Health and Disability Complaints

Office of Health Review

ANNUAL REPORT 03-2004

Contact Details

Complaints can be made in person, over the telephone, by email or in writing. All complaints will have to be confirmed in writing, and we can help you with this if required. Complaint forms are available on our website or by contacting us.

Street Address:
Level 12, St Martin's Tower
44 St Georges Tce
PERTH WA 6000

Office Hours:
8am to 5pm Monday to Friday

Postal Address:
GPO Box B61
PERTH WA 6838

Telephone:
(08) 9323 0600

Freecall (Country WA only):
1800 813 583

Facsimile:
(08) 9221 3675

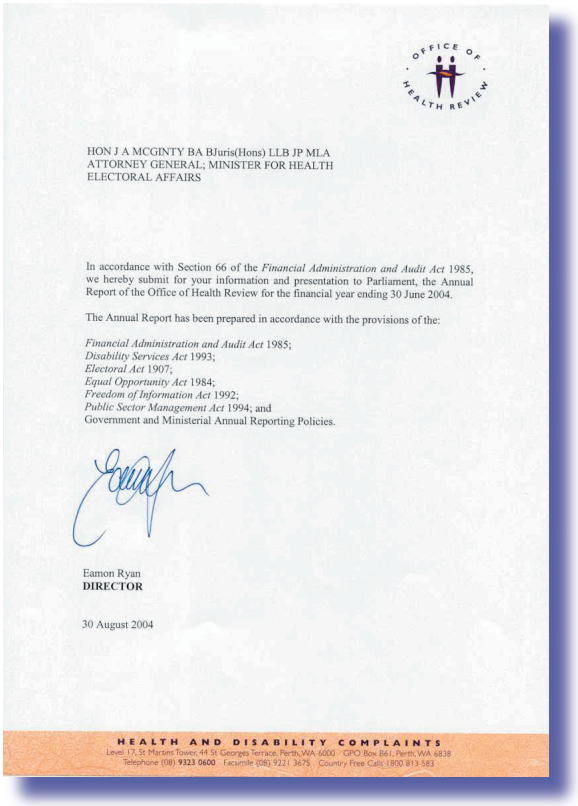
Email:
officehealthreview@health.wa.gov.au

Website:
http://www.healthreview.wa.gov.au

Inside this Report

This report describes the functions and operations of the Office of Health Review and presents the financial statements and performance indicators for the year ending 30 June 2004. The report also provides information about our work and activities undertaken during the year in dealing with and resolving complaints about health and disability service providers.

Statement of Compliance



OFFICE OF HEALTH REVIEW

HON J A MCGINTY BA BJuris(Hons) LLB JP MLA
ATTORNEY GENERAL; MINISTER FOR HEALTH
ELECTORAL AFFAIRS

In accordance with Section 66 of the *Financial Administration and Audit Act* 1985, we hereby submit for your information and presentation to Parliament, the Annual Report of the Office of Health Review for the financial year ending 30 June 2004.

The Annual Report has been prepared in accordance with the provisions of the:

Financial Administration and Audit Act 1985;
Disability Services Act 1993;
Electoral Act 1907;
Equal Opportunity Act 1984;
Freedom of Information Act 1992;
Public Sector Management Act 1994; and
Government and Ministerial Annual Reporting Policies.

Eamon Ryan
DIRECTOR

30 August 2004

HEALTH AND DISABILITY COMPLAINTS
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Contents of this Report

Part 1: An Introduction to the Office of Health Review

About us

We were established in 1996 to provide an independent and confidential means of resolving complaints about health service providers. In 1999, complaints about disability service providers were included within our jurisdiction.

We have 13 FTEs, 11 of whom are directly involved in the resolution of complaints. As at 30 June 2004, two vacant positions were in the process of being filled.

Our mission

Our mission is to make health and disability services better through the impartial resolution of complaints.

Our vision

That we are recognised and valued as a professional complaints organisation with a resolution focussed approach. We respect and protect the rights and responsibilities of both consumers and providers in the resolution process.

In practice this means -

Rights

- Consumers and providers have certain rights as set out in the legislation and we strive to protect these.

Responsibilities

- Consumers and providers both have the same responsibilities – to act in good faith, to disclose all information that is relevant and to actively participate in the resolution process.

Recognised

- People know what their rights are and how to access the resolution process.

Respected

- People are able to exercise their rights and do so with faith in the resolution process.

Protected

- People have redress when their rights are not respected during the resolution process.

Our values

Our fundamental values that guide us in all aspects of our work and relationships are –

Fairness

- Ensuring all Western Australians have equitable access to our services.
- Being equally accessible to consumers and providers.
- Being consistent and rigorous in our processes.
- Acting with integrity at all times.
- Remaining independent and impartial.

Responsiveness

- Being approachable and available for consumers and providers.
- Being sensitive to consumers and providers given the nature of complaints.
- Recognising that people are waiting on our decisions.
- Being open to different perspectives and change.
- Being open and accountable for our work.

Professionalism

- Maintaining high standards of quality at all times.
- Treating others with respect.
- Being willing to learn and improve all aspects of our work.
- Using appropriate tools and work methods.

Consistency

- Our approach to each other within the Office is reflective of how we treat consumers and providers.

Courage

- Having the courage to stand up for the things we believe in.
- Having the courage to pursue issues that require action.

- Having the courage to make decisions in a difficult operating environment and being open and accountable for these decisions.

Our operating environment

Our potential clients are all users and providers of health and disability services in Western Australia.

To put into context the broad nature of our operating environment, consider the following. Western Australia has a population of just under 2 million people.[1] The Disability Services Commission estimates that there are 381,000 Western Australians with a disability.[2] According to the Health Insurance Commission, between July 2003 and June 2004 there were over 20 million professional attendances, diagnostic procedures, pathology services and other services billed to Medicare in Western Australia.[3] This does not take into account the large number of services that do not attract a Medicare rebate. The Australian Institute of Health and Welfare records that there were over 2,000,000 patient days spent in public and private hospitals in Western Australia in 2002-2003.[4]

Functions of the Director

The *Health Services (Conciliation and Review) Act* 1995 (the Act) sets out the functions of the Director.

These functions include –

- To undertake the receipt, conciliation and investigation of complaints;
- To review and identify the causes of complaints;
- To take steps to bring to the notice of users and providers details of complaints procedures under the Act;
- To assist providers in developing and improving complaints procedures and the training of staff in handling complaints;
- With the approval of the Minister, to inquire into broader issues of health care arising out of complaints received;
- To cause information about the work of the office to be published from time to time; and
- To provide advice generally on any matter relating to complaints under the Act, and in particular –
  - (i) advice to users on the making of complaints to registration boards; and
  - (ii) advice to users as to other avenues available for dealing with complaints.

Our activities relevant to each of these functions are addressed in the body of this report.

The *Disability Services Act* 1993, in particular Part 6, sets out the provisions relevant to how we receive and resolve complaints about disability service providers.

Guiding principles for the provision of health care

The Act also sets out a number of guiding principles for the provision of health care. These principles act as a guide for providers in the provision of health care and are also a reference point for the Director in making decisions under the Act.

These principles are –

For the guidance of providers, health services should be provided so as to promote –

- Quality health care, given as promptly as circumstances permit;
- Respect for the privacy and dignity of persons receiving health care;
- The provision of adequate information on services provided or treatment available and the effects and costs of treatment, in terms that are understandable;
- Participation in decision-making affecting individual health care;
- Informed choice in the acceptance or refusal of treatment or participation in education or research programs;
- Reasonable access to information in records relating to personal use of the health care system, except information that is expressly prohibited by law from being disclosed or information contained in personal notes by a person giving health care; and
- The protection of personal health records and personal information from disclosure except for proper purposes.

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1 Australian Bureau of Statistics <http://www.abs.gov.au>

2 Disability Services Commission Annual Report 2002-2003. <http://www.dsc.wa.gov.au>

3 Health Insurance Commission <http://hic.gov.au>

4 Australian Institute of Health and Welfare <http://www.aihw.gov.au>

Principles and objectives relevant to the provision of disability services

The *Disability Services Act* 1993 has a broad application beyond Part 6, which establishes the complaints mechanism.

The *Disability Services Act* 1993 outlines principles applicable to people with disabilities and objectives for services and programmes relating to people with disabilities, many of which have relevance in the complaints context. Some of these include –

- People with disabilities are individuals who have the inherent right to respect for their human worth and dignity.
- People with disabilities, whatever the origin, nature, type or degree of disability, have the same basic human rights as other members of society and should be enabled to exercise those basic human rights.
- People with disabilities have the same right as other members of society to services which will support their attaining a reasonable quality of life in a way that also recognises the role of the family unit.
- People with disabilities have the same right as other members of society to receive services in a manner which results in the least restriction of their rights and opportunities.
- People with disabilities have the same right of pursuit of any grievance in relation to services as have other members of society.
- Services are to have as their focus the achievement of positive outcomes for people with disabilities, such as increased independence, employment opportunities and integration into the community.
- Services are to be tailored to meet the individual needs and goals of the people with disabilities receiving these services.
- Organisations providing services, whether those services are provided specifically to people with disabilities or generally to members of the community, are to be accountable to those people with disabilities who use their services, the advocates of such people, the State and the community generally for the provision of information from which the quality of their services can be judged.
- Programmes and services are to be designed and administered so as to ensure that appropriate avenues exist for people with disabilities to raise and have resolved any grievances about the services.
- Programmes and services are to be designed and administered so as to respect the rights of people with disabilities to privacy and confidentiality.

Part 2: Overview by the Director

Overview by the Director

The 2003-2004 year was both a challenging and rewarding one for us. We are currently undergoing a process of considerable change and evaluation to ensure that we continue to meet the needs of all of our stakeholders. This year we handled an increased number of complaints and also undertook additional work in implementing the recommendations arising from the review of our Office.

We were pleased to receive additional resources from the State Government in this year's budget. This will allow us to recruit an additional staff member to assist with increased complaint numbers, particularly prison complaints.

Funding to cover the cost of providing an independent complaints mechanism for complaints about disability service providers is now received directly as part of our overall funding. In the past it was provided via the Disability Services Commission. Resolving complaints about disability services is an important part of our work. We maintain a focus on disability issues and a senior officer, with broad experience in the disability sector, deals with all of these complaints. We have also developed good networks within the disability sector to assist us in resolving complaints. This focus will continue next year and beyond.

During the year we reorganised how we operate internally and now have two units within the Office to deal with complaints. The Complaints Assessment Unit focuses on the initial phase of the resolution process and the Investigation and Conciliation Unit concentrates on resolving more complex matters.

Complaints handling

In 2003/2004, complaint numbers increased by 7% compared to last year. This continues a trend which has seen a 27% increase in complaints since the 2001–2002 financial year. When considering the number of complaints received by us, it is important to note that this year, as in previous years, we count each complaint from an individual about a specific provider as one complaint, regardless of the numbers of separate issues involved in that complaint.

The issues and trends identified in complaints received this year were generally similar to previous years. However, complaints about Medical Practitioners, as a percentage of total complaints received, have fallen by 6% compared to last year. At the same time, complaints about the provision of health services in prisons, as a percentage of total complaints received, rose by 9% this year. The increase in complaint numbers from prisoners may be a reflection of our continued focus on raising awareness within the prison system about our role in resolving health and disability complaints.

As in previous years, a significant number of consumers who made an oral complaint did not confirm their complaint in writing, which they are required to do under the Act. We conducted a survey of 200 of these consumers, to see if we could identify reasons for this and whether there was more we could do to assist. Unfortunately, the number of responses we received was disappointing, although the results were generally positive about the assistance we had given to these consumers. The results of the survey are set out in Part 5 of this report.

Complaints about costs involving Medical Practitioners continue to be an issue of concern, particularly in complaints involving Anaesthetists and General Surgeons. During the year, we conducted a survey of Anaesthetists and General Surgeons who had not been the subject of a complaint about costs. The result of this research confirmed that the provision of adequate information about costs before treatment commences can contribute to a reduction in the likelihood of receiving a complaint about this issue. The results of this research are detailed in Part 5 of this report.

During the year our jurisdiction was expanded to cover complaints from consumers of health and disability services in the Australian Territories of Christmas and Cocos (Keeling) Islands. We signed a Service Delivery Agreement with the Federal Government to provide, on a fee for service basis, an independent complaints mechanism for consumers in these Territories. In the coming year, specific awareness activities will be undertaken

to promote our services to consumers in these Territories.

We were also invited to participate in a working group with the Department of Premier and Cabinet to develop the Government's Complaints Management Website and related brochures. Having the opportunity to share our complaints management experience was very rewarding.

Review of our Office

In addition to our work in dealing with health and disability complaints, we also undertook additional work this year towards implementing the recommendations arising from the review of our Office. This additional work had to be done using our existing resources and required a careful balance between maintaining a focus on our core business of complaints resolution and, at the same time, focussing on the important task of improving what we do.

Some of the recommendations require legislative change and will take longer to complete, but I am pleased to report that many of the remaining recommendations have either been implemented or considerable progress has been made toward their implementation. Details of the work we have done on this task are set out in detail later in Part 3 of this report.

Form and content of this year's Annual Report

One of the major recommendations arising from the review focussed on how we report what we do. This year we have changed the format and expanded the content of our Annual Report to reflect this recommendation. We reviewed the content of Annual Reports prepared by agencies similar to us and, in particular, agencies within the Western Australian public sector who have received awards for excellence in annual reporting. We also consulted with the Chairman of the Judging Panel of the WS Lonnie Awards to obtain feedback about the Panel's assessment of our previous Annual Report and also what the panel considered to be best practice in annual reporting.

It is hoped that the Parliament, consumers, providers, stakeholders and the general public find this Annual Report to be both informative and useful in assessing our performance over the past year.

Challenges

Meeting the challenges we faced this year has been a difficult task. Our efforts towards pursuing many competing priorities, (ie implementing the review recommendations, dealing with complaints, and continuing with our awareness activities) has put enormous pressure on our staff and other resources.

We undertook a strategic planning process which, although primarily looking at implementing the recommendations of the Review, also identified future directions for the Office and the changes necessary to meet the challenges ahead. At the same time we have endeavoured to maintain our focus on raising awareness within the community about our role and functions. In addition to this work, we have also tried to ensure that training and development activities for staff continue so that they have the knowledge and skills necessary to meet the challenges ahead.

Dealing with complaints is a difficult and challenging role and measuring our effectiveness involves a degree of subjectivity. Hopefully, this report provides sufficient information to allow the Parliament and other stakeholders to assess whether we make a difference. I am confident, however, that the work we do contributes positively to overall improvements in the provision of health and disability services. It is also important to recognise that we are only one of many organisations and individuals who have responsibility for improving health and disability services. An enormous amount of work is done each year towards improving health and disability services and it is important to acknowledge that health consumers, disability consumers, providers and others, have a responsibility to embrace positively the process of continual improvement.

We encourage feedback and complaints about our services from both consumers and providers. We have reported the feedback we received together with details of complaints about our services in Part 5 of this report.

Relationships

It is important to acknowledge the excellent working relationships and co-operation we receive from a number of key consumer and provider groups. We have worked hard to maintain and improve these relationships which are vital to how we resolve complaints and as

a means of providing statistical feedback and other information arising from complaints to promote system wide learning. In particular, I would like to acknowledge the assistance we receive from the large number of providers who give the independent expert advice that we use in resolving complaints. Such advice is invaluable to our work and is greatly appreciated by us.

This year we continued to take advantage of the opportunities that arise from our co-location with the State Ombudsman, the Office of the Public Sector Standards Commissioner, the Freedom of Information Commissioner and the Commonwealth Ombudsman. These opportunities include training and development of staff, secondments, sharing resources and shared community awareness activities. This initiative also provides a single entry point for members of the public who wish to access the various complaints mechanisms provided by each of our agencies.

Finally, it has once again been my great pleasure throughout the year to have worked with a small team of dedicated and hard working individuals who make up the staff of our office. Without exception, they are intelligent, hardworking and dedicated to the work we do. I am very grateful for their positive outlook and continued efforts in such a difficult environment.

Eamon Ryan
DIRECTOR

Part 3: Implementation of the Recommendations arising from the Review of the Office of Health Review

In December 2003 the report containing recommendations following the Review of our Office was tabled in Parliament by the Minister for Health. The Review was conducted by an Independent Reference Group who consulted widely in the course of their work. The Review focussed on the operations and effectiveness of our Office and made 47 recommendations. The Government accepted 44 of the 47 recommendations, including three that were accepted with amendments. The Minister directed that we implement the accepted recommendations.

In summary, the recommendations seek to:

- remove inconsistencies between the legislation and processes for dealing with health and disability complaints;
- make the process and reporting of complaints more efficient; and
- raise awareness of the services provided by the Office.

A complete list of the Review recommendations is provided at Appendix A. The full report of the Review is available on our website at http://www.healthreview.wa.gov.au.

We undertook a detailed analysis of the recommendations in preparing an implementation plan. We held a planning day which included looking at the way we do our work and prioritising and grouping the recommendations. An implementation plan was developed and 16 projects identified to address the recommendations.

Each project was allocated to a "Project Leader" who had responsibility for delivery of the project. Many of the projects have been completed and significant progress has been made on the majority of the remaining ones.

Recommendations 1 and 2 did not require any work on our part as they simply reinforced the continuation of our Office and the conciliation framework in which we operate.

Recommendation 33 has been deferred until such time as other recommendations have been implemented. Recommendation 40 was not included in a specific project. Disability complaints continue to receive equal recognition within the Office and we have a specialist officer nominated to deal with these complaints. This focus will continue and be enhanced in the coming year with a specific outreach and awareness strategy aimed at providing improved services to people with disabilities who wish to make a complaint.

Recommendation 44 has not been included in a specific project because it envisages enhancement of our performance management system to reflect recommended changes. Obviously, the majority of these changes will have to be implemented before any substantive work can be done on this recommendation.

A progress report has been provided to the Minister outlining the progress of the implementation of these recommendations, as required by Recommendation 47. A more detailed follow up report will be provided early in the next financial year.

The following summarises each project and the work done to date.

Project 1 ***Amending Legislation***
[Recommendations 3, 6, 7, 8, 9, 11, 15, 16, 17, 18, 19, 22, 27, 35, 36, 37, 38 & 39]

This project will involve considerable work in obtaining approval and drafting the proposed changes to the legislation. Some of these changes include: changing the name of the office; changing the time limit allowed to accept complaints; allowing us to deal with complaints about private providers refusing to provide a health service; and changing the grounds for complaints about disability services.

Discussions have been held with relevant ministerial staff and also officers in the Disability Services Commission and the WA Department of Health. Work has commenced on drafting the relevant documentation necessary to proceed with amendments to the legislation.

Project 2 ***Case Review***
[Recommendation 21]

This project has been completed.

This recommendation involved the preparation of a report for the Director for every case that has not been concluded within three months. This report allows the case officer to advise the Director on the progress and likely outcome of

the complaint and to make recommendations for further action.

A template report was developed and is currently being used. The report is required to be completed if a complaint has not been resolved within three months of the complaint being made.

Project 3 ***Core Values***
[Recommendations 4 & 5]

This project has been completed.

These recommendations involved developing a set of core values and vision for the office and disseminating these in our publications.

A set of core values and vision was developed following consultation with our staff and extensive review of what similar agencies publish. These values and vision have been published for the first time in this Report. They will also be published in our promotional material and will be available on our website.

Project 4 ***Assistance to Consumers***
[Recommendation 12]

This project has been completed.

This recommendation was that we offer consumers assistance to complete their complaint in writing.

An offer of assistance is routinely made to consumers at the first point of contact with us and this offer is reiterated in the first letter that we send to consumers. The complaint forms also contain such an offer on the first and last page, and this offer will be made more prominent when the forms are next re-printed.

