HEALTH COMPLAINTS COMMISSIONER

2018 Annual Report

Supporting safe and ethical healthcare

Commissioner's foreword

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Welcome to this annual report for the Health Complaints Commissioner covering our first full financial year of operation. The office began operation on 1 February 2017 with the introduction of the *Health Complaints Act 2016* (HCA) and so we have continued a period of significant change and massive growth during the 2017-2018 financial year. I hope you take the time to read this and consider both the scale of the work we do and the positive impact that well-handled complaints can have on all parties.

I am passionate about the crucial role we play in supporting quality and safety in health care and am proud of the positive impact we have on the experiences and outcomes for consumers and providers of health services across Victoria.

A year of continued growth

The 6,835 complaints received over the past 12 months represents a 13% increase on last financial year. This has been a more steady increase in complaint numbers than in the first 12 months of operation from 1 February 2017 to 31 January 2018. During that period we saw a massive increase of 65% compared with the same period under the previous office of the Health Services Commissioner.

When considering such numbers we should remember the complexity of many complaints. While some are more straightforward issues, many involve miscommunication leading to confusion or anger, or loss leading to grief. Each complaint is about real people and their lives.

While we continue to raise awareness about our office, we expect there will continue to be increasing numbers of complaints. This does not reflect a diminution in the quality of health services in Victoria; it is reflective of a responsive and person-centred approach to providing patients, their carers and their families with a voice in the health services they receive. It is an opportunity to improve services through feedback.

The continuing professionalism and patience of my staff in managing this increasing workload is commendable. My staff deserve congratulations for bearing the weight of this increasing load without compromising the service they provide to Victorians.

A year of action

Alongside the core business of complaints resolution, the office has increasingly taken action through investigations and prosecutions.

Our investigations team has grown considerably over the past financial year in a consolidated effort to build our capacity to take action against dangerous or unethical practitioners. We have now begun 16 investigations, including Commissioner-initiated and a minister-referred investigation, with most of these having begun since January 2018, and successfully prosecuted a banned interstate provider who was preying on vulnerable Victorians.

What these figures don't show is the amount of work that goes into building a case for a successful investigation or prosecution, including gathering evidence, interviewing witnesses, in some cases executing search warrants and preparing investigation reports and briefs of evidence.

In addition to our investigations under Part 4 of the Act, we also began an inquiry into the practice of conversion therapy or 'ex-gay ideology', and the terms of reference for this inquiry have been established. Once completed we will report to the Minister for Health on the findings and any recommendations from the inquiry.

The powers introduced in February 2017 under the HCA give us the ability to not only take action to investigate and prosecute but to warn the Victorian public. We have done this through issuing interim prohibition orders and publishing warning statements on our website and in widely circulating newspapers, as well as through the media and news releases.

It is also worth noting the beginning of a major sector-wide investigation into private drug and alcohol rehabilitation services. This was launched after we received an alarming number of serious complaints about this sector in our first year of operation. Funding of $550,000 from the Victorian Government has allowed us to focus specifically on this area.

The past year has marked a significant phase of maturation for the office as we have fully embraced the powers and responsibilities granted to us in the HCA for the purpose they were designed: to protect Victorians from dangerous or unethical health service providers. Investigations will continue to be an important part of our work, not only because they allow us to take action to protect against unsafe and unethical practices, but also because they provide a mechanism for us to publicly alert Victorians to those practices. That, in turn, gives the public more confidence to raise their concerns with us.

A year of engagement

During the reporting period we have also seen a huge increase in engagement activities, with an extended calendar of fully booked training events targeted at all parts of the sector and continued media activity to spread the word about the service we provide.

We have worked in partnership with the Health Complaints Commissioner Advisory Council to consult widely on the development of a service charter for our office and complaints handling standards that will apply to all health service providers across the state. The scale of this consultation alone has been significant, and more information on this and our broader engagement work appears later in this report.

I would like to thank my staff once more for their hard work and commitment under the strain of ever-increasing workloads and for maintaining a strong commitment to our important work during such a significant stage for the office.

Karen Cusack

Health Complaints Commissioner

2017–18 at a glance

- First full financial year of operation of the new office of the Health Complaints Commissioner under the *Health Complaints Act 2016*.
- 6,835 complaints received, which represents a 13% increase compared with the previous 12 months.
- 18,893 telephone calls received by our complaints and enquiries line.
- Customer service and resolutions officers closed 69% of complaints in less than one month and 87% in less than three months.
- Six orders and warning statements were issued.
- One minister-referred investigation, eight Commissioner-initiated investigations, seven complaint investigations and an inquiry under section 103 of the HCA into gay conversion therapy were commenced by the investigations team.
- Launch of a major sector-wide drug and alcohol investigation began in February 2018 following funding from the state government.
- Successful prosecution of a banned drug and alcohol counsellor resulting in conviction and costs being awarded against the provider.
- 52 training and information sessions delivered. The sessions have been attended by a broad range of registered and general health services staff.
- Development of the HCC Strategic Plan to 2020 (see Appendix A).
- We continue to disseminate information via presentations, our website, brochures and social media.

Legislation and the advisory council

Health Complaints Act

The Health Complaints Commissioner (HCC) was established under the HCA. The Act defines our powers and responsibilities to resolve complaints about health service providers in Victoria.

The Act includes a general code of conduct for all general health service providers, meaning those not regulated by the Australian Health Practitioner Regulation Agency (AHPRA) or operating outside that registration in Victoria (see Appendix B). Any potential breach of this code is grounds for a complaint to us, which may be resolved or may lead to an investigation, a prohibition order or public warnings.

When complaints resolution is unsuitable or unsuccessful, or a provider fails to participate, we have powers to investigate. Investigations can be Commissioner-initiated, referred by the Minister for Health, a follow-up or based on a complaint. They must occur expeditiously and include submissions prior to decisions affecting a person.

Health Records Act

The *Health Records Act 2001* (HRA) defines the rights and responsibilities for handling health information in Victoria.

In brief, it states that health information should be collected with consent and used or disclosed for the primary purpose it was collected, or for a directly related and reasonable secondary purpose. Health information can only be used or disclosed for a non-related purpose in some circumstances, such as when there's a serious risk to someone or the information is needed to evaluate the service received.

Any organisation collecting health information must ensure the information is up to date and relevant to their work. They must also store, transfer and dispose of health information securely to protect privacy. If a health service provider moves premises or closes down, they must post a public notice about what will happen with their records and how patients can access their health records.

HCC Advisory Council

The HCC Advisory Council is appointed by the Victorian Minister for Health. The Advisory Council's functions as set out in the HCA are to:

- liaise with health service providers and consumers to advise the Commissioner on the development of the practice protocol and complaint handling standards, and
- provide advice to the Commissioner, on the request of the Commissioner, regarding any function or power of the Commissioner.

The Commissioner must not commence a Commissioner initiated investigation unless the Commissioner has consulted the Advisory Council President in relation to that investigation.

The Advisory Council members are profiled below.

Ms Catherine Dunlop (President)

Catherine is a lawyer specialising in safety, mental and physical health at work, disciplinary matters, coronial inquests and inquiries. She is a partner at Maddocks Lawyers and has experience acting in many of Victoria's most significant safety matters, inquisitorial hearings and royal commissions.

She serves as the deputy chair of the not-for-profit Emergency Services Foundation and is a board member of OzChild.

Mrs Wendy Wood

Over a health career spanning 40 years, Wendy has maintained a passion for quality and safety, ensuring positive experiences for patient and carers.

She brings a unique breadth of academic, operational and strategic expertise across several areas including: professional nursing leadership and practice; general hospital operations; human resources; risk management; internal audit; business and services planning; governance; administration; and major redevelopment project management.

Wendy has been interim CEO of Federation Training and held senior executive positions at Peter MacCallum Cancer Centre, including as Associate Professor of Nursing and Chief Nurse, Deputy CEO and Director of Operations.

She currently runs an independent consultancy for health and education projects and coordinates the National Standards for Quality and Safety in Health Care for the Australian Council on Health Care Standards. Wendy is an inaugural member of the Better Care Victoria board.

Professor Andrea Driscoll

Andrea is a nurse practitioner at Austin Health and a Professor of Nursing and Midwifery at Deakin University within the Quality and Patient Safety Strategic Research Centre. She is a Heart Foundation Fellow and has received several prestigious national and international awards for her research and clinical work in cardiovascular health.

