Office of Health Review

ANNUAL REPORT 2002-2003

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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 2003.

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

29 August 2003

FOREWORD

This year has been a challenging and eventful one for our office. We received 1650 new complaints (an increase of 267 compared to last year) and we closed 1594 complaints (an increase of 96 compared to last year). These are the highest numbers of new and closed complaints handled by us in any one year.

During the year, in addition to dealing with record complaint numbers, we were also able to reduce both the average time to finalise complaints and the average cost per finalised complaint. All of this was achieved within our allocated budget appropriation from Government.

In November 2002, the Minister for Health, as required by section 79 of the *Health Services (Conciliation & Review) Act* 1995, appointed an Independent Reference Group to conduct a review of the operations and effectiveness of our office. We were pleased to contribute to the work of the Reference Group by providing a considerable amount of information and statistics about our work. We met with the Reference Group, gave a presentation and answered questions about our office. We also made a written submission addressing the terms of reference for the review. We look forward to the Government's response to recommendations arising from the review and the opportunities that this will present for us to improve the services we offer to the people of Western Australia.

In this financial year the report on the review of the *Disability Services Act* 1993 was released and, amongst other things, recommended that the Office of Health Review continue to handle disability complaints under Part 6 of the Act. We were pleased to be able to continue our contribution to the resolution of grievances about the provision of disability services.

During the year we were also involved in implementing one of the recommendations arising from the Machinery of Government Taskforce. Recommendation 22 suggested consideration of the feasibility of collocating the various accountability agencies in one central location. We, along with the State Ombudsman, the Public Sector Standards Commissioner and the Director of Equal Opportunity in Public Employment, were involved in the design and planning of accommodation changes to facilitate the collocation of these agencies. This created a number of particular challenges for us and has resulted in us having to move to significantly smaller accommodation. However, this should lead to significant cost savings for us in reduced rental charges. The physical move has recently been completed and we are continuing to develop effective working relationships with the other agencies to capitalise on the benefits of collocation.

Through our membership of the Australia and New Zealand Council of Health Complaints Commissioners we have been able to contribute to a national project called "Turning Wrongs into Rights". The Australian Council for Safety and Quality in Health Care (ACSQHS) has sponsored the project to improve the way consumer complaints are managed by health services and to ensure they are linked to quality improvement. The project will develop interim better practice guidelines on complaints management in health care services based on evidence of good practice in Australia and internationally.

The project team is comprised of the NSW Health Care Complaints Commission (HCCC) (representing the Australia and New Zealand Council of Health Complaints Commissioners), the Royal Australasian College of Physicians (representing the Committee of Presidents of Medical Colleges), Resource Resolution Network and the Health Issues Centre. More information about this project can be obtained from the websites of either the ACSQHC (http://www.safetyandquality.org) or HCCC (http://www.hccc.nsw.gov.au).

During the year, we were delighted to be invited to participate as a non-voting member of the Health Standards and Surveillance Council, or *"Watch on Health"* as it is to be known. We have also agreed to be an Endorsed Agency for *Watch on Health.* This is a significant opportunity for us to draw on experience gained from dealing with specific complaints and to provide input and feedback on systemic issues about the provision of health services in Western Australia.

Given that we are such a small agency and we deal with a significant number of health and disability complaints each year, it is a difficult balancing act to focus on resolving individual complaints in a timely and effective manner and, at the same time, increasing awareness of our functions and role. We do this as best as we can, but we recognise that there is probably more that could be done in this area. This year we have continued our efforts to increase the awareness of our office and the work we do in resolving health and disability complaints. This has involved our staff speaking about the office in various forums, including national conferences, seminars and meetings. We also continue to distribute written material about the office to consumer and provider organisations as well as other interest groups. Appendix A to this report contains a detailed list of these activities. We will continue to look for opportunities to increase the level of awareness within the community about the services we offer to both consumers and providers of health and disability services.

Once again, we are very grateful for the excellent working relationships we enjoy with key stakeholders. These include consumer and provider groups, professional bodies, providers of disability services and also the large number of people involved in the public health system. Without the high level of cooperation and assistance we receive from key stakeholders we could not operate effectively.

Finally, nothing could be achieved without the considerable efforts of our talented and dedicated staff. Dealing with complaints is a difficult area of work and our staff are often the subject of criticism from disgruntled clients, occasionally of a personal or threatening nature. Nevertheless, the results we have achieved this year, at a time of considerable pressure and uncertainty, is largely due to the hard work and individual contributions of each of the staff within our office. I am very grateful for their efforts.

Eamon Ryan
DIRECTOR

WHO WE ARE AND WHAT WE DO

Role

The Office of Health Review was established in 1996 by the *Health Services (Conciliation & Review) Act* 1995 (the Act) as a readily accessible means of having complaints about the provision of health services reviewed, conciliated and dealt with in confidence. The Office of Health Review is an independent statutory agency.

The Act defines "health services" broadly to include: diagnosis, treatment, health care, preventative programs, research, and other allied services such as ambulance services or welfare services that are complementary to a health service. The Act is applicable to both public and private providers of health services.

In 1999, following amendments to Part 6 of the *Disability Services Act* 1993, the Office of Health Review assumed responsibility for resolving complaints about disability service providers. For the purposes of Part 6, the *Disability Services Act* 1993 defines "disability services" as a service provided specifically to people with disabilities, excluding services provided wholly or partly from funds provided by the WA Department of Health or wholly from funds provided by the Commonwealth.

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

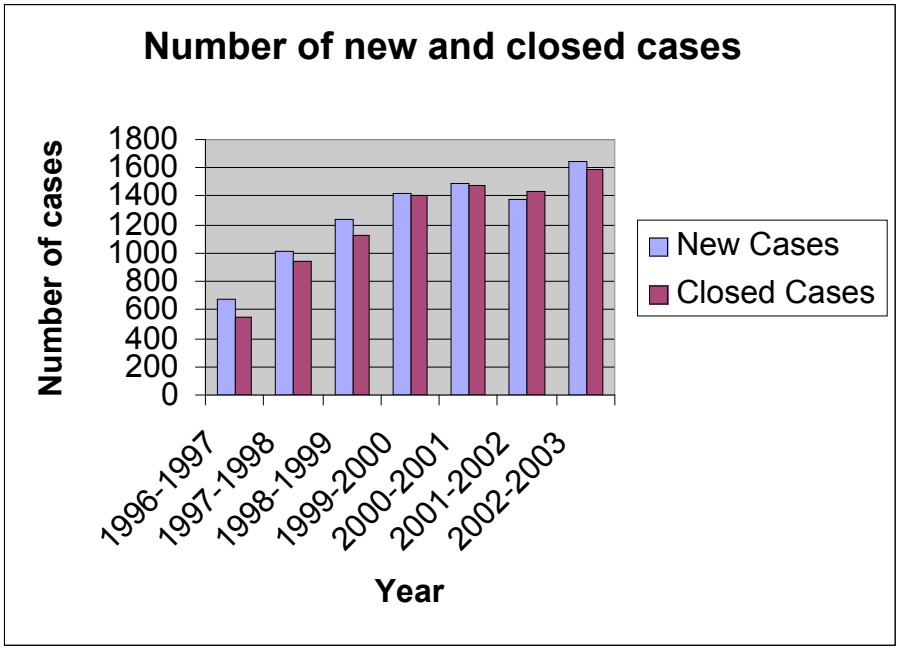
Objectives
- To resolve complaints about health and disability services by providing systems for dealing with complaints that meet the needs of both consumers and providers.
- To suggest ways of minimising or removing the causes of complaints.
- To provide feedback into the system with the aim of improving the quality of health and disability services.
- To promote the OHR and the work we do.

Values
We regard the following core values as fundamental:
- Ethical conduct, professionalism and conformity to statutory obligations.
- Responsive and sensitive service to clients.
- Objective, thorough and timely complaints management.
- A constructive and collaborative approach to resolving complaints.
- Equitable access to our services for all Western Australians.
- The effectiveness of our staff is the basis for success, therefore staff competence, involvement and teamwork are given a high priority.

When we recruit new staff we focus on these core values.

NEW AND CLOSED COMPLAINTS

In 2002-2003 we received a total of 1650 new complaints and closed a total of 1594 complaints. These are the highest numbers of new and closed complaints handled in any one year since the establishment of our office in September 1996. Of the new complaints received, 1607 were health complaints and 43 were disability complaints. Of the closed complaints, 1552 were health complaints and 42 were disability complaints.



