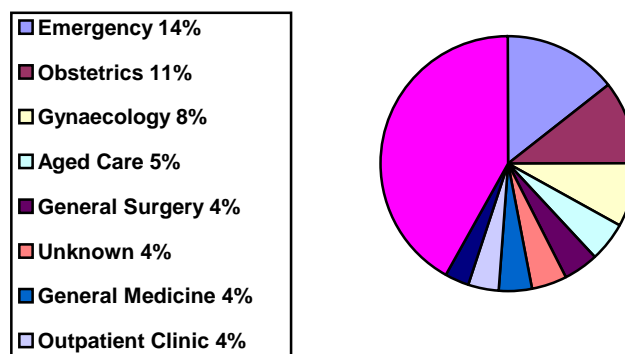
Figure 16: HCIP - Site



Services

Figure 17 shows that 14% of complaints were made about services provided in the emergency department, general medicine 4%, general and orthopaedic surgery 7% and outpatient clinic 4%. A more specific list of services forms Appendix 4.

Figure 17: HCIP – Services



How Serious Were the Complaints?

Seven percent of complaints were categorised as serious or substantial and 60% as routine. The remaining 33% were listed as either minor or trivial.

What Were the Outcomes of the Complaints?

Table 19: Outcomes of Complaints

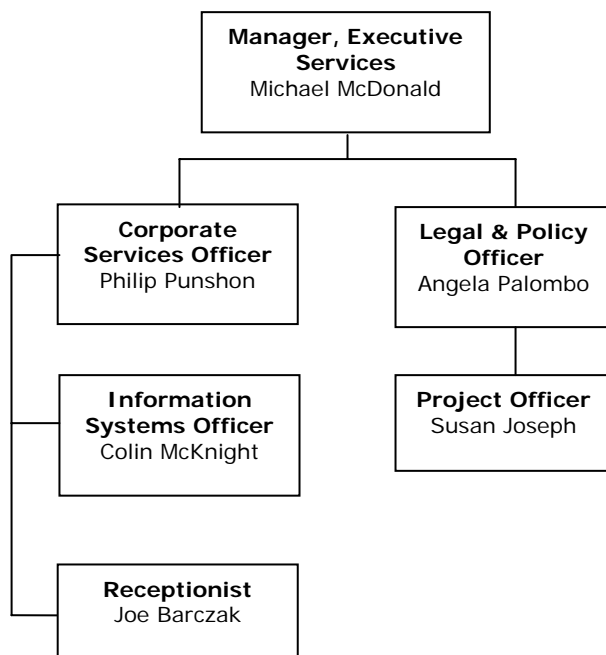
Stage of Complaint Process	Number of Complaints
Resolved	3534
Lapsed	678
Not Upheld	133
Remedial	127
Referred	81
Change in Policy	79
Total Number of Complaints	4632

If complaints are not resolved internally (the majority) they may be referred elsewhere for example to the HSC or appropriate registration board.

Please refer to Appendix 5 for a full categorisation of complaint outcomes.

EXECUTIVE SERVICES

The Executive Services Unit comprises two staffing streams and provides corporate support services for the Office including Finance, Human Resources, Information Technology, Purchasing, Vehicle Management, Building Services and Reception Services. It is also responsible for the operation of the HRA and the provision of legal advice to the Commissioner and staff.



Department of Human Services – Statement of Understanding

The Office has a Statement of Understanding (SOU) with the Department of Human Services (DHS).

The purpose of the SOU is to specify the services delivered, including key performance indicators (kpi), by the OHSC as required by the *Health Services (Conciliation & Review) Act 1987* and the HRA and it also sets out the funding requirements to deliver the services.

In developing funding requirements and kpi for the delivery of services, the parties agreed to the following general principles:

- The Department recognises and respects the independent status of the OHSC;
- All dealings between the parties are based upon a cooperative partnership;
- All services will be provided in a timely fashion, with skill, care and diligence, according to statutory requirements and to service delivery targets; and
- Communication between the parties will be transparent, direct and timely.

The Commissioner and Manager, Executive Services develop the SOU annually and meet with DHS to review the operations of the OHSC and negotiate priorities and budget requirements for the office.

HRA

The HRA became operational 2 years ago and feedback from stakeholders indicates a relatively smooth implementation, which in part can be attributed to the communications strategy deployed by the OHSC.

The Office continues to educate holders of health information and consumers on their respective responsibilities and rights under the legislation. These organisations include health service providers, government departments and agencies, local government and a number of other holders of health information ranging from employers to child care centres. This has been done by presenting to approximately 80 groups attended by over 2,600 individuals, distributing more than 55,000 brochures, answering over 3,500 telephone enquiries and providing written responses to issues raised.

The team has written two information booklets titled '*Information to private health service providers for handling request for access or correction under the HRA*' and '*Information to private non - health service providers for handling request for access or correction under the HRA*' aimed at holders of health information. Special thanks goes to the Medical Practitioners Board for distributing 20,000 copies to all medical practitioners in Victoria. These booklets, along with all our publications are available from the Office website www.health.vic.gov.au/hsc or by contacting the Office.