Project 5 ***Review of Data and Statistics***
[Recommendation 28, 31, 32 & 41]

This project encompasses the recommendations relating to collection, maintenance, review and analysis of complaints data. This includes identifying issues and trends emerging from the data and taking action on these issues. The recommendations also relate to the systems we use for recording and reporting complaints. The ultimate aim of the recommendations is to improve the way that complaints are recorded and reported.

This project has been divided into two phases. Phase 1 relates to a six monthly review of data and the first of these has been completed. Six month data was produced, analysed and research was undertaken into an area identified from the Review relating to complaints about costs, the results of which are covered in Part 5 of this report. Phase 2 is underway but is likely to take longer to complete. This aspect involves a review of our reporting requirements and whether our current database can accommodate our future needs. We are reviewing the reporting practices and databases used by other complaints bodies to identify how they report outcomes and trends. We have identified an outline of desirable reporting capabilities to guide us in identifying a suitable database. We are also part of a working group with the Department of Health, which is reviewing the existing complaints management system used within the public health system.

Project 6 ***Clarification of Written Complaints***
[Recommendation 14]

This project has been completed.

This recommendation was aimed at ensuring that written complaints received are clear and accurate before they are sent to providers seeking a response.

A procedure is now in place which requires the officer conducting the initial assessment of the complaint to ensure not only that the complaint complies with legislative requirements under the Act but also that it clearly articulates the substance of the complaint. Where a complaint is unclear, the officer must clarify the information with the complainant.

Project 7 ***Disability Funding***
[Recommendation 42]

This project has been completed.

This recommendation required that the funding of our disability complaints function be independent of the Disability Services Commission.

Following a successful budget submission by us, we now receive direct funding from Treasury for the cost of providing an external complaints mechanism for disability complaints.

Project 8 ***Disability Forum***
[Recommendation 34]

This project is aimed at establishing a forum of complaints staff from disability service providers to share information and matters of interest in complaints handling.

An updated list of funded disability providers has been developed and letters seeking interest

in a forum have been sent to each of these providers. When the responses have been received, they will be analysed to assist in the development of the forum, which is planned to be held later in 2004.

Project 9 ***Consumer Information Regarding Registration Boards***
[Recommendation 24]

This project has been completed.

The project implements a recommendation about information to be given to consumers about the role, jurisdiction and activities of registration boards and the relationship we have with them in the complaints process.

An information sheet has been developed, following consultation with each of the registration boards, briefly outlining the role and jurisdiction of each board. This has been used by us for several months and, when appropriate, it is sent to consumers to assist them with their complaint. These will also be available on our website.

Project 10 ***Consumer Information Regarding Advocacy Services***
[Recommendation 20]

This recommendation is about information we give to consumers about the advocacy services that are available to them.

We are finalising two information sheets containing details of the major health and disability advocacy services. These will be sent to all consumers who contact us and will also be available on our website.

Project 11 ***Lodging Complaints On-line***
[Recommendation 13]

This project is about consumers having the ability to lodge complaints on line via our web site. As part of this project we have identified other areas of our website that can be improved.

We have agreed on modified text and procedural changes required to improve our website including lodging complaints on line. The final phase of this project involves working with our web site provider to redesign the site to accommodate our needs. This will be completed before the end of 2004.

Project 12 ***Frontline Staff Competencies and Training***
[Recommendation 43]

This recommendation was that we formally identify the competencies and skills required by frontline staff and to arrange appropriate training.

We have decided to expand this project to include the current and future competencies of all our staff to ensure effective complaints resolution. A training needs analysis tool has been developed for each position in the Office. These have been circulated for staff input and will be analysed to determine training needs. From this, key competencies and skills will be identified and a training plan developed.

Project 13 ***Development of Revised Key Performance Indicators***
[Recommendation 26]

This project deals with the recommendation that we develop a more comprehensive set of Key Performance Indicators (KPIs), with the intention being to measure the extent to which the outcomes sought by the Office are being achieved.

The research phase of this project is underway. The project leader is conducting research and considering what KPIs other similar agencies use. This research will assist us in the development of our KPIs. Ultimately, we will also need to consult with the Auditor General and the Department of Treasury and Finance to ensure any modifications to our KPIs meet our reporting obligations.

Project 14 ***Meetings with Inspector of Custodial Services and Executive Manager of Prisons Division***
[Recommendations 45 & 46]

This project has been completed.

These recommendations required that we schedule regular meetings between the Director and the Inspector of Custodial Services and the Executive Manager of Prisons Division, to discuss issues of common interest.

Agreement has been reached with the Inspector of Custodial Services and Executive Director of Prisons Division to meet on a formal basis at least twice a year. These formal arrangements will supplement our existing regular contact at an operational level.

Project 15 ***Raising Awareness***
[Recommendation 23 - intent only accepted]

This project relates to the importance of an increased public awareness campaign and provides the Director with a list of specific groups that could be the focus of such a campaign.

The initial scoping of this project has been completed. Some aspects of the project overlap with other projects. It was therefore determined that due to the numerous changes going on within the Office, this project would be progressed after other projects were completed. A detailed strategy will be developed to focus awareness activities on the identified areas of need.

Project 16 ***Review of Annual Report***
[Recommendation 25 & 41]

This project has been completed.

This project and recommendations related to the information we provide in our Annual Report and how we report statistics on disability complaints.

We considered the form and content of previous Annual Reports published by similar agencies. We also considered the Annual Reports of agencies and departments that had previously been the recipient of awards for excellence in Annual Reporting. We consulted with the Chair of the judging committee of the WS Lonnie Awards for excellence in annual reporting to assist in formulating our Annual Report for this year. We are also required to follow a number of legislative and government annual reporting requirements. All of this, together with the comments of the review group have influenced the form and content of this Annual Report. This process will be ongoing as we ensure that each Annual Report we produce continues to meet the needs of our stakeholders.

Part 4: Functions of the Director

This year we are reporting activities under each of the functions of the Director as set out in section 10 of the Act.

Our work in carrying out each of our functions is set out below.

Function —The receipt, conciliation and investigation of complaints under Part 3 of the Act

Introduction

This is our core area of business and takes up most of our resources.

This year we restructured our complaints team into two units, the Complaints Assessment Unit (the CAU) and the Investigation Conciliation Unit (the ICU). The CAU is our first point of contact with consumers and providers and is responsible for the initial phase of the resolution process. This includes providing advice and assistance about the complaints process, including other options which may assist in resolving the complaint. The CAU receives all new complaints and conducts an assessment to ensure that the complaint is clearly worded and within jurisdiction. They also make the first contact with the provider seeking an initial response to the issues raised in the complaint. Once the response is received, a second assessment of the complaint is made to determine if the matter can be resolved or whether further enquiries are warranted. In the latter case, the matter progresses to the ICU for conciliation or investigation.

The ICU conciliates and investigates more complex matters which usually require independent opinions, research and a more detailed assessment.

Complaints Data - Overview

During 2003-2004 we received a total of 1768 new complaints and closed 1751 complaints. This represents an increase of 7% in new complaints and 10% in closed complaints compared to last year.

The following table gives a breakdown of new and closed health and disability complaints this year.

	New Complaints	Closed Complaints
Health Complaints	1740	1718
Disability Complaints	28	33
Total	1768	1751

Table 1: Health and Disability Complaints 2003/2004

The increase in complaints received this year continues the recent trend which has seen an increase of 27% in new complaints since the 2001-2002 financial year. Refer Figure 1 on the next page.

Demographic Analysis

Wherever possible, we try to gather demographic information about the complaints we receive. This information is usually collected from our complaint form. Providing this information is optional, and therefore it is not always possible to collect demographic data about all complaints.

Gender

Female	Male	Not Identified
45%	49%	6%

Table 2: Gender of Consumers

Age of consumer*

Age Group	Percentage
Age 0-10	5%
Age 11-20	7%
Age 21-30	24%
Age 31-40	23%
Age 41-50	17%
Age 51-60	10%
Age 61-70	6%
Age 71 and Over	8%

Table 3: Age of Consumers

* In 1230 complaints, the consumer chose not to disclose their date of birth. The above figures are for the 538 consumers who provided this information.

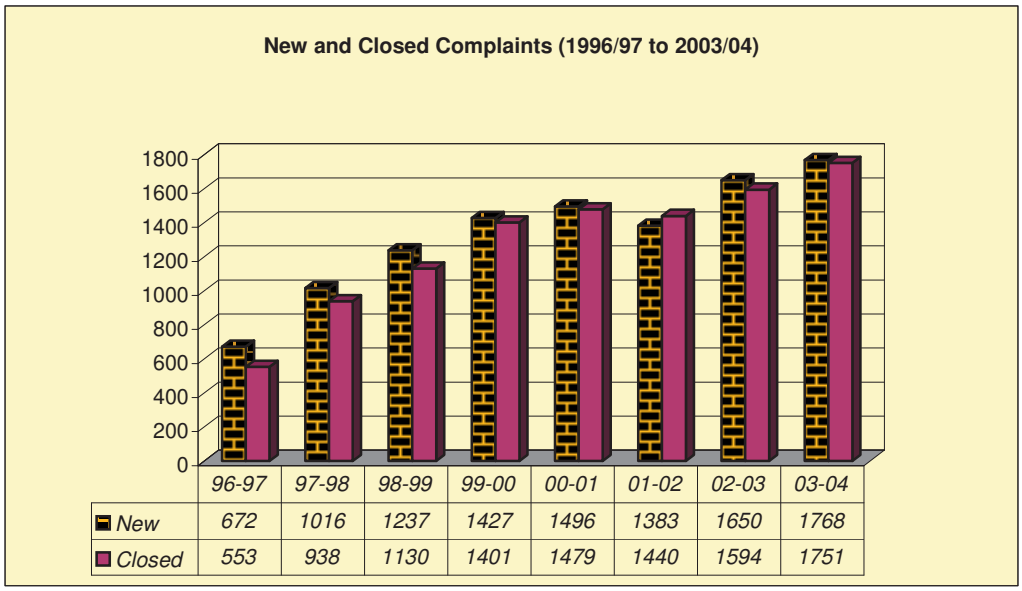

Figure 1: New and closed complaints per year

Geographical Location

Geographical information is drawn from the postcodes of the residential or postal address of the consumer.

	2003-2004	2002-2003
Metropolitan WA	69%	72%
Rural/Regional WA	18%	17%
Interstate/Overseas	1%	0%
Unknown	12%	11%

Table 4: Geographical Location of Consumers 2003/2004 and 2002/2003

The number of complaints for each postcode range in rural and regional Western Australia were as follows:

	2003-2004	2002-2003
6200 – 6299	115	100
6300 – 6399	44	47
6400 – 6499	47	34
6500 – 6599	75	66
6600 – 6699	8	2
6700 – 6799	30	41
6800 – 6899	2	0

Table 5: Rural and Regional Consumers 2003/2004 and 2002/2003

These figures are representative of the population distribution in Western Australia[5].

Workload Data

The following figures relate to the changes in active complaints on hand during the year.

Active Complaints at 1/7/2003	336
New Complaints received during the year	1768
Complaints Closed during the year	1751
Active Complaints as at 30/6/2004	353

Table 6: Workload Data 2003/2004

Active complaints as at 30/6/2004 were allocated as follows:

Complaint Assessment Unit:	175
Investigation Conciliation Unit:	178

Age analysis of active complaints:

0 – 3 months:	211
3 – 6 months:	65
6 – 9 months:	28
9 – 12 months:	17
12 – 18 months:	20
18 – 24 months:	9
Over 24 months:	3

[5] Australian Bureau of Statistics <http://www.abs.gov.au> Local government population information.

It is important to note that during the year our workload includes those complaints that were active at the beginning of the year together with the new complaints we received during the year. As noted above, not all of these were finalised, but nevertheless they were part of our overall workload throughout the year.

Complaints on hand 1 July 2003	336
New complaints 2003-2004	1768
Total complaints Handled 2003-2004	2104
Oral complaints closed 2003-2004	994
Written complaints closed 2003-2004	757
Total Complaints Closed 2003-2004	1751

Table 7: Workload for 2003/2004

Analysis of Closed Complaints

Enquiries

Enquiries about issues which are clearly outside our jurisdiction are recorded separately and include such things as enquiries about food standards or other public health issues. This year the CAU received approximately 600 calls about such issues. This figure does not include the large number of similar calls which are screened by our receptionist.

Oral Complaints

During the year we closed 994 oral complaints. This was 57% of the total number of complaints received. Oral complaints are a significant part of the work of the CAU. We only record as oral complaints those matters which, on initial assessment, are within our jurisdiction.

If an oral complaint is not confirmed in writing then, under the Act, it must be rejected by the Director. There are many possible reasons which may explain why people do not confirm their complaint in writing. We conducted a survey of 200 such complainants to see if we could identify the reasons some people do not pursue their complaint. The results of this survey are set out in Part 5 of this report.

In dealing with oral complaints, we provide the complainant with information and options for the resolution of their complaint. Often this may include some simple work on our part, such as a telephone call to a provider aimed at assisting in the resolution of the complaint.

Written complaints

Once a written complaint is received, it is assessed by CAU staff and some are rejected at this point. The following table shows the number of complaints that were rejected and reasons they were not accepted.

Complaints Rejected	
The incident occurred more than 12 months before the complaint was made	23
The complaint did not allege an issue outlined in section 25 of the Act	15
The complaint was vexatious, trivial or without substance	1
The complaint did not warrant any further action	7
The complaint did not comply with the Act	18
The issue had already been determined by a court, industrial tribunal or registration board	6
The complainant did not provide sufficient information requested by the Director	6
Outside the jurisdiction of the Office and referred appropriately	23
Total number of complaints rejected:	**99**

Table 8: Written Complaints Rejected 2003/2004

There are occasions where a complaint may be within jurisdiction, but it is appropriate to formally refer the matter to a registration board or other body. The following table sets out the number of such referrals.

Complaints Referred	
Referred to a registration board	8
More appropriately handled by another body and referred elsewhere	18
Total number of complaints referred	**26**

Table 9: Written complaints referred 2003/2004

Of the remaining 632 written complaints, the following outcomes were achieved.

Written Complaints Accepted	
Resolved mainly or completely in favour of the complainant	96
Resolved partly in favour of the complainant	115
Complaint not upheld – detailed assessment undertaken and detailed explanation given to all parties	308
Unable to be determined	23
Complaint withdrawn, lapsed or not pursued by the complainant	90
Total number of written complaints accepted:	**632**

Table 10: Written Complaints Accepted 2003/2004

Total Number of Written Complaints Closed **757**

Detailed Analysis of Health Complaints in 2003-2004

In 2003/2004 we closed 1718 health complaints. The following analysis includes oral and written health complaints.

Provider types

What provider types do consumers complain about?

Complaints are categorised by provider types. The following table shows the numbers of complaints about the major provider types over the past two years.

	2003-2004	2002-2003
Medical Practitioners	25%	31%
Prison Health Services	20%	11%
Public Hospitals	19%	21%
Medical Practices	7%	7%
Dentists	5%	7%
Dental Practices	4%	4%
Private Hospitals	4%	4%

Table 11: Major Provider types 2003/2004 and 2002/2003

Other provider types each accounted for 2% or less of closed complaints. A full list of complaints for each provider type is available at Appendix B.

There has been a significant increase in complaints about prison health services and these issues are discussed in detail in Part 5 of this report.

It is worth considering in more detail complaints data about some of the major provider types.

Complaints about Medical Practitioners

The following table shows a breakdown of the complaints about specific areas of speciality for medical practitioners.

	2003-2004	2002-2003
General Practitioners	45%	44%
Anaesthetists	8%	5%
Psychiatrists	7%	7%
Obstetricians/Gynaecologists	6%	8%
General Surgeons	4.5%	12%
Orthopaedic Surgeons	4%	5%
Plastic/Cosmetic Surgeons	3%	3%

Table 12: Complaints about Medical Specialities

Other areas of medical speciality each accounted for fewer than 3% of complaints against Medical Practitioners.

Of note is the significant decrease in the percentage of complaints about General Surgeons. We have not identified a specific reason for this decrease.

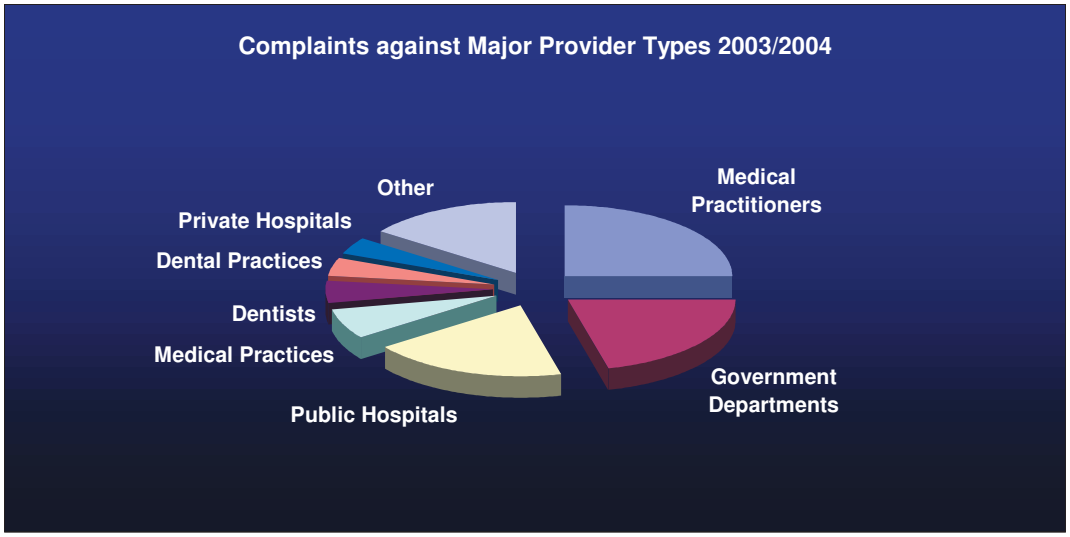

Figure 2: Complaints against major provider types 2003/2004

Complaints about Public Hospitals

The following table shows a breakdown of the complaints about specific areas of medicine within public hospitals.

	2003-2004	2002-2003
General Medicine	26.0%	29.0%
Psychiatry	22.0%	16.5%
Emergency Departments	17.0%	17.0%
General Surgery	10.0%	7.5%
Obstetrics/Gynaecology	7.0%	5.0%
Paediatrics	4.0%	2.0%

Table 13: Complaints about Public Hospitals

The remaining specialities within hospitals each accounted for fewer than 2% of complaints against public hospitals.

Issues

What issues do consumers complain about?

Issues raised in complaints are categorised under major issue types. The following table shows a breakdown of complaints under each issue type.

Issues	%
Treatment	50%
Cost	15%
Access	10%
Information	9%
Privacy	8%
Decision Making	3%
Other	5%

Table 14: Complaint Issues 2003-2004

Do issues change over time?

	2003-2004	2002-2003	2001-2002
Treatment	50%	49%	50%
Cost	15%	15%	15%
Access	10%	11%	12%
Information	9%	9%	6%
Privacy	8%	7%	8%
Decision Making	3%	3%	N/A
Other	5%	6%	9%

Table 15: Comparison of issue types 2001/2002 to 2003/2004

The three issues attracting the greatest number of complaints this financial year, as in previous years, were treatment, costs and access. A more detailed breakdown of these complaints follows.

Detailed analysis of major issues this year

Treatment complaints (Total number: 873)

- Inadequate treatment: 74.0%
- Adverse outcomes: 6.5%
- Inadequate diagnosis: 6.0%
- Wrong treatment: 3.0%
- Unskilful/incomplete treatment: 3.0%
- Failure to diagnose: 3.0%
- Wrong diagnosis: 2.5%
- Negligent treatment: 1.0%
- Rough treatment: 1.0%

Cost complaints (Total Number: 253)

- Unsatisfactory billing practices: 40%
- Inadequate information on costs: 30%
- Overcharging: 22%
- Fraud: 3%
- Medicare scheduled fee issues: 3%
- Private health insurance issues: 2%

Access complaints (Total Number: 191)

- Delay in treatment: 37.0%
- No or inadequate service: 23.0%
- Refused admission or treatment: 14.0%
- Discharge arrangements: 8.0%
- Waiting lists: 7.0%
- Access to transport: 4.0%
- Delay in admission: 3.0%
- Refusal to refer: 2.0%
- Non attendance: 1.5%
- Failure to diagnose: 0.5%

Do the issues vary between provider types?