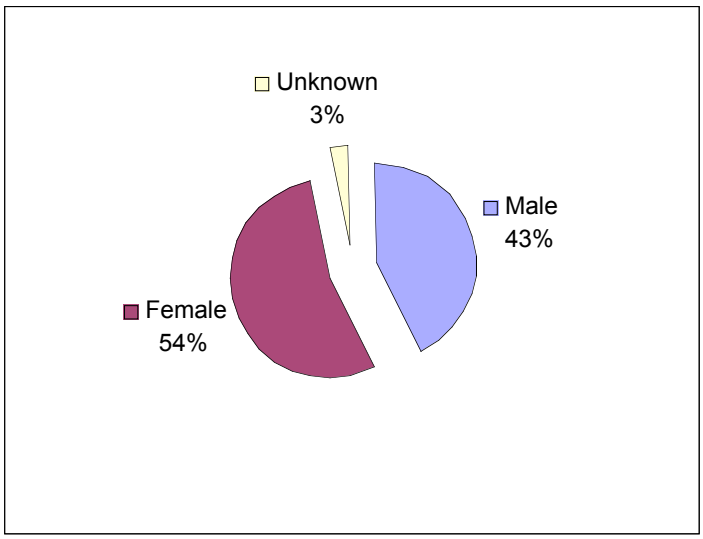
Demographic Analysis of Complaints in 2002-2003

Wherever possible we try to gather demographic information about the complaints we receive. We do this in a number of ways but the most effective method is through our complaint form.

Providing this information is optional and, as such, it is not possible to gather demographic information about all complaints. In the next financial year we are going to try to gather more accurate demographic information from the complaints we receive.

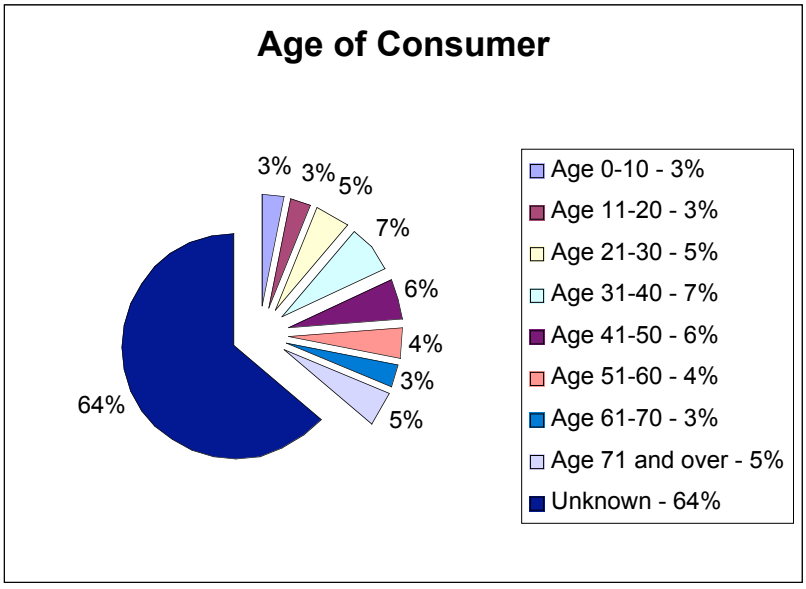
Gender

Of the new cases received this financial year, 55% of consumers were identified as female and 43% as male. 3% of complaints did not identify the gender of the consumer. These 3% of complaints were all single contact enquiries that did not progress to a formal written complaint.



Age

We ask that the age of the consumer be identified when a complaint form is completed. Complaints this year came from a wide variety of age groups. Unfortunately, in 1062 cases the consumer's age was not identified. Complaints relating to consumers in the 0-10 age group were made by parents or guardians on behalf of their children. Many of the complaints relating to consumers in the 71 and over age group came from adult children complaining on behalf of their elderly or deceased parents.



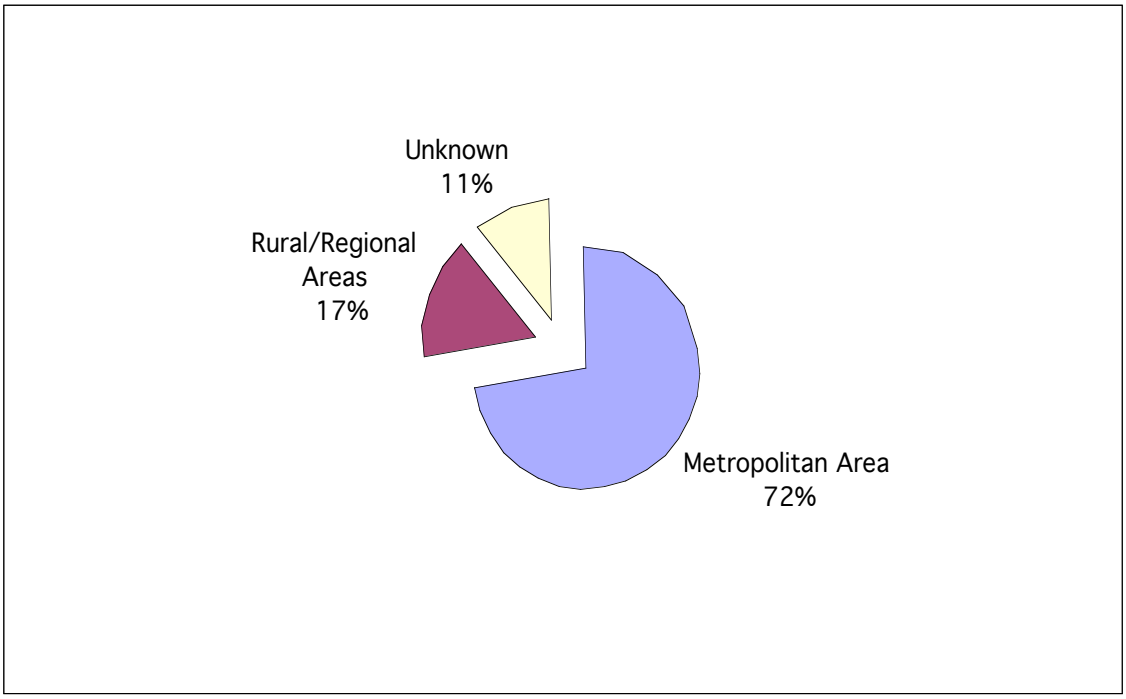
Geographical Location

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

72% of consumers came from the Perth metropolitan area (postcodes 6000-6199 and 6900-6999), and 17% from rural and regional areas of Western Australia. 11% of the 1650 new cases this year did not have a postcode listed, these were cases where no written form was received and the case was closed at enquiry stage.

Information available from the Australian Bureau of Statistics website[1] indicates that approximately 73% of the population of WA live in the Perth metropolitan area. The proportion of metropolitan and rural/regional complaints we have received accurately reflects the demographic distribution of the WA population. Only 5 complainants were from interstate or overseas.

Of the complaints from rural and regional WA, 100 were in the postcode range of 6200-6299, 47 were in the postcode range 6300-6399, 34 in the postcode range 6400-6499, 66 in the postcode range 6500-6599, 2 in the postcode range 6600-6699 and 41 in the postcode range 6700-6799.



[1] http://www.abs.gov.au Webpage on Local Government Area Populations.

HEALTH COMPLAINTS IN 2002-2003

New Health Complaints

Of the 1607 new health complaints received this year, 704 were written complaints where a complaint form was received and the matter progressed. The remaining 903 cases were enquiries, where a complainant lodged their concerns with the office but did not confirm their complaint in writing and the matter was not progressed. Many of the enquiries we received were single contact complaints.

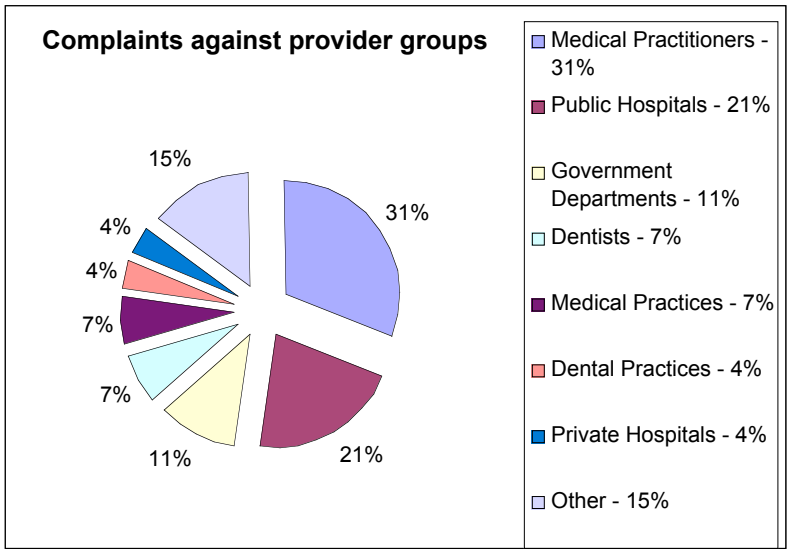
Closed Health Complaints

We closed 1552 health complaints in 2002-2003. Of these complaints, 677 were written complaints and 875 were enquiries.

The remainder of this analysis relates to the 1552 closed health complaints in the 2002-2003 financial year.

Who do consumers complain about?

The largest provider group complained about was Medical Practitioners (31%), followed by Public Hospitals (21%) and Government Departments (11%) – Government Departments include prison health services and concerns relating to Department of Health policies. The remaining groups were dentists (7%), medical practices (7%), dental practices (4%) and private hospitals (4%). Other provider types each accounted for 1% of complaints or less.