Human Research Ethics Committees (HREC)

Throughout the year a number of discussions have occurred with various ethics committees and researchers on the impact of the HRA on research activities. In particular the issue of screening for research participants was raised. The research guidelines issued by the HSC apply where it is impracticable to obtain consent or when the information is used to obtain consent.

The guidelines require approval for the research project by a HREC, which should have regard for the matters listed within the guidelines. The task for the HREC is to decide whether the public interest in the research substantially outweighs the public interest in the protection of privacy, in relation to the use of information or recruitment to a research project. If the HREC, having considered all the matters as required by the guidelines considers that such a test has been met, then the researchers have complied with the legal requirements of the Act.

The guidelines require HREC to report on the use of the HSC guidelines for the purposes of Health Privacy Principle 1.1(e)(iii) & 2.2(g)(iii) of the HRA. Thank you to the six HREC who complied for the previous reporting year.

Office of the Privacy Commissioner - Privacy Victoria

A key component in the HRA communications strategy success has been the continued close working relationship the OHSC enjoys with the Privacy Commissioner Paul Chadwick and his staff. Consultation and collaboration between the offices ensures consistent, clear information and advice is provided to stakeholders on the issues of privacy and health privacy. Special thanks go to David Taylor, Director, Privacy Awareness and his team for encouraging and developing the mutually beneficial relationship.

Royal Melbourne Show

The OHSC joined Privacy Victoria on their stand in the Government Expo Centre at the 2003 Royal Melbourne Show (18-28 September). Over 500,000 people attended the Show and approximately 65% of them visited the Government Expo Centre.

It provided an enjoyable opportunity to inform the public of their privacy rights and also the fact an organisation exists where they can complain about health services. Together we provided information to the public on information privacy in the public sector and privacy of health information in the public and private sectors. Brochures, information sheets and 6000 stress balls were distributed over the duration of the show.

Privacy Victoria and this office intend to continue our partnership in participating in the Royal Melbourne Show each year.

Train the Trainer

The HRA team continued to offer 'Train the Trainer' training so privacy and training officers of various organisations could attend and develop their knowledge of the legislation and train staff in their own organisations. Fifteen individuals, from various organisations, attended two sessions held in August and December 2003. The package is available on our website and the offer for training is open to all organisations covered by the HRA.

Culturally and Linguistically Diverse Communities (CALD)

The OHSC continues its campaign to increase awareness of the office and ensure Victoria's diverse community is fully informed about their rights under the HRA. Part of the strategy is, in conjunction with Privacy Victoria, the creation of a 'Multicultural Advisory Group' to offer assistance and advice in broadening and further developing relationships with CALD communities by both offices.

The Commissioner has had concerns about the provision of language services, particularly in hospitals, raised with her. The HSC is working with the Victorian Multicultural Commissioner, George Lekakis, to monitor the situation and suggest strategies to address the issue.

Infomed

The OHSC again utilised the services of Infomed which displays patient information in over 300 medical centres throughout Victoria. We rotated our generic brochure, advising patients of our role, with a brochure on the HRA explaining patient's rights and the obligations of health services providers in handling health information. On average over 500 brochures were distributed per month for an annual total of 6200.

Expos

The Office provided a passive display at the two day Aged Care Expo in February and the Disability Services Expo held in May at the Caulfield Racecourse. This included an ongoing PowerPoint presentation on the role of the office and, in particular, the HRA.

The various brochures and posters of the office were displayed and distributed to a large number of providers and consumers in the aged care and disability fields.

Legal

Complaints concerning refusals of access to health information often involve other jurisdictions, in particular WorkCover or family law. Whether a WorkCover claimant, for example, has a right of access to a medico-legal report commissioned by the employer's claims agent, requires a consideration of the *Accident Compensation Act 1985*. In the case of complaints about disclosures in the area of child protection notifications, this requires a consideration of the *Children and Young Person's Act 1989*. The Legal Officer's role is to determine how other legislation which relates to the handling of information interacts with the HRA.

Complaints about breaches of the HRA, which are not resolved in the assessment phase, are referred to conciliation. During the reporting year, there were 4 complaints either declined or not successfully conciliated where the complainant requested a referral to VCAT. To date, VCAT has made no decisions regarding breaches of the HRA. To ensure a consistent approach is taken in interpreting privacy legislation, the HRA team monitors the Federal Privacy Commissioner's case notes and maintains contact with other States and Territories.

Freedom of Information Changes

The introduction of the HRA resulted in changes to the *Freedom of Information Act 1982* (FOI Act) which were not well understood by all agencies. The changes to the FOI Act gave individuals the right to apply to the HSC for conciliation, where there has been a decision to refuse access to health information under certain sections of the FOI Act, instead of seeking internal review. To assist agencies in their interpretation of the changes, the team produced a circular regarding the amendments, which was distributed to all agencies subject to FOI in Victoria.

Newborn Screening Cards

The HSRC President's report provides details of involvement with the collection and storage of newborn screening cards commonly referred to as "Guthrie Cards". The HSC is part of the Newborn Screening Review Committee, which met for the first time in February 2004. Its terms of reference are to develop an options paper to advise the Minister for Health as to policies and procedures pertinent to the newborn screening program, including informed consent and collection, retention, storage, access and the legal status of the cards.