Andrea brings more than 25 years of clinical experience as well as experience from her former role as chair of disciplinary hearings panels into nurse misconduct at AHPRA. She is passionate about healthcare quality and safety to ensure patients receive excellence in service delivery and outcomes.

Mr Tony McBride

Tony has more than 35 years' experience in the health and community sectors and has worked in non-government organisations, local and federal governments and a university.

He currently works as a consultant, predominantly with the not-for-profit health sector, and is a board director of the Eastern Melbourne Primary Health Network.

In recent years he has been the chair of the Australian Health Care Reform Alliance, a member of a Medicare Local Board, the National Health and Medical Research Council's Prevention and Community Health Committee, and other national level GP and oral health committees. He is a past CEO of a Victorian consumer advocacy and research organisation, the Health Issues Centre.

Ms Jen Morris

Jen is a science communicator, healthcare quality and safety researcher and consumer representative. She represents consumer perspectives on a wide variety of health sector committees and speaks and publishes widely on healthcare quality and safety, healthcare regulation, service improvement and patient perspectives.

In her position at the University of Melbourne's Centre for Health Policy, Jen's research interests include harm in health care, complaints systems, complaints-based service improvement, patient experience, healthcare regulation and consumer involvement in governance. She is also a non-executive director of NPS MedicineWise.

Dr Susan Sdrinis

Susan is a specialist medical administrator whose current role is as director of Medical Services – Governance at Alfred Health. She has previously held senior positions within health services and the former Victorian Department of Human Services and as a consultant undertaking projects in hospitals and other healthcare-related organisations.

She is also an accreditation surveyor with the Australian Council of Healthcare Standards and an Australian Medical Council assessor. Susan has held positions on the State Committee of the Royal Australasian College of Medical Administrators, most recently as chair in 2012–13.

Associate Professor Rosemary McKenzie

Rosemary is the Director of Teaching and Learning in the Melbourne School of Population and Global Health and Deputy Director of the Centre for Health Policy at the University of Melbourne. She is an evaluator and health services researcher with extensive experience in health program evaluation and assessment of health service quality. Rosemary has considerable experience in organisational governance including as a board member of Hepatitis Victoria (2011–2017) and as a member of the Victorian Health Services Review Council (2015–2017).

Rosemary has led national and state evaluations with a focus on after-hours primary care, telehealth, ageing, blood-borne viruses, health promotion and capacity building. Rosemary's current research focuses on after-hours primary care policy and innovations that improve access for high-need population groups, including digital health strategies.

Complaints to the HCC

Number of complaints received

The HCC received 6,835 complaints between 1 July 2017 and 30 June 2018.

For the same 12-month period from 1 July 2016 to 30 June 2017, the total number of complaints received was 6,036, but these comprised complaints to the HCC (from 1 February 2017 to 30 June 2017) and the former Office of the Health Services Commissioner (from 1 July 2016 to 31 January 2017).

The total complaints received in this current reporting period represents a 13% increase in the volume of complaints received in the previous financial year.

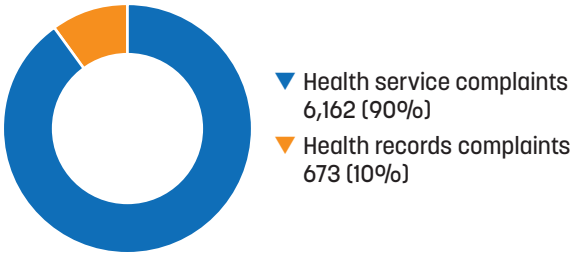
Complaints about the provision of health services that occurred after 1 February 2017 are handled under the HCA.

Complaints about the handling of health records are dealt with under the HRA.

Remaining consistent with previous years is the breakdown between health service complaints (90%) and health records complaints (10%) (see Figure 1).

Complaints that are assessed as out of jurisdiction are not counted in our total number of complaints received for the reporting period, but these account for 653 complaints, and include matters such as complaints against insurance companies.

Figure 1: *All complaints received, 2017-18*



Case study 1:
Quality change and refund

The complaint

Chris arranged for a cardiovascular procedure to be performed by a private specialist at a hospital. After receiving confirmation that the procedure had been booked, Chris contacted the specialist's rooms to ask for a breakdown of the costs for the procedure. He received a reply that said the specialist would bill his private health fund directly and that there would be no out-of-pocket expenses.

Following the procedure, Chris received an invoice from the specialist rooms because his private health policy did not cover the cardiovascular procedure.

He made a complaint to the HCC, disputing the bill on the grounds that he was not given accurate information about the costs to him and was not provided an opportunity to give his informed financial consent.

The response

We contacted the specialist for a response and to present Chris' request for a refund. The specialist said they rarely saw a patient whose private health policy did not cover the procedure, and if they were aware of this they would have referred the patient to have the procedure done in the public system.

The specialist said it had responded to Chris' initial enquiry on the assumption that he had adequate private health insurance for the procedure. The specialist noted that neither the patient or the hospital notified them that the procedure was not covered by the patient's private health insurance.

The outcome

The specialist offered to waive the fees as a gesture of goodwill and took this as an opportunity to reconsider the way future fee enquiries will be responded to. Specifically, the specialist will now mention that there are no out-of-pocket expenses if the patient's private health insurance covers the procedure, provide an estimate of costs if not covered, and advise the patient to check with their private health fund to confirm if the procedure will incur costs.

Who handled the complaints

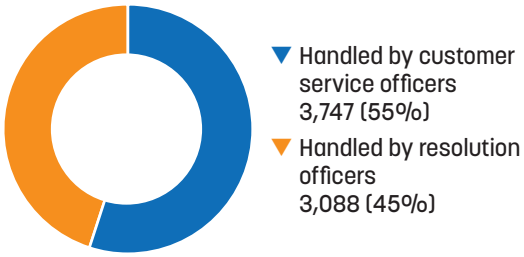
All complaints coming into the office pass through a dedicated customer service team.

This team handled just over half of the complaints received (55%), typically through advice on how to present complaints to a provider in the first instance. As direct resolution is often the quickest and easiest way for complaints to be resolved, the legislation expects this to be attempted before we accept a complaint, where appropriate. Supporting this direct resolution with health service providers is an important way our customer service team adds value to complaints handling.

All remaining complaints (45%) that could not be resolved directly with the provider or through other advice were allocated to complaint resolution officers. Complaint resolution officers may deal with complaints in early resolution or through more formal methods such as conciliation.

Figure 2 shows the breakdown of complaints according to who handled them.

Figure 2: *Who handled complaints, 2017-18*



How complaints were received

Complaints were primarily received via telephone (see Table 1).

During the reporting period 4,965 complaints were received by telephone (72.6%), while 1,516 came through the website's online complaint form (22.2%).

The HCC enquiry line received 18,893 telephone calls during the reporting period. These included 4,478 calls where the caller did not wait to talk to a customer service officer. While waiting, the caller hears a recording explaining what the HCC can help with and the appropriate contact details of the organisations responsible for things such as food safety and quality, public housing and dental health bookings. After hearing these options callers may elect whether to continue with their call or not.

Also included in the total number of calls received were 3,751 calls from prisoners who have a toll free direct line to the complaints and enquiry line. Not all of these calls resulted in complaints to our office.

Apart from lodging complaints, typically the calls received to our enquiry line were follow-up calls from complainants but also included enquiries from providers about their obligations, requests for training or brochures and about matters outside our jurisdiction.

Table 1: *How complaints were received, 2017-18*

	Number of complaints	As a % of total complaints
Telephone	4,965	72.6%
Online	1,516	22.2%
Email	163	2.4%
Letter	150	2.2%
In person	37	0.5%
Fax	4	0.1%

Complaints to the HCC

Who complaints were about

General health service providers

General, or non-registered, providers refer to anyone providing a health service who is not regulated by AHPRA, such as massage therapists, counsellors, alternative therapists, speech pathologists and many more.

During the past financial year we received 468 complaints about this group of providers, which demonstrates that one of the objectives of the HCA, namely to improve the oversight of non-registered providers, is being achieved.

Hospitals

We received 1,822 complaints about public, private and psychiatric hospitals. This represents a 14% increase from the 1,583 hospital-related complaints received for the same period the previous year.

Medical clinics

We received 722 complaints about group practice and 24-hour medical clinics during this reporting period. This represents a 34% increase from the 538 medical clinic complaints received for the same period last year.