Complaints about Medical Practitioners

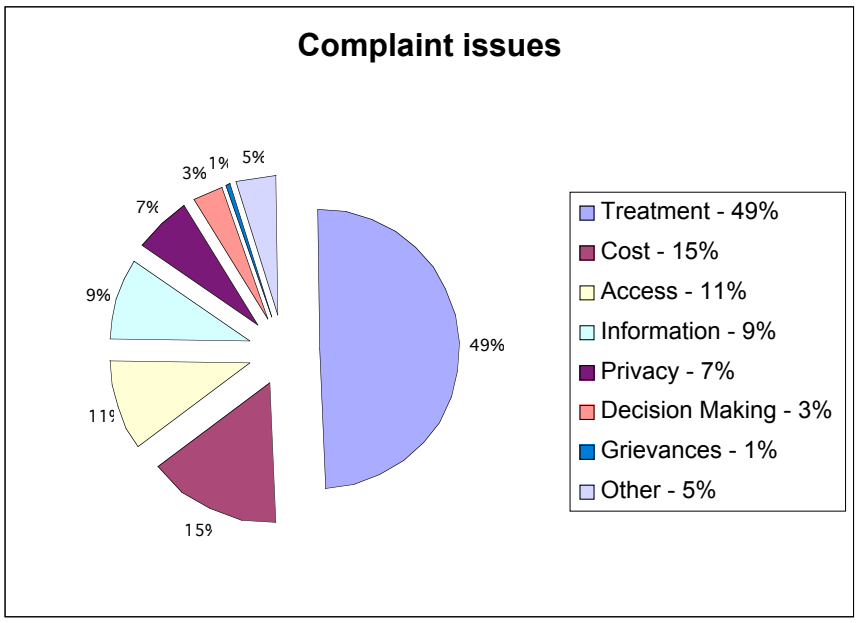
Within the broad category of Medical Practitioners, there are several areas of specialty such as General Practitioners and Surgeons. General Practitioners were the highest in this category, representing 44% of complaints about Medical Practitioners. Other specialty areas within this category were General Surgeons (12%), Obstetricians/Gynaecologists (8%), Psychiatrists (7%), Orthopaedic Surgeons (5%), Anaesthetists (5%), Plastic/Cosmetic Surgeons (3%) and Ophthalmologists (3%). Other medical specialties each received fewer than 10 complaints.

Complaints about Public Hospitals

Of the complaints about public hospitals, 29% were about general medicine, 17% were about emergency departments, 16.5% were about psychiatry, 8% were about administration matters, 7.5% were about general surgery, 5% about obstetrics and gynaecology and 2% about paediatrics. The remaining specialties within public hospitals each accounted for less than 2% of complaints about public hospitals.

What Issues do Consumers Complain about?

As in previous years, the issue most frequently complained about was treatment (49%). Other issues complained about were cost (15%), access to services (11%), information (9%), privacy (7%) and decision making (3%). Of the complaints about treatment, 67% were about inadequate treatment, 10% related to unskilful or incomplete treatment, and 5% to inadequate diagnosis.



Do the issues vary between provider types?

It is interesting to consider the four main issues raised in all complaints and compare whether the issues change for some specific provider types.

Table 1: Comparison of Issues and provider types 2002-2003

	Treatment	Cost	Access	Information
All complaints	49%	15%	11%	9%
Medical Practitioners	50%	17%	5.8%	11%
Public Hospitals	49%	2%	24%	9.6%
Government Departments	69%	2%	9%	3%
Dentists	67%	23%	2%	4%
Private Hospitals	40.6%	34%	6%	6%

Table 1 identifies differences and similarities in the issues raised in complaints about various provider types and enables consideration of whether there are any meaningful conclusions that can be drawn from the data.

A degree of caution needs to be applied to the data because some of the raw figures are small and may not have statistical relevance. Also, there are differences in how some complaints are recorded. For example, complaints about public hospitals include complaints about medical practitioners who provide care to public patients within each hospital. On the other hand, complaints about private hospitals only include complaints about the services provided by the facility and its employees. Medical practitioners in the private system are largely independent practitioners who have admitting rights to the individual facility and, as such, complaints are recorded against them as individuals rather than against the hospital. Nevertheless, we feel that as an overall comparison, the data is informative.

It is clear from Table 1 that treatment issues are consistently the most reported across these provider groups, with Government Departments and dentists having a higher than average percentage of complaints about treatment. An interesting comparison is in the areas of cost and access, where, as one would expect, there is a clear distinction between private and public providers. Issues about access do not appear to be so significant for consumers accessing private services, such as medical practitioners and dentists. However, issues about access are a serious consideration for consumers using public hospitals. Similarly, very few complaints relate to costs in public health services, but costs are clearly a concern to consumers in a private hospital setting.

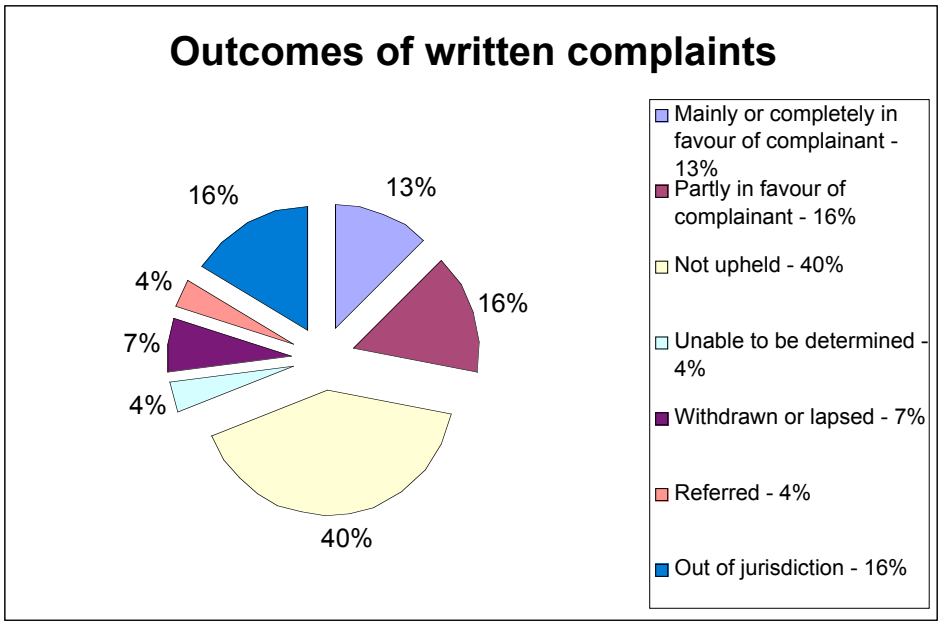
Outcomes

56% of complaints were closed at the enquiry stage. This means that the matter did not proceed past the initial stage. Many of these were single contact complaints where information or advice was given about how the complainant could try to resolve the matter directly with the health service provider (as required by the Act), or where other information or sources of redress were provided. During the next financial year we intend to survey a sample of complaints that do not proceed beyond the enquiry stage to determine why the individual did not proceed with the complaint.

Written complaints

Currently, the Act requires that a complaint must be confirmed in writing.

Of the 677 written complaints we closed, 13% were resolved mainly or completely in favour of the complainant and 16% were resolved partly in favour of the complainant. 40% of complaints were not upheld and 4% were unable to be determined. 7% of written complaints were withdrawn or lapsed. 4% of complaints were referred, either to a registration board or to another appropriate body and 16% were either declined or considered out of jurisdiction for various reasons. A matter may be out of jurisdiction if it has already been considered by a registration board or court, if the incident occurred more than 12 months before the complaint was made or if the complaint does not allege an issue that is outlined in section 25 of the Act.



Resolved Partly or Completely in Favour of the Complainant

Of those 190 matters resolved in favour of the complainant, 43 cases involved the complainant obtaining an apology, 34 involved some change in procedures or policies on the part of the provider, 7 led to compensation being paid, 36 led to costs being refunded, 84 led to a detailed explanation being given and 37 led to the service being obtained.

These cases add up to more than 190 because a number of cases have two outcomes, for example, a provider may refund the consumer's money and apologise, this is counted as one case, with two closure outcomes.

How we resolve health complaints

It may be helpful to provide some explanation about how we resolved the complaints we closed this year. Complaints can be resolved at the enquiry stage, or following some preliminary enquiries, or by a process of conciliation or investigation.

Enquiries

1097 health complaints were resolved at enquiry stage in the 2002-2003 financial year. 875 of these were enquiries where no written complaint was received. 222 were where a written complaint was received, but the matter did not proceed and was closed at enquiry stage. There are several reasons for this such as the complaint being out of jurisdiction, referred elsewhere, withdrawn by the complaint or the matter was resolved by a few telephone calls.

Our first point of contact with complainants is usually through a telephone call received by one of our enquiries officers. This is an opportunity for the complainant to discuss their concerns and obtain advice from our staff. Often matters can be resolved directly at this stage by our enquiries staff giving information and advice to the complainant to assist them in resolving their complaint. Our enquiries officers have access to a large network of resources and relevant information and this enables them to give appropriate information and advice to complainants.