The consent procedure in hospitals when the blood sample is taken from the newborn is an issue of concern. It is recognised more work needs to be done to ensure parents understand the program and what is done with the samples. The HSC was pleased to be involved in the re-drafting of the parent information pamphlet on newborn screening. It is anticipated the options paper will be finalised towards the end of 2004.

Tort Law Reform

In May 2003 the Victorian government introduced changes to laws relating to recovery of damages for personal injury, which includes medical negligence. The changes effective from 1 October 2003 require plaintiffs to reach an impairment threshold for physical and psychiatric impairment before they are able to recover damages for pain and suffering. The changes have significantly reduced the number of writs issued by Victorian Courts seeking damages for personal injury. In the case of medical negligence claims where the individual is seeking only damages for pain and suffering and they are unable to reach the thresholds, their only avenue of complaint is the HSC or a complaint to the Medical Practitioners Board about the doctor's professional conduct. The OHSC is continuing to monitor the effects of the changes.

Human Resources

Staffing Overview

During the 2003/04 financial year Susan Herbert, the Commissioner's Executive Assistant was successful in obtaining a position at the Royal College of General Practitioner's.

Kate Kennedy who was working as the receptionist, after the promotion of Kate Adamson to the Department of Natural Resources and Environment, replaced Susan in this important role. Joe Barczak who has worked with the Office on various projects continues to demonstrate his versatility by taking on the receptionist role.

Fahna Ammett our inaugural Legal Officer transferred to DHS following a secondment with their Privacy Unit. Angela Palombo who was acting in the role, successfully retained the position on an ongoing basis. Loretta Hoban, Project Officer on the HRA team obtained a position with the Department of Education and Training. A big thank you to Susan, Kate, Fahna and Loretta for their work while employed at the OHSC and we wish them well in their new roles.

Staffing profile at 30 June 2004

Classification	Male	Female	Full Time	Part Time	Ongoing	Fixed Term	EFT*
Executive Officer		1	1			1	1
VPS 6	1		1		1		1
VPS 5	2	7	6	3	7	2	7.6
VPS 4	1	3	3	1	4		3.4
VPS 3	2	6	7	1	6	2	8
VPS 2	1		1			1	1
Total	7	17	19	5	18	6	22

* Effective Full Time

Merit and Equity Employment

The OHSC supports specific initiatives of the Office of Public Employment Managing Diversity and Employment Equity goals. The Office follows equal employment opportunity policies when recruiting.

Staff by gender at 30 June 2004 was 17 women and 7 men.

Performance Management

The Office utilises the DHS Progression, Performance and Development performance management system, which provides a framework to manage and develop staff to achieve corporate objectives. The scheme provides for regular and formal assessment of an employee's work performance and allows for access to training and skill development with a greater emphasis on career progression.

Training

The ongoing training and development of staff is a priority of the Commissioner and staff are encouraged to expand their knowledge and skill base wherever possible. During the year various staff attended a number of training opportunities including the 25th International Conference of Data Protection, the Body as Data conference, 7th National Mediation conference held in Darwin, Adverse Events conference, Electronic Health Records Symposium, Mediation for Managers course, Law and Medicine conference and Medical Terminology courses.

Lunchtime seminars are an informal way of staff receiving information on various subjects that impact on their work. During the year we were fortunate to have Dr Craig White, Chief Medical Officer, Austin Hospital present to staff on the subject of evidence based medicine. We also had Mr Justin McHenry, Registrar, Victorian Civil and Administrative Tribunal - Civil List present to staff on the operations of the tribunal. We thank them both for their time and informative session.

Occupational Health and Safety

The OHSC is co-located on the same floor with the Mental Health Review Board, Intellectual Disability Review Panel and the Infertility Treatment Authority. Given the similar work environments and relatively small number of staff, the agencies have one Occupational Health and Safety Officer for the floor.

A commitment exists to preventing occupational injuries and incidents are monitored and recorded. Initiatives taken this year include the offer of flu vaccinations to all staff, a review of security procedures and ergonomic workstation assessments.

Counselling services are available to all staff through the DHS Employee Assistance Program.

Information Technology

During the year a new complaints management database named 'Ciril', developed by Colin McKnight our Information Systems Officer, was installed. This database is significantly more robust and has additional functionality than its predecessor.

The Office also developed a web-enabled version of the Health Complaints Information Program (HCIP) to assist larger public hospitals, requiring multiple access to the program over a wide area network, with the recording of health complaints data.

A colour photocopier, printer, scanner was purchased to enable staff to produce colour print runs without the expense of going to external printers. To improve the common meeting facilities the OHSC arranged installation of new audio visual equipment.

Website

The website (www.health.vic.gov.au/hsc) is featured prominently in all of the Office promotional material. It is a source of information for the community on the role of the OHSC and includes publications produced by the office, appropriate links and the latest information. It again proved very popular in 2003/04 with an average of over 23000 unique visitors averaging over 23,000 hits per month. The average number of hits is an increase of over 5000 on last year.

The following table is for the period 1 July 2003 to 30 June 2004.