Medical practitioners

We received 1,244 complaints about medical practitioners during this reporting period. This represents an 18% increase from the 1,054 medical practitioner complaints received for the same period last year. Medical practitioners include general practitioners (GPs) and specialist practitioners such as obstetricians, gynaecologists and surgeons.

Dentists

We received 347 complaints about dentists in private practice during this reporting period. This represents a 20% increase from the 288 dentist-related complaints received for the same period last year.

Other registered providers

We received 312 complaints about other registered providers during this reporting period. This represents a 45% increase from the 214 other registered provider complaints received for the same period last year.

This category includes all practitioners registered with AHPRA, apart from those captured under ‘medical practitioners’. This category encompasses pharmacists, optometrists and nurses, among others.

Prison health service providers

Over the reporting period we received 1,641 complaints against providers subcontracted to deliver health services for Victorian prisoners. This represents a minimal increase of 0.02% from the 1,606 prisoner-related complaints received for the same period last year.

The large numbers of health service complaints from prisoners can partly be explained by the ease with which they can lodge complaints with us via toll-free telephones and their high levels of awareness of our service.

Case study 2:
Paying for unnecessary care

The complaint

Rania complained about the care she’d received at a major hospital and the bill she’d been left with at the end.

During an operation on her neck, Rania went into cardiac arrest and was resuscitated, taken to ICU and had five chest x-rays conducted.

After the incident, Rania wanted to complain about the care. She wanted to know if the anaesthetic caused the arrest and whether the surgeon had done something wrong. If not, why was it necessary to take five separate x-rays in ICU? And why did she have to pay for the cost of them?

What we did

We gave Rania advice on how to break down the complex complaint against the hospital and clarify who each separate issue related to.

We helped her take her complaints to the relevant people to resolve directly, outside of the formal complaints resolution process.

The outcome

Rania received detailed responses from each practitioner – the anaesthetist, the surgeon and the ICU team – about what had happened during and after the operation and why they had made certain decisions, including to take five chest x-rays.

The explanations made sense to Rania and addressed her concerns.

Table 2 and Figure 3 break down the complaints received by provider type.

Table 2: *Complaints by health service provider type, 2017-18*

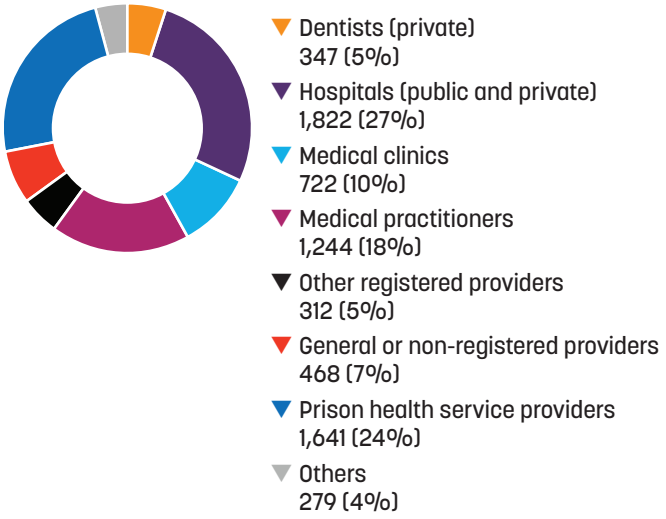
Health service provider type	Total number of complaints
Dentists (private)	347
Hospitals	1,822
Medical clinics	722
Medical practitioners	1,244
Other registered health service providers*	312
General or non-registered health service providers**	468
Prison health service providers	1,641
Complaints about other services which are not health services as defined under the HCA and organisations as defined under the HRA	279
Total	**6,835**

* *Registered health service providers refer to those professions that are regulated by AHPRA.*

** *General health service providers are those providers that are not regulated by AHPRA but are subject to the Code of Conduct as set out in the Act.*

See Appendix E for more detail about specialities and subspecialties in each provider type listed in the Table 2.

Figure 3: *Complaints by health service provider grouping, 2017-18*



Case study 3:
Complaint about cosmetic procedures – settlement

The complaint

Mei had a cosmetic procedure undertaken by a registered medical practitioner with dermal fillers injected into the cheeks, which then got infected. She suffered a severe infection around the eyes that required surgery from a different practitioner to remove the dermal filler and was treated with both intravenous and oral antibiotics. This necessitated time off work.

Mei alleged the infection had damaged and altered her facial features including scarring and yellowing of the skin under her eyes.

What we did

We sought a copy of the doctor's records and found Mei was never provided with any information about the procedure, associated risks or a written consent.

We also sought a report from the hospital and treating doctor who undertook the surgery to remove the dermal filler.

Mei provided a copy of receipts for all the out-of-pocket expenses, a quote for the reparative surgery and payslips verifying the amount of loss of income as a consequence of the infection.

The outcome

Our office assisted in negotiating a settlement between Mei and the cosmetic service's insurer for the cost of the reparative surgery, out-of-pocket expenses and loss of income.

Case study 4:
Challenging an incorrect diagnosis

The complaint

Carol complained to us after her mother presented to the GP with broken vertebrae. Her mother suffers from osteoporosis and had a fall from a ladder. She felt the GP should have taken extra steps to ensure that her mother was correctly diagnosed. Carol advised that her mother's injury was more serious than first thought.

Carol had attempted direct resolution in which the GP told her he would have treated her mother differently if he'd seen the x-ray images himself. He said the radiology report was inadequate and he was going to follow up with the radiologist.

Carol complained that her mother's care and treatment by the GP was inadequate and she was seeking information about what the practice had done as a result of her mother's experience.

What we did

We contacted the GP practice and asked them to respond in writing to the issues raised by Carol within a set timeframe.

After delays in responding to the complaint, we spoke with the GP, who assured us he was considering the complaint with the utmost seriousness.

He noted that he had spoken to Carol a couple of times on the telephone and given his verbal explanations and assurances.

He talked about the clinical issues regarding his patient, Carol's mother, and advised he had since reviewed the x-ray and considers that the film was not properly reported – the degree of wedging was more severe than a simple compression fracture and it should have been 'flagged' in the report.

The GP noted that his practice can now review imaging online.

As a systems response to the complaint, he is developing a protocol for the practice. If the degree of wedging is not noted in the report, doctors are to call the radiologist to ask them to further elaborate.

It was agreed that the written response would be provided by the end of the week.

The outcome

Carol was advised of the verbal information from the GP and was satisfied with explanations and the improvements noted.

When the written response was received, Carol was not as satisfied with the written response because she did not feel that their follow-up with the radiologist was as she expected. However, overall Carol was satisfied the issues she raised were resolved.

Issues in complaints received

Health service complaints

The most common issues among health service complaints were treatment (35%) and access to services (27%) While communication was not identified as a major issue in many complaints (5%), it is often an underlying issue in many of the complaints we see.

As complaints can involve multiple issues there are more issues than complaints recorded for this reporting period (see Table 3). Complaint issues are defined in Appendix C.

Table 3: *Issues in health service complaints, 2017-18*

Issues	
Access to services	2,446
Communication	467
Complaints management	200
Conduct and behaviour	733
Diagnosis	593
Facilities	167
Medication	1,011
Records	216
Treatment	3,187
Total issues	**9,020**

Health records complaints

Table 4 shows that the most common issues in health records complaints were access to and correction of health records (63%), followed by use and disclosure of health information (15%) and data quality (10%).

Table 4: *Issues in health records complaints, 2017-18*

Issues	
Access and correction	463
Anonymity	2
Collection	27
Data quality	71
Identifiers	2
Information available to another health service	26
Openness	6
Transborder data flows	13
Transfer or closure of a practice	17
Use and disclosure	108
Total issues	**735**

Case study 5:

Health Records Act complaint – referral to VCAT

The complaint

Sanjeet complained on behalf of his wife that an independent medical examination report contained inaccurate and misleading information. He sought a refund for the cost of the report.

What we did

We helped Sanjeet to clarify what the inaccuracies in the report were and how they were substantiated. We then put the complaint to the provider, who declined to respond but stated he would issue a refund for the cost of his services.

The outcome

Sanjeet contacted us one month later to say he had not received a refund within the agreed timeframe. The provider stated they had sent a cheque, but no substantiation of this was provided. Sanjeet believed the cheque had never been sent and decided to take the matter to the Victorian Civil and Administrative Tribunal (VCAT).