Many complainants who telephone the office have not approached the provider directly and our enquiries officers usually encourage them to try to resolve the matter initially with the provider. We do this for two reasons. First, it is a requirement under the Act, and second it is our experience that many matters can be resolved adequately at the level of service provision. There are occasions where an approach to the provider has not been successful or where this may not be appropriate. In these situations, we send the complainant a complaint form and other information about our office. Once the complaint form is returned, it is analysed and allocated to a case officer for action.

CASE STUDY – Transfer of Medical Records

A woman who lived in a small country town wanted to change medical practices. There were only two practices in the town and she telephoned our office to complain that her records had not been transferred to her new doctor. Staff at the first practice told her that the records had been copied, but that they were waiting for them to be collected.

Our enquiries officer telephoned the first practice and a staff member explained that they used to deliver records to the other practice, but they had recently decided that they would wait for the records to be collected by the second practice. Staff at the second practice said that they were not aware of this and that they were waiting for the records to be delivered.

Our enquiries officer negotiated with the staff at the first practice who agreed to deliver the records to the second practice as a means of resolving the matter. Such complaints do not require the formality of a written complaint in order to be resolved.

Preliminary enquiries into complaints

444 health complaints were closed at the preliminary enquiry stage in the 2002-2003 financial year. Of those, 62 were resolved mainly or completely in favour of the complainant, 90 were resolved partly in favour of the complainant, 221 were not upheld and 22 were unable to be determined. The remaining 49 cases had various other outcomes including being withdrawn or allowed to lapse by the complainant or being referred elsewhere by us.

When a written complaint is received by the office it is often not possible to make an informed decision about the matter without gathering more information. In doing this, a copy of the complaint is usually sent to the provider to obtain their response. This allows us to have both the consumer's and provider's perspective or account of what occurred. On receipt of the response, the case officer assesses the matter. This may involve obtaining copies of the relevant records and seeking an independent opinion from a suitably qualified expert. Once all of this information is available, the case officer critically analyses the material to consider what further action is necessary or warranted. Consideration is given to whether the matter warrants commencing a formal investigation or conciliation. In practice, most of our complaints are resolved at this stage.

In every case, both the complainant and provider are given a detailed letter of explanation for the outcome reached.

The following case studies are examples of matters that have been resolved informally at this stage.

CASE STUDY – Private hospital emergency department

A man was referred by his GP to a private hospital emergency department to receive treatment for intense back pain. He complained about the attitude of staff who told him upon arrival that he would be charged for treatment and also that his GP should have telephoned first to ensure that a bed was available. He was then asked if he wished to proceed with treatment. As he was experiencing intense pain, he agreed to be treated and signed the necessary forms. He was assessed by a doctor who conducted various tests but could not find anything wrong. He was given an injection for pain and oral pain medication and, when the pain subsided, he was discharged. Later that day the pain returned but it was more severe. His wife rang the hospital emergency department and she was told to bring her husband in but that it was "probably only sciatica and there are no beds available". The couple decided then to go to a public hospital emergency department where the man was diagnosed as having an abscess on his spine that required surgery.

This complaint raised a number of interesting issues such as, the role of the private emergency department and the necessity to discuss fees and charges prior to admission. We are not critical of the need to discuss fees because it is appropriate for a service provider to ensure that a patient gives informed financial consent prior to receiving any treatment. However, it does pose particular challenges for private providers who choose to offer such services.

The private hospital responded promptly to the complaint and enclosed copies of the patient's records and results of the various tests conducted. The hospital acknowledged and expressed regret that the abscess had not been diagnosed and explained why this had occurred. The hospital acknowledged the complainant's frustration at the apparent over-emphasis on charges when he first arrived at the emergency department and apologised for the attitude of the nurse when the man's wife telephoned as his condition deteriorated. The hospital advised that as a result of this complaint, it would be changing its policy to ensure that when a patient has attended the emergency department and, after discharge, telephones with further concerns, the person will speak to a doctor.

The hospital also advised that it was expanding its emergency department and was providing more beds and operating theatres, which should reduce the pressure on bed availability. The complainant was satisfied with this outcome and welcomed the steps being taken by the hospital.

CASE STUDY – Delayed diagnosis

A young woman complained about the management of her labour at a local public hospital following a delay in the diagnosis of a ruptured uterus. Eventually, she had to be transferred to another hospital where the rupture was diagnosed and treated.

We sought independent advice on the matter. The advice indicated that the management of the labour was appropriate and that the rupture was a very rare complication and would have been difficult to diagnose. The advice also raised the issue of delay by the hospital in recognising that there was a serious problem. The advice concluded that the rupture could not have been prevented and the woman would have required surgery regardless of where or when it had been diagnosed. However, the delay did mean that the woman was in pain for an additional period of time and would also have suffered additional blood loss throughout the day.

On our recommendation, an apology was provided to the woman together with an offer of confidential counselling services. Staff from the hospital also met with the woman and put in place a number of procedural changes, including the employment of a lead midwife, mandatory performance evaluation and management policies, the implementation of medical and midwifery written care plans for all patients, the production of a handbook for new parents, mandatory training for medical and midwifery staff in cardiotocograph interpretation and the development and implementation of guidelines to ensure responsibility for the care of seriously ill obstetrics patients. The complainant was satisfied with the outcome.

CASE STUDY – Working with complainants and providers

The office received a complaint from a young woman who, because of several medical conditions, had multiple attendances at a hospital emergency department complaining of pain. In addition to this, the patient has a physical disability and uses a urinary catheter. She was concerned that the hospital staff were not taking adequate care of her catheter, and that this had led to regular infections which required treatment. When she presented to the emergency department for treatment, she was often turned away with no pain relief and she felt that her concerns were not being taken seriously.

It appeared that the patient was unsure about when it was appropriate to seek treatment from her GP, the emergency department or a specialist. Equally, there appeared to be some frustration in the emergency department with the number of attendances from this patient. All of this led to a strained clinical relationship.

After some time spent assessing this matter, the Office concluded that, given the various disciplines involved, a management plan should be in place at the hospital. We approached the various providers involved and arranged a meeting which was attended by the patient and her mother, the patient's GP, representatives from the hospital emergency department, the nurse who visits the patient at home to provide care, the Manager of Customer Services at the hospital and the case officer from the Office of Health Review. At this meeting, discussions were held about the issues of concern and the patient's various medical conditions which require ongoing management. A plan was developed for management of the patient's catheter, pain and infections. An agreement was reached about when the patient would attend the hospital and when she would see her GP, and arrangements were put in place for regular outpatient urology appointments to monitor the care of the catheter. The woman was happy with this arrangement as she felt that she had contributed to the process and that her concerns had been listened to and taken seriously. The hospital arranged for a copy of the plan to be placed on the patient's file and for her to have her own copy, which she could take with her when she presented to the emergency department. Both parties were satisfied with the outcome of this complaint.

Conciliation

Six health complaints were closed in formal conciliation this financial year. Three were resolved mainly or completely in favour of the complainant, one was not upheld, one was withdrawn by the complainant and one was referred to the relevant Registration Board.

The *Health Services (Conciliation and Review) Act* 1995, enables the Director to decide which process is the most appropriate to resolve individual complaints. One of the processes set out in the legislation is conciliation. We use both formal and informal conciliation processes to resolve complaints. Informal conciliations are resolved at the preliminary enquiry stage.

Background information is usually gathered during the initial stages of dealing with a complaint to determine whether there is any need to pursue the matter formally. If it appears from this information that the matter is suitable for formal conciliation, the Director can refer the matter for conciliation. The conciliation process is then used to gather further information in a confidential and privileged environment, and, if appropriate, explore possible outcomes, including compensation. Given the increased formality, these matters take much longer to resolve as the parties often seek external advice about issues such as damages, treatment and compensation.

One of the outcomes from conciliation can be compensation and during the year we successfully negotiated amounts of between $18,000 and $70,000 through this process. Other outcomes achieved during conciliation included an apology, explanation and service improvements.

The types of services dealt with in conciliation included dentists, medical practitioners, allied health and hospital care.

Although we have been operating since 1996, it has taken some time for us to establish a general awareness of our services and gain acceptance for a process that is not widely understood. In recent years, we have seen a shift in the acceptance of conciliation, both formal and informal, as a viable means of resolving matters. For example, we recently had a case where the provider's legal representative recommended our conciliation process to the complainant's solicitor and encouraged them to use our services to explore compensation. This was put forward as a viable alternative to litigation.

However, for some people, both providers and consumers, legal action may be a more familiar process. For this reason we usually have several cases each year where one party (usually the complainant) withdraws from the conciliation process to pursue their concerns through legal channels. One possible reason for this is likely to be that we routinely advise complainants of their rights to seek legal and other advice about the matter. We specifically encourage this if the matter involves consideration of any offer of settlement or questions of quantum. There is always a risk that some individuals will choose to withdraw from the conciliation process to pursue their complaint through legal channels, but this is their choice and we respect an individual's right to make such decisions.