<u>Month</u>	<u>Hits</u>	<u>Sessions</u>	<u>Visitors</u>	<u>Pages</u>
Jul	22,187	2,945	2,190	4,141
Aug	24,810	3,302	2,544	4,436
Sep	24,336	3,251	2,527	4,227
Oct	24,396	3,423	2,522	4,278
Nov	18,576	2,571	1,948	3,302
Dec	17,050	2,407	1,789	3,454
Jan	18,975	2,726	2,026	3,544
Feb	21,166	2,955	2,254	3,771
Mar	29,899	3,960	2,933	5,079
Apr	27,402	3,457	2,587	4,399
May	29,514	3,723	2,715	4,783
Jun	28,480	3,802	2,584	4,750
Average	23,899	3,210	2,385	4,180
Totals	286,791	38,522	28,619	50,164

Customer Feedback

Evaluation Survey

At the conclusion of a complaint the OHSC sends with the closure letter an evaluation survey form to complainants and providers. The information returned provides the OHSC with indicators on how we are performing and often contains useful suggestions for further improvement, and where follow up action may be required. The form lists six questions:

1. OHSC staff were helpful in explaining the complaints process
2. I was able to speak to HSC staff when I needed to
3. OHSC Staff returned my calls within 24 hours
4. I felt OHSC staff listened to what I had to say
5. I was satisfied with the way the complaint was handled
6. I was satisfied with the outcome of the complaint

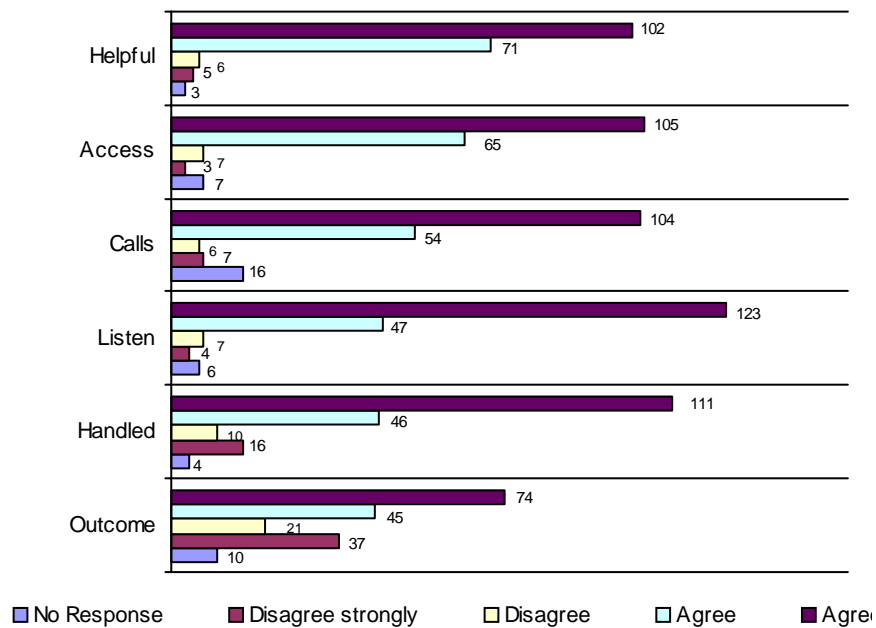
Respondents are asked whether they strongly agreed, agreed, disagreed or strongly disagreed with the question.

Complainants

Complainants who responded indicated an overall greater satisfaction with the service provided by the OHSC compared to the previous reporting period. Over 90% said that the staff were helpful, they were able to access staff who listened to them and returned calls promptly. Eighty three per cent were satisfied with the way the complaint was handled and 65% were satisfied with the outcome of the complaint. Obviously not all complainants receive the outcome they want with 31 % not satisfied, however compared to the previous year's figure of 45% this shows more complainants are satisfied with the outcome of their complaint.

Complainants Evaluations

Response Total = 187 from 661 (28%return)

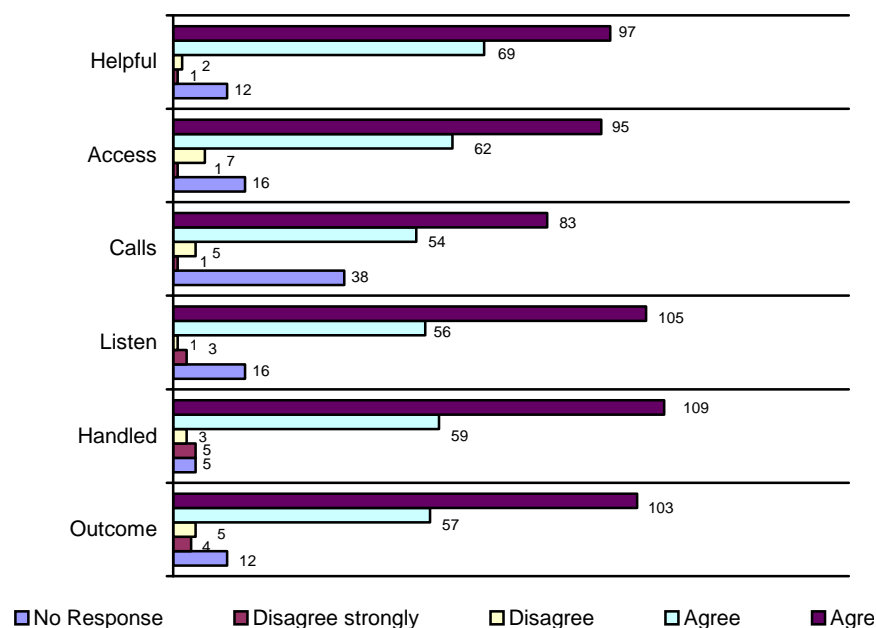


Providers

Conversely the percentage of satisfied providers who responded, although still positive, dropped slightly. Eighty eight per cent of providers who responded indicated they were satisfied with the outcome; a 3% drop on last year. Ninety two per cent were satisfied how the complaint was handled compared to 100%. Ninety one per cent of providers agreed the staff were helpful, they were able to access staff who listened to them and 75% agreed their calls were returned within 24 hours which is a significant drop of 10% and an area the Office will be looking to improve.