We then referred the matter to VCAT as is required under the HRA.

Issues by provider type

Across each provider type, the issues in complaints follow a similar pattern, with treatment as the most common issue in each category, followed by access to services and health records issues (see Tables 5–8). Conduct and behaviour issues are also common in all categories.

Table 5: *Issues in medical practitioner complaints, 2017-18*

Issues	
Access to services	298
Communication	108
Complaints management	41
Conduct and behaviour	239
Diagnosis	157
Facilities	16
Medication	105
Records	258
Treatment	613
Total issues	**1,835**

Table 6: *Issues in dental complaints, 2017-18*

Issues	
Access to services	96
Communication	27
Complaints management	18
Conduct and behaviour	19
Diagnosis	30
Facilities	5
Medication	0
Records	23
Treatment	279
Total issues	**497**

Table 7: *Issues in public hospital complaints, 2017-18*

Issues	
Access to services	455
Communication	144
Complaints management	51
Conduct and behaviour	188
Diagnosis	212
Facilities	43
Medication	77
Records	153
Treatment	1,142
Total issues	**2,465**

Table 8: *Issues in private hospital complaints, 2017-18*

Issues	
Access to services	75
Communication	31
Complaints management	11
Conduct and behaviour	22
Diagnosis	16
Facilities	21
Medication	8
Records	27
Treatment	159
Total issues	**370**

Time taken to close complaints

In addition to the number of complaints received in the reporting period, an important measure is also the number of complaints closed in any reporting period.

Overall, of the 7,078 complaint cases closed during the reporting period, 4,869 (69%) were closed in less than one month, while 6,148 (87%) were closed in less than three months. This includes cases closed by customer service officers and cases closed by resolution officers.

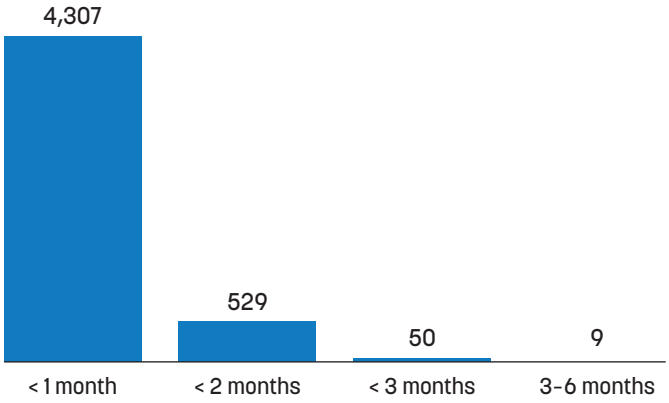
Complaints handled by customer service officers

Of the 4,895 complaints closed by the customer service team, 4,307 (88%) were closed in less than one month and the remaining 588 (12%) closed in between one and six months' time (see Figure 4).

These short timelines reflect the role customer service officers play in assisting people to resolve complaints directly with providers in the first instance. Typically this work involves providing assistance to complainants regarding who to speak with about their complaint, what information to include and when to expect a response so that direct resolution can proceed as smoothly as possible. The team also has an educational role in setting expectations for complainants about what can and cannot be achieved through complaints resolution.

Where this initial step is not successful then the customer service officer's record of the complaint provides a starting point for further work by our complaint resolution officers.

Figure 4: *Time taken to close complaints by customer service officers, 2017-18*

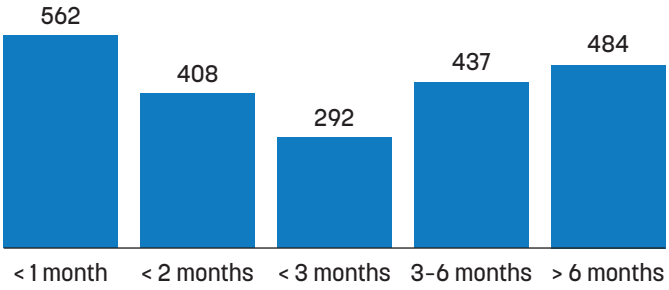


Complaints handled by resolution officers

Resolution officers closed 2,183 complaints in the reporting period. Of these complaints closed, 562 (26%) were done so in less than one month, while a further 700 (33%) took between one month and three months to resolve. This means that 59% of complaints handled by resolution officers were resolved in less than three months.

A total of 437 complaints (20%) took between three and six months to resolve. The remaining 484 complaints (22%) took more than six months to resolve (see Figure 5). These longer timeframes are reflective of the complexity of many of the complaints to our office. It is not unusual to see more complex cases generally taking longer to resolve and therefore to close.

Figure 5: *Time taken to close complaints by resolution officers, 2017-18*



Case study 6:
Access to health information

The complaint

Charlie complained that his local GP clinic would not give him a copy of his health records, which he wanted because he was moving house and planned to find a new doctor in the future.

The clinic receptionist told him they were the property of the clinic and if he wanted to access them he'd need to get a lawyer.

What we did

We contacted the clinic to explain that individuals have a right to access their personal health information, do not need a reason for doing so and do not need a lawyer.

We also showed them information about the maximum fees they can charge for providing copies of records.

The outcome

Charlie received a copy of his health records and the clinic staff learnt about their responsibilities regarding access to health records.

Outcomes in closed complaints

Health service complaints

The most common outcomes for health service complaints in the reporting period were: advice given by HCC staff (69%); explanations obtained from health service providers (14%); service obtained (4%); and refunds or compensation (4%).

'Advice given' accounts for the majority of outcomes we delivered people (see Table 9) and is a major part of the service provided by the customer service team.

Table 9: *Outcomes from health service complaints, 2017-18*

Outcomes	
Advice given	4,259
Explanation	884
Withdrawn	283
Service obtained	255
Refund or compensation	231
Apology	141
Quality change	62
Referred to AHPRA	34
Referred to another agency	25
Non-conciliable	32

Health records complaints

Table 10 shows that the most common outcomes for health records complaints were advice given (59%), explanations (8%), access to records (9%) or referral to VCAT (5%).

Table 10: *Outcomes from health records complaints, 2017-18*

Outcomes	
Advice given	476
Access to records	73
Withdrawn	64
Explanation	61
Referred to VCAT	39
Service obtained	24
Dismissed	19
Refund or compensation	15
Quality change	13
Apology	12
Non-conciliable	6
Refer out to AHPRA	2
Refer another agency	2
Action/compliance order	1

Investigations

The power to investigate and take action following an investigation has increased significantly under the HCA. The HCC can launch investigations based on information we receive, on the Commissioner's own initiative or by referral from the Victorian Minister for Health. Investigations generally follow a formal process, including a detailed examination of a complaint. Investigations are sometimes conducted in more complex matters but may also be used in simple matters like following up any undertakings made in a complaints resolution process. We may investigate public or private organisations as well as individual providers.

Why we investigate

The primary aim of any investigation is to establish the facts. This allows us to understand what measures, if any, should be taken to protect an individual or the public from serious risks to their health, safety or welfare.

We may look into ongoing issues or significant concerns about the appropriateness of care provided to consumers. We might investigate if we consider the complaint too complex for our complaints resolution process or where a health service provider has unreasonably refused to participate in the complaints resolution process. Allegations about serious breaches of the general code of conduct, which applies to general providers not registered with AHPRA or operating outside their registration, may also be investigated.

How we investigate

The HCC will notify relevant parties in writing of the decision to investigate and of the subject matter of the investigation. However, notification may not be appropriate in some cases if there is a serious risk to the health, safety or welfare of a person or the public and notification may prejudice an investigation.

We have powers to obtain any information relevant to an investigation. We may require access to clinical notes, relevant internal reports, policies and procedures or names of other providers involved. During the evidence-gathering phase, we may conduct hearings or interviews, seek independent expert advice or exercise our compulsory powers.

Procedural fairness

We are committed to acting fairly, impartially and independently towards all parties involved in the investigation. We also act as quickly and with as little formality as is reasonably possible. Before making a decision affecting a person, the HCC will give that person an opportunity to make submissions about the decision.

Timing

We aim to complete investigations as quickly as possible but timeframes will depend on the nature and complexity of the matter. More straightforward investigations might be completed within a matter of weeks, while more complex matters involving many providers and wide-ranging issues may take much longer to investigate. In any event, the HCC will provide regular updates to all parties during the investigation.