The acceptance of our conciliation process by both consumers and providers alike is important because the process simply cannot work effectively if both parties are not willing participants.

Whatever the reason for the increase in conciliations, it has given us the opportunity to refine our process, develop staff skills and establish conciliation as a viable and cost effective alternative to legal action.

The conciliations undertaken this year have raised some new and challenging situations. There have been cases where there was more than one provider and more than one complainant as a party to the conciliation. We have also dealt with cases where agreement has been obtained to allow the complainant to lodge a writ to enable them to claim under existing legislation and, therefore, protect their legal position if the conciliation process was not successful. These examples support the contention that conciliation is becoming accepted as a viable alternative to litigation.

We anticipate that the number of successful outcomes from conciliations in the coming financial year will increase. Our intention is to continue to take a robust approach to encouraging resolution of contentious matters through our conciliation process.

CASE STUDY – Epilepsy and pregnancy

A woman who has epilepsy went to her doctor to confirm her pregnancy. After confirmation of her pregnancy, the doctor advised her that she should stop taking her epilepsy medication, as this was harmful to her unborn baby. He also reduced the amount of Folate that she was taking. Two days after seeing the doctor she had two Grand Mal seizures and was admitted to hospital. She was advised by doctors at the hospital that having seizures was more dangerous to the baby and that she should not have stopped her epilepsy medication.

The matter was considered suitable for conciliation. Our research confirmed that although there were risks to her baby associated with taking epilepsy medication, it was considered that the risk of seizure was more dangerous to the baby if she stopped taking the medication. The research suggested that the medication and patient should be closely monitored throughout the pregnancy.

This research, together with other information gathered, was forwarded to the doctor to obtain his response. After receiving advice, he acknowledged that he should have obtained a second opinion and that the patient should have been continued on the epilepsy medication. He agreed to pay for the cost of the ambulance, her partner's taxi fares to the hospital, and the woman and her partner's sick leave from work during the relevant time period. The complainant was happy with this as it achieved the outcome she was seeking.

CASE STUDY – Implanting a contraceptive device

A woman complained that a contraceptive device had been implanted too deeply in her arm and had to be surgically removed.

The woman had the implant fitted by her GP but found it irritating even after several weeks. After one month she returned to have it removed and saw another doctor at the

practice. That doctor was unable to remove the device, and nor could several other doctors who were available on the day. The woman was referred to a surgeon who removed it under general anaesthetic.

The matter was considered suitable for conciliation. We conducted enquiries into the woman's concerns and found that the doctor who inserted the implant had not undertaken the recommended one-day training course on the use of the device, even though other colleagues in the same practice had done so. Information obtained by us indicated that the Royal College of Obstetricians and Gynaecologists also recommended the training course and had assisted in its development. Experience overseas had shown that the technique to insert the device is slightly different to other routine medical techniques and that, without training, there was a tendency for doctors to insert the implant too deeply under the skin.

It appeared from the information available that the GP had inserted the implant too deeply in the patient's arm, probably because he had not undertaken the recommended training. The matter was referred for conciliation and, after negotiations between the parties, the matter was settled by payment of compensation.

Formal Investigation

This year we finalised five formal investigations. One of these was resolved mainly or completely in favour of the complainant, two were resolved partly in favour of the complainant, one was not upheld and one was unable to be determined.

The purpose of an investigation is to determine whether any unreasonable conduct as described in section 25 of the Act has occurred. As previously stated, the majority of cases are resolved without the need to commence a formal investigation.

The Act gives us wide powers of investigation. These include the power to:

- issue notices requiring the production of records or other information;
- require the attendance of individuals to answer questions under oath or affirmation;
- decide if any unreasonable conduct as described in section 25 of the Act has occurred; and
- make recommendations for remedial action.

There are a variety of circumstances where we feel it is appropriate to use these powers of investigation. For example, where a provider or a third party refuses to cooperate or produce records, or where the circumstances are such that it is appropriate to proceed in a more formal manner.

CASE STUDY – An unregistered provider

We received a complaint from a person who had been treated by an unregistered provider. The allegations were of a very serious nature and it was likely that the issue would come down to different versions of events. We decided to proceed to formal investigation and interview the provider under oath. Two other witnesses were also interviewed under oath. Although the matter was not able to be resolved, by proceeding formally we were able to gather the best possible evidence. Also the provider understood the serious nature of the allegations and the impact that the incident had on the patient. The patient was satisfied that the issue had been brought to the attention of the provider in a formal way, and did not wish to pursue her complaint through other avenues available to her, including complaining to the Police.

Relationships with Registration Boards

The *Health Services (Conciliation and Review) Act* 1995 allows us to refer appropriate matters to the various Registration Boards. The Act requires that we consult with the relevant Board prior to referring a matter and then only with written authorisation from the person who made the complaint. When a referral is made, we are required to give to the provider and complainant a copy of all the material sent to the Board. The Board is also required to report back to us on the outcome of their consideration of the matter.

Although the circumstances vary, we tend to refer matters to the Registration Boards if a question of professional competence is raised by the complainant or identified by our investigation. These cases are often those where consideration needs to be given to disciplinary action or where some other form of monitoring of the provider's clinical practices would be an appropriate outcome.

Often there is a need for us to continue to consider certain aspects of a matter while also referring issues of concern to the Board. We manage this situation by maintaining ongoing liaison with the Board as enquiries progress.

Part of the role of our Office is to analyse our data and recognise emerging patterns or issues of concern arising from complaints. A recent example of this occurred when we received a number of complaints concerning one particular provider. The concerns included hygiene standards, use of inappropriate or abusive language and other concerns about inappropriate behaviour. We became concerned about these complaints and the possible implications arising from them. It was decided that each of these cases should be referred to the Medical Board of WA for action. The Board dealt with each matter separately. Two of the cases referred went on to formal inquiry at the Board.

CASE STUDY – Inappropriate conduct

In the first case, the Board conducted an inquiry and found the doctor guilty of improper conduct in that he had sworn repeatedly at the patient in the course of a consultation. He was reprimanded and fined $1000 for that finding. The doctor was also found guilty of infamous conduct for going to the patient's home to coerce him into withdrawing the complaint. He was reprimanded, fined $3000 and suspended for a period of eight months.

CASE STUDY – Insensitive manner

In the second case, the inquiry found the doctor guilty of improper conduct in that he had behaved in an aggressive and insensitive manner which was likely to humiliate and embarrass his patient and her two children. He was fined $1000 and suspended for a period of four months.

The Board concluded that the two periods of suspension were to be served cumulatively, in other words, the doctor was suspended for a total of 12 months.

Prison Complaints

Background

The Office of Health Review accepts complaints from prisoners about health services provided to them while they are in prison.

In 2002-2003 we received 180 health complaints from prisoners in public or private prisons within WA. This was an increase of 150% compared to last financial year where we received 72 health complaints from prisoners. This increase is most likely due to a number of factors, including close liaison between the Office of Health Review and the other complaints agencies to clarify the jurisdiction on health complaints and an increase in awareness activities by our staff with both prison staff and prisoners.

During the year our staff visited most metropolitan public and private prisons to meet with complainants and staff involved in the provision of health services. We also distributed complaint forms and brochures for health providers and prisoners. We believe that this awareness activity may have contributed to the increase in complaint numbers to the office. Anecdotally, it seems that the awareness of our office among prisoners has also spread by word of mouth.

Relationships with other stakeholders

The Director and/or our Complaints Manager have also met several times with the Department of Justice Director of Medical Services, and also with the new General Manager at Acacia. These meetings have reinforced the importance we place on prison health complaints and enhanced the positive relationship between our office and prison health providers. Our staff also liaise regularly with the Inspector of Custodial Services and the State Ombudsman about prison health complaints and issues.

Issues

Issues raised by prisoners were overwhelmingly about treatment (78%), and within that category, concerns about inadequate treatment was the largest issue. The next most significant category was access (7.22%) (for example, concerns about being refused a service), and other issues included concerns about administrative practices or policy issues (6.67%).

Resolving complaints

Of the 180 complaints received in this financial year, 161 complaints (89%) were closed by 30 June 2003.

Cases were closed in an average of 33 days. This is due to many factors, including good communication channels between our office and prison health staff which facilitates easy access to information and records, a dedicated prisoner complaints contact officer within our office, and inclusion on the prison's Arunta telephone system this financial year.

Our inclusion on the prison telephone system allows prisoners easy access to contact our office and discuss their concerns and, where appropriate, written complaint forms can be

sent out. When written complaints are received, they are usually actioned within a few days by our prison complaints officer who liaises with the contact person at the relevant prison health service. Prison complaints can usually be resolved faster than other health or disability complaints because, generally, answers to the issues raised by the complaint are provided by the prison medical staff or are available from the medical records of the prisoner. This information and the relevant records are routinely provided to us within a short time. However, where an independent opinion or further information is required, for example, medical records from outside the prison or a medical opinion, closure times are longer. As we receive a greater number of complaints, it is likely that the time taken to resolve such issues may increase in the next financial year.