Provider's Evaluations

Response Total= 181 from 661 (27%return)



Finance

Budget

Following the successful implementation of the HRA in the previous year the Budget for the 2003/2004 financial year was recalculated. The OHSC was allocated \$1,737,000 (excluding indirect expenses) and expended \$1,717,000 being 98.9% of its total allocation resulting in a surplus of \$20,000.

Financial Statements

	Allocated	Actual
Operating Expenses	\$334,000	\$302,329
WorkCover	\$12,697	\$11,740
Salaries	\$1,379,488	\$1,374,764
Sub Total	\$1,726,185	\$1,688,833
Capital Expenditure	\$11,000	\$28,567
Total	\$1,737,185	\$1,717,400

Expenditure

Salaries		\$1,374,764
Administrative stationery & operating supplies	\$13,856	
Advertising, publicity & information	\$16,167	
Books/publications/subscriptions/memberships	\$8,857	
Catering	\$6,224	
Graphic design & editing	\$7,713	
Furniture, fittings & equipment	\$4,049	
HSRC payments & expenses	\$3,288	
Information technology costs	\$17,788	
Interpreter Services	\$8,277	
Legal expenses	\$19,318	
Maintenance	\$678	
Medical reports	\$36,321	
Miscellaneous	\$8,534	
Postal /courier	\$3,791	
Printing	\$70,732	
Staff development, seminars & training	\$24,399	
Telephones	\$33,295	
Travel-Airfares, Taxis, Personal Expenses	\$18,799	
Vehicle	\$243	\$302,329
Sub Total		\$1,677,093
WorkCover	\$11,740	
Capital Expenditure	\$28,567	\$40,307
Total		\$1,717,400

Compliance and Accountability

Whistleblowers Protection Act 2001

Section 104 of the above legislation requires public bodies to prepare an annual report of operations including a copy of current procedures for dealing with disclosures under the Act. (see Appendix 6)

For the year under review the OHSC reports:

a. Number of Disclosures

No disclosures of any type were made to the Office.

b. Public Interest Disclosures Referred to the Ombudsman

No disclosures of any type were referred by the Office to the Ombudsman for determination as to whether they were public interest disclosures.

c. Disclosures Referred to the Office

No disclosures of any type were referred to the Office by the Ombudsman.

d. Disclosures of Any Nature Referred to the Ombudsman

No disclosures of any type were referred by the Office to the Ombudsman to investigate.

e. Investigations Taken Over by Ombudsman

No investigations of disclosed matters of any type were taken over from the Office by the Ombudsman.

f. Requests Under Section 74

No requests were made under section 74 to the Ombudsman to investigate disclosed matters.

g. Disclosed Matters Declined to be Investigated

There were no disclosed matters of any type that the Office declined to investigate.

h. Disclosed Matters Substantiated on Investigation

No disclosed matters of any type were investigated, or substantiated on investigation.