Outcomes of an investigation

After completing an investigation a report containing evidence, comments or recommendations will be prepared. This report may be shared with the health service provider, the complainant, AHPRA, the Minister for Health, the Secretary to the Department of Health and Human Services and other relevant parties.

If a report recommends that a health service provider undertake quality improvements, we will ask the provider to report back to us on the implementation of those recommendations. If we believe the provider has failed to make these quality improvements we may take further action.

We can also launch a follow-up investigation if a provider fails to undertake:

- any actions agreed to during a complaints resolution
- any actions recommended in an investigation report.

In the case of general health service providers, we can issue prohibition orders and public warning statements where the Commissioner is satisfied there is a serious risk to the health, safety or welfare of an individual or the public.

Case study 7:
Investigation into a 'healer'

The complaint

Katrina complained about a self-proclaimed 'healer' that claimed to be able to cure cancer. Her sister-in-law Heather had been diagnosed with ovarian cancer but had been given treatment options by her oncologist. A colleague of Heather's mentioned an alternative therapist who claimed to be able to cure cancer. Heather contacted the 'healer' and was encouraged to stop all conventional treatment and to apply 'black salve' to her abdomen to 'treat' the cancer. Heather's condition worsened dramatically and she passed away.

What we did

The complaint was considered not suitable for complaints resolution and an investigation began. The 'healer' was considered to be a serious risk to the health, safety or welfare of the public and so an interim prohibition order was made while the investigation was conducted.

The outcome

The investigation has not yet concluded, but the interim prohibition order remains in force. Once the investigation is concluded, an investigation report will be prepared.

Statements and orders

Orders can prohibit a health practitioner or organisation from providing health services.

These orders can prohibit part, or all, of a health service for a set period of time or permanently, or impose conditions on the provision of the health service. Interim prohibition orders of up to 12 weeks' duration can also be made.

Orders are only made against general health service providers, meaning those not regulated by AHPRA, and only if the Commissioner believes they've breached the general code of conduct and pose an unacceptable risk to the public.

Prohibition orders issued in New South Wales, Queensland and South Australia may be prosecuted in Victoria if the banned provider provides services here. Other states and territories don't currently have the power to issue prohibition orders, so the power to prosecute in Victoria only relates to the states referred to above. This may change over time.

We issued five interim prohibition orders and prosecuted one provider subject to an interstate prohibition order in the reporting period.

Case study 8:
Investigation into massage therapist

The complaint
Clarissa reported that her massage therapist had made lewd comments and touched her inappropriately several times. Over the course of four sessions his advances became increasingly inappropriate and clearly sexual in nature.

What we did
We decided that the matter was not appropriate for voluntary complaints resolution and referred the matter to our investigations team, who interviewed Clarissa, did background checks and other investigations into the provider before compiling a preliminary report.

The outcome
The Commissioner reviewed the report and decided to issue an interim prohibition order against the massage therapist, banning him from providing any massage services for up to 12 weeks while a full investigation was conducted. At the completion of the full investigation the Commissioner will determine whether to issue a permanent prohibition order banning the massage therapist from providing any general health services, issue a prohibition order that imposes conditions or not issue a prohibition order. An investigation report will be prepared.

External advice and participation
Given our role and the expertise we hold, the HCC is often asked to provide comment or input into consultations and the development of key initiatives that relate to health services and health complaints or health information. We welcome these valuable opportunities to contribute to the discussion underpinning health information and complaints.

During this reporting period the HCC was engaged in providing advice and input to a broad range of matters, examples of which are below.

Following the Royal Commission into Family Violence, the government implemented a range of initiatives including the Family Violence Information Sharing Scheme. The HCC provided expertise into the operation of that scheme where the information exchanged includes health information. The HCC has received ongoing funding to deal with complaints with respect to the way health information is handled under the scheme.

The Health Services (Private Hospitals and Day Procedure Centres) Amendment Regulations 2018 have been developed and again the HCC made submissions and provided expertise on those Regulations, particularly in relation to their application to providers offering acute alcohol and drug detoxification services and cosmetic treatments.

The *Victorian Data Sharing Act 2017* enables data sharing across government to address key priorities in the community. It also establishes a Chief Data Officer, who must provide an annual report to the HCC and the Office of Victorian Information Commissioner on projects involving personal or health information. The HCC was actively involved in providing feedback on the introduction of this legislation, particularly as it relates to health information.

Engagement and education

Overview

Our engagement and education work focuses on ensuring the role of the HCC is clearly understood and we are recognised across the Victorian community. An engagement officer works with health service providers and consumers to establish and develop relationships, build the capacity of health service providers and to increase awareness and access to our service.

Consultation

We have delivered a range of engagement activities in-house and across the state to reach out to a diverse group of stakeholders including consumers, health service providers, peak bodies, regulatory agencies, legal entities and industry groups to support the development and implementation of complaints handling standards and an HCC service charter. This consultative process involved using open forums, focus groups, an online survey and a discussion paper to consult on a range of matters and to understand the needs and expectations of stakeholders. We received 389 responses to the survey, 21 responses to the discussion paper and 338 participants attended the focus groups and open forums. Consultation has closed and the complaints handling standards and service charter are being developed. Further input will be sought from stakeholders before approval is sought from the Minister for Health.

Training and education

In addition to specific consultation on developing complaints handling standards and our service charter, we have engaged with key stakeholders through the delivery of training and information sessions both in-house and externally. A broad range of health service providers, general health service providers, consumers, staff of other agencies and other key stakeholders attended three sessions during the reporting period. Our in-house training and education sessions have been extremely well received, with all sessions being fully booked by more than 400 attendees. This has assisted us in continuing to strengthen relationships and foster recognition across Victoria.

Our in-house training and education sessions cover four main areas:

- understanding the HRA
- new standards for general health service providers
- managing complaints and tricky situations
- successful meetings to manage complaints.

We have continued to engage more widely about our role and the value of good complaints handling in quality improvement through presentations at forums, conferences, Grand Rounds, to students in a range of health disciplines and to a broad range of stakeholders.

Appendix D provides details of the key stakeholder groups engaged in our consultation process and the presentations provided during the reporting period.

Accessibility

We have taken measures to increase engagement with under-represented groups, in particular Aboriginal and Torres Strait Islander and other culturally diverse communities. We have built partnerships with key agencies and peak bodies to support engagement, increase accessibility and to address service gaps.

We have assessed the inclusivity of our current training programs and have developed a plan to increase access to training and development opportunities for health services in regional and rural Victoria. This involves exploring digital options for participation and opportunities to visit those communities.

Understanding consumers

We have implemented a feedback project to understand our consumers' needs and expectations and to track our performance. We engaged 222 previous complainants to provide feedback on a range of areas including satisfaction, communication and overall experience. We found that satisfaction was highly correlated with complaint outcomes. The majority of consumers felt positive about their first interaction with us and the most common desired outcomes were a change in policy and financial compensation.

Digital engagement

Many of our priorities have focused on strengthening digital engagement channels to communicate key messages and build relationships. These include the website, Facebook, Twitter, LinkedIn and YouTube. We have experienced a surge in social media engagement, with an average following of approximately 70 new users per month. Reach and interactions have also increased, with 23% of posts referring back to the website and reaching 35% of total followers.

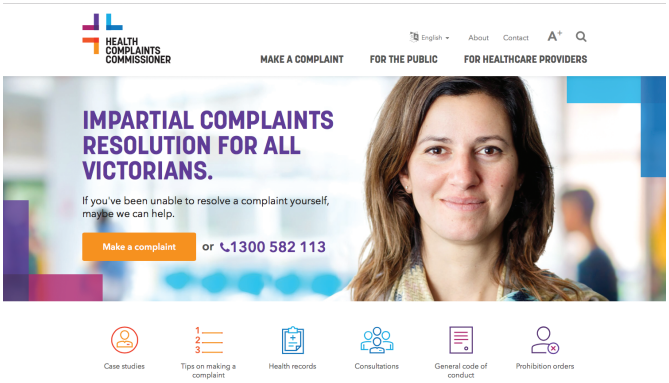
A series of animated videos that explain our service has been successful in increasing retention of website users, with traffic spending the longest duration of time on the page with video links.