It is interesting to consider the main issues raised in all complaints and compare whether the issues change for the more commonly complained about provider types. This allows us to make an assessment of whether certain provider types draw a particular type of complaint (refer Table 16).

It is important to exercise a degree of caution when analysing this data, as in some cases the raw figures are low and may not have statistical relevance.

Largely, the data shows similar results compared to last year. However, complaints about treatment issues involving medical practitioners have fallen by 7% compared to last year. At the same time, complaints about medical practitioners involving costs rose by 6% during the year. Complaints about costs were an issue we identified during a mid-year analysis of complaints data and we conducted a survey of medical practitioners about this issue. The results of this survey are covered in detail in the features section in Part 5 of this report.

Public hospital complaints and issue types

Because of the significant public interest in this issue, it is worthwhile examining the issues raised in complaints about the metropolitan public hospitals.

These figures have been grouped into teaching hospitals and non-teaching hospitals. The analysis looks at the numbers of complaints and the issues raised and allows comparison between similar facilities and also comparison to complains received about all health services. We sought and received permission from the Director-General of the Department of Health to provide the information in Tables 17 and 18 in an identified form.

	Treatment		Cost		Access		Information		Privacy	
	03-04	02-03	03-04	02-03	03-04	02-03	03-04	02-03	03-04	02-03
All Complaints	50%	49%	15%	15%	10%	11%	9%	9%	8%	7%
Medical Practitioners	43%	50%	23%	17%	5%	6%	11%	11%	13%	9%
Prison Health Services	75%	69%	0%	2%	8%	9%	2%	3%	2%	3%
Public Hospitals	50%	49%	1%	2%	22%	24%	11%	10%	7%	6%
Dentists	61%	67%	22%	23%	1%	2%	6%	4%	3%	0%
Private Hospitals	42%	41%	30%	34%	14%	6%	5%	6%	8%	5%

Table 16: Comparison of Issues and Provider Types 2003/2004 and 2002/2003

Metropolitan Public Hospital issues

Teaching hospitals

	Fremantle	King Edward	Princess Margaret	Royal Perth	Sir Charles Gairdner
Treatment	12	11	7	18	13
Access	6	2	3	10	9
Information	4	1	3	4	7
Privacy	1	2	1	5	1
Decision Making	0	0	0	0	2
Cost	0	0	0	0	1
Grievances	0	0	0	1	0
Other	0	0	0	2	2
TOTAL	**23**	**16**	**14**	**40**	**35**

Table 17: Teaching Hospital issues

Non-Teaching hospitals

	Armadale	Bentley	Graylands	Osborne Park	Rockingham/ Kwinana	Swan Districts
Treatment	5	7	12	1	4	4
Access	3	0	3	2	2	2
Information	0	1	0	0	1	1
Privacy	0	2	2	0	0	0
Decision Making	1	0	2	0	0	0
Cost	0	0	0	0	0	0
Grievances	0	0	0	0	0	0
Other	0	1	2	0	0	0
TOTAL	**9**	**11**	**21**	**3**	**7**	**7**

Table 18: Non-teaching hospital issues

It is clear that the issues do not differ significantly between each facility. Nor do they differ from complaints across all health services – the exception being cost, which, understandably, is not usually an issue in the public system. The major complaint issue raised consistently involve treatment and access. This data also suggests that there is no one issue type that is of particular cause for concern in an individual facility. Where a specific issue of concern or a potential systemic issue arises from an individual complaint, we, as part of the resolution process, provide information to the Office of Safety and Quality at the Department of Health with a view to promoting system-wide learning and improvements from complaints.

As one would expect the number of complaints received about individual hospitals should reflect the size of the individual facility. The above statistics (set out in Tables 17 and 18) are consistent with this contention.

Function — To review and identify the causes of complaints and to suggest ways of removing and minimising those causes and bringing them to the notice of the public.

There are a number of things we do throughout the year to fulfil this function, including regular liaison with key stakeholder groups on general issues and also dealing with providers on specific complaints. There are some issues that arise more frequently and the following relates to a couple of the more significant of these issues.

Communication and record keeping

There are many reasons consumers make complaints about health care providers. In its simplest form, one could say it is because the consumer's expectations have not been met. Whether these expectations are reasonable is a moot point. Often a complaint takes different forms, for example, a consumer suffers an adverse outcome, a mistake has been made, confusion has arisen, a misunderstanding has taken place and so on.

One of the specific reasons consumers complain relates to concerns about communication and documentation. Last year, 9% of the complaints we received were specifically about "information" (eg. lack of written or verbal information about treatment options, outcomes and risks, etc). This was the fourth largest category of complaint. Although a cause for concern, it is even more disturbing that, in our experience, a significant number of the other complaints we received also involved aspects of communication and documentation.

Where communication or documentation issues appear to be the root cause of a complaint, it is often difficult to resolve the matter to the satisfaction of all parties. When a complaint comes down to conflicting versions of an event, we look to other sources of information to assist in finding a resolution. The medical records are an obvious first source of such evidence, but if the records are inadequate or poorly written then this only compounds the problem.

We often seek an independent expert opinion to assist in resolving complaints. Occasionally, this involves the adviser actually seeing the patient, but in most cases, the opinion is provided on a review of de-identified copies of the medical records and other information. Our independent advisers often comment on the poor quality of record keeping. These comments are used to support feedback to providers about the importance of good record keeping, which we hope promotes specific learning from individual complaints.

From a provider's perspective, there are also many reasons why effective communication and documentation is good practice. Consumers now have access to their health care records, via Federal Privacy or State Freedom of Information legislation, and expect that these records should be an accurate record of their care. It is also a good risk management practice in the event of a complaint, a formal inquiry by a registration board or, worse still, litigation. Comprehensive documentation is an essential element of accountability and assists providers in answering complaints or responding to other actions.

So why does communication and documentation continue to be a problem?

It is inconceivable that health care providers are unaware of the need to follow good practice in communication and documentation. We are confident in saying this because of the numerous policies, guidelines and better practice examples regarding communication and documentation available to providers of health services.

For example, the General Practice Standards[6], which are used to accredit General Practices, contain several Standards regarding communication and documentation. Standard 1.2 states "*the practice provides the opportunity for patients to communicate their health problems and concerns and to receive sufficient information to make informed decisions regarding their care*". Standard 1.4[7] requires that the medical record is well documented. Although there is no standard which deals specifically with writing style, it is nonsensical to suggest that the record should be anything other than legible.

If health care providers want more evidence of the need for good communication and documentation they should consider the views of medical insurers. A recent article in the Medical Insurance Australia Group Bulletin[8] covered a number of issues including following up test results. The duty of a medical practitioner in this regard was cited as; "DOCUMENT (their emphasis) *the consultation and importantly the symptoms, complaints, examination findings and recommendations*". The issue of referral to a specialist was also discussed and the authors stated very strongly that the referring doctor must "*clearly explain to the patient the reason for referral, indicate the degree of urgency and the potential consequence for the patient of a failure to act on the advice*" and to minimise exposure to claim "t*he doctor should DOCUMENT (again their emphasis) the referral and follow up process*."

Another significant development relating to improving communication with patients is the Open Disclosure Standard which was an initiative of the Australian Council for Safety and Quality in Health Care and Standards Australia. The Standard aims to promote a clear and consistent approach by hospitals (and other organisations where appropriate) to open communication with patients and their nominated support person following an adverse event. Part of the Standard requires that the adverse event be investigated. Clearly, if the medical record is illegible, too brief, or inaccurate it will hinder the investigation and reduce the opportunity to be able to learn from the incident and also provide a factual account of what happened. If this is the case then the event could be repeated. It is not inconceivable

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6 *Standards for General Practices, (2nd Edition)* Royal Australian College of General Practitioners, Melbourne, 2000. (These are reviewed regularly to ensure that they are current.)

7 Standard 1.4 states that: "*Patient medical records contain sufficient information to identify the patient, and to document assessment, management, progress and outcomes.*"

8 June 2004, p.4.

that an adverse event, such as the death of a patient, could occur largely as a result of poor documentation. Such an outcome would simply be unacceptable.

Will the situation ever improve?

One has to be optimistic that good communication and documentation will become standard practice in all areas of health care. Educational institutions which specialise in health care provide evidence that these two aspects are considered important. For example, those seeking entrance to tertiary health care courses must show evidence of certain standards of both verbal and written English.[9] Medical students are now routinely assessed on criteria other than academic performance. Prospective students have to perform satisfactorily at an interview as well as in other performance based tests. In addition, many of these courses have units which deal with communication and documentation in a clinical setting[10].

However, we probably cannot wait for a new generation of health care providers. It is essential that all health care providers take positive steps to improve communication and documentation in their daily work. Providers who already listen to their patients, provide full information about treatment and associated costs and accurately document what they do will probably read this and wonder what all the fuss is about. These are more than likely to be the same providers who do not receive complaints.

Cost complaints

Another issue of interest, which was identified in our six monthly data review, was that cost complaints for medical practitioners had risen from 17% to 23%. In particular, we noticed that Anaesthetists and General Surgeons appeared to draw a higher proportion of cost complaints than other types of medical practitioners. We did some research into this issue, the results of which are detailed in Part 5 of this report.

[9] To be eligible for consideration for an undergraduate place at both Curtin University and the University of WA, the applicant must demonstrate English competence. Source - http://www.curtin.edu.au; and http://www.uwa.edu.au.

[10] Information obtained from the School of Medicine and Dentistry, UWA.

***Function* — To take steps to bring to the notice of users and providers details of complaints procedures under the Act.**

***Function* — To cause information about the work of the Office to be published from time to time.**

Throughout the year we undertook a variety of activities to promote our work and the complaints procedures available under the Act.

These activities range from the distribution of brochures and complaint forms (estimated to be around 8000 over the past three years), speaking about our role at provider and consumer seminars and conferences, participating in committees or working groups, and providing media comment on issues of public interest.

A sample of the activities where we promoted our work and role during the year include:

- Presentation to students at Murdoch University.
- Attended the Women's Multicultural Health Forum.
- Exhibition at the WA Council of Social Services Conference.
- Provided comment for newspaper articles.
- Attended conference on Effective Complaints Management in Health Care.
- Representation on the Opioid Replacement Pharmacotherapy Advocacy and Complaints Service.
- Conducted an information session for staff at the Aged Care Complaints Resolution Scheme.
- Presentation to volunteers at the Citizen's Advice Bureau.
- Provided input for television news coverage.
- Presentation to TAFE Disability Services Students.
- Meeting with staff at the Aboriginal Alternative Dispute Resolution Scheme.
- Participation in Breastscreen Consumer Reference Group.
- Ex-Officio member of Watch on Health (until it ceased functioning).

A full list of these activities is included at Appendix C.

Function — To assist providers in developing and improving complaints procedures and the training of staff in handling complaints.

We have a twofold strategy in meeting this function. In dealing with individual complaints, we regularly provide feedback to providers on ways to improve their complaints handling procedures. We also seek opportunities to promote this issue from a more systemic perspective. To achieve this objective we have a good working relationship with key consumer and provider groups. Some examples of specific projects and programs we are involved with are discussed below.

Health Care Complaints Network

We have been a member of the Health Care Complaints Network since its inception. This Network consists of complaints and customer liaison staff from public and private hospitals in Western Australia. All metropolitan public hospitals are represented and a number of rural, regional and private hospitals also contribute. This Network provides an opportunity for members to share information and develop best practice complaints handling procedures. The Network was instrumental in implementing a state-wide complaints management policy for public hospitals which ensures that consistent guidelines are followed across the public health system. We have a liaison role on this Network and regularly share information with members on complaints handling issues.

"Turning Wrongs into Rights" Project

The Director is a member of the Australasian Council of Health Care Complaints Commissioners and Ombudsman. The Council co-sponsored a project aimed at improving complaints handling procedures and developing a national set of best practice guidelines.

The NSW Health Care Complaints Commission has coordinated the project which is titled "Turning Wrongs into Rights: learning from consumer reported incidents". The outcomes achieved by this project include the development of National Complaints Management Guidelines together with draft Policies and Handbooks for health services to use in developing and improving their complaints management systems. These will be published later this year. The project has also provided tips to providers on how to implement better practice guidelines for health care services.

Function — With the approval of the Minister, to inquire into broader issues of health care arising out of complaints received.

No inquiries covering broader issues of health care were undertaken during the 2003-2004 financial year.

Function — To provide advice generally on any matter relating to complaints under this Act, and in particular —

(i) advice to users on the making of complaints to registration boards

(ii) advice to users as to other avenues available for dealing with complaints.

This year we have produced the first two of a series of information sheets which will be available to consumers and providers. We have developed information sheets on making a complaint to registration boards and also the guiding principles in the provision of health services. More information sheets will be developed as a means of providing advice and information about the complaints process, and will be available on our website once its redevelopment is complete.

Our CAU staff routinely provide consumers and providers with advice and information about our processes and other options for dealing with complaints. This includes providing information about the role of registration boards and also about advocacy resources that are available.

Our CAU staff have access to various resources and information about other avenues available for dealing with complaints. They maintain regular contact with complaints and advocacy agencies to determine questions about jurisdiction and ensure that consumers have a variety of options and pursue their concerns with the most appropriate agency. Other awareness activities conducted throughout the year supplement the work covered above.

Part 5: Feature Articles

Prosecution for failure to respond to a notice issued during an investigation

Sometimes it is necessary for us to vigorously pursue complaints, including those involving relatively minor issues.

A man complained about not being able to have his medical records transferred to his new GP. He had unsuccessfully attempted to arrange the transfer himself. When he approached us, we contacted the provider and requested a response. Over many months, despite repeated letters and telephone calls to the provider, no response was received. We commenced a formal investigation under the Act and issued a notice to the provider requiring him to attend the office and produce the records. He did not respond to the notice or the several reminders we sent.

We sought advice from the State Solicitor and commenced a prosecution of the doctor for failing to respond to the notice. Throughout the time in the lead up to the hearing the doctor did not provide the records to us.

At the hearing in the Court of Petty Sessions, the Magistrate accepted the doctor's evidence that he had written to us explaining that he could not find the records, although we had no record of having received such a letter. The doctor also gave evidence that he had only recently located the records. The Magistrate dismissed the charge, but recommended that the doctor provide the full records to us. No award of costs was made and the Magistrate noted that it was appropriate to proceed with the prosecution. We took possession of the records at the conclusion of the hearing and these were subsequently sent to the complainant's new GP.

What should have been a very straightforward matter that was resolved quickly, ended up being protracted and inconvenient for all parties.

Administration of Botox by a Registered Nurse

The rise in popularity of certain cosmetic procedures and treatments has created a potential new source of complaints.

A woman approached us with concerns about Botox treatment she had received for cosmetic purposes. In her complaint, the woman noted that a nurse had administered the Botox before she had been seen by a doctor.

At the conclusion of our enquiries, we gave feedback to the provider on a number of treatment and management issues arising from the complaint. However, we remained concerned about the issue of a nurse administering Botox without the patient having first seen a doctor. Our legal advice was that the decision to prescribe Botox could only be made by a Medical Practitioner. The advice also noted that because of the required skill and judgement necessary in selection of the injection site, it was arguable that the actual administration of Botox could be practicing medicine and, as such, it should only be performed by a Medical Practitioner.

Because of our concerns about this issue and also anecdotal information available to us which suggested that the practice of a nurse administering Botox without supervision could be common, we referred this matter to the Medical Board and the Nurses Board for consideration. We also contacted the Australian Nurses Federation (ANF) to raise awareness of the issue with their members. Following our discussions, the ANF published an article in their magazine, the Western Nurse, alerting their members to this issue and advising them to seek advice from the ANF if they were concerned about the practice.

Survey of complainants – Oral complaints not confirmed in writing

Each year a significant number of oral complaints are not confirmed in writing as required under the Act. Unfortunately, this means that we must reject these complaints and can not take any action on the issues raised.

This year we surveyed 200 such consumers to identify whether there was anything more we could have done to assist them in pursuing their complaint. Our sample was drawn from the total number of consumers who had made an oral complaint that was not subsequently confirmed in writing. We received only 27 responses, a return rate of just 13.5%, which was a little disappointing. Eight surveys were returned unclaimed by the postal service. The survey sought responses to questions about:

- Whether it was easy to contact us;
- The process of completing a complaint form; and
- The assistance and information given by us.

The results are outlined below.

	Yes	No
Was it easy to contact us?	78%	22%
Did you find the process of making a complaint too difficult?	33%	67%
Did you find the complaint form difficult to complete?	24%	76%
Would you have liked us to help you to complete the complaint form?	31%	69%
Did we assist you with your complaint when you first contacted us?	70%	30%
Did we resolve your concerns directly with the Health Service Provider?	23%	77%
Did we assist you in resolving your complaint with the Provider?	28%	72%
Did we assist you in deciding whether to pursue your complaint?	48%	52%
Was there any other information we could have given you?	22%	68%
Was there any other assistance we could have given you?	30%	70%
Was there anything else we could have done to assist you to make your complaint?	26%	74%

Table 19: Complainant Survey responses

[Note: Although twenty-seven responses were received, not all respondents answered every question. The percentages shown above are based on the total number of respondents who answered that question.]

We also asked respondents to indicate the main reason why they did not pursue their complaint. [*Note: Some respondents gave more than one response and others did not answer the question.]*

It was too difficult to complain.	10
The form was too hard to complete.	1
I was given enough information to resolve it myself.	5
I was referred to someone else.	1
Other reasons.	17

Table 20: Main reasons complainants did not pursue their complaint.

So what does this tell us?

The small number of respondents is probably not statistically representative of all consumers who do not confirm their complaint in writing. The results, nevertheless, give us valuable insight and feedback on the assistance we provide to consumers when they first contact us. The responses were generally positive in answering questions about the assistance we provided to consumers. They also highlight areas where we may be able to improve our service and we will use the results to focus our attention on these areas. Many of these areas align with the work we are already doing to implement the recommendations arising from the review.

Survey of Medical Practitioners — Cost complaints

When we look to renovate our homes or put our car in for a service we get a quote. Likewise very few trades-people would contemplate starting work on either of these jobs without at least giving a verbal quote. In fact, if we are undertaking renovations on our home we would consider it such a major issue that we would often "shop around" and get a few quotes to compare prices and to see what we are getting for our money.

Why is it then, that when we access health services we often obtain little detailed information about the costs involved? It is true that health care is a far more personal experience compared to something like home renovations or servicing our car and we do not mean to trivialise the issue. However, the financial implications are the same and the complaints that we receive about this issue suggest that it is a problem.

Complaints about medical practitioners comprise a significant proportion of the total complaints received by the Office.

Complaints about Medical Practitioners		
2001/2002	**2002/2003**	**2003/2004**
30%	31%	28%

Table 21: Complaints about medical practitioners as a percentage of total complaints

The following table shows that there have been some changes in the major issues raised in complaints about medical practitioners over the past three years. It can be seen that complaints about treatment appear to be falling but complaints about costs have risen.

Issue type	2001-2002	2002-2003	2003-2004
Treatment	57%	50%	43%
Cost	17%	17%	23%
Privacy	10%	9%	13%
Information	5%	11%	11%
Access	5%	6%	5%

Table 22: Issue types identified in complaints about medical practitioners

A mid-year analysis of complaints data identified that complaints about costs involving medical practitioners had risen compared to the previous two years, with complaints about anaesthetists and general surgeons being disproportionately higher than other types of medical practitioners. For example, cost complaints about anaesthetists accounted for 86% of all complaints about anaesthetists and they accounted for 56% of all complaints about general surgeons. Generally, cost complaints about other types of medical practitioners were in the range of 15-20%.