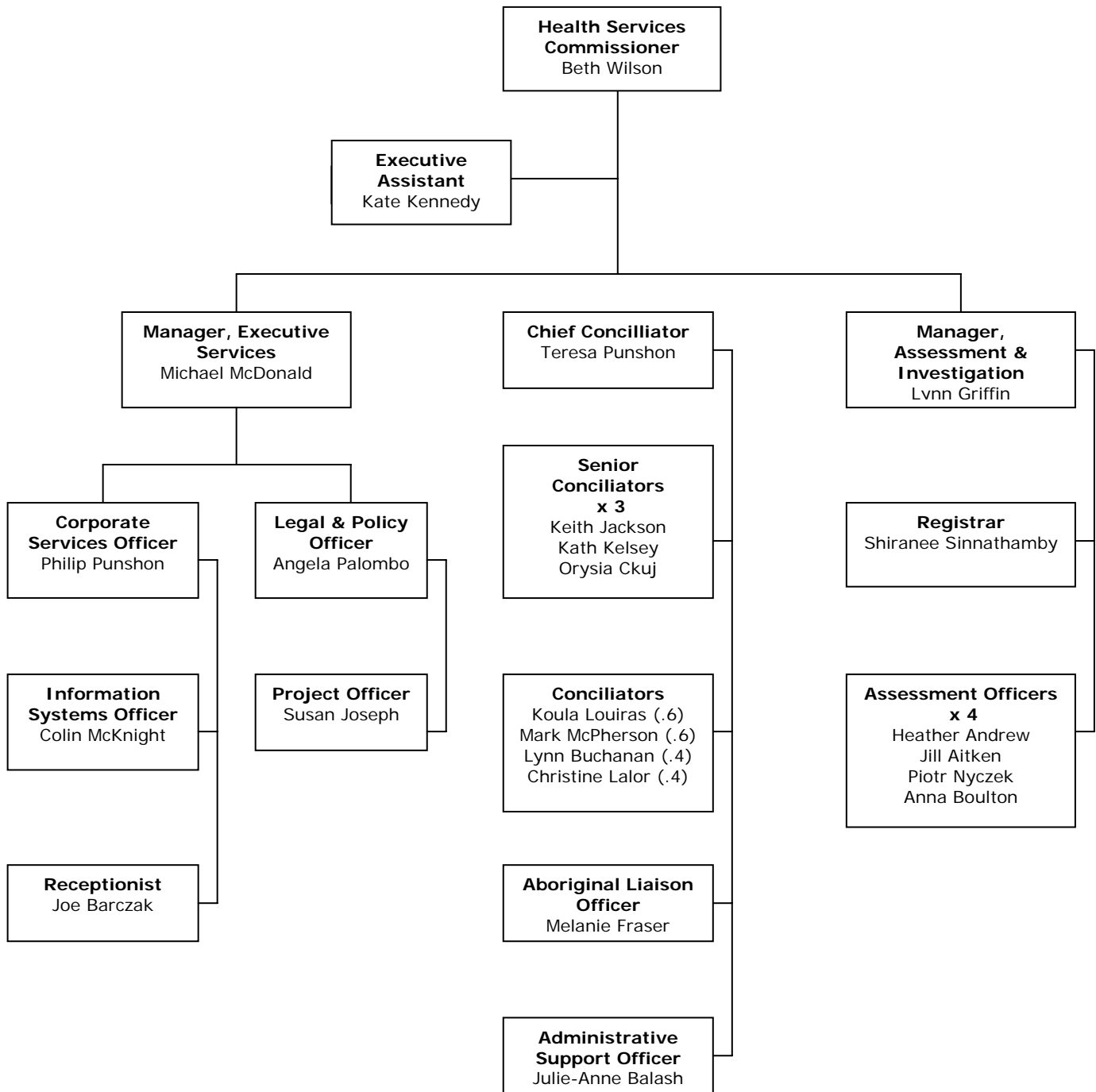
i. Recommendations by Ombudsman

No recommendations were made by the Ombudsman under the *Whistleblowers Protection Act* relating to the Office.

Information Privacy Act 2000

The OHSC is an organisation covered under section 9 of the above legislation. We comply with the *Information Privacy Act* in its collection and handling of personal information.

Organisational Structure



APPENDICES

Appendix 1: Providers by Type

Dentists in Private Practice	183
Hospitals	646
Medical Practitioners	874
Remaining Providers	
Aboriginal Health Worker	5
Alcohol & Drug Service	2
Alternative Therapist	11
Alternative Therapist Clinic	1
Ambulance Service	14
Appliances and Equipment	1
Audiologist	1
Beauticians / Laser Therapists	2
Beauty Therapist	2
Beauty Therapy Clinic	2
Chiropractor	6
Commonwealth Department H&CS	1
Community Health Centre	44
Corrections Health	226
Counselling Services	4
Counsellor	3
Dental Prosthetist	6
Diagnostic Service	33
Department of Human Services	3
Family Planning	3
Health Insurance	1
Health Retreat	3
Hostel	4
Locum Service	1
Mental Health	1
Not a Health Service Provider (Individual)	1
Not a Health Service Provider (Organisation)	36
Nurse	3
Nursing Home	6
Nursing Service	5
Occupational Therapist	2
Optical Dispenser	82
Optometrist	22
Osteopath	1
Pharmaceutical supplier	8
Pharmacist	17
Physiotherapist	5
Physiotherapy Service	1
Podiatrist	2
Podiatry Service	3
Psychiatric Health Service	21
Psychological Service	2
Psychologist	7
Radiographer	5
Radiology Service	1
Rehabilitation Service	2
Social Services	1
Social Worker	3
Supported Residential Service	5
Not specified	126
	747
Total	2450

Appendix 2: Medical Practitioner Specialities

Specialty	Total
Anaesthetist	13
Cardiologist	4
Cardio-Thoracic Surgeon	2
Dermatologist	8
Ear, Nose and Throat	7
Gastroenterologist	6
General Practitioner	499
General Surgeon	33
Locum	4
Medico-legal Examiner	7
Mens Health	30
Neurological Surgeon	2
Neurologist	4
Obstetrician / Gynaecologist	25
Ophthalmologist	18
Orthopedic Surgeon	29
Paediatrician	3
Physician	20
Plastic Surgeon	18
Psychiatrist	36
Radiologist	2
Rehabilitation Medicine	2
Rheumatologist	1
Urologist	10
Vascular Surgeon	3
Not Specified	88
	874