The use of our online complaint form has increased by 8%, with more than 20% of total complaints coming through this channel. Fifty per cent of consumers who engaged in the feedback project indicated that they became aware of our service through digital channels, demonstrating that our online presence is influential and impactful in supporting engagement.

Website

We have seen a significant increase in website visitors during the reporting period, with new users representing 81% of traffic to the site. This has been a result of key social media campaigns, consultation activities, increased media attention and promotion of the training calendar with health service providers.

The HCC website and online complaint form is a major avenue for information and complaint lodgement. This reporting year the website has been visited by 48,350 unique users over 74,319 sessions, totalling 259,554 page views. The average session duration was two minutes and 54 seconds.



Organisation and staffing

With the core business of our office being complaints handling, the majority of our 47 staff work directly in this area, either in customer service officer or resolution officer roles. But with the growth in complaints numbers and increasing focus on investigations, we have seen an increase in the number of staff engaged across the office, with a total of just under 45 FTE. Figure 6 shows the functional areas of responsibility within HCC. Table 11 shows the level and employment type for all staff.

Figure 6: *Functional organisational chart*

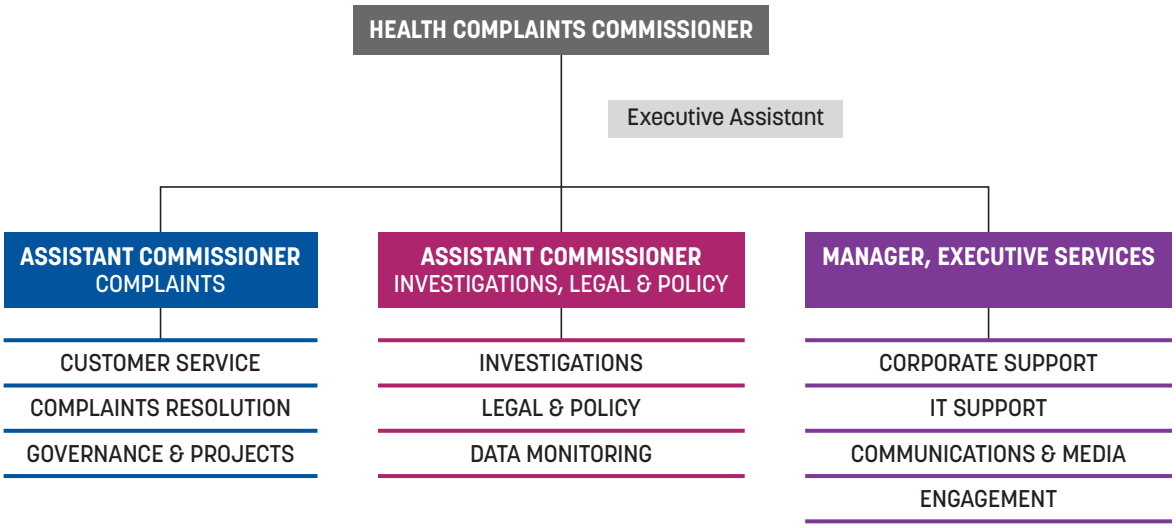


Table 11: *Staff employment type and level at 30/6/18*

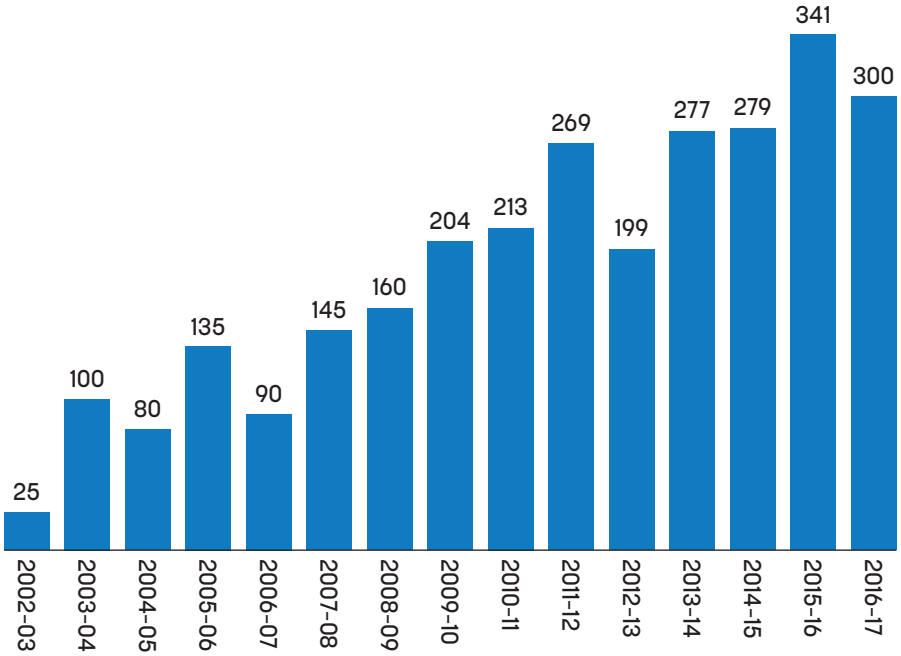
	Male	Female	Full time	Part time	Ongoing	Fixed term	Agency	FTE
Executive officer		1	1		1			1
VPS 6	2	1	3	0	3			3
VPS 5	6	14	14	6	15	4	1	18.65
VPS 4	5	10	12	3	5	10	0	14.4
VPS 3	3	4	6	1	1	1	5	6.8
VPS2	0	1	1	0	0	1	0	1
Total	16	31	37	10	25	16	6	44.85

Human research ethics committees

Statutory guidelines exist on the collection, use and disclosure of health information for research purposes. Human research ethics committees at hospitals, universities and other agencies use these guidelines to decide whether the public interest of research outweighs the public interest of protecting privacy in the use of information for research projects.

Up to 56 of these committees report to the HCC each September on their use of the guidelines. Last year 54 of the 56 committees returned reports to the office. These showed that 300 research proposals had been made, of which 289 were approved. There were seven proposals not approved and four awaiting a decision. The trend in approved proposals over the past decade is shown at Figure 7.

Figure 7: *Human research ethics committee proposals approved, 2002–2017*



Protected disclosures

The *Protected Disclosure Act 2012* (the PD Act) creates the legislative framework for receiving protected disclosures and protecting those who make them. Under the PD Act, the Independent Broad-based Anticorruption Commission (IBAC) has a key role in receiving, assessing and investigating disclosures about corrupt or improper conduct and police personnel conduct or improper conduct as well as preparing and publishing guidelines to assist public bodies to interpret and comply with the protected disclosures regime.

The PD Act also broadens the operation of the previous whistleblowers scheme to match the scope of the new integrity system and applies to disclosures about all public bodies and officers within IBAC's jurisdiction.

Section 16 of the PD Act requires that any disclosures relating to the HCC must be made to either the Victorian Ombudsman or IBAC.

For the current reporting period, the HCC provides the following in relation to the PD Act.

a. Number of disclosures

No disclosures of any type were made to the HCC.

b. Public interest disclosures referred to the Ombudsman or IBAC

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

c. Disclosures referred to the HCC

No disclosures of any type were referred to the HCC by the Ombudsman or IBAC.

d. Disclosures of any nature referred to the Ombudsman

No disclosures of any type were referred by the HCC to the Ombudsman or IBAC to investigate.

e. Investigations taken over by the Ombudsman

No investigations of disclosed matters of any type were taken over from the HCC by the Ombudsman or IBAC.

Financial statement

The financial operations of HCC are consolidated into those of the Department of Health and Human Services and are audited by the Victorian Auditor-General's Office. A complete financial report is therefore not provided in this annual report. A financial summary of budget and expenditure for 2017–18 is provided below.

For the 2017–18 financial year, the HCC received total funding of $6,033,673. This includes one-off funding of $550,000 for alcohol and drug investigations, which we have requested to carry over into the 2018–19 financial year due to the duration and nature of the investigations.