Outcomes

Of the matters that were resolved, the outcomes included:

- Resolved mainly or completely in favour of consumer (for example, the service was obtained, or an explanation given) (14%)
- Resolved partly in favour of consumer (16%)
- Complaint not upheld (for example, an explanation was provided) (43%)

CASE STUDY – Prisoners on the public waiting list

A man was concerned that treatment for a knee condition was being delayed. Enquiries indicated that he had been given an arthrogram and was seen by a specialist orthopaedic surgeon who reviewed his knee, and placed him on the public waiting list for surgery. The prisoner felt that his surgery should proceed urgently. However, we obtained an independent orthopaedic opinion on his condition, which indicated that, clinically, the condition was not one that warranted urgent treatment. As such, being placed on the public waiting list was not inappropriate and was consistent with treatment that would be available for members of the general public. This information and explanation was provided to the prisoner.

CASE STUDY – A long wait for surgery

A woman was concerned that her medical treatment had been unreasonable and that she had been waiting too long for a tonsilectomy. A case officer met with the consumer and discussed her medical concerns in detail. The case officer also met with the treating health provider at the prison and looked through the consumer's medical records. Evidence indicated that the consumer had a number of tests and procedures which were followed up appropriately. In addition, we were able to confirm she was on the wait list for tonsilectomy but because of the possibility of complications (arising from her associated medical conditions) the surgery had to be performed at a teaching hospital. The wait list for such surgery was long, regardless of whether the individual was in prison or not. The consumer was provided with a detailed explanation.

CASE STUDY – Privacy of a gynaecological examination

We received a complaint from a woman who required a gynaecological examination at a public hospital. She had previously had a minimum security rating until a positive urinalysis for cannabis increased her rating to medium. She complained that she had been handcuffed to a female security officer when the examination was undertaken, and that

this had caused her embarrassment and humiliation. We negotiated with prison staff and, from these negotiations, an agreement was reached that security officers would remain outside the door of the treating room for any subsequent gynaecological examinations.

CASE STUDY – Methadone program in prison

A man who had agreed to a methadone maintenance program within the prison wrote to us to complain that he was concerned that a nurse was preventing him from participating in the program. We made enquiries and found that a medical officer required him to provide a clean urine sample prior to commencing the program. He was unable to provide a sample when he attended the doctor for his first review, so the program was held off until the next review, when a sample was produced. The man was provided with an explanation and the program commenced.

ISSUES OF CONCERN ARISING FROM HEALTH COMPLAINTS

Impotency Treatment

We have received complaints about providers of impotency treatment who advertise guaranteed results irrespective of the patient's age. Patients are usually required to pay for their treatment in advance. Many complainants have raised concerns that the treatment was not working, that the cost of the treatment was unexpectedly high, and when they have tried to seek a refund – in accordance with the guarantee given in the advertisements – the person responsible for refunds was difficult to contact.

We received nine enquiries, three of which progressed to written complaints about this matter. Of those three written complaints, following our involvement, two consumers received a full refund and one received a partial refund.

Although the number of complaints is relatively small, this issue is of particular concern because of the vulnerability of many of the consumers of these services. From our perspective, it appears that providers of these services should at least provide full and comprehensive written information on the treatment, the associated charges and their refund policies before asking patients to pay in advance. We also believe that patients should be given time (at least overnight) to consider the treatment options and costs before being asked to pay for the treatment.

We will continue to deal with and monitor complaints about this issue.

CASE STUDY – No chance to change his mind

A man complained that he had not been given the opportunity to change his mind about paying for treatment for impotency. He telephoned the provider the day after writing a cheque for the cost of treatment and asked if he could review his decision to have the treatment. He was told that the cheque had been cashed and that he was therefore committed to the treatment.

We provided information to this consumer about how to lodge a written complaint, but because no written complaint was received we could not proceed with the matter.

CASE STUDY – Confusion over Medicare rebates available for the treatment

A man had a consultation with the provider and was prescribed a course of treatment. After the consultation, he was given information about the cost of the treatment. He expressed concern at the cost, as he is a pensioner and felt he could not afford the treatment. He was told that the cost of the treatment could be subject to a Medicare rebate. When he took the receipt to Medicare he could not claim a refund because there were no item numbers on the receipt.

The man returned the medication to the provider and lodged a written complaint with our office. He was given information about our complaints process and other options. Following our intervention a full refund was received.

The Importance of Good Record Keeping

In dealing with complaints we routinely access medical and other records as a means of resolving consumers' concerns. Often contemporaneous records can help in establishing what took place and, as such, they are an essential element in complaints resolution.

Unfortunately, the standard of record keeping is often below what one should reasonably expect in the circumstances. This is not a new problem and there have been improvements but more needs to be done.

Good records need to be more than just contemporaneous notes. They should provide an appropriate and acceptable level of detail. The importance of this should be obvious to all concerned. Health care is increasingly taking on a multi-disciplinary approach. This is certainly true in the hospital setting, but it is also becoming more applicable in the primary setting, for example, where care is being provided by different General Practitioners within the same practice.

Good record keeping ensures continuity of care for the patient and allows different treating providers to have confidence in identifying the patient's treatment history.

Finally, there is absolutely no point in making contemporaneous records if they are illegible. To be fair, many doctors clearly document their consultations and, generally, nursing notes are clearly written. However, in our experience, doctors are often the source of indecipherable notes in a patient's record. Individual providers have an obligation to ensure that their notes can be easily read by others.

Many health service providers have policies and procedures about good record keeping, however, if they are not enforced rigorously then the problem will not improve.

The quality and standard of record keeping is an issue that we will continue to focus on in the future.

Two case studies help to illustrate this issue.

CASE STUDY – Numerous attendances to a General Practitioner

A woman complained that she was seen by her GP on four occasions over an eight day period. She complained of experiencing a high fever, headache and a cough. She was prescribed two courses of antibiotics. She told us that she felt worse on each occasion and subsequently, she was diagnosed with pneumonia. The woman claimed that her GP did not manage her care adequately and should have sent her for a chest x-ray earlier.

The GP's response to this complaint was that he had examined the woman's chest on each occasion and that she had reported feeling 'much better' as time went on. Although the notes gave details of the antibiotics prescribed they provided little or no detail of any clinical measures taken. Our independent adviser on this case noted that: "the GP has done him/herself no favours by virtue of the sparsely and inadequately written case notes". It was thought that terms such as 'chest reasonable' were of no value without a proper description of the presence or absence of relevant clinical signs. The issue of the adequacy of the provider's notes was subsequently referred to the Medical Board.

CASE STUDY – Recording a patient's instructions

A man raised concerns about the health care his wife received while being treated in a public hospital for emphysema. He was specifically concerned that his wife received pain medication which resulted in her death.

According to the medical records, the patient's condition began to deteriorate and, following discussions with medical staff, she advised that she no longer wished to receive respiratory support and she required pain relief and sedatives. On the basis of the patient's wishes, Morphine was prescribed.

The medical registrar clearly documented the discussion with the patient and that the patient understood that without respiratory support she was at risk of respiratory failure and cardiac arrest.

The detailed entry in the medical records supported the explanation provided by the doctor and we were able to advise the patient's husband that his wife consented to the administration of Morphine and clearly understood the risks involved.

Complainants from Culturally and Linguistically Diverse Backgrounds

Cultural diversity is not a new experience in Australia. We are a multicultural society and, because of this, we all need to recognise that there will be times where cultural and linguistic factors have an impact on how we do our work. This is equally applicable to how our office deals with complaints from people from culturally and linguistically diverse backgrounds, as it is a relevant factor for health and disability service providers to consider.

What we do

In recognition of our need to be aware of and responsive to this issue, a staff member from this Office participates in the Multicultural Access Contact Officers' network run by the Multicultural Access Unit at the Department of Health. This has enabled us to improve our services to clients from culturally and linguistically diverse backgrounds. It has also given us strategies for managing such complaints and it provides us with access to a range of information, resources and the network of staff responsible for implementing language services strategies within the public health system.

We have noticed an increase in the number of complainants who require the use of interpreters when making a complaint. Where necessary, we arrange for an independent, qualified interpreter to be present at meetings with consumers or alternatively, we arrange for the use of the telephone interpreting service. We have also arranged for correspondence to and from complainants to be translated. The costs of these services are met by us.

We have found that these services are an essential element in communicating effectively with people from culturally and linguistically diverse backgrounds. Our experience has been that the use of these services is appreciated by complainants and it has helped us obtain a better understanding of the issues involved and improves the overall confidence in the process by the complainant.

What others do

We have noticed in a number of complaints that cultural insensitivity or failure to acknowledge linguistic differences has been a central issue.

We have also received a number of complaints which raise specific issues about the use of interpreters. It is of concern when a complainant tells us that they were not offered the use of an independent interpreter and family members were used as interpreters to obtain important or sensitive information. This is particularly worrying in circumstances where a young child of a patient is used as an interpreter.

The use of family members, both adults and children, can lead to confusion and uncertainty. Questions arise about the impartiality of the family member, that their English may not be as good as that of a qualified interpreter, or that children may not have the capacity to understand and properly translate complex or sensitive information.