Appendix 3: HCIP Issues

Access		Rights	
Absence of caring	131	Accuracy of records	34
Delay in admission	47	Access to records	41
Delay in treatment	194	Assault	7
Discharge arrangements	138	Discrimination	26
Discharge/transfer	46	Failure to provide an interpreter	5
No/inadequate service	222	No/insufficient consent	10
Non attendance	9	Other	84
Other	197	Property	76
Refused admission	6	Privacy/confidentiality	90
Refused to refer	0	Refusal to treat	3
Service busy	15	Unprofessional conduct	23
Transport	4		399
Transfer unsuitable	8		
Waiting list	13		
	1152		
Treatment		Cost	
Absence of caring	90	Amount charged	33
Inadequate diagnosis	116	Billing practice	50
Inadequate treatment	171	Information on cost	8
Inadequate nursing care	138	Other	37
Medication omission/error	66	Private health insurance	7
Negligent treatment	99	Public/private election	20
Other	99	Unnecessary treatment	6
Rough treatment	85		161
Unskilful/incompetent treatment	21		
Unexpected outcome	134		
Wrong diagnosis	22		
Wrong treatment	15		
	1056		
Communication		Administration	
Absence of caring	163	Failure to provide a certificate	6
Conflicting information	110	Incorrect documentation	22
Communication breakdown	293	No/Inadequate response	22
Failure to consult 71	71	Other	85
Inadequate information	251	Policy	23
Other	202	Public health standards	19
Poor attitude/discourtesy	480	Treatment cancelled	6
Undignified service 49	49		183
Wrong/misleading Information	62		
	1681		
		Total	4632

Appendix 4: HCIP Service Provided at time of Complaint

Accommodation	23	Neurology	36
Administrative	94	Neurosurgery	22
Admissions	46	Nursing Home	80
Aged Care	243	Nutrition	2
Alcohol & drug	0	Obstetrics	492
Anaesthetics	18	Obstetrics/Gynaecology	80
Audiology	1	Occupational Therapy	12
Awaiting admission	8	Oncology	74
Car Parking	41	Operating Theatre	13
Cardiac Surgery	25	Ophthalmology	57
Cardiology	54	Orthopaedic surgery	142
Chaplaincy	0	Outpatients clinic	175
Colorectal	13	Paediatrics	75
Day procedure	48	Pain services	13
Dentistry	32	Palliative care	9
Dermatology	3	Pathology	19
Ear, Nose & Throat	57	Patient Services	53
Emergency	664	Pharmacy	15
Emergency Triage	32	Physiotherapy	45
Endocrinology	7	Plastic surgery	36
Environmental	17	Podiatry	23
Finance &	23	Prosthetics/Orthotics	5
Food Services	51	Psychiatry	78
Gastroenterology	41	Radiology	92
General medicine	192	Reception/Administration	26
General practice	7	Rehabilitation medicine	67
General surgery	205	Renal/Nephrology	32
Gerontology	5	Respiratory Medicine	33
GP support Res.	15	Rheumatology	5
Gynaecology	369	Social work	17
Haematology	13	Speech therapy	7
Home Care	21	Specialist Medical	14
Hostel	4	Specialist Surgical	8
Infectious diseases	23	Spinal Injuries Unit	9
Intensive Care Unit	25	Telecommunications	8
Interpreter	7	Unknown	204
Medical	24	Urology	78
Medical technician	0	Vascular surgery	25
		Total	4632

Appendix 5: HCIP Outcomes

Resolved	
Agreement reached	276
Apology	1018
Compensation Paid	33
Explanation offered	1018
Fee waived or reduced	20
Fee refunded	33
Frivolous/vexatious	44
Information Provided	318
Misunderstanding	112
No further action	48
Service/facility provided	245
Users view acknowledged	318
Waiting Time Reduced	51
Insufficient detail	496
	3534
Change of Policy	
Policy change	13
Procedural change	66
	79
Remedial	
Censure or Reprimand	20
Remedial action	42
Caution or warning	65
	127
Referred	
Outcome in Referral	81
	81
Not Upheld	
Complaint not upheld	66
No action possible	67
	133
Lapsed	
Insufficient detail	496
Allowed to lapse by user	44
Not confirmed	25
Unsubstantiated	67
Withdrawn by user	46
	678
Total	4632

Appendix 6: Reporting procedure guidelines under the *Whistleblowers Protection Act 2001*

September 2003

Contact: Michael McDonald
Manager, Executive Services
Phone: 8601 5222

Executive Approval: 9 September, 2003

Ombudsman Approval: 14 October, 2003

Guideline No. 0302

Prepared by: Michael McDonald

These guidelines are for all employees of the Office of the Health Services Commissioner (OHSC) and are available to all members of the public free of charge. They can also be viewed at the OHSC website www.health.vic.gov.au/hsc

Whistleblowers Protection Act 2001

These guidelines are made in accordance with the *Whistleblowers Protection Act 2001* (the Act), which came into effect on 1st January 2002. Consistent with the Act, the policy of the Health Services Commissioner is to encourage and facilitate the making of disclosures, where these are supported by reasonable grounds, related to alleged improper or corrupt conduct.

A staff person or member of the public, who has reasonable grounds to believe improper or corrupt conduct has occurred, is occurring or is about to occur is encouraged to disclose this in accordance with these procedures.

Introduction

- (a) The aim of these procedures is to establish an objective system to encourage and provide support to persons making disclosures ("whistleblowers"), to investigate disclosed allegations of improper conduct, or detrimental action against the person making the disclosure and to enable appropriate action to be taken.
- (b) A disclosure may be made about improper conduct by a public body or public official.