Our experience suggests that the most significant factor contributing to these complaints is the nature and extent of information given to consumers about the cost of their medical care. Somewhat surprisingly, in many of these complaints, there appeared to have been little or no discussion about costs prior to the commencement of treatment. In our view, both consumers and providers have a responsibility to initiate such discussions.

The Guiding Principles set out in the Act support the provision of adequate information about costs. There also appears to be general acceptance within the professions of the need to provide information about costs prior to the commencement of treatment. For example, the AMA's *Code of Ethics* acknowledges the need for doctors, where possible, to provide consumers with information about fees and it also encourages discussions about costs. This view is endorsed by many of the professional bodies and colleges.

The constant theme emphasised is the need to give sufficient information to consumers to allow them to make informed decisions and choices about their health care and the cost of their health care ***before*** any treatment commences. There are some exceptions, such as care provided in an emergency situation.

From the data shown above, one can assume that the message is not getting through to all health care providers, or if it is, it is being ignored.

We decided to survey providers who had not drawn complaints about costs to see if we could identify the reasons for this. We surveyed 38 general surgeons and anaesthetists asking about the level of information they give to consumers about costs. We were pleased to receive a 68% return rate, and express our gratitude to those providers who gave up their time to respond.

The results are set out below.

Overall results [N = 26]

	All Respondents	Yes	No
1	Routinely provide information about costs	69%	31%
2	Provide information only if asked	48%	52%
3	Provide written information on costs	50%	50%
4	Provide written quote or estimate of fees	52%	48%
5	Encourage discussions about costs	56%	44%
6	Document discussions about costs	19%	81%

Table 23: Results from all respondents

Nine of the respondents indicated that they were no-gap providers (ie. there is no out of pocket expenses to the consumer). Therefore, we re-analysed the data separating the identified no-gap providers from the gap providers.

Gap Providers [N = 17]

	Gap Providers	Yes	No
1	Routinely provide information about costs	94%	6%
2	Provide information only if asked	21%	79%
3	Provide written information on costs	81%	19%
4	Provide written quote or estimate of fees	87%	13%
5	Encourage discussions about costs	69%	31%
6	Document discussions about costs	25%	75%

Table 24: Responses from gap providers

No-Gap Providers [N = 9]

	No-Gap Providers	Yes	No
1	Routinely provide information about costs	33%	67%
2	Provide information only if asked	88%	12%
3	Provide written information on costs	0%	100%
4	Provide written quote or estimate of fees	0%	100%
5	Encourage discussions about costs	33%	67%
6	Document discussions about costs	11%	89%

Table 25: Responses of no-gap providers

Once the two groups were separated, it was clear that the overwhelming majority (94%) of gap providers routinely provide information to consumers about costs. A significant majority also provide written information on costs (81%), an estimate or quote of their fee (87%), and encourage discussions on fees (69%).

Of note was the relatively low number of providers, both gap and no-gap, that routinely document in the consumer's records discussions about costs.

In analysing these results, one needs to recognise that the number of respondents was relatively small and, therefore, the data is likely to be indicative rather than definitive. Some meaningful conclusions can, however, be drawn from the results.

It is reasonable to conclude from the foregoing that providers who give sufficient information to consumers about the cost of treatment are significantly less likely to draw complaints about this issue.

In addition, it appears that other good practices to follow include:

- The provision of written information about costs;
- The provision of a quote or estimate of fees; and
- Encouraging discussions about costs.

There is probably nothing new or startling in any of these results, especially to those of us involved in dealing with complaints, as this is something we have been saying for a very long time. The only difference is that this survey sample supports the generally held view that if providers follow good practice by providing sufficient information prior to commencing treatment, then they will benefit by not drawing complaints.

It follows that:

- consumers can concentrate on dealing with their treatment and, hopefully, getting well;
- consumers are more likely to be happy with the service they receive from their doctor; and
- ultimately, the therapeutic relationship with their doctor remains intact.

We hope that this work highlights the benefits to be gained by providers who follow best

practice. Any strategy which improves information given to consumers and, at the same time, reduces the likelihood of complaints must provide benefits to all concerned.

Customer feedback and complaints

Consumer and Provider surveys

At the conclusion of each written complaint, a client survey form is sent to both the complainant and provider seeking their feedback on the process we followed. It is often the case that a complainant or provider may be unhappy with the specific outcome of a complaint but otherwise are satisfied with the processes we followed and the manner of our staff. We ask a series of questions to gauge the level of satisfaction with each of the areas of our work.

This year we received 126 provider responses and 100 complainant responses, which is a return rate of approximately 17% for providers and 13% for complainants. This is probably too low for the sample to be statistically valid, but the responses received are valuable feedback for us.

Complainant responses (100)

	Strongly agree	Agree	Disagree	Strongly Disagree	No Answer
The staff were polite	73%	24%	0	1%	2%
The staff listened to what I had to say	67%	25%	4%	3%	1%
The reasons for decision were clearly explained to me	45%	36%	8%	3%	8%
The written information provided was easy to understand	52%	42%	1%	2%	3%
I found it easy to make contact with the office	60%	32%	3%	1%	4%
The staff were prompt in responding to my letters and phone calls	56%	29%	5%	5%	5%
I was kept informed of the progress of the complaint	54%	30%	10%	3%	3%

Table 26: Complainant satisfaction

Provider responses (126)

	Strongly agree	Agree	Disagree	Strongly Disagree	No Answer
The staff were polite	58%	32.5%	0	0	9.5%
The staff listened to what I had to say	55.5%	30%	1%	0	13.5%
The reasons for decision were clearly explained to me	51%	37%	4%	0	8%
The written information provided was easy to understand	51%	40%	1.5%	1%	6.5%
I found it east to make contact with the office	44%	36%	3%	0	17%
The staff were prompt in responding to my letters and phone calls	46%	32.5%	6.5%	0	15%
I was kept informed of the progress of the complaint	39%	45%	6.5%	1.5%	8%

Table 27: Provider satisfaction

Outcomes*

		Yes	No
I was satisfied with the outcome of the complaint	**Complainant**	49%	40%
	Provider	83%	5%
I was satisfied that the complaint was dealt with in an unbiased manner	**Complainant**	78%	10%
	Provider	82%	2%

Table 28: Satisfaction with outcome

* Not all respondents answered these questions and the figures show a percentage of total respondents.

Comments from complainants and providers

We encourage comments and suggestions from providers and complainants on our survey forms. At the end of the year, these are collated and circulated to all staff as feedback.

Some of the comments this year included:

Complainants

"*Very happy with the service"*

"It would be better if the clients received regular contact with the office, either weekly or fortnightly. Just so they know that their concerns are not forgotten"

"Your help was excellent"

"I personally found the lady who handled my complaint very competent and fair. I cannot see how you can improve on that service"

"My impression was of a staff whose mission is to justify and defend the profession against criticism"

"You did your best for us, but there are too many unanswered questions. Also if you got independent opinions they should have been taken from the Eastern States to avoid biased reports".

"I didn't need your services as I was able to resolve the matter. But you were very helpful and if I had not been able to resolve it then I would be confident that you could".

Providers

"The Office of Health Review does not seem to have a very high profile – the Office does an excellent job but I wonder if health consumers generally know of its existence."

"The whole process took a long time"

"(Staff member) is a real asset to your service. She is such a delightful person in your communication and people skills"

"What a complete waste of time. Surely you could do something worthwhile!"

"I think this is a terrific service and is an excellent unbiased way to sort out patient problems"

"I thought it was a waste of resources all round for a trivial and unreasonable complaint"

Complaints about our services

We routinely advise complainants and providers that they have a right to request an internal review if they are not satisfied with the outcome or processes we followed in resolving their complaints. This year 19 complainants requested an internal review. A senior staff member reviewed these files and, where appropriate, made recommendations for further action.

In 12 of these cases, the review by the senior officer confirmed the original conclusions made on the case. In five cases, further information was sought from the provider, independent adviser or other organisations to assist in the review. Once this clarification was sought, the reviewer confirmed the conclusions originally made by the case officer. Two reviews are still ongoing as at 30 June.

We also advise complainants and providers that they can complain to the Ombudsman if they are unhappy with the processes we followed. In 2003-2004 the Ombudsman received 11 complaints about the Office of Health Review, and finalised 13. One was referred back to us, nine were not sustained and three were closed because an opinion was unnecessary.

Prison complaints

Introduction

We have jurisdiction to accept complaints from prisoners about the provision of health services in both public and private prisons in Western Australia. This includes public prisons operated by the Department of Justice (DOJ) and private prisons managed by the Australian Integration Management Services Corporation (AIMS).

This year we received 337 health complaints from prisoners, an increase of 87% over the 180 complaints received last year. This increase is particularly satisfying because over the past few years we have put a considerable amount of work into promoting awareness of the Office within the prison environment.

Increased awareness about our Office has been assisted by our outreach program, aimed at increasing awareness among prisoners and prison health providers. Our staff have attended most metropolitan prisons to discuss our role and responsibilities with the health centre staff. We also meet with prisoners, when necessary, to discuss their specific complaints. One of our senior staff members was also involved in a prison inspection carried out by the Inspector of Custodial Services.

Complaints

	2003-2004	2002-2003
New complaints	337	180
Closed complaints	342	161

Table 29: Prison complaint numbers

Issues in closed complaints

	2003-2004	2002-2003
Treatment	80%	78%
Access	7%	7%
Policy/Administration	8%	7%
Other	5%	8%

Table 30: Issues in prison complaints

Closed complaints relating to treatment in 2003-2004

Of the complaints relating to treatment, the following issues were raised:

Inadequate treatment:	96.0%
Inadequate diagnosis:	3.0%
Wrong diagnosis:	0.5%
Negligent treatment:	0.5%

Closed Cases

We closed 342 prison health complaints this year. Of these, 7% were resolved mainly or completely in favour of consumer (for example, the service was obtained, or an explanation given), 9% were resolved partly in favour of consumer and 31.5% were not upheld.

34.5% of complaints were oral complaints and, because the complaint was not confirmed in writing, we were obliged to reject the complaint.

Just under 5% of complaints received were not within the jurisdiction of this Office and were referred to another appropriate agency. Our complaint form, which was specifically modified for prison complaints, contains an authority that allows us to refer the complaint to other bodies with the permission of the complainant. Most of these complaints were referred to the State Ombudsman.

Resolving complaints

This year we simplified the complaint form for prisoners to a single sheet, which can be faxed or mailed to the prisoner for completion.

There appears to be an unmet need for immediate advocacy for prisoners to deal with health issues. Many of the complaints we receive relate to matters that need to be addressed quickly. In recognition of this, we have an agreed process with each of the prisons where we send an email to the Director of Nursing at the prison alerting them to the prisoner's concerns. This is done with the agreement of the prisoner and often results in the concern being addressed and resolved without the need for our further involvement. This may be one of the reasons many complaints are not confirmed in writing.

Written complaints continue to be actioned quickly and a complaint form is usually sent out on the same day that we receive contact from the prisoner. We have also developed a contact network with staff in each prison health facility which helps speedy resolution. We have found that, generally, prison complaints can be resolved faster than other health complaints because information and answers to the issues raised in the complaint often lie within the medical records of the prison. This information is usually provided to us within a short time by staff at the prison health facility.

Where a complaint is of a more complex nature, the matter is referred to our Investigation Conciliation Unit for further work. Such

complaints include matters that require us to obtain medical records from sources outside the prison (for example, from a treating specialist, GP or hospital), or obtaining an independent medical opinion on the facts of the case. These complaints generally take longer to resolve, due to the additional investigative steps required to gather sufficient information for conclusions to be drawn about whether or not the services provided were appropriate.

Analysis of complaints for each prison

We sought and obtained consent from the Director General of the DOJ to report complaints about specific prisons this financial year. Of the 337 new complaints received this financial year, the following is a breakdown of complaints received about each prison (refer to Table 31).

Relationships with key stakeholders

The Director, Complaints Manager and other staff continue to liaise and meet regularly with other prison health stakeholders on specific and systemic matters. The Director and Complaints Manager also meet regularly with the Director of Health Services for DOJ and staff from the Office of the Inspector of Custodial Services. The Inspector often refers complaints to us that have been received through the Prison Visitor Service. This year we also participated as a member of the inspection team for the recent announced inspection of Rangeview Juvenile facility. We have also met with Prison Support Officers and other stakeholders, including the Deaths in Custody Watch Committee (WA) Inc.

Prison Case Studies

Specialist appointment

A prisoner complained that he had missed an appointment with a specialist who attended the prison to conduct a clinic. When we brought this to the attention of the prison medical staff, the appointment was rescheduled so that the prisoner could see the specialist at the next clinic in two weeks time. We also made enquiries about how to prevent this happening again in the future. It appeared that the missed appointment was due to the prisoner's appointment card not being received by the staff in charge of prisoner movements. The security staff maintained that a card was not provided to them, whereas the medical staff stated they did provide the card.

To prevent such misunderstandings occurring again in the future, the Prison Superintendent requested that health staff provide security staff with a list of prisoners who have appointments for a particular day, as well as the individual appointment cards. As such, the complaint has led to a system improvement for all prisoners.

Prison	Total Number of Complaints	Issues				
		Treatment	Access	Administrative Practice	Privacy	Other
Acacia	**81**	57	14	7	0	3
Albany	**5**	4	0	1	0	0
Bandyup	**33**	26	3	1	1	2
Rangeview	**1**	1	0	0	0	0
Broome	**3**	3	0	0	0	0
Bunbury	**9**	7	2	0	0	0
Casuarina	**60**	43	6	6	1	4
Eastern Goldfields	**1**	0	0	0	0	1
Greenough	**5**	4	1	0	0	0
Hakea	**99**	78	9	6	2	4
Karnet	**10**	5	0	4	0	1
Nyandi	**18**	14	0	2	2	0
Roebourne	**3**	3	0	0	0	0
Wooroloo	**9**	8	0	0	0	1
Total	**337**	**253**	**35**	**27**	**6**	**16**

Table 31: Complaint issues for each prison

Provision of medication

A prisoner was concerned that he had not been provided with special cream for a dermatological condition in a timely way by health staff. Although it had been prescribed to him during his admission assessment, it had not been dispensed. We discovered that the cream was not a medication usually stocked in the prison pharmacy, and, as such, when it was prescribed by the doctor, it had to be ordered. The prisoner was admitted to the prison on 1 January 2004 and the medical records indicated that the ointment was unavailable but had been ordered on 2 January. His skin was assessed as being in a very bad condition when he first entered prison and was difficult to bring under control with other medications which were being used in the interim. He eventually received his cream, with repeats, and was advised to let medical or nursing staff know when he was running low on the cream, so it could be re-ordered in plenty of time. He was also put on a program where his condition was regularly reviewed.

Manner of staff in a prison

During this financial year, a number of complaints were received regarding the manner of the provision of health services in a prison. These usually involved a prisoner being withdrawn from opioid replacement therapy treatments by a doctor at the prison. The Director and the Complaints Manager met with the Director of Prison Medical Services, the Director of Prison Nursing Services and a prison chaplain about this issue.

It was usually found during our enquiries that the withdrawal of the medication had not been inappropriate. It appeared, however, that manner issues were involved in many of the cases. Prisoners raised concerns that they felt they were being punished by the withdrawal occurring. It was obvious that better communication, or more standardised pharmacotherapy withdrawal regimes would have assisted to reassure the consumer about the treatment.

This has now largely been provided by the Prisoner Addiction Service Team (PAST), which was established to provide a comprehensive pharmacotherapies program for prisoners in line with the Justice Drug Plan. The PAST's objective is to provide a comprehensive pharmacotherapies program to help offenders reduce their drug use. This team has protocols and procedures in place which appear to have reduced this type of complaint – that is, since the introduction of the PAST, prisoners have raised fewer concerns that their opioid replacement therapy was being arbitrarily withdrawn or reduced.

Mental Health Complaints

During the year we received 134 complaints about mental health services. As expected, there were significantly more complaints about public mental health services (98 complaints) than private mental health services (36 complaints).

For both public and private providers of mental health services the overwhelming majority of complaints were about treatment. Access was the second most significant issue in public mental health complaints, whereas costs and privacy were the second most significant issue in the private setting.

The majority of complaints about private mental health services were complaints about individual Psychiatrists.

The following table presents analysis of complaints data relevant to both public and private providers of mental health services in comparison to the major issues raised in all complaints.

It is important to apply a degree of caution when interpreting this data as some of the raw figures are quite small and may not have statistical relevance.

The two major issues raised in complaints about public mental health services, ie treatment and access, are the same as the major issues raised in complaints about public hospitals.

67% of mental health complaints we received this year were not confirmed in writing as required by the Act. A large number of these oral complaints were from involuntary patients who raised concerns about their involuntary status or compulsory treatment received under the *Mental Health Act*. In addition to providing information about our role, we routinely provide these consumers with information about the role and functions of the Mental Health Review Board and the assistance that is available from the Mental Health Law Centre and the Council of Official Visitors. In our experience these consumers are particularly vulnerable and it is crucial that they have access to adequate support and advocacy services to meet their needs.

	Treatment	Cost	Access	Information	Privacy
All complaints	50%	15%	10%	9%	8%
Public Mental Health Services	59%	0%	17%	4%	7%
Private Mental Health Services	44%	17%	5%	8%	17%

Table 32: Comparison of public and private mental health complaints 2003/2004

Part 6: Health Case Studies

Travel subsidies for rural patients

Some public patients travelling from rural, regional and remote areas for treatment are entitled to a Patient Assisted Travel Scheme (PATS) subsidy to assist with travel and accommodation expenses.

A man complained that his wife was not given an accommodation voucher for an indefinite stay when the couple travelled to Perth for her cancer treatment. He was told by staff at the rural hospital that PATS would only cover accommodation for three nights and that the hospital in Perth would need to arrange any further accommodation needs.

When we received the complaint, we contacted the PATS staff at the Department of Health to clarify the woman's entitlements. The matter was resolved once PATS staff in Perth clarified the situation with all parties involved. The country health service had been correct in initially only providing three nights accommodation. It appeared that the man had been given inaccurate information in Perth and once the matter was clarified, the woman's PATS approval was updated to allow for further accommodation as required.

What can we learn from this? If seeking PATS approval, always ask for clarification about your entitlements. If in doubt, clarify with the facility in Perth and/or the Department of Health.

Health service responds positively to a complaint

A relatively straightforward complaint was resolved quickly by a positive response by the provider.

A woman complained that her elderly mother had been given confusing information in a letter about public dental treatment and that when she attempted to resolve the matter with the health service, they were rude to her.

When we sent the complaint to the health service, they replied promptly and apologised to the woman for the confusion in relation to the information provided. They recognised that their letter could be ambiguous and undertook to amend it to ensure that their service was improved for future patients. They also apologised that the patient's expectations had not been met and, as a gesture of goodwill, offered to reimburse the fee paid for the service.

Detailed explanation can resolve distressing complaints

Sometimes a detailed response saves time in the long run and can resolve matters quickly.

A 12–year old child received an immunisation at his school and subsequently had a reaction and fainted. The child's mother was concerned that the service provider had not appropriately monitored her child after the immunisation and had rushed the children through the immunisation process.

When we sent the complaint to the local government authority who were responsible for giving the immunisations, they wrote a very detailed explanation about what had happened. They included copies of their relevant policies and protocols, and the Australian Immunisation Guidelines. This information allowed us to resolve the matter and provide an explanation to the mother about what had happened. We were also able to reassure the mother that her child had experienced a common side effect and had been observed for the required length of time following the immunisation.

Confused response to a potential SARS risk

An unusual situation caused concern for both the complainant and provider.