Budget

Supplies and consumables	$ 626,152
Salaries and oncosts	$ 4,473,869
Agency staff	$ 383,652
	$ 6,033,673
Requested carry over	$ 550,000
Total	**$ 5,483,673**

Expenditure

Supplies and consumables	
Administrative, stationery and operating supplies	$ 13,484
Advertising, publicity and information	$ 128,172
Books and publications	$ 8,053
Catering	$ 3,216
Consulting services	$ 33,300
Data research and analysis	$ 40,000
Fees for internally delivered services	$ 11,398
Furniture, fittings and equipment	$ 19,738
Interpreter services and translation services	$ 12,302
IT	$ 40,198
Medical reports	$ 56,598
Office maintenance and security	$ 5,809
Postal/courier	$ 3,757
Printing	$ 18,352
Solicitors	$ 107,032
Staff development, seminars and training	$ 27,910
Telephones	$ 54,670
Travel – airfares, taxis, personal expenses	$ 3,970
Total	**$ 587,959**

Appendix A
HCC strategic plan

Vision

We work with Victorians towards safe and ethical healthcare.

Values

Impartiality: **We are fair and transparent in all we do.**

Integrity: **We provide services in a respectful and ethical manner.**

Collaboration: **We are inclusive and engaged in our approach.**

Courage: **We act with strength and are committed to our purpose.**

Priorities and success statements

Data integrity

Priority:
Implement systems and processes to ensure comprehensive, reliable data that enables us to improve standards in the sector.

Success statement:
We have robust and agile systems to support evidence-based decision making that Victorians can trust. We can proactively and reliably identify key trends to support planning and action.

Legislative requirements

Priority:
To comply with the requirements of the *Health Complaints Act 2016* and *Health Records Act 2001* and use these powers responsibly and impartially across all areas of our office.

Success statement:
We have successfully implemented a practice protocol and complaint handling standards.

Communication

Priority:
We are recognised in the Victorian community and our role is clearly understood.

Success statement:
We have successfully implemented a targeted communications strategy focused on increased awareness of and access to our service by those who need it.

People

Priority:
To create a sense of purpose where staff feel supported in a well-resourced and collaborative work environment.

Success statement:
We have successfully implemented HCC staff engagement measures to improve our 2017 Job Satisfaction and Engagement Index ratings in the People Matter Survey.

Appendix B
Code of conduct for general health services

This code applies to general health service providers who are not regulated by the Australian Health Practitioner Regulation Agency. Any possible breach of this code should be raised with the provider first.

The Code of Conduct in respect of General Health Services forms part of the Act in Schedule 2 and is set out in full below.

1 General health service providers to provide services in a safe and ethical manner

1. A general health service provider must provide general health services in a safe and ethical manner.
2. Without limiting subclause (1), general health service providers must comply with the following:
   a) a general health service provider must maintain the necessary competence in the provider's field of practice;
   b) a general health service provider must not provide a health service of a type that is outside the provider's experience or training, or provide services that the provider is not qualified to provide;
   c) a general health service provider must only prescribe or recommend treatments or appliances that serve the needs of clients;
   d) a general health service provider must recognise the limitations of the treatment the provider can provide and refer clients to other competent health service providers in appropriate circumstances;
   e) a general health service provider must recommend to clients that additional opinions and services be sought, where appropriate;
   f) a general health service provider must assist a client to find other appropriate health care services, if required and practicable;
   g) a general health service provider must encourage clients to inform their treating medical practitioner (if any) of the treatments or care being provided;
   h) a general health service provider must have a sound understanding of any possible adverse interactions between the therapies and treatments being provided or prescribed and any other medications or treatments, whether prescribed or not, that the provider is, or should be, aware that a client is taking or receiving, and advise the client of these interactions;
   i) a general health service provider must provide general health services in a manner that is culturally sensitive to the needs of the provider's clients.

2 General health service providers to obtain consent

Prior to commencing a treatment or service, a general health service provider must ensure that consent appropriate to that treatment or service has been obtained and complies with the laws applying in Victoria.

3 Appropriate conduct in relation to treatment advice

1. A general health service provider must accept the right of the provider's clients to make informed choices in relation to the health services the client seeks or receives.
2. A general health service provider must not attempt to dissuade a client from seeking or continuing medical treatment.
3. A general health service provider must communicate and co-operate with colleagues and other health service providers and agencies in the best interests of their clients.

4 General health service providers to report concerns about the conduct of other health service providers

A general health service provider who, in the course of providing treatment or care, forms the reasonable belief that another health service provider has placed or is placing clients at serious risk of harm must refer the matter to the Commissioner.

5 General health service providers to take appropriate action in response to adverse events

1. A general health service provider must take appropriate and timely measures to minimise harm to clients when an adverse event occurs in the course of providing treatment or care.
2. Without limiting subclause (1), a general health service provider must:
   a) ensure that appropriate first aid is available to deal with any adverse event; and
   b) obtain appropriate emergency assistance in the event of any serious adverse event; and
   c) promptly disclose the adverse event to the client and take appropriate remedial steps to reduce the risk of recurrence; and
   d) report the adverse event to the relevant authority, where appropriate.

6 General health service providers to adopt standard precautions for infection control

1. A general health service provider must adopt standard precautions for the control of infection in the course of providing treatment or care.
2. Without limiting subclause (1), a general health service provider who carries out skin penetration or other invasive procedures must comply with the laws applying in Victoria.

7 General health service providers diagnosed with infectious medical conditions

1. A general health service provider who has been diagnosed with a medical condition that can be passed on to clients must practise in a manner that does not put clients at risk.
2. Without limiting subclause (1), a general health service provider who has been diagnosed with a medical condition that can be passed on to clients must take and follow advice from a suitably qualified registered health practitioner on the necessary steps to be taken to modify the provider's practice to avoid the possibility of transmitting that condition to clients.

8 General health service providers not to make claims to cure certain serious illnesses

1. A general health service provider must not claim or represent that the provider is qualified, able or willing to cure cancer or other terminal illnesses.
2. A general health service provider who claims to be able to treat or alleviate the symptoms of cancer or other terminal illnesses must be able to substantiate such claims.

9 General health service providers not to misinform their clients

1. A general health service provider must not engage in any form of misinformation or misrepresentation in relation to the products or services the provider provides or the qualifications, training or professional affiliations the provider holds.
2. Without limiting subclause (1):
   a) a general health service provider must not use the provider's possession of a particular qualification to mislead or deceive clients or the public as to the provider's competence in a field of practice or ability to provide treatment; and
   b) a general health service provider must provide truthful information as to the provider's qualifications, training or professional affiliations; and
   c) a general health service provider must not make claims either directly to clients or in advertising or promotional materials about the efficacy of treatment or services the provider provides if those claims cannot be substantiated.

10 General health service providers not to practise under the influence of alcohol or unlawful substances

1. A general health service provider must not provide treatment or care to clients while under the influence of alcohol or unlawful substances.
2. A general health service provider who is taking prescribed medication must obtain advice from the prescribing health practitioner or dispensing pharmacist on the impact of the medication on the provider's ability to practise and must refrain from treating or caring for clients in circumstances where the provider's capacity is or may be impaired.

11 General health service providers with certain mental or physical impairment

1. A general health service provider must not provide treatment or care to clients while suffering from a physical or mental impairment, disability, condition or disorder (including an addiction to alcohol or a drug, whether or not prescribed) that places or is likely to place clients at risk of harm.
2. Without limiting subclause (1), if a general health service provider has a mental or physical impairment that could place clients at risk, the general health service provider must seek advice from a suitably qualified health practitioner to determine whether, and in what ways, the provider should modify the provider's practice, including stopping practice if necessary.

12 General health service providers not to financially exploit clients

1. A general health service provider must not financially exploit the provider's clients.
2. Without limiting subclause (1):
   a) a general health service provider must only provide services or treatments to clients that are designed to maintain or improve clients' health or wellbeing; and
   b) a general health service provider must not accept or offer financial inducements or gifts as a part of client referral arrangements with other health service providers; and
   c) a general health service provider must not ask clients to give, lend or bequeath money or gifts that will benefit the general health service provider directly or indirectly.

13 General health service providers not to engage in sexual misconduct

1. A general health service provider must not engage in behaviour of a sexual or close personal nature with a client.
2. A general health service provider must not engage in a sexual or other inappropriate close personal, physical or emotional relationship with a client.
3. A general health service provider should ensure that a reasonable period of time has elapsed since the conclusion of the therapeutic relationship before engaging in a sexual relationship with a client.

14 General health service providers to comply with relevant privacy laws

A general health service provider must comply with the relevant privacy laws that apply to clients' health information, including:

a) the *Health Records Act 2001*; and

b) the *Privacy and Data Protection Act 2014*; and

c) the *Privacy Act 1988* of the Commonwealth.

15 General health service providers to keep appropriate records

1. A general health service provider must maintain accurate, legible and up-to-date clinical records for each client consultation and ensure that these are held securely and not subject to unauthorised access.
2. A general health service provider must take necessary steps to facilitate clients' access to information contained in their health records if requested.
3. A general health service provider must facilitate the transfer of a client's health record in a timely manner when requested to do so by the client or the client's legal representative.

16 General health service providers to be covered by appropriate insurance

A general health service provider should ensure that appropriate indemnity insurance arrangements are in place in relation to the provider's practice.

17 General health service providers to provide access to code of conduct and other information

1. A general health service provider must bring each of the following documents to the attention of, or make available a copy of each of the following documents to, the clients of the general health service provider when providing or offering to provide a general health service:
   a) a copy of this code of conduct;
   b) a document that gives information about the way in which clients may make a complaint to the Commissioner.
2. Copies of these documents must be made available in a manner that makes them easily accessible to clients.

Appendix C
Definitions

Health service complaint issues

Treatment
Any issue regarding therapies provided including safety, quality and cost.

Access to services
Availability of services in terms of accessibility, waiting times, refusal of service and other constraints that limit use of the service.

Medication
Access to medication, errors in prescribing and dispensing or other decisions regarding medication.

Conduct and behaviour
The manner in which health service providers interact in relation to the delivery of their service.

Communication
Manners of communication such as rudeness, disinterest, quantity and quality of information provided about treatment, risks, benefits, outcomes and prognosis.

Diagnosis
Delayed or incorrect diagnosis.

Complaint handling
The policies and processes in place for complaint handling, including a lack of complaint handling avenues, or insufficient or delayed complaint handling response.

Facilities
The quality and cleanliness of facilities and any ancillary services.

Health records complaint issues

Access and correction
Right of individuals to access and correct health information held about them, subject to certain criteria.

Use and disclosure
How an organisation has used or disclosed an individual's health information.

Data quality
How accurate, complete, up to date and relevant the health information is, having regard to the purpose for which it is held.

Collection
How and when health information is collected.

Information available to another health service
One health service or organisation making information available to another.

Transfer or closure of a practice
The process to be followed when a practice or business of a health service provider is sold or closed.

Transborder data flows
The transfer of an individual's health information outside Victoria.

Identifiers
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.

Openness
An organisation's policies on the management of health information and steps an individual must take to access their health information.

Appendix D
Stakeholder engagement

Key stakeholder engagement/consultation

- Aboriginal Hospital Liaison Officers
- Ambulance Victoria
- Asia Pacific Reiki Institute
- Australian and New Zealand College of Perfusionists
- Australian Health Practitioner Regulation Agency
- Australian Homeopathic Association
- Australian Register of Naturopaths and Herbalists
- Australasian Sonographers Association
- Banyule Multicultural Advisory Committee
- Carers Victoria
- CGU Workers Compensation
- Dental Health Services Victoria
- Disability Services Commissioner
- Frontyard Youth Services
- Health Issues Centre consumers
- Justice Health
- Lilydale Seniors' Group
- Mental Health Complaints Commissioner
- Metropolitan and Regional quality managers
- MIGA
- Safer Care Victoria
- Safer Care Victoria Patient and Family Group
- Speech Pathology Australia
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- The Royal Australian College of General Practitioners
- U3A Kilmore
- UFS Dispensaries
- Victorian Aboriginal Community Controlled Health Organisation
- Victorian Equal Opportunity and Human Rights Commission
- Victorian Healthcare Association
- Western Victoria Primary Health Network

Presentations

- Australian Conference on Health Justice Partnership
- Australian Nurses and Midwives 2017 Conference
- Australian Shiatsu College
- Australasian Association for Quality in Health Care – VHQA Conference
- Australasian College of Health Services Management – Victorian Branch
- Bendigo Health Board
- Colac Regional Forum
- Dental Board of Australia 2017 National Conference
- Health Justice Partnerships Conference
- Hepatitis Victoria – Stigma and Discrimination Forum
- La Trobe University
  - Master of Public Health
  - Master of Health Administration
- Maurice Blackburn Lawyers
- Mental Health Complaints Commissioner staff
- Monash University, Health Law
- Patient Experience Network Group
- Royal Children's Hospital Grand Round
- Southern School of Natural Therapies Forum
- University of Melbourne
  - Doctor of Dental Surgery
  - Bachelor of Oral Health
  - Interprofessional Education and Practice Health Students' Network
- Victorian Aboriginal Community Controlled Health Organisation CQI Forum
- Victorian Board of the Medical Board of Australia
- Victorian Board of the Podiatry Board of Australia
- Victorian Healthcare Association – Chairs of Quality Committees' Network
- Victorian Managed Insurance Authority

Appendix E

Complaints received by health service provider type and speciality

Provider type	Total	Provider type speciality		Subspeciality
Dentists (private)	**347**	Dental prosthetist	21	
		Dental surgery	127	
		Dentist	199	
Hospitals	**1,822**	Private	238	
		Public	1,568	
		Psychiatric	16	
Medical clinics	**722**	24-hour clinic	149	
		Group practice	499	
		Laser eye clinic	3	
		Men's health	6	
		Not specified	57	
		Reproductive clinic	8	
Medical practitioners	**1,244**	Allergist	14	
		Anaesthetist	40	
		Cardiologist	7	
		Dermatologist	16	
		Ear, nose and throat	15	
		Emergency medicine	3	
		Gastroenterologist	6	
		General practitioner	613	
		Gerontologist	3	
		Infectious diseases	2	
		Locum	1	
		Medico-legal examiner	2	
		Neurologist	9	
		Not specified	99	
		Obstetrician/gynaecologist	52	
		Oncologist	2	
		Ophthalmologist	39	
		Paediatrician	14	
		Pathologist	4	
		Physician	17	
		Psychiatrist	99	
		Radiologist	6	
		Rehabilitation medicine	3	
		Respiratory medicine	2	
		Rheumatologist	6	
		Urologist	13	

Provider type	Total	Provider type speciality		Subspeciality	
Medical practitioners cont.		Surgeon	157	General	53
				Cardio-thoracic	16
				Orthopaedic	28
				Plastic	53
				Neurological	4
				Vascular	3
Other registered providers*	**312**	Chinese medicine practitioner	6		
		Chiropractor	19		
		Nurse	28		
		Optometrist	27		
		Osteopath	4		
		Pharmacist	84		
		Physiotherapist	27		
		Podiatrist	16		
		Psychologist	86		
		Radiology service	15		
General or non-registered health service providers**	**468**	Alcohol and drug service	44		
		Acupuncture	1		
		Alternative therapist clinic	12		
		Ambulance service	103		
		Audiologist	6		
		Beautician / laser therapist	36		
		Beauty therapy clinic	45		
		Counsellor	15		
		Day procedure centre	20		
		Diagnostic imaging service	66		
		Dietician	2		
		Disability health service	1		
		Herbalist	1		
		Hypnotherapist	4		
		Masseur	26		
		Medical technician	1		
		Naturopath	8		
		Occupational therapist	7		
		Other	5		
		Pathology services	58		
		Relaxation therapy	1		
		Social worker	4		
		Speech therapist	2		

Appendix E *continued*

Provider type	Total	Provider type speciality		Subspeciality
Prison health service providers	**1,641**			
Complaints about non-health services (as defined under the *Health Complaints Act 2016*) and organisation (as defined under the *Health Records Act 2001*)	**279**	Aged care	41	
		Appliances and equipment	3	
		Community health centre	64	
		Educational institution	15	
		Employer / workplace relations	25	
		Family planning	2	
		Fitness centre / gym	3	
		Food establishment	7	
		Government department / agency	36	
		Health / insurance	6	
		Health retreat	1	
		Hostel	2	
		Infant welfare centre	1	
		Insurance company	8	
		Law firm	7	
		Nursing home	11	
		Police	4	
		Recreational / sporting club	1	
		Rehabilitation service	13	
		Supported residential service	4	
		Other – not specified	25	
Total	**6,835**			

* *Registered health service providers refer to those professions that are regulated by the Australian Health Practitioner Regulation Agency.*

** *General health service providers are those providers that are not regulated by AHPRA but are subject to the Code of Conduct as set out in the Health Complaints Act 2016.*

HEALTH COMPLAINTS COMMISSIONER

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