Improper conduct means conduct that is corrupt, a substantial mismanagement of agency resources or conduct involving substantial risk to public health, or to safety or to the environment. The improper conduct must be sufficiently serious to establish (if proved) a criminal offence or reasonable grounds for dismissal from employment.

Corrupt conduct includes conduct by any person (not necessarily an employee) that adversely affects the honest performance of the functions of a public body or a public officer; an employee performing their functions dishonestly or with inappropriate partiality; conduct by an employee or a former employee that amounts to a breach of public trust, or a misuse of information or material acquired in the course of performing their official functions; a conspiracy or attempted conspiracy to engage in corrupt conduct.

- (c) Detrimental action is action taken or threatened against a person disclosing alleged improper conduct and includes action causing injury, loss or damage, intimidation or harassment, discrimination, disadvantage, or adverse treatment to a person's employment, career, profession, trade or business and includes the taking of disciplinary action because of the fact of a disclosure of alleged improper conduct.

Procedures for Handling Disclosures

The OHSC has established the following procedures to facilitate the making of disclosures, investigation of disclosures, and for the protection of persons making disclosures from reprisals by the Health Services Commissioner, or any other employee of the OHSC. A disclosure may be made to the Manager, Executive Services of the OHSC or to the Victorian Ombudsman.

The following procedures apply where a disclosure is made to the OHSC:

1. A disclosure of alleged improper conduct shall be made direct to the Manager, Executive Services (or specifically nominated delegate). Alternatively, the disclosure may be made to the Ombudsman.
2. On receipt of a disclosure, the Manager, Executive Services (or specifically nominated delegate) shall assume the role of the Protected Disclosure Coordinator (PDC) and shall promptly:
 - (a) Meet with the person making the disclosure (unless it is provided anonymously) to ascertain the details of the disclosed matter and invite the complainant to provide a detailed written statement on an "in confidence" basis.
 - (b) Impartially assess the disclosure to determine whether it amounts to a protected disclosure:
 - i. If not, the PDC will explain to the complainant what other remedial action can be taken in the circumstances;
 - ii. If so, the PDC will explain to the whistleblower the protections that s/he receives under Part 3 of the Act and will offer the whistleblower welfare management. Thereafter, the PDC will move to step (c).
 - (c) Determine whether the protected disclosure amounts to a Public Interest Disclosure (PID) within Part 4 of the Act:
 - i. If not, the PDC will explain what remedial action can be taken in the circumstances and that the whistleblower has the right to request that the protected disclosure be referred to the Ombudsman for a review of the PDC's determination. Where the whistleblower is satisfied with the proposed remedial action the PDC will give effect to such action subject to the protection, that the whistleblower enjoys under the Act;
 - ii. If so, the PDC will refer the PID to the Ombudsman for a formal determination as to whether the protected disclosure amounts to a PID.
 - (d) If the Ombudsman determines that the disclosure is a protected disclosure, the Ombudsman may refer it back to the Manager, Executive Services to be investigated.
 - (e) If it is referred back to the Manager, Executive Services, the PDC shall promptly assign an investigator (who may be a senior employee or external solicitor/consultant) to investigate the disclosure and report direct to the PDC who will refer the report to the Ombudsman.
3. If the disclosure relates to the Manager, Executive Services, the disclosure should be made directly to the Ombudsman.
4. Disclosure and investigation material will be treated with the utmost confidentiality and security. Such material is only to be accessed by the Manager, Executive Services as the PDC or by the investigator. Disclosures made under this policy will be investigated swiftly, professionally and discretely.
5. The OHSC is required to include in its annual reports material including the number (if any) and types of disclosures made to it.
6. Where an investigation of a PID reveals that the improper conduct occurred, the PDC will:
 - i. Report the findings of the investigation to the Minister;
 - ii. Take all reasonable steps to prevent the conduct occurring in the future;
 - iii. Bring disciplinary proceedings against the person responsible for the conduct;
 - iv. Refer the matter to the appropriate regulatory body for further consideration.

7. It is a criminal offence:

- (a) For a person to take detrimental action against a person in reprisal for a protected disclosure (\$6,000 fine or two years imprisonment or both)
- (b) For a person to reveal confidential information received in the course of or as a result of a protected disclosure except as provided for under the Act (\$6,000 fine or 6 months imprisonment or both)
- (c) For a person to willfully obstruct, hinder or fail to comply with a lawful requirement of the Ombudsman (\$24,000 fine or two years imprisonment or both)
- (d) For a person to knowingly mislead or attempt to mislead the Ombudsman (\$24,000 fine or two years imprisonment or both)
- (e) For a person to knowingly provide false information to the OHSC's Manager, Executive Services intending it to be acted on as a disclosed matter (\$24,000 fine or two years imprisonment or both).

The OHSC is committed to the highest standards of ethics and probity in the performance of its duties and the delivery of its services to the community.

The Ombudsman has published a set of detailed guidelines and the agency will follow these in dealing with a disclosure. A copy of these guidelines is available from the OHSC or can be downloaded from the Ombudsman's website www.ombudsman.vic.gov.au

Health Services Commissioner

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