A woman who had recently returned from Indonesia consulted her GP for what she thought was an ear and throat infection. The doctor was concerned that the symptoms raised the possibility of Severe Acute Respiratory Syndrome (SARS) and followed protocols outlined in the Commonwealth Government's Interim Australian Infection Control Guidelines. He put on a surgical mask, gloves and a hair net and also required the patient to wear a surgical mask.

The doctor noted in his response to the complaint that, although his examination convinced him that the woman was a low SARS risk, he had followed the recommended guidelines and advised her to go to the nearest hospital emergency department

without delay should her symptoms worsen. He also prescribed antibiotics and asked the woman to wear the surgical mask until she left the surgery. The woman said that she was distressed and anxious and felt that she had not received adequate guidance and information on what she should do next.

The doctor apologised for the stress the woman had experienced and said that he regretted any offence caused by the procedures implemented by him. The doctor's actions did not seem to be inappropriate, given the national guidelines, however, we suggested that he could improve his procedures to ensure that such patients are given printed information about SARS, the incubation period, symptoms and precautions.

Complaint leads to a procedural change

A man complained that his child had been referred for public orthodontic treatment and was placed on a waiting list. After waiting for 18 months, the child attended the orthodontic clinic and was told that the work he needed was only cosmetic and, therefore, he was not eligible for public treatment. Understandably, the man was very unhappy and said that if they had been told this 18 months earlier, they would have sought treatment privately, rather than waiting in the belief that they would obtain treatment.

Following consideration of the matter, we concluded that the provider's policy was appropriate and consistently applied. They only provide publicly funded orthodontic treatment to those patients with a serious functional dental problem and not simply for cosmetic purposes. We were concerned, however, that the provider was not able to assess patients before placing them on a waiting list in order to screen which patients were not eligible. After discussing this matter with the provider, they agreed to clarify the letter they send to all new patients when a referral is first received and explain the policy. The existing letter was modified to clarify that patients who need orthodontic work for cosmetic purposes only will not be treated, and if patients are uncertain whether their needs are purely cosmetic, then they may wish to arrange an appointment with a private orthodontist for advice. The provider also undertook to remind all referring dentists and clinics of the criteria for treatment.

Lawyers and others at psychiatric interviews

A man was being admitted to a hospital as an involuntary psychiatric patient and wanted to have his lawyer, who was also present at the time, with him during his assessment. The hospital staff initially refused to allow the lawyer to be present during the interview, arguing that there was no requirement to do so under the *Mental Health Act.* The man was concerned that if he wished to have his lawyer present then he should be allowed to do so. We agreed that the man's request seemed reasonable.

We discussed this matter with the Mental Health Review Board, the Mental Health Law Centre and the Office of Mental Health to seek their views. These discussions confirmed that there did not appear to be any impediment to this happening under the *Mental Health Act*. Our view was that if a patient wished to have a lawyer present, and it would not interfere with the clinical assessment, then they should be able to do so, in the same way that they should be able to have any other support person present.

We also discussed the issue with the Chief Psychiatrist at the Department of Health. The agreed position was that as long as the presence of a lawyer (or other support person) did not interfere with the clinical assessment required under the *Mental Health Act*, then a patient should be allowed to have a lawyer present during an interview. However, there was no obligation on a doctor to wait for a lawyer to attend. The Chief Psychiatrist undertook to raise awareness about this issue at an upcoming meeting of the Clinical Advisory Group within the Department of Health.

Reconsideration of a decision to refuse an electric scooter

It is important that assessments are made taking into account all of the relevant information.

A man with an acquired brain injury was referred by an occupational therapist to a public hospital for an assessment and, if appropriate, provision of an electric scooter. A specialist assessed his ability to control a scooter and rejected his application on safety grounds. The man complained to us that the assessment was inadequate because it did not take into account positive occupational

therapy (OT) assessments or his request that conditional approval for local use be given.

Following review of the hospital records and the occupational therapy case notes we established that the specialist did not have all of the notes made following the OT assessments and no consideration had been given to the possibility of a conditional approval. We requested that the hospital obtain a second medical opinion from the specialist, reconsider the man's application and examine the possibility of a conditional or restricted approval for the use of the scooter. We also suggested that the man's Local Area Coordinator attend any future assessments or consultations to provide support and to assist with communication. These recommendations were accepted and a subsequent review resulted in the approval of the man's application for an electric scooter.

A GP's error

Positive action by a GP leads to a complaint with a satisfactory outcome.

A GP treated a two year old child who had sustained a laceration above his eye. The following day, the GP telephoned the child's mother to inform her that he had applied the wrong solution to the child's face around the sutured laceration site. The solution used by the GP caused a superficial burn to the skin. Following the incident, the parents took their child to a dermatologist for review. At the second consultation, four months after the injury, the dermatologist advised that there would be no scarring from the superficial burn.

The case was resolved by the GP reimbursing the parents for the two visits to the dermatologist. The GP also made changes within the surgery to the way in which the solution bottles are stored to ensure that such an incident could not happen again.

A new pair of orthotics

Independent advice obtained by us often results in the resolution of complaints.

A man attended an orthotist for new inner soles (orthotics). He has been attending the practice for some years but it had recently been taken over by another orthotist. The man was provided with new orthotics and told to return within a month if there were any problems. When he returned after two months he was experiencing problems with his knee and felt that this was a result of the new orthotics.

The orthotist made some minor adjustments over four subsequent visits but the problems persisted. The man then requested a refund so that he could seek treatment elsewhere. The provider refused this request and the man then complained to us.

We obtained independent advice on the matter, which indicated that the leg length measurement was incorrect and insufficient height had been added to one inner sole. This information was given to the provider who admitted that he had not re-measured the man's leg length even after he had returned a number of times to get the orthotics adjusted. The provider agreed to refund the consumer's health insurance fund and also reimbursed the out of pocket expenses that had been incurred as a result of the ill fitting orthotics.

Unsatisfactory Dentures

Sometimes, despite our best efforts, it is not possible to reach a satisfactory resolution.

A man complained to us that his dentures were not satisfactory as they were uncomfortable and unsuitable for his needs. Prior to approaching us he had a new set of dentures made by a different provider which were comfortable, so he was seeking a refund from the first provider for the amount paid for the original set of dentures.

We obtained an independent opinion which was critical of the first dentures. Our independent adviser explained that the bite and fit were incorrect and that, although clinically the patient did have a difficult mouth, it was possible to make suitable dentures for him.

We put this opinion to the prosthetist and suggested that he consider a full refund. The prosthetist argued that this was not an appropriate remedy because the patient had not attended for the full 12 months of adjustments that he had recommended. In light of this view, we proposed that he consider a partial refund, but the prosthetist refused. He disagreed with our independent advice and felt that we were not in a position to recommend a refund. Ultimately, we were unable to achieve resolution, so we concluded that his treatment of the patient was unreasonable and formally recommended that he refund the cost of the dentures. The prosthetist refused to accept this recommendation. We considered what other options were available. There is no Registration Board for Dental Prosthetists and because it appeared to be an isolated

incident, the matter did not warrant a report to Parliament. For this reason, there was nothing more we could achieve. We closed the file and suggested to the complainant that he may wish to pursue the matter via the Small Claims Tribunal.

Formal powers required to obtain a response

Occasionally, a provider will ignore a complaint because they appear to give it little or no priority. This type of approach simply causes more problems than it solves and is a frustrating waste of everyone's time and resources.

A woman complained that the account she had received for surgery was more than she had expected. We sent the complaint to the provider for a response. Despite numerous reminders, we did not receive a response. We commenced a formal investigation and the provider was issued with a notice to appear to answer questions about the matter. The provider then telephoned us and stated he was preparing his response. Accepting the provider's word, the notice was withdrawn but once again, the response, as promised, was not forthcoming. The notice was reissued, the response promised, but again it did not arrive. Finally, after contacting the provider's indemnity insurers and discussing the matter with them, we received the response. The response was sufficient to allow the matter to be resolved and the matter was closed within a day of us receiving the response. The complaint was not substantiated but we had sufficient information to provide an explanation to the complainant. We pointed out to the provider in our closing letter that the distress that had been caused to the consumer and to him and his staff could easily have been avoided by providing the response at the earliest opportunity.

Part 7: Disability Complaints

Disability complaints receive particular attention within the Office. We have a specialist investigation officer who handles all disability complaints. This officer has broad experience in the disability sector and has established a vast network of contacts to assist in our work and promote what we do.

Although the actual number of complaints remains relatively small in comparison to health complaints we will continue with the specialised attention we give to disability complaints.

Analysis of Disability Complaints

Complaint Numbers

We received 28 new disability complaints in 2003/2004 and closed 33 complaints. 14 of the new complaints were confirmed in writing.

Five complaints remained open at the end of the financial year. Four of these are in conciliation and one complaint is awaiting further information from the complainant before any further action can be taken.

	2003-2004	2002-2003	2001-2002	2000-2001
New complaints	28	43	24	17
Closed complaints	33	42	23	12

Table 33: New and closed complaints 2000/2001 to 2003/2004

Number of complaints carried forward from previous year:	10
New complaints received 2003/2004:	28
Total number handled 2003/2004:	38
Number of complaints closed 2003/2004:	33
Complaints on hand 30 June 2004:	5

Table 34: Active Cases

What issues and services do people complain about?

Provider types

Of the complaints received this year, 13 were about non-government service providers, 11 were about the Disability Services Commission and three were about public authorities. In one complaint the provider was not identified.

	2003-2004	2002-2003	2001-2002	2000-2001
Non government service provider	13	22	17	9
Disability Services Commission	11	16	5	5
Public authority	3	2	2	3
Not identified/Other	1	3	0	0

Table 35: Provider types 2000/2001 to 2003/2004

Who complains

24 complaints were made by family members, carers or advocates acting on behalf of adults or children with disabilities. Four complaints were made by people with disabilities acting on their own behalf.

	2003-2004	2002-2003
Complaint by carer/family member	24	36
Complaint by consumer	4	7

Table 36: Source of complaints 2002/2003 and 2003/2004

Issues

The majority of complaints were about service quality (18). The remaining complaints were spread evenly over several issue types. Two complaints were about service eligibility, two about funding or not making a grant, two about privacy and confidentiality, one about staff conduct, one about refusal of service, one about policy, and one about communication.

This year we changed the way issues are recorded on our database to more accurately reflect the specific issues associated with disability complaints. For this reason, it is not possible to make a direct comparison with issues in disability complaints in previous years. However, we can state that service quality is consistently the greatest area of complaint. In future years we will be able to provide comparative analysis of the issues raised in complaints.

Service Quality	18
Service Eligibility	2
Funding	2
Privacy/Confidentiality	2
Staff Conduct	1
Service Refused	1
Policy	1
Communication	1

Table 37: Disability complaint issues

Outcomes of closed complaints

This year we closed 33 disability complaints.

Five complaints were resolved partly in favour of the complainant. Five were withdrawn or lapsed, three were unable to be determined, two were not upheld, one was referred elsewhere, one was out of jurisdiction and one was declined. The Director rejected 15 complaints because the complainant did not confirm the complaint in writing as required by the Act.

Partly in favour of complainant	5
Withdrawn or lapsed	5
Unable to be determined	3
Referred elsewhere	1
Out of Jurisdiction	1
Not upheld	2
Declined	1
Not confirmed in writing	15

Table 38: Outcomes of closed disability complaints

Why disability complaints are not confirmed in writing

When a complaint is received by telephone or at a personal interview, the complainant is provided with information about the complaints process, advice about how to resolve their complaint and also a brochure about the Office of Health Review and a Complaint Form. We provide resources and information about other agencies where assistance may be available (such as advocacy services). When required we also offer assistance with completing the Complaint Form.

In an effort to determine why some complainants do not proceed with their complaint and confirm it in writing, each complainant was contacted by telephone or in writing after their initial contact with this office.

Of the 15 oral complaints that were not confirmed in writing this year, two were unable to be contacted; five did not return calls or reply to correspondence; two wanted their concerns registered but did not wish to pursue their complaint through the Office and six were receiving assistance from other agencies or the situation had been resolved directly with the provider. This feedback is useful to us and it was reassuring that we were doing all that we could to assist those people who required our help.

Disability Complaints — the Year in Review

Review of the Office of Health Review

The review of the Office, which was completed during the year, included an examination of our role and functions as the independent complaint mechanism for disability services under Part 6 of the *Disability Services Act* 1993.

The Reference Group made several recommendations specifically relating to complaints about disability services. The Reference Group acknowledged that extensive consultations on this issue had occurred during the review of the *Disability Services Act* 1993. Amendments to the *Disability Services Act* 1993 have been proposed to address a number of the operational inconsistencies between the *Health Services (Conciliation and Review) Act* 1995 and the *Disability Services Act* 1993. These proposals include changes to align the functions of the Director in relation to health and disability complaints and to broaden the issues about which a complaint can be made.

It was also recommended that the name of the Office be changed to include the word "disability" to better reflect our dual functions in receiving complaints about health and disability services. This change should address the problem of the name of the Office not readily identifying our role and functions in resolving health and disability complaints.

Many of the specific recommendations have been previously discussed in Part 3 of this report and a full list of the recommendations is available at Appendix A.

Providing assistance to providers

The Director has taken steps to implement a recommendation made by the Reference Group that we coordinate a forum of complaints officers from disability service providers in order to discuss matters of common interest in relation to complaints handling processes. We have updated our data base to include details of all funded non-government disability service providers and a small number of private for-profit service providers. We have sent each provider a letter and a questionnaire to ascertain the level of interest in such a forum, what form it should take, and whether it should be followed by regular meetings on, for example, a quarterly basis. We hope to proceed with this project early in the 2004-2005 financial year.

Public Awareness

Public awareness activities conducted over the past twelve months include maintaining contact with service providers and attending meetings, forums and other events attended by consumers of disability services and their families. We presented a talk at Thornlie TAFE to disability services students and participated in a Disability Services Commission consultation workshop on the 9th Disability Service Standard. We distributed brochures to service providers and other agencies that support people with disabilities and their carers in the community. A short visit to the south west of the State enabled meetings to take place with the DSC Local Area Coordinators and service providers in the Bunbury and Busselton area.

We have also developed a good working relationship with the Health Resource and Consultancy Team (HRCT) at the DSC to facilitate the exchange of information regarding the experiences of people with disabilities in the health system. This contact enables both of our agencies to work with health providers to improve service access and quality for people with disabilities.

National Disability Abuse and Neglect Hotline

Following a meeting with the General Manager of the National Disability Abuse and Neglect Hotline in 2003, we signed a Protocol aimed at ensuring a prompt and effective referral of notifications received by the Hotline concerning disability services in Western Australia. The primary focus of the Protocol is to ensure that allegations of abuse and neglect are investigated and a resolution is achieved. Since the Protocol was signed on 15 November 2003 we have received three notifications. One was withdrawn by the complainant, one is in conciliation and one is awaiting authorisation from the complainant before being taken any further.

Private providers and the Disability Service Standards

Two complaints regarding service quality and costs have raised the issue of how we can encourage private-for-profit providers to meet standards similar to the National Disability Service Standards (the Standards) when providing services to individuals. The DSC agreed with our view that the Standards were an appropriate benchmark for disability service provision. Unfortunately, the DSC have no

jurisdiction or responsibility for services that are not funded by them.

When complaints are made to us about disability services received from private for-profit providers, we endeavour to use the Standards as well as the Principles and Objectives contained in the *Disability Services Act* 1993 as benchmarks for our assessment of the services provided and to help form recommendations for service improvement or other action.

Disability Case Studies

No Standard or Benchmark exists

A complaint about a private autism service provider highlighted the difficulties in determining what a reasonable standard of service delivery should be in an area where no standards or regulations exist. The complaint concerned the cost and quality of a private home based autism program. In the course of our enquiries, we sought advice from an interstate expert who advised that although it was preferable for a speech pathologist or a psychologist to be involved in the assessment and implementation of a home based autism program, there was no regulation that required a practitioner to have formal qualifications or to be supervised. The quality issue was resolved when we confirmed that the provider had extensive experience in home based educational programs for children with autism and that the assessment process had involved a clinical psychologist.

The cost of the home based program was also a matter of dispute between the complainant and the service provider and was a difficult issue to resolve. A clinical psychologist was involved in the assessment and we established that the rate charged was close to the standard hourly rate for a qualified psychologist. The advice we received supported the view that the amount charged for individual therapy services carried out by trained but unqualified providers was in a range considered to be reasonable. Conciliation in this matter resulted in a without prejudice offer by the provider to reduce the account by 20% and this was accepted by the complainant. A private disability service provider is not constrained by any particular schedule or recommended fee for this type of service. Accordingly, the lesson here is that it is a good practice for consumers to obtain quote, check the credentials of the person providing the service, and try to determine if the amount appears reasonable.

Importance of a service plan

The parent of an adult with a disability complained about the quality of a community access and recreation service received from a private for-profit service provider. Our enquiries revealed that there was no service plan in place and that there was some misunderstanding between the parent, the referring agency and the provider about whose responsibility it was to prepare such a plan prior to the service commencing. The parent believed that the referring agency and the provider had prepared a service plan based on information they had supplied. The provider, in the absence of a service plan, proceeded to provide services with what little information they had acquired from the person who made the referral. As a result, the service did not meet the needs of the consumer and after two incidents over a twelve-day period the service was cancelled.

Following conciliation of this matter, we made recommendations to the service provider about the importance of ensuring that a service plan is agreed between the consumer and his or her family before a service is commenced. As a result of this complaint, the provider has introduced a policy that requires a service plan to accompany referrals before it will agree to provide the service.

Grant of funds not made

The DSC refused to grant additional funds for a consumer through its Combined Applications Process. The complainant, who is a parent of an adult with a disability, complained that the DSC did not take into account her son's deteriorating condition when considering his application and that there was no appeals process available. We established that the process undertaken by the Independent Priority Assessment Panel included consideration of the applicant's deteriorating condition, based on medical reports. We also concluded that the process of allocating funds through the Combined Applications Process was fair and equitable. In relation to the absence of an appeals process we concluded that, because of the finite amount of resources available, if one decision is altered it would effect the basis of all other decisions and, as such, an appeal process may not be workable. Although this may not seem to be a perfect outcome, another

solution could not be identified. The complaint was not upheld.

Service improvement as a result of a complaint

A man complained that his elderly father who has a disability received a poor standard of in-home support from a non-government service provider. Because the service was not subsidised, and involved the provision of 24 hour care, 7 days a week, considerable costs were involved. We identified a number of shortcomings in the agency's procedures, which contributed to misunderstandings between the agency, the carers and the family. This resulted in some failures in service delivery and a cancellation of the service after only eight days. We made a number of recommendations for service improvement, including: where written contracts are required, these should be agreed and signed prior to the commencement of the service; that appropriately qualified professionals should be engaged to conduct needs assessments; that a comprehensive Care Plan is prepared in consultation with the client and family; that the client should meet carers before they are engaged for personal care duties; and that where a hoist is involved carers should be appropriately trained. The provider advised us that new procedures have been introduced as a result of the recommendations made by us.

Part 8: Reporting

Statutory Report

In accordance with the Government's *Strategic Planning Framework for the Western Australian Public Sector* we are pleased to report our contribution to the specific goals which are relevant to our operations.

GOAL 1 — People and Communities

Agency specific reporting

During the year our work contributed to the following outcomes for this goal:

- Outcome 4 – an excellent public health system.
- Outcome 9 – opportunities for health, participation and security are optimised in order to enhance quality of life as people age.
- Outcome 10 – a positive difference to the lives of people with disabilities, their families and carers.

We provide an independent complaints resolution process which allows members of the community to have concerns about health and disability services resolved in confidence. The complaints resolution process often identifies improvements which, in turn, contribute to better health and disability services. Our services are available at no cost to members of the community and are an important means by which an individual's concerns and experiences can lead to positive improvements. Ultimately, the availability of such services contributes to the quality of life and wellbeing of all Western Australians.

Obligatory reporting

Disability Service Plan Outcomes

Our Disability Service Plan identifies potential barriers for people with disabilities in accessing our services and looks at ways to overcome such barriers. Our new accommodation includes a reception area that is spacious and wheelchair accessible.