Apart from the obvious benefit to consumers, we believe that it is also in the interests of providers to use an independent, qualified interpreter when communicating with patients

who are from culturally and linguistically diverse backgrounds. If providers use a qualified independent interpreter, particularly when they are obtaining consent or explaining risks involved in a procedure, they can be more confident that they have done all they reasonably can to ensure that the patient was fully informed. Not using an interpreter, or using a family or community member, may not lead to this assurance and could possibly leave providers exposed to criticism.

Medical practitioners can readily access interpreting services, for example through the Translation and Interpreting Service Doctors Priority Line. Using an interpreter over the telephone while the patient is in the office may be inconvenient, but it is certainly a preferable alternative to not using an interpreter, or using a person who is not qualified to carry out the role.

The Language Services Policy established by the Multicultural Access Unit within the Department of Health is an excellent guideline for use in the public health system. Ideally, there should be similar guidelines in place within the private sector.

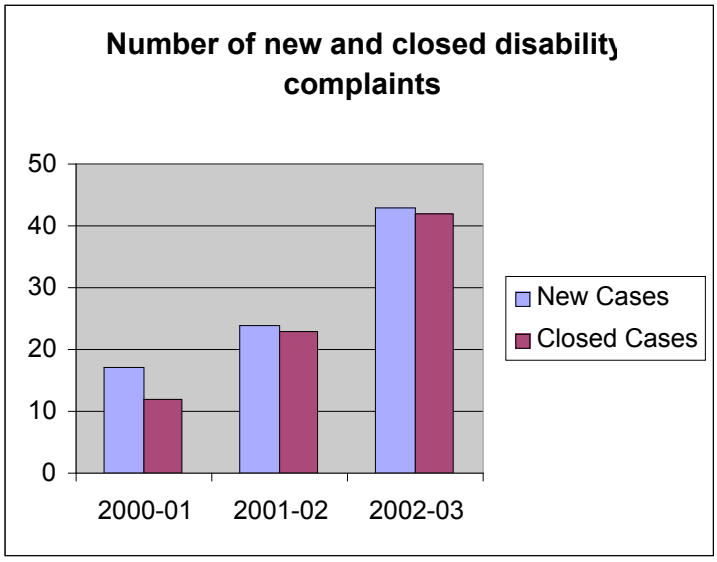
It is important that health providers keep themselves informed of current thinking in relation to providing health care to people from culturally and linguistically diverse backgrounds. Much work has been done within the public health system. The Multicultural Access Unit provides excellent resources outlining various issues affecting different cultural groups living in Western Australia. These resources are available for public health providers and the Multicultural Access Contact Officer at each hospital is responsible for disseminating this information.

Unfortunately, this sort of service and information is not currently available in the private health sector. We intend to approach various professional colleges and associations to encourage them, if they have not already done so, to develop policy statements and guidelines for their members in the area of multicultural health, particularly regarding the use of interpreters.

DISABILITY COMPLAINTS IN 2002/2003

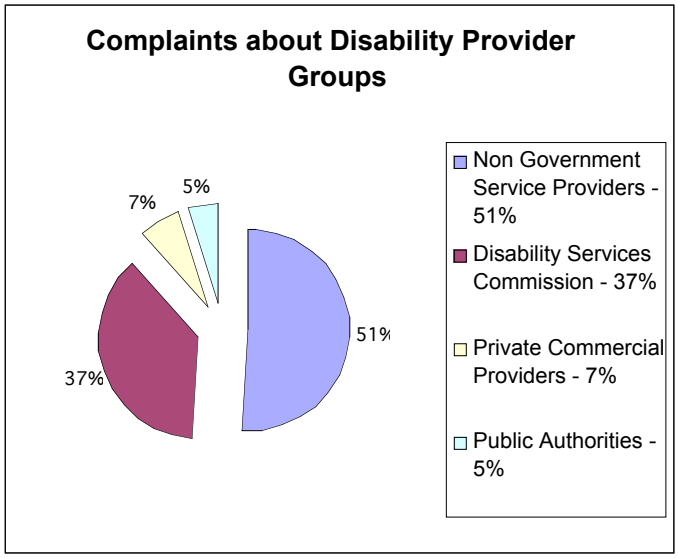
Analysis of Disability Complaints

43 disability complaints were received in 2002/2003 and 42 complaints were closed. Of the 43 new complaints, 26 were made orally and 17 were received in writing. These are the highest numbers of new and closed disability complaints handled by us in any one year.



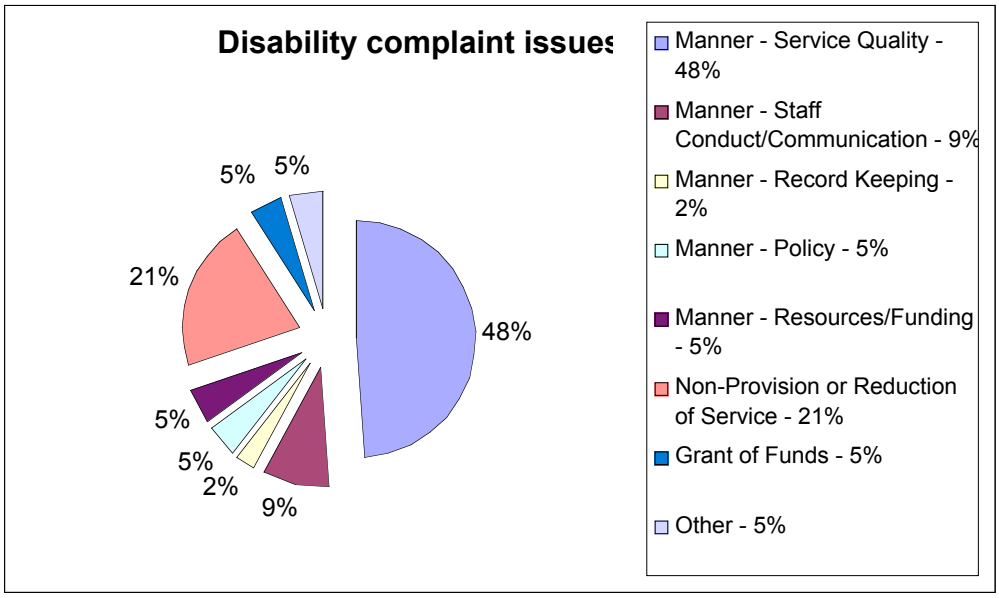
What issues and services do people complaint about?

22 new complaints were about non-government service providers, 16 complaints were about the Disability Services Commission, three complaints were about private commercial providers and two complaints were about public authorities.



36 complaints were made by family members, carers or advocates on behalf of adults or children with disabilities, the remainder were made directly by people with disabilities.

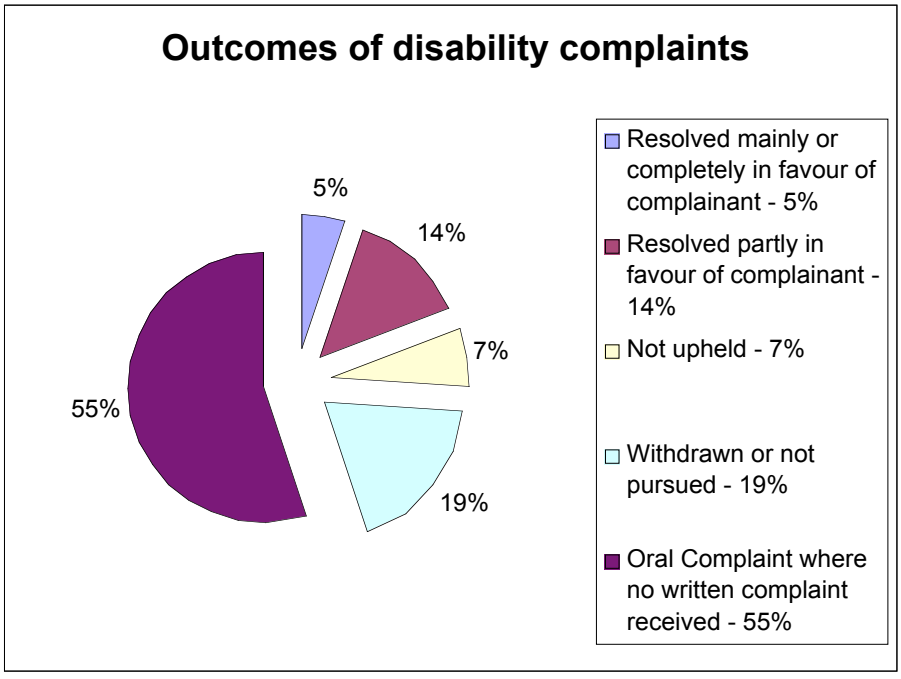
32 complaints were about the manner of providing services (including service quality, staff conduct and communication, record keeping, policy and resources or funding), nine were about non-provision or reduction of services and two were about the Disability Services Commission not granting funds.