All of our publications, including our brochures, are available in braille or on audiotape, and are available on our website. Our website is currently under review, and one of the objectives is to improve its accessibility to people with disabilities. Our senior investigation officer, who deals with complaints about disability services, has extensive experience in the disability sector. This officer provides staff with information and support to assist in handling complaints from people with disabilities.

This year we did not hold any public consultations. However, in our Disability Services Plan we identify people with disabilities as being key stakeholders who must be encouraged to participate in any such consultations.

Cultural Diversity and Language Services Outcomes

We have a language services strategy that we follow. Our policy is to:

- Where required, use independent, qualified interpreters and translators when dealing with clients from culturally and linguistically diverse backgrounds.
- Translate correspondence to and from clients who do not have English as their first language.
- Provide multilingual guides. These provide information about our services in 15 community languages.

Youth Outcomes

We do not have a specific strategy targeting young people, as our service is available to all Western Australian users of health and disability services. Many of the complaints we deal with are from parents or guardians and, occasionally, from young people themselves. There is no age restriction on making a complaint to our Office.

GOAL 2 — The Economy

The services provided by us do not specifically target economic growth or the promotion of the economy. For this reason, there is no agency specific reporting against this Goal. Obligatory reporting requirements to meet this goal are outlined in the Operational Report, which follows and includes our Performance Indicators and Financial Statements.

GOAL 3 – The Environment

Obligatory Reporting

Waste Paper Recycling

We use a free paper recycling service provided by our building managers. Our staff are encouraged to recycle all used paper, and documents containing confidential information are shredded and recycled.

Energy Smart Government Policy

Given that we have fewer than 25 FTE's we are not required to report on this issue. However, as part of our collocation with other agencies, we adopt strategies to minimise energy use, including minimising the use of lighting where possible.

GOAL 4 – The Regions

Obligatory Reporting

Regional Development Policy

Outcomes:

- Government decision making is based on a thorough understanding of regional issues.
- Planning in partnership for a sustainable future.
- Effective Government service delivery.
- Effective health service delivery.

We deal with many complaints from users of health and disability services throughout Western Australia, including in regional areas. Analysis of our complaints data suggests that the proportion of complaints we receive from individuals who live in the regions compared to the metropolitan area accurately reflects the distribution of the WA population.

In dealing with complaints about health and disability services provided in regional areas, we attempt to ensure that they are viewed in the context of where the service is delivered. This focus is to ensure that service delivery is of an acceptable standard, regardless of the regional setting.

We are a small office and, therefore, it is not practical to have a regional office. However, occasionally we are able to attend regional areas to meet with staff or complainants and, when we do so, we take the opportunity to promote our services to health and disability providers, consumers and advocacy groups in the region.

We also maintain regular liaison with the Regional Managers and Chief Executive Officers of the Area Health Services, in relation to specific complaints and general issues arising from them.

GOAL 5 – Governance

Agency Specific Reporting

Coordinated, integrated high quality service delivery to the community

There are many agencies and departments that have a role in the resolution of complaints about health and disability services. To ensure that such complaints are handled by the most appropriate agency and to eliminate duplication of complaints processes, we work closely with key stakeholders, many of which are government agencies. This reduces duplication of services and contributes to better service delivery to the community.

Whole of government approaches to planning, decision-making and resource allocation

At the beginning of this financial year we moved to new accommodation, which was the first step in a collocation process with the State Ombudsman, the Commonwealth Ombudsman, the Office of the Public Sector Standards Commissioner, and the Freedom of Information Commissioner. This has provided a single entry point for members of the public and improved access to complaints mechanisms. Sharing services has also led to a reduction in resources used by each of the collocated agencies.

Effective partnerships with Federal and Local Governments, the private sector and the wider community

The nature of our work requires that we have referral relationships with a large number of public and private sector organisations. For example, we have protocols with the National Disability Abuse and Neglect Hotline, a federally funded initiative, and also with the Aged Care Complaints Resolution Scheme within the Commonwealth Department of Health and Aging. We liaise with the Health Insurance Commission over issues relating to Medicare and the Pharmaceutical Benefits Scheme. Many local governments provide health and disability services and we work with these

organisations when dealing with complaints about their services.

Partnerships with the private sector are also a vital part of the work we do. We have effective working relationships with many professional associations such as the Australian Dental Association and the Australian Medical Association, and various professional colleges regarding specific complaints and more general matters of interest.

With the aim of building partnerships with the wider community, we participated in the WA Council of Social Services (WACOSS) conference this year. We are also participating in the upcoming WA on Show Expo, to be held in August 2004.

We have good working and referral relationships with advocacy organisations such as People with Disabilities Inc and the Health Consumers' Council. Staff members attend various community forums including the Woman's Multicultural Health Forum and use these opportunities to link into community networks. We also have representation on the Opioid Replacement Pharmacotherpy Advocacy and Complaints Service, the WA Association for Mental Health Human Rights and Social Justice Sub Committee and the Breastscreen Consumer Reference Group.

Greater community confidence in the processes and actions of government agencies through effective independent oversight and reporting

We contribute to this role in two ways, in relation to our own work and in our role in resolving complaints.

In relation to our own work, we aim to be transparent and accountable in what we do. We advise participants in the resolution process of our internal review procedures and their right to complain to the Ombudsman if they are dissatisfied with the service we have provided. We use the internal and external review processes as a means of improving our services to consumers.

We also play a role in increasing community confidence in the processes and actions of health and disability service providers – both public and private – by resolving complaints and making recommendations for improvements to services.

Obligatory Reporting

Equal Employment Opportunity Outcomes

As of 30 June 2004, eight of the 11 staff employed by us were women. Women occupy 75% of senior positions in the office. Two main ethnic groups are represented within our staff.

In the 2002-2003 Report, we identified that we do not have staff with disabilities, staff from indigenous backgrounds or staff under 25. Consequently, all of our recruitment campaigns actively encourage applications from individuals within these groups.

Evaluations

There were no evaluations undertaken in 2003-2004.

Information Statement

We operate under statutory confidentiality requirements which reflect the type of work we do. All new staff are required to take an oath or make an affirmation about the performance of their duty and the confidentiality of information. People who are directly involved in a complaint (complainants and providers) are able to access information on their file by applying to us.

We are subject to the *Freedom of Information Act* 1992. However, under s14(3) of Schedule 1 of the *Freedom of Information Act* 1992, matters that are in conciliation under the *Health Services (Conciliation and Review) Act* 1995 are exempt from Freedom of Information applications.

Freedom of Information Statistics 2003-2004:

Freedom of Information requests this year:	10
Number relating to personal information:	9
Number relating to non-personal information:	1
Number of requests finalised this year:	10
Granted full access:	1
Granted edited access:	7
Access refused:	1
Referred to another agency:	1
Number of reviews:	0
Requests for amendment of personal information: (amended but not exactly as requested)	1
Average time taken to process each application:	28 days
Charges raised for access to information:	Nil
Requests received from the media:	1

Enquiries about access to information under the Freedom of Information Act 1992 should be made to the Complaints Manager, Office of Health Review, GPO Box B61, Perth 6838, or on (08) 9323 0600.

The Office has brochures, complaint forms and copies of our Annual Report readily available to members of the public at no cost. Members of the public can request these by telephoning or visiting the office. They are also available on our website. No documents are available for purchase.

We create and maintain a separate file for each written complaint received. These files contain all of the information gathered as part of our complaints resolution process. The Office also maintains administrative files relevant to the operation of the Office.

Reporting on Recordkeeping Plans

We are working with a consultant engaged by the Department of Health to prepare our recordkeeping plan. Our recordkeeping plan, once finalised, will follow that developed by the Department of Health. All staff are regularly reminded of our standard recordkeeping processes, both in relation to the complaints database and hard copies of information. New staff are given specific training in the area of maintaining and updating complaint files and records.

Compliance with Public Sector Standards and Ethical Codes

- Compliance with Human Resource Management Standards

The Office of Health Review has complied with the Public Sector Standards in Human Resource Management. All recruitment and selection processes are reviewed by the Department of Health. No applications were made for breach of standards review in 2003-2004.

- Compliance with Codes of Ethics and Codes of Conduct

The Office of Health Review has complied with the WA Public Sector Code of Ethics and our own Code of Conduct. No complaints have been lodged with the office or with external agencies relating to the Office's compliance with the Code of Ethics or Code of Conduct.

Public Interest Disclosures

In 2003-2004, the Director appointed a senior officer to be the Public Interest Disclosure Officer. Internal public interest disclosure procedures and information were developed and circulated to all staff.

We will continue to meet our obligations to provide protection for people who make a public interest disclosure and the outcome of that assessment by:

- maintaining comprehensive and secure records for each disclosure;
- providing for the confidentiality of the identity of the person making the disclosure, and any person who is the subject of a disclosure; and
- providing natural justice to those who may be the subject of a disclosure.

Advertising and Sponsorship

Section 175ZE of the *Electoral Act* 1907 requires us to report any expenses associated with advertising, market research, polling, direct mail and media advertising in excess of $1600 in 2003-2004. There were no such expenses incurred this year.

Operational Report

General matters

The Office of Health Review resolves complaints about health and disability services by providing an independent mechanism for dealing with complaints and improving practices and actions of health and disability service providers.

Enabling Legislation

The Office of Health Review was established by the *Health Services (Conciliation and Review) Act* 1995. We also operate under Part 6 of the *Disability Services Act* 1993, which was amended in 1999 to bring complaints about disability services within our jurisdiction.

Mission Statement

We are committed to making health and disability services better through the impartial resolution of complaints.

Operations

The functions of the Director are specified in section 10 of the *Health Services (Conciliation and Review) Act* 1995. These are –

- to undertake the receipt, conciliation and investigation of complaints and to perform any other function vested in the Director by the Act or another written law;
- to review and identify the causes of complaints, and to suggest ways of removing and minimising those causes and bringing them to the notice of the public;
- to take steps to bring to the notice of users and providers details of complaints procedures under the Act;
- to assist providers in developing and improving complaints procedures and the training of staff in handling complaints;
- with the approval of the Minister, to inquire into broader issues of health care arising out of complaints received;
- to cause information about the work of the office to be published from time to time; and
- to provide advice generally on any matter relating to complaints under the Act, and in particular –
  - (i) advice to users on the making of complaints to registration boards; and
  - (ii) advice to users as to other avenues available for dealing with complaints.

Administrative

Eamon Ryan was appointed as Acting Director in August 2002. This appointment continues until 15 September 2004.

The Office of Health Review has 13 FTEs. Ten full time and one part time staff were employed by us at 30 June 2004. As at 30 June 2004, vacant positions are in the process of being filled (refer to the Organisational Chart as at 30 June 2004).

Research, Promotions and Publications

The Office of Health Review has not been directly involved in any formal research activities in 2003-2004. However, we have commented on, or made submissions to, various research projects being conducted elsewhere.

We promote our Office through brochures and complaint forms that are widely distributed and available on request. Staff participate in various activities to promote public awareness of our Office. A full list of these activities is available at Appendix C.

Declaration of Interest

The Office of Health Review has no contracts in which an officer has a substantial interest or is in a position to benefit from the appointment of these contracts.

Subsequent events

There are no events that have occurred between 30 June 2004 and the tabling of this report which may impact on operations.

Office of Health Review - Organisational Chart as at 30 June 2004

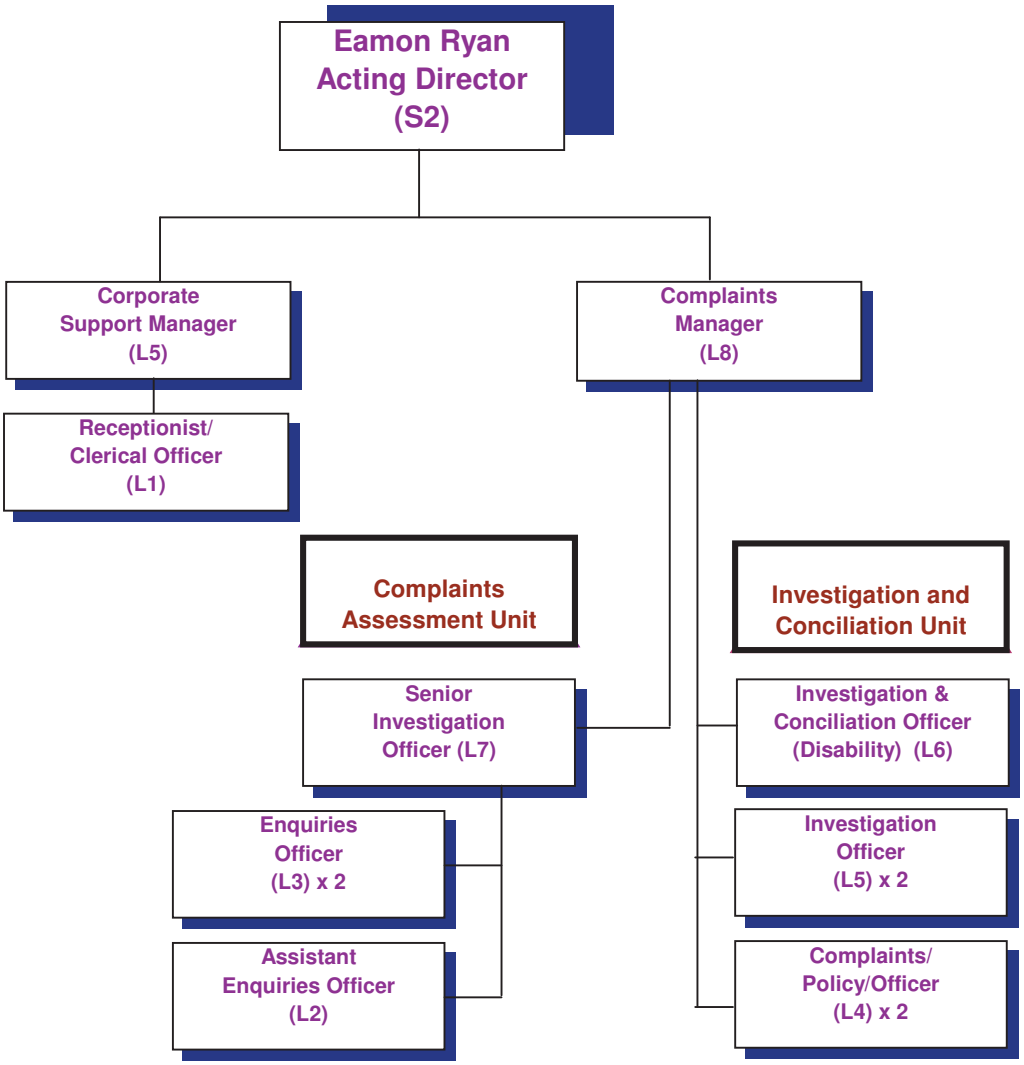

Figure 3: Organisational Chart as at 30 June 2004

Certification of Performance Indicators

I hereby certify that the Performance Indicators are based on proper records, are relevant and appropriate for assisting users to assess the performance of the Office of Health Review and fairly represent the performance of the Office of Health Review in the financial year ending June 30 2004.

Eamon Ryan
Director
ACCOUNTABLE AUTHORITY

30 August 2004

AUDITOR GENERAL

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2004

Audit Opinion
In my opinion, the key effectiveness and efficiency performance indicators of the Office of Health Review are relevant and appropriate to help users assess the Office's performance and fairly represent the indicated performance for the year ended June 30, 2004.

Scope
The Director's Role
The Director is responsible for developing and maintaining proper records and systems for preparing performance indicators.

The performance indicators consist of key indicators of effectiveness and efficiency.

Summary of my Role
As required by the Financial Administration and Audit Act 1985, I have independently audited the performance indicators to express an opinion on them. This was done by looking at a sample of the evidence.

An audit does not guarantee that every amount and disclosure in the performance indicators is error free, nor does it examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the performance indicators.

D D R PEARSON
AUDITOR GENERAL
October 15, 2004

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

Performance Indicators

One of the Review recommendations was that we reassess our performance indicators to ensure they remain appropriate. Accordingly, our key performance indicators are under review.

Four indicators, two for efficiency and two for effectiveness are reported on. The indicators are the same as those used in previous Annual Reports and therefore comparative figures are given.

Efficiency Indicators		**2003-2004**	**2002-2003**	**2001-2002**
a)	Cost per finalised complaint[11]	$650	$639	$697
b)	Number of days taken to finalise a complaint[12]	122 days	104 days	118 days
Effectiveness Indicators				
a)	Number of improvements in practices and actions taken by agencies/providers as a result of OHR recommendations[13]	38[14]	40	59
b)	Percentage of complaints finalised this year[15]	83%[16]	96%	104%[17]

Additional information to assist in understanding the above Performance Indicators

The following additional information is provided to assist in understanding the above performance indicators and to put some of that information into its relevant context.

Workload data as at 30 June 2004

Complaints on hand 1 July 2003:	336
New complaints received	1768
Total complaints handled during the year	2104
Complaints closed	1751
Complaints on hand 30 June 2004	353

[11] Based on the accrual costs for the period 1 July 2003 to 30 June 2004

[12] This KPI relates only to written complaints and is taken from the date of receipt of the complaint form, or written confirmation of the complaint to the date of closure of the file

[13] Many of these improvements are implemented over time, for example, where changes in policies require consultation prior to implementation. As at 30 June 2004 30 of these recommendations have been implemented, the remaining 8 are being followed up by us.

[14] 30 of these have been implemented by the providers as of 30 June 2004. The remaining 8 recommendations are still being followed up.

[15] The percentage of complaints closed reflects the overall effectiveness of the OHR in dealing with complaints.

[16] We have changed the way that this figure was reported this year. In previous years, the figure was taken as closed complaints as a percentage of new complaints. This year, and for future years, this figure is closed complaints as a percentage of all complaints handled in the year.

[17] In the 2001-2002 financial year, more cases were closed than the number received, a number of these had been received in the previous financial year.

Age analysis of active cases as at 30 June 2004

0 – 3 months:	211
3 – 6 months:	65
6 – 9 months:	28
9 – 12 months:	17
12 – 18 months:	20
18 – 24 months:	9
Over 24 months:	3
Total:	353

Other indicators

We routinely advise complainants and providers that they have a right to request an internal review if they are not satisfied with the outcome or processes we followed in resolving their complaints. This year 19 complainants requested an internal review. A senior staff member reviewed these files and, where appropriate, made recommendations for further action.

In 12 of these cases, the review by the senior officer confirmed the original conclusions made on the case. In five cases, further information was sought from the provider, independent adviser or other organisations to assist in the review. Once this clarification was sought, the reviewer confirmed the conclusions originally made by the case officer. Two reviews are still ongoing.

We also advise complainants and providers that they can complain to the Ombudsman if they are unhappy with the processes we followed. In 2003-2004 the Ombudsman received 11 complaints about the Office of Health Review, and finalised 13. One was referred back to us, nine were not sustained and three were closed because an opinion was unnecessary.

OFFICE OF HEALTH REVIEW

FINANCIAL STATEMENTS

CERTIFICATION OF FINANCIAL STATEMENTS

The accompanying financial statements of the Office of Health Review have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the financial year ending 30 June 2004 and the financial position as at 30 June 2004.

At the date of signing we are not aware of any circumstances which would render the particulars included in the financial statements misleading or inaccurate.

Eamon Ryan
ACCOUNTABLE AUTHORITY

30 August 2004

Charles Spadaro
PRINCIPAL ACCOUNTING OFFICER

30 August 2004

AUDITOR GENERAL

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2004

Audit Opinion
In my opinion,

(i) the controls exercised by the Office of Health Review provide reasonable assurance that the receipt and expenditure of moneys, the acquisition and disposal of property, and the incurring of liabilities have been in accordance with legislative provisions; and

(ii) the financial statements are based on proper accounts and present fairly in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia and the Treasurer's Instructions, the financial position of the Office at June 30, 2004 and its financial performance and cash flows for the year ended on that date.

Scope
The Director's Role
The Director is responsible for keeping proper accounts and maintaining adequate systems of internal control, preparing the financial statements, and complying with the Financial Administration and Audit Act 1985 (the Act) and other relevant written law.

The financial statements consist of the Statement of Financial Performance, Statement of Financial Position, Statement of Cash Flows and the Notes to the Financial Statements.

Summary of my Role
As required by the Act, I have independently audited the accounts and financial statements to express an opinion on the controls and financial statements. This was done by looking at a sample of the evidence.

An audit does not guarantee that every amount and disclosure in the financial statements is error free. The term "reasonable assurance" recognises that an audit does not examine all evidence and every transaction. However, my audit procedures should identify errors or omissions significant enough to adversely affect the decisions of users of the financial statements.

D D R PEARSON
AUDITOR GENERAL
October 15, 2004

4th Floor Dumas House 2 Havelock Street West Perth 6005 Western Australia Tel: 08 9222 7500 Fax: 08 9322 5664

Office of Health Review

Statement of Financial Performance
For the year ended 30th June 2004

	Note	2004 $	2003 $
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses	2	853,468	754,027
External Services	3	28,457	7,936
Depreciation expense	4	10,848	14,798
Costs of disposal of non-current assets		2,141	-
Other expenses from ordinary activities	6	244,896	242,287
Total cost of services		1,139,810	1,019,048
Revenues from Ordinary Activities			
Revenue from operating activities			
Other revenues from operating activities	7	1,296	-
Revenue from non-operating activities			
Proceeds from disposal of non-current assets	5	1,000	-
Total revenues from ordinary activities		2,296	-
NET COST OF SERVICES		**1,137,514**	**1,019,048**
Revenues from State Government			
Output appropriations	8	1,036,000	1,009,783
Resources received free of charge	9	15,550	22,824
Total revenues from State Government		1,051,550	1,032,607
CHANGE IN NET ASSETS		**(85,964)**	**13,559**
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	16	-	(1,768)
Total revenues, expenses and valuation adjustments recognised directly in equity		-	(1,768)
Total changes in equity other than those resulting from transactions with WA State Government as owners		**(85,964)**	**11,791**

The Statement of Financial Performance should be read in conjunction with the notes to the financial statements.

Office of Health Review

Statement of Financial Position
As at 30th June 2004

	Note	2004 $	2003 $
CURRENT ASSETS			
Cash assets	10	418,803	455,708
Receivables	11	5,902	-
Total current assets		424,705	455,708
NON-CURRENT ASSET			
Property, plant and equipment	12	25,434	38,422
Total non-current assets		25,434	38,422
Total assets		**450,139**	**494,130**
CURRENT LIABILITIES			
Payables	13	2,569	4,356
Provisions	14	112,844	85,135
Other liabilities	15	33,420	16,367
Total current liabilities		148,833	105,858
NON-CURRENT LIABILITIES			
Provisions	14	46,568	47,570
TOTAL NON-CURRENT LIABILITIES		46,568	47,570
Total liabilities		**195,401**	**153,428**
NET ASSETS		**254,738**	**340,702**
EQUITY			
Accumulated surplus / (deficiency)	16	254,738	340,702
Total Equity		**254,738**	**340,702**

The Statement of Financial Position should be read in conjunction with the notes to the financial statements.

Office of Health Review

Statement of Cash Flows
For the year ended 30th June 2004

	Note	2004 $ Inflows (Outflows)	2003 $ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Output appropriations		1,036,000	1,009,783
Net cash provided by State Government		1,036,000	1,009,783
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(260,138)	(237,184)
Employee costs		(815,074)	(770,035)
Receipts			
Other receipts		1,307	-
Net cash (used in) / provided by operating activities	17(b)	(1,073,905)	(1,007,219)
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from disposal of non-current assets	5(a)	1,000	-
Net cash (used in) / provided by investing activities		1,000	-
Net increase / (decrease) in cash held		(36,905)	2,564
Cash assets at the beginning of the financial year		455,708	453,144
CASH ASSETS AT THE END OF THE FINANCIAL YEAR	17(a)	418,803	455,708

The Statement of Cash Flows should be read in conjunction with the notes to the financial statements.

Office of Health Review

Notes to the Financial Statements
For the year ended 30th June 2004

Note 1 Significant accounting policies

The following accounting policies have been adopted in the preparation of the financial statements. Unless otherwise stated these policies are consistent with those adopted in the previous year.

(a) General Statement

The financial statements constitute a general purpose financial report which has been prepared in accordance with Accounting Standards, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board, and Urgent Issues Group (UIG) Consensus Views as applied by the Treasurer's Instructions. Several of these are modified by the Treasurer's Instructions to vary application, disclosure, format and wording. The Financial Administration and Audit Act and the Treasurer's Instructions are legislative provisions governing the preparation of financial statements and take precedence over Accounting Standards, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board, and UIG Consensus Views. The modifications are intended to fulfil the requirements of general application to the public sector, together with the need for greater disclosure and also to satisfy accountability requirements.

If any such modification has a material or significant financial effect upon the reported results, details of that modification and where practicable, the resulting financial effect, are disclosed in individual notes to these financial statements.

(b) Basis of Accounting

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention, except for certain assets and liabilities which, as noted, are measured at fair value.

(c) Output Appropriations

Output Appropriations are recognised as revenues in the period in which the Office of Health Review gains control of the appropriated funds. The Office of Health Review gains control of appropriated funds at the time those funds are deposited into the Office of Health Review's bank account or credited to the holding account held at the Department of Treasury and Finance.

(d) Acquisitions of Assets

The cost method of accounting is used for all acquisitions of assets. Cost is measured as the fair value of the assets given up or liabilities undertaken at the date of acquisition plus incidental costs directly attributable to the acquisition.

Assets acquired at no cost or for nominal consideration are initially recognised at their fair value at the date of acquisition.

Assets costing less than $1,000 are expensed in the year of acquisition (other than where they form part of the group of similar items which are significant in total).

(e) Property, Plant and Equipment

Depreciation of Non-Current Assets

All property, plant and equipment having a limited useful life are systematically depreciated over their estimated useful lives in a manner which reflects the consumption of their future economic benefits.

Depreciation is calculated on the reducing balance basis, using rates which are reviewed annually. Expected useful lives for each class of depreciable asset are:

Computer equipment and software	5 to 15 years
Furniture and fittings	5 to 50 years
Other plant and equipment	4 to 50 years

(f) Leases

The Office of Health Review has entered into a number of operating lease arrangements for the rent of buildings and equipment where the lessors effectively retain all of the risks and benefits incident to ownership of the items held under the operating leases. Equal instalments of the lease payments are charged to the Statement of Financial Performance over the lease term as this is representative of the pattern of benefits to be derived from the leased items.

The Office of Health Review has no contractual obligations under finance leases.

(g) Cash

For the purpose of the Statement of Cash Flows, cash includes cash assets and restricted cash assets net of outstanding bank overdrafts. These include short-term deposits that are readily convertible to cash on hand and are subject to insignificant risk of changes in value.

(h) Receivables

Receivables are recognised at the amounts receivable as they are due for settlement no more than 30 days from the date of recognition. Collectability of receivables is reviewed on an ongoing basis. Debts which are known to be uncollectable are written off. A provision for doubtful debts is raised where some doubts as to collection exist.

(i) Payables

Payables, including accruals not yet billed, are recognised when the Office of Health Review becomes obliged to make future payments as a result of a purchase of assets or services. Payables are generally settled within 30 days.

(j) Accrued Salaries

Accrued salaries (refer note 15) represent the amount due to staff but unpaid at the end of the financial year, as the end of the last pay period for that financial year does not coincide with the end of the financial year. The Office of Health Review considers the carrying amount approximates net fair value.

(k) Employee Benefits

Annual Leave

This benefit is recognised at the reporting date in respect to employees' services up to that date and is measured at the nominal amounts expected to be paid when the liabilities are settled.

Long Service Leave

The liability for long service leave expected to be settled within 12 months of the reporting date is recognised in the provisions for employee benefits, and is measured at the nominal amounts expected to be paid when the liability is settled. The liability for long service leave expected to be settled more than 12 months from the reporting date is recognised in the provisions for employee benefits and is measured at the present value of expected future payments to be made in respect of services provided by employees up to the reporting date. Consideration is given, when assessing expected future payments, to expected future wage and salary levels including relevant on costs, experience of employee departures and periods of service. Expected future payments are discounted using market yields at the reporting date on national government bonds with terms to maturity and currency that match, as closely as possible, the estimated future cash outflows.

This method of measurement of the liability is consistent with the requirements of Accounting Standard AASB 1028 "Employee Benefits".

Superannuation

Staff may contribute to the Gold State Superannuation Scheme, a defined benefit lump sum scheme now also closed to new members. All staff who do not contribute to this scheme become non-contributory members of the West State Superannuation Scheme, an accumulation fund complying with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. All of these schemes are administered by the Government Employees Superannuation Board (GESB).

The liabilities for superannuation charges under the Gold State Superannuation Scheme and West State Superannuation Scheme are extinguished by payment of employer contributions to the GESB.

The note disclosure required by paragraph 6.10 of AASB 1028 (being the employer's share of the difference between employees' accrued superannuation benefits and the attributable net market value of plan assets) has not been provided. State scheme deficiencies are recognised by the State in its whole of government reporting. The GESB's records are not structured to provide the information for the Office of Health Review. Accordingly, deriving the information for the Office of Health Review is impractical under current arrangements, and thus any benefits thereof would be exceeded by the cost of obtaining the information.

Employee benefit on-costs

Employee benefit on-costs are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities and expenses. (See notes 2 and 14)

(l) Revenue Recognition

Revenue from the sale of goods, disposal of other assets and the rendering of services, is recognised when the Office of Health Review has passed control of the goods or other assets or has delivered the services to the customer.

(m) Resources Received Free of Charge or For Nominal Value

Resources received free of charge or for nominal value which can be reliably measured are recognised as revenues and as assets or expenses as appropriate at fair value.

(n) Comparative Figures

Comparative figures are, where appropriate, reclassified so as to be comparable with the figures presented in the current financial year.

		2004	2003
Note 2	**Employee expenses**	$	$
	Salaries and wages (i)	746,145	640,740
	Superannuation	64,360	65,923
	Other related expenses	42,964	47,364
		853,468	754,027

(i) These employee expenses include employment on-costs associated with the recognition of annual and long service leave liability.

The related on-costs liability is included in employee benefit liabilities at Note 14.

Note 3 External Services

Domestic charges	32	25
Fuel, light and power	3,390	3,785
Food supplies	1,077	757
Purchase of external services	23,957	3,369
	28,457	7,936

Note 4 Depreciation expense

Computer equipment and software	6,824	10,704
Furniture and fittings	948	1,019
Other plant and equipment	3,075	3,075
	10,848	14,798

Note 5 Net gain / (loss) on disposal of non-current assets

a)	Proceeds from disposal of non-current assets	1,000	-
b)	Gain / (Loss) on disposal of non-current assets:		
	Furniture and fittings	(1,140)	-

Note 6 Other expenses from ordinary activities

Motor vehicle expenses	1,333	2,248
Insurance	10,951	9,068
Communications	22,378	17,642
Printing and stationery	12,682	8,945
Audit fees - external	-	11,000
Repairs, maintenance and consumable equipment expense	24,796	24,401
Rental accommodation expense	99,960	99,272
Other	72,794	69,711
	244,896	242,287

		2004 $	2003 $
Note 7	**Other revenues from ordinary activities**		
	Revenue from operating activities		
	Other	1,296	-
Note 8	**Output appropriations**		
	Appropriation revenue received during the year:		
	Output appropriations	1,036,000	1,009,783
	Output appropriations are accrual amounts reflecting the full cost of outputs delivered. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the estimated depreciation expense for the year and any agreed increase in leave liability during the year.		
Note 9	**Resources received free of charge**		
	Resources received free of charge has been determined on the basis of the following estimates provided by agencies.		
	Office of the Auditor General		
	- Audit services (ii)	-	11,000
	Other		
	- State Solicitor's Office	15,550	11,824
		15,550	22,824
	(i) Where assets or services have been received free of charge or for nominal consideration, the Office of Health Review recognises revenues (except where the contribution of assets or services is in the nature of contributions by owners, in which case the Office of Health Review shall make a direct adjustment to equity) equivalent to the fair value of the assets and/or the fair value of those services that can be reliably determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable.		
	(ii) Commencing with the 2003-04 audit, the Office of the Auditor General will be charging a fee for auditing the accounts, financial statements and performance indicators. The fee for the 2003-04 audit of $13,750 (GST inclusive) will be due and payable in the 2004-05 financial year.		
Note 10	**Cash assets**		
	Cash on hand	400	400
	Cash at bank - general	418,403	455,308
		418,803	455,708
Note 11	**Receivables**		
	Other receivables	5,902	-
		5,902	-

Note 12 Property, plant and equipment	2004 $	2003 $
Computer equipment and software		
At cost	76,711	76,710
Accumulated depreciation	(69,337)	(62,512)
	7,374	14,198
Furniture and fittings		
At cost	14,129	18,074
Accumulated depreciation	(4,153)	(5,009)
	9,976	13,065
Other plant and equipment		
At cost	35,269	35,269
Accumulated depreciation	(27,185)	(24,110)
	8,084	11,159
Total of property, plant and equipment	25,434	38,422

Reconciliations

Reconciliations of the carrying amounts of property, plant and equipment at the beginning and end of the current financial year are set out below.

	2004 $
Computer equipment and software	
Carrying amount at start of year	14,198
Depreciation	(6,824)
Carrying amount at end of year	7,374
Furniture and fittings	
Carrying amount at start of year	13,065
Disposals	(2,141)
Depreciation	(948)
Carrying amount at end of year	9,976
Other plant and equipment	
Carrying amount at start of year	11,159
Depreciation	(3,075)
Carrying amount at end of year	8,084
Total property, plant and equipment	
Carrying amount at start of year	38,422
Disposals	(2,141)
Depreciation	(10,848)
Carrying amount at end of year	25,434

Note13 Payables		
Creditors and accruals	2,569	4,356

Note 14 Provisions		
Current liabilities:		
Annual leave	59,651	51,395
Long service leave	51,033	29,290
Superannuation	2,161	4,450
	112,844	85,135
Non-current liabilities:		
Long service leave	46,568	47,570
	46,568	47,570
Total employee benefit liabilities	159,412	132,705

The settlement of annual and long service leave liabilities give rise to the payment of superannuation and other employment on-costs. The liability for such on-costs is included here. The associated expense is included under Employee expenses at Note 2.

The Office of Health Review considers the carrying amount of employee benefits approximates the net fair value.

Note 15 Other liabilities

Accrued salaries	33,420	16,367

Note 16 Accumulated surplus / (deficiency)

	2004 $	2003 $
Balance at beginning of the year	340,702	328,911
Change in net assets	(85,964)	13,559
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	-	(1,768)
Balance at end of the year	254,738	340,702

Note 17 Notes to the statement of cash flows

a) Reconciliation of cash

Cash assets at the end of the financial year as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:

Cash assets (Refer note 10)	418,803	455,708
	418,803	455,708

b) Reconciliation of net cash flows used in operating Activities to net cost of services

Net cash used in operating activities (Statement of Cash Flows)	(1,073,905)	(1,007,219)
Increase / (decrease) in assets:		
GST receivable	-	-
Other receivables	5,902	-
Decrease / (increase) in liabilities:		
Payables	1,787	11,707
Accrued salaries	(17,053)	1,867
Provisions	(26,707)	10,452
Non-cash items:		
Depreciation expense	(10,848)	(14,798)
Net gain / (loss) from disposal of non-current assets	(1,140)	-
Resources received free of charge	(15,550)	(22,824)
Other	0	1,767
Net cost of services (Statement of Financial Performance)	(1,137,514)	(1,019,048)

Note 18 Remuneration of members of the accountable authority and senior officers

Remuneration of senior officers

The number of Senior Officers other than senior officers reported as members of the Accountable Authority, whose total of fees, salaries, superannuation and other benefits for the financial year, fall within the following bands are:

	2004	2003
$40,001 - $50,000	-	1
$130,001 - $140,000	-	1
$140,001 - $150,000	1	-
$150,001 - $160,000	-	-
Total	1	2
	$	$
The total remuneration of senior officers is:	149,147	182,993

The superannuation included here represents the superannuation expense incurred by the Office of Health Review in respect of Senior Officers other than senior officers reported as members of the Accountable Authority.

No member of the Office of Health Review is member of the Pension Scheme.

Note 19 Commitments for Expenditure	2004 $	2003 $
Operating lease commitments: Commitments in relation to leases contracted for at the reporting date but not recognised as liabilities, are payable as follows:		
Within one year	114,757	119,897
Later than one year, and not later than five years	229,514	254,216
	344,271	374,113

Note 20 Contingent liabilities and contingent assets

At the reporting date, the Office of Health Review is not aware of any contingent liabilities and contingent assets.

Note 21 Events occurring after reporting date

There were no events occurring after reporting date which have significant financial effects on these financial statements.

Note 22 Related bodies

The Office of Health Review had no related bodies during the reporting period.

Note 23 Affiliated bodies

The Office of Health Review had no affiliated bodies during the reporting period.

Note 24 The Impact of Adopting International Financial Reporting Standards

The International Financial Reporting Standards (IFRSs) will be applicable to reporting periods beginning on or after 1 January 2005. The Australian Accounting Standards Board (AASB) has adopted a convergence policy under which the Australian Accounting Standards are converged with their IFRS equivalents. The AASB will issue Australian equivalents to IFRSs, and Urgent Issues Group abstracts to harmonise with the International Financial Reporting Standards issued by the International Accounting Standards Board. The Office of Health Review will prepare its first Australian-equivalents-to-IFRSs financial statements for the year ending 30 June 2006.

The following are the key differences in accounting policies identified to date that are expected to arise from adopting Australian equivalents to IFRSs:

(a) Impairment of Assets

Under AASB 136, the Australian equivalent to IAS 36 "Impairment of Assets", assets will be measured at the recoverable amount if there is an indication of impairment. This will result in a change to the current accounting policy, under which assets are not required to be measured at their recoverable amounts.

(b) Employee Benefits

Under the AASB 119, the Australian equivalent to IAS 19 "Employee Benefits", annual leave that are not short term employee benefits, will be measured at present value. This will result in a change to the current accounting policy, under which liabilities for annual leave is measured at nominal amounts in all circumstances.

The above should not be regarded as a complete list of changes in accounting policies that will result from the transition to IFRSs, as not all Standards have been analysed as yet. For these reasons it is not yet possible to quantify the impacts of the transition to IFRSs on Office of Health Review's reported financial position and financial performance.

Note 25 Financial instruments

(a) Interest rate risk exposure

The following table details the Office of Health Review's exposure to interest rate risk as at the reporting date:

	Weighted average effective interest rate %	$	Non-interest bearing $	Total $
As at 30th June 2004				
Financial Assets				
Cash assets	0.0%		418,803	418,803
Receivables	0.0%		5,902	5,902
			424,705	424,705
Financial Liabilities				
Payables	0.0%		2,569	2,569
			2,569	2,569
Net financial assets / (liabilities)			422,136	422,136

(b) Credit risk exposure

All financial assets are unsecured. Amounts owing by other government agencies are guaranteed and therefore no credit risk exists in respect of those amounts. The carrying amounts of financial assets recorded in the financial statements, net of any provisions or losses, represent the Office of Health Review's maximum exposure to credit risk.

(c) Net fair values

The carrying amounts of financial assets and financial liabilities recorded in the financial statements are not materially different from their net fair values, determined in accordance with the accounting policies disclosed in Note 1 to the financial statements.

Note 26 Explanatory Statement

(A) Significant variations between actual revenues and expenditures for the financial year and revenues and expenditures for the immediately preceding financial year.