Outcomes of closed complaints

Two written complaints were resolved mainly or completely in favour of the complainant. Six written complaints were resolved partly in favour of the complainant. Three written complaints were not upheld. Eight complaints were confirmed in writing, but were either withdrawn or were not pursued by the complainant.

23 oral complaints were made without being confirmed in writing by the complainant. Although the number of oral complaints that were not pursued is disappointing, there may be a number of reasons for this. Most, if not all, disability service providers who receive some level of public funding are required to have an internal grievance and complaints handling policy. This often leads to a realistic and effective means of resolving complaints in the first instance. When we receive an oral complaint we routinely provide advice and assistance about all of the options available to resolve the complaint. For example: assistance is provided to complainants to find the most appropriate avenue to resolve their complaint and advice and resources are provided to assist complainants, where appropriate, to act on their own behalf. Information is made available about how we deal with complaints and whether we can achieve a satisfactory outcome from the complainant's perspective.



Disability Complaints - the Year in Review

The Review of the *Disability Services Act* 1993

The Hon Sheila McHale, Minister for Disability Services, released the Report on the Review of the *Disability Services Act* 1993 earlier this year. We were pleased that one of the recommendations was that we should continue to deal with complaints under Part 6 of the Act.

The Review Steering Committee also made a number of recommendations for amendments to Part 6 of the Act with the objective of improving the complaints mechanism. These included a recommendation that the name of the Office of Health Review be changed to reflect our role in resolving disability complaints. We supported such a change in our submission to the review last year. Changing the name of the office to include a reference to disability should assist in raising public awareness of the services available to resolve complaints from people with disabilities.

Other recommendations, which we supported included:

- We should be funded independently from the Disability Services Commission to provide complaints services under Part 6.
- The Director of the Office of Health Review should have "own motion" powers to initiate an investigation of serious public interest issues.
- The Director should be able to report directly to Parliament.
- The Director should be able to advise the Disability Services Commission of complaints which relate to systemic issues or other issues which significantly impact on the quality of service delivery to people with disabilities in WA.

The Review Steering Committee did not accept all of our suggestions, including, that the complaint provisions, now found in Part 6 of the *Disability Services Act* 1993 should be in a separate Act to that which establishes the Disability Services Commission. This would have recognised the principle that an external complaints mechanism should be completely separate and independent from one of the major service providers.

The number of complaints received continues to increase

There has been a significant increase in the number of oral and written complaints about disability services in the past twelve months. A total of 43 complaints were received compared with 24 for the last financial year. We do not believe this is a reflection on a decrease in the quality or standard of service delivery, but rather it is an indication of an increase in public awareness of the role of our office in resolving disability complaints. This increased awareness is largely a result of the continuing effort on the part of our staff to widely distribute written material, attend forums, conferences and meetings about disability services and issues and to promote our services to disability service providers. The Disability Services Commission also continues to play an important and significant role in informing disability service consumers about the services provided by this office.

Over the past twelve months, we have also received a number of referrals from the Commonwealth Disability Services Abuse and Neglect Hotline, some of which have resulted in complaints.

During the year we also wrote to all WA Federal Members of Parliament enclosing brochures about our services in an effort to raise the awareness of their staff and constituents about our role in resolving disability complaints.

New funding model for autism services

The Disability Services Commission's move to a new funding model for early intervention autism services resulted in a number of complaints to this office from parents of children with autism. The main focus of these complaints was that the new funding model had resulted in a reduction in hours of service for their children. Two of our investigation staff attended a meeting of concerned parents to listen to their concerns and to discuss ways in which this office may be able to assist. Subsequently, the Disability Services Commission also met with the parent group and, as a result of their concerns, commissioned an independent consultant to review the impact of the new funding model. The consultant's report concluded that there had been an increase in client numbers in 2002-2003, which resulted in all service providers experiencing a real funding reduction which translated into a reduction in service hours for clients. The consultant said that the dispute between parents, service providers and the funding body (the Disability Services Commission), stemmed from a lack of clarity over terminology and definitions which impacted on how funding was allocated in relation to service "targets". A recommendation was made to standardise definitions for the program in 2003-2004. Although this did not provide the parents with the outcome they were seeking, it did provide an explanation and hopefully will clarify the situation for the future.

Security of tenure in supported accommodation

The issue of security of tenure for people with disabilities living in supported accommodation was highlighted in a complaint which was successfully conciliated this year. We received legal advice that the *Residential Tenancies Act* 1987 was applicable in the situation where two women were sharing a house and paying rent to the disability service provider. This arrangement meant that the tenants had the same rights under law as other citizens and that the service provider had the same responsibilities as other landlord/owners under the *Residential Tenancies Act* 1987.

We are not sure of the extent of such arrangements for the provisions of supported accommodation for people with disabilities. However, it is an issue that we intend to consider further in the next financial year to see whether it has wider implications.

Conciliation

When we receive a written complaint, it is assessed to ensure that it is within our jurisdiction. Once accepted the parties are notified that matter has been placed into conciliation. We approach the resolution of complaints with as little formality as possible. In order to assist in this process, the parties are advised that anything said or admitted during conciliation is not admissible in proceedings before a court or tribunal. The Act provides for the conciliator to encourage the complainant and the provider to hold informal discussions about the complaint and to assist them to reach agreement. In most cases discussions have been held before the complaint reaches this office, and our role is one of collecting evidence and trying to resolve the matter by mutual agreement.

The vast majority of cases are resolved at an early stage and do not proceed to investigation. However, during the past year two complaints have moved to the investigation stage, one for the purpose of obtaining documents from a public authority and another due to the failure of conciliation. The Act enables conciliation at any stage and in the latter complaint a recommendation for remedial action was made by the Director and a settlement was agreed to by the parties, resulting in an ex-gratia payment for the complainant.

Disability Case Studies

The nature of disability services is such that the types of complaints we receive are as varied as the services provided. These require a broad range of skills in understanding the underlying issues and resolving these complaints. The following case examples are a sample of the variety of matters resolved.

CASE STUDY – Lack of adequate communication

The mother of a boy with a disability complained about the quality of service provided by a disability service provider and a public hospital. The boy had significant physical and intellectual disabilities as a result of a rare cerebrovascular disorder. The boy usually lived at home with his family, but at the time of the incident he was staying at a residential respite service.

In the early hours of the morning, the boy fell ill and the respite service called an ambulance which transported him to a public hospital emergency department.

His mother complained that the respite service did not contact her immediately once the decision was made to send her son to hospital and that, as a result of this delay, she was not with him when he died some two and half hours later. She also complained that the hospital did not confirm that she had been contacted when her son arrived unaccompanied at the emergency department. She believed that the respite service and the hospital shared the responsibility for contacting her and that they both failed in this regard.

The respite service advised us that their procedure was that families should be contacted as soon as practicable when a child is transferred to hospital. On this occasion, they contacted the mother two hours after the boy was admitted to hospital. As a result of our conciliation of this complaint, the respite service changed its procedures to ensure that in future, parents or carers are notified immediately when a child is transferred to hospital. The referral form accompanying the child was also amended to include confirmation that parents or carers had been notified.

The respite service also met with the mother, provided a written apology and paid an amount of monetary compensation.

Negotiations with the hospital resulted in the revision of its emergency department policy on contacting a patient's next of kin. The hospital also wrote to the mother conveying sympathy and apologising for the breakdown in communication that resulted in a delay in notifying her of her son's admission.

CASE STUDY – Cessation of physiotherapy service

A mother complained that a non-government disability service provider had ceased physiotherapy services for her 7 year old son who has Down Syndrome. She said that her son's physical and motor skills development was being hampered by the lack of specialist physiotherapy services and that she was not in a position to pay for private services.

The service provider responded that the funding available from the Disability Services Commission was insufficient to meet the needs of all eligible children and, as a

consequence, services were only available for those in critical need. In this case the provider said that although the boy had been assessed as benefiting from physiotherapy, this was only a recommendation and not a promise that they could continue to deliver services.

The service provider received funding from the Disability Services Commission to provide therapy services each year for a specific number of children with disabilities. This meant that several hundred children who were assessed as being in need were unable to receive services. In response to further questions from us, the service provider supplied information on the criteria used for the allocation of physiotherapy services, the amount of annual funding received from the Disability Services Commission, the number of children who received services and the number of children who did not receive services. We also sought specific information on how the complainant's son's needs were assessed relative to other children. This information enabled us to conclude that the system of assessment and allocation of services was reasonable and had been consistently applied. Accordingly, we were unable to uphold the complaint.

We explained to the complainant that even if we were to obtain an independent assessment of her child's needs this would not assist in assessing his needs relative to the needs of other children. The demand for services exceeded available resources and this resulted in services being allocated to those children assessed as being in most critical need. Consequently, children with genuine physiotherapy needs missed out on services or had to obtain them privately. Unfortunately, this situation of greater demand than available resources is a common problem that we encounter in the course of our investigations.

CASE STUDY – Concerns on personal safety and mismanagement of finances

A complainant was referred to us from the National Disability Service Abuse and Neglect Hotline. The complainant alleged on behalf of her adult sister – who has an intellectual disability