Reasons for significant variations between actual results with the corresponding items of the preceding reporting period are detailed below. Significant variations are those greater than 10% or $40,000.

	Note	2004 Actual $	2003 Actual $	Variance $
Statement of Financial Performance – Expenses				
Employee expenses	(a)	853,468	754,027	99,441
External Services	(b)	28,457	7,936	20,521
Depreciation expense	(c)	10,848	14,798	(3,950)
Costs of disposal of non-current assets	(d)	2,141	0	2,141
Other expenses from ordinary activities		244,896	242,287	2,609

	Note	2004 Actual $	2003 Actual $	Variance $
Statement of Financial Performance - Revenues				
Other revenues from operating activities	(e)	1,296	-	1,296
Proceeds from disposal of non-current assets		1,000	-	1,000
Output appropriations		1,036,000	1,009,783	26,217
Resources received free of charge	(f)	15,550	22,824	(7,274)

(a) Employee expenses

The increase in expenses was mainly caused by the employment of additional staff on a temporary basis for managing the increased number of complaints in 2003-04.

(b) External Services

The increase is due to a higher number of independent medical opinions being obtained to assist in the resolution of health and disability complaints.

(c) Depreciation expense

The decrease was for computer desktops, most of which were in the final year for depreciation in 2003-04.

(d) Proceeds from disposal of non-current assets

$1,000 was received from the Department of Health for surplus furniture, with a book value of $2,141.

(e) Staff contribution to the government motor vehicle scheme.

(f) Resources received free of charge

The decrease primarily due to the introduction of the full cost recovery of audit services by the Office of the Auditor General. The audit fee for 2003-04 audit will be due and payable in the 2004-05 financial year. Accordingly, no expense or corresponding revenue has been recognised for audit fees in the 2003-04 financial year.

Note 26 Explanatory Statement (continued)

(B) Significant variations between estimates and actual results for the financial year

Section 42 of the Financial Administration and Audit Act requires the Office of Health Review to prepare annual budget estimates. Details and reasons for significant variations between these estimates and actual results are detailed below. Significant variations are considered to be those greater than 10% of budget.

	Note	2004 Actual $	2003 Actual $	Variance $
Operating expenses				
Employee expenses		853,468	764,370	(8,274)
Other goods and services	(a)	286,341	271,630	(92,247)
Total expenses from ordinary activities		1,139,809	1,036,000	(100,521)
Less: Revenues from ordinary activities	(b)	(2,296)	(1,573)	(606)
Net cost of services		1,137,514	1,034,427	(101,126)

(a) Other goods and services

Other goods and services were lesser than those estimated mainly due to the reclassification of workers compensation insurance, fringe benefit tax and other employee expenses to employee expenses in 2003-04.

(b) Revenues from ordinary activities

The estimates do not include the $1,000 proceeds received from disposal of surplus furniture.

Estimates of Expenditure for 2004-2005

The following Estimates of Expenditure for the year 2004-2005 are prepared on an accrual accounting basis. The estimates are required under Section 42 of the *Financial Administration and Audit Act* 1985 and by instruction from the Treasury Department of Western Australia.

The following Estimates of Expenditure for the year 2004-2005 do not form part of the preceding audited financial statements.

Revenue	**2004/2005**
Consolidated Fund	$1 189 000

Appendix A: Recommendations from the Review of the Office of Health Review.

Recommendation 1 *The Office of Health Review continues to have responsibility for the administration of the independent health and disability complaints system, established by the Medicare Agreement of 1993-1998.*

Recommendation 2 *The Office of Health Review continue to operate within the framework of a conciliation model.*

Recommendation 3 *The name of the Office of Health Review be changed to the Health and Disability Complaints Commission of Western Australia.*

This recommendation was amended by government. The name will now be changed to Office of Health and Disability Complaints.

Recommendation 4 *The Office of Health Review affirm a set of values and principles which underpin its operations and aspirations as a quality complaints agency and guide its process of continuous improvement.*

Recommendation 5 *These values and principles be published in the Annual Report and promulgated through the Office of Health Review's informational and promotional literature and through other channels as appropriate.*

Recommendation 6 *Within 28 days of a complaint being lodged, the Office of Health Review is to accept the complaint if it cannot be rejected on the basis of section 26 or 28 of the Health Services (Conciliation and Review) Act 1995 and is not referred on the basis of sections 31 and 32 of the Act, and in the case of a disability complaint, cannot be rejected on the basis of section 38 of the Disability Services Act 1993. No attempt to resolve the complaint should occur while this assessment is being made.*

Recommendation 7 *Once a complaint has been accepted by the Office of Health Review, it should move to a process to be known as the Resolution Process, which encompasses a Negotiated Settlement, Conciliation, Investigation and Review.*

Recommendation 8 *The Resolution process includes any further preliminary actions that may be necessary to implement a negotiated settlement, a conciliated settlement, an investigation or a review and includes the forwarding of details of the complaint to the provider and any subsequent meetings, discussions or proposals aimed at resolving the complaint.*

Recommendation 9 *Section 42 of the Health Services (Conciliation and Review) Act 1995 ('Protection of statements made') and section 39(5) of the Disability Services Act 1993 apply when the resolution process commences; that is, as soon as the complaint has been accepted as per recommendation 6.*

Recommendation 10 *An independent Complaints Review Committee, comprising a chair who is a consumer representative and two other members, one of whom is a legal practitioner with expertise in administrative law and the other a professional with relevant health or disability expertise for the purposes of the particular review, be established. The Independent Complaints Review Committee will provide a further, independent avenue of review to complainants who wish to have the outcome or aspects of their case re-examined.*

This recommendation was not accepted by Government.

Recommendation 11 *In respect of both health and disability complaints, the Director must reject a complaint the subject matter of which occurred more than 24 months before the complaint is made unless, in the Director's opinion, the complainant has shown good reason for the delay.*

Recommendation 12 *(i) In all cases where an initial determination has been made by the Office of Health Review staff member that the complaint is within the jurisdiction of the Office, an offer of assistance to complete the complaint form be made to the complainant; and (ii) as part of this requirement to offer assistance, there be a clearly worded, plain English advice to this effect printed on all complaint forms.*

Recommendation 13 *Methods of receiving complaints be extended to include submission of complaints via the Internet. The website should therefore be modified to advise consumers of this method of lodging a complaint, and carry an explanation that, in cases requiring access to medical records, signed authorisation by the consumer or the consumer's representative will be necessary.*

Recommendation 14 *(i) The Office of Health Review routinely check the clarity and quality of written information contained in submitted complaint forms, in order to ensure that the form enables all parties to have a common understanding of the circumstances leading to the complaint and the key issues involved. (ii) here the Officer believes that greater clarity is required, he/she is to contact the complainant and assist with clarification.*

Recommendation 15 *Delete section 26(1)(b) from the Health Services (Conciliation and Review) Act 1995.*

Recommendation 16 *Amend section 30 of the Health Services (Conciliation and Review) Act 1995 to provide the Director with the discretion to refer the complaint for resolution, whether or not the complainant, or a person acting on behalf of the complainant, has taken steps to resolve the matter with the provider.*

Recommendation 17 *Section 25(1)(a) of the Health Services (Conciliation and Review) Act 1995 be amended to read "a provider" rather than a "public provider" as is presently the case. This would align what may be included in a health complaint with disability complaints (section 33(2) of the Disability Services Act 1993).*

Recommendation 18 *(i) Further legal opinion be sought in relation to the right of people subject to insurance claims to lodge a complaint to the Office of Health Review, based on the provisions of section 25(1)(b) of the Health Services (Conciliation and Review) Act 1995 and failing any change in interpretation to include this group, (ii) the Act be amended to enable people who are subject to Workers Compensation, and other insurance cases, to lodge a complaint in relation to any clinical interview or intervention received as part of the insurance process, based on section 25(1)(b) of the Act.*

Recommendation 19 *(i) Both the Health Services (Conciliation and Review) Act 1995 and the Disability Services Act 1993 be expanded to include a provision that providers are required to respond to a complaint within 28 days of the Director notifying them of the complaint; and that the Director may, if s/he deems there is good reason, extend the response period further, after which time the Director may advise the provider that s/he may proceed to draw conclusions without a response; and (ii) if without good reason, the provider fails to provide the Director with a response, the Director must report on the provider's failure to respond in the Office of Health Review's subsequent Annual Report.*

Recommendation 20 *The Office of Health Review routinely provide a current list of advocacy services to any complainant involved in the resolution process.*

Recommendation 21 *In every case which has not been concluded within a three month period, a report be prepared for the Director which recommends on the future conduct of the case. Recommendation options include:*

(i) where there is still a good chance of achieving resolution, continue the conciliation process;
(ii) investigation and subsequent recommendations for action; and
(iii) where not suitable for investigation and there is little chance of a conciliated settlement:
- *closure of the case with no finding other than that resolution was not achievable;*
- *if the complainant wishes, referral for internal review or review by the Independent complaints Review Committee.*

Recommendation 22 *As per section 44 of the Disability Services Act 1993, the Director must report to the Minister if his/her recommendations with regard to remedying a situation involving a health complaint are not carried out by the provider.*

Recommendation 23 *A full time position of Information and Community Liaison Officer be established to develop and, with the Director, take lead responsibility for a comprehensive information and communications strategy which will: (i) support the Director's role of increasing the community's awareness of the Office of Health Review and its role and functions; (ii) improve information about, and access to, the Office of Health Review and its services, with particular reference to groups with special needs including indigenous people, people from culturally and linguistically diverse backgrounds, people with disabilities, people with mental health issues, seniors, young people and those living in rural and remote areas of the state; (iii) Ensure that publications and official forms are user friendly and of high quality; and (iv) work with health and disability service providers to ensure that consumers have access to information about the Office of Health Review and its role and functions, at points of service, and are informed of their rights with regard to health and disability services.*

This recommendation was not accepted by the Government, although the intent of the recommendation was accepted and added to the role of the Director.

Recommendation 24 *The Office of Health Review ensure, where appropriate, that consumers are provided with relevant information about the role, jurisdiction and activities of registration boards and the relationship between registration boards and the Office of Health Review in the complaints process.*

Recommendation 25 *As part of the strategic planning process, the Office of Health Review seek information on best practice guidelines in relation to the structure and content of its future Annual Reports and that the 2003-2004 Annual Report incorporate changes which will engender greater clarity and quality of information and presentation.*

Recommendation 26 *As part of the strategic planning process, the Office of Health Review develop a more comprehensive set of key performance indicators ("KPIs") than is presently the case. Such KPIs should measure the extent to which the outcomes sought by the Office of Health Review are being achieved. In the first instance this relates to: (i) resolving (rather than finalising) complaints about health and disability services; and (ii) improving practices and actions of health and disability services.*

Recommendation 27 *The words "and bringing them to the notice of the public" be discarded as an explicit part of function 10(1)(b), but integrated into a broad communication strategy.*

Recommendation 28 *The Office of Health Review systematically review complaints data on a six-monthly basis in order to identify any actual or emerging systemic issues of concern.*

Recommendation 29 *Where there is evidence of any systemic health or disability issue of concern, based on accurate complaints data and the Office of Health Review is not in a position to investigate the matter, the matter be actively considered for referral to Watch on Health or other appropriate bodies for monitoring and/or investigation.*

This recommendation was not accepted by the government, as Watch on Health has ceased to function.

Recommendation 30 *The Director of the Office of Health Review approach Watch on Health with a view to becoming an ex-officio member of the Watch on Health Council.*

This recommendation was not accepted by the government, as Watch on Health has ceased to function.

Recommendation 31 *Within the Office of Health Review there be an urgent review of management systems, with a view to establishing a strategic approach to the collation, analysis, maintenance, reporting and referral of complaints data. Amongst other things, such data must enable the Office to assess the extent to which it is reaching and serving the needs of groups with special needs, including indigenous people, people from culturally and linguistically diverse backgrounds, people with disabilities, people with mental health issues, seniors, young people and those living in rural and remote areas of the state.*

Recommendation 32 *The Office of Health Review establish an effective mechanism for transmitting relevant statistical information on health system issues to stakeholders.*

Recommendation 33 *The present system of regular meetings with customer service officers from metropolitan health services continue and the system be expanded to other groups of like service providers in the health system.*

Recommendation 34 *The Office of Health Review coordinate a forum of complaints officers from disability service providers in order to discuss matters of common interest in relation to complaints handling processes.*

Recommendation 35 *The present functions of the Office of Health Review as set out in 10(1) of the Health Services (Conciliation and Review) Act 1995 remain (with the modification to 10(1)(b) proposed in recommendation 26).*

Recommendation 36 *Part 6 of the Disability Services Act 1993 be amended so that the Office of Health Review has comparable authority and powers with respect to disability and health issues, specifically: (i) with the approval of the Minister, the power to inquire into broader issues relating to disability services arising out of complaints received, similar to section 10(1) of the Health Services (Conciliation and Review) Act 1995; (ii) provisions for directly reporting to Parliament similar to section 56 of the Health Services (Conciliation and Review) Act 1995; (iii) provisions for the Office of Health Review to take direction for a review from Parliament or the Minister for Disability Services, similar to section 56 and 11 of the Health Services (Conciliation and Review) Act 1995.*

Recommendation 37 *The Disability Services Act 1993 be amended to permit the Minister for Disability Services to have the same powers under the Act as the Minister for Health has in the Health Services (Conciliation and Review) Act 1995.*

Recommendation 38 *Grounds for complaints about disability services be extended to include excessive cost, in keeping with the grounds for complaint in section 25(1)(g) of the Health Services (Conciliation and Review) Act 1995.*

Recommendation 39 *The Disability Services Act 1993 be amended, as per section 25(1)(f) of the Health Services (Conciliation and Review) Act 1995, to include as a ground for complaint failure by a manager of a service to properly investigate a complaint.*

Recommendation 40 *The Office of Health Review is to ensure that there is equal recognition of the importance of appropriately and continuously addressing disability complaints and associated issues and that sufficient discrete resources are allocated for this purpose.*

Recommendation 41 *The Office of Health Review collect data and statistics on disability complaints, which adequately and appropriately reflect issues relevant to disability and report separately on these in the Annual Report.*

Recommendation 42 *Disability complaints dealt with by the Office of Health Review must be funded independently of the Disability Services Commission; that is, through an administered fund.*

Recommendation 43 *In order to respond to the recommendations of this report, which proposes a significant re-engineering of the processes and procedures of the Office of Health Review, the Director is to formally identify the competencies and skills required by frontline staff and arrange appropriate training.*

Recommendation 44 *The Director is to ensure that the performance management system be enhanced to take account of the changes to process and procedure outlined in this report.*

Recommendation 45 *The Director meet formally with the Inspector of Custodial Services, on not less than a six monthly basis, to discuss issues relating to the role of the Office of Health Review in the context of the prison health system.*

Recommendation 46 *The Director meet formally, on not less than a six monthly basis or as required, with the Executive Manager of the Prisons Division to discuss operational matters relating to the Office of Health Review's performance of its role in the prison environment.*

Recommendation 47 *Not later than 6 months after the Minister has accepted the Report, the Director of the Office of Health Review (or new name) is to provide a progress report to the Minister on the implementation of recommendations agreed to by the Minister.*

Appendix B: Number of Health Complaints for Each Provider Type

Provider Type	Number of complaints	Percentage of all health complaints
Aged Care Hostel	6	0.35%
Alternative Health Service	11	0.64%
Alternative Health Therapist	2	0.12%
Ambulance Service	21	1.22%
Chiropractor	3	0.17%
Community Health Service (Private)	13	0.76%
Community Health Service (Public)	21	1.22%
Counsellor	3	0.17%
Day Surgery	1	0.06%
Dental Prosthetist	1	0.06%
Dental Surgery	72	4.19%
Dental Technician	1	0.06%
Dentist	93	5.41%
Detention Centre	2	0.12%
Diagnostic Service	24	1.4%
Dietician	1	0.06%
Disability/Rehabilitation	1	0.06%
Government Department	365	21.24%
Hearing Service	8	0.47%
Hospital (Private)	64	3.73%
Hospital (Public)	323	18.8%
Locum Service	3	0.17%
Medical Practice	115	6.69%
Medical Practitioner	437	25.44%
Mental Health Service (non-hospital)	20	1.16%
Naturopath	1	0.06%
Nurse (Enrolled)	2	0.12%
Nurse (Registered)	4	0.23%
Nursing Home	9	0.52%
Occupational Therapist	1	0.06%
Optical Service	2	0.12%
Optometrist	34	1.97%
Orthopaedic	2	0.12%
Other	7	0.41%
Pharmacist	12	0.7%
Physiotherapist	5	0.29%
Podiatrist/Chiropodist	4	0.23%
Podiatry	1	0.06%
Prosthetist/Orthotist	1	0.06%
Psychologist	4	0.23%
Radiographer	2	0.12%
Retail Pharmacy	4	0.23%
Speech Therapist/Speech Pathologist	3	0.17%
Therapeutic Counsellor	1	0.06%
TOTAL	**1718**	**100%**

Table 38: Complaint numbers for health provider types

Appendix C: Outreach, Community Awareness, Training and Development and Other Involvement.

In the 2003-2004 financial year, we participated in or were represented on the following forums and committees:

Committees

- Multicultural Access Contact Officers Network
- Health Complaints Coordinators Network
- Schools Conflict Resolution and Mediation Competition
- Opioid Replacement and Pharmacotherapy Advocacy and Complaints Service
- WA Association for Mental Health Human Rights and Social Justice Sub Committee
- Inspector of Custodial Services Inspection Team for Rangeview
- Australasian Council of Health Complaints Commissioners
- Breastscreen Consumer Reference Group
- Department of Premier and Cabinet working group on complaints handling website
- Ex-Officio member of Watch on Health (until it ceased functioning)
- Medical Board Complaints Sub-Committee
- Medical Defence Association Risk Management Consultative Group
- Offender Health Council

Forums

- Women's Multicultural Health Forum
- People with Disabilities Inc Advocacy Forum

In addition, staff have participated in or given presentations at the following conferences, seminars and meetings:

Conferences/Seminars

- Seminar on Impaired Medical Practitioners
- IPAA Seminar – Engaging with Aboriginal Western Australians
- Complications in Health Care Seminar
- WA Council of Social Services Conference
- Seminar on drugs in prisons – Department of Justice
- Launch of State Aged Care Plan
- WA Association for Mental Health – Prisoners and Mental Health
- National Disability Abuse and Neglect Hotline workshop
- Seminar with NSW Deputy Ombudsman and Commissioner for Community Services (NSW)
- Office of Public Sector Standards Commission Ethics Consultation workshop
- Bullying in the Workplace Seminar
- New Zealand Health Consumers Advocacy Conference
- Briefing on the Crime and Corruption Commission
- Office of Public Sector Standards Commissioner seminar into Insights Strategies
- IPAA Corporate Governance Seminar
- Seminar on Public Interest Disclosure Bill
- Safety and Quality in Health Care Conference
- SOCAP Accountability Seminar
- Risk Management Conference
- Effective Complaint Management in Health Care Conference

Presentations/Meetings

- Presentation to Legal Studies Students – Murdoch University
- Presentation to Physiotherapy staff – Osborne Park Hospital
- Presentation to Aged Care Complaints Resolution Scheme staff
- Presentation to Citizen's Advice Bureau volunteers
- Presentation to Disability Services Students – Thornlie TAFE
- Presentation to Aboriginal Alternative Dispute Resolution Service

Staff have also attended the following training courses:

- Basic Survey Design
- Workplace First Aid Certificate
- Root Cause Analysis (attended by all investigative staff)
- Dealing with People with Personality Disorders
- Mediation and Conciliation
- Informed Consent
- Advanced Writing Skills
- Report Writing in Plain English
- Understanding Unlawful Discrimination in WA
- Media Relations
- Successful Job Applications and Interview Performance
- Leadership in the Management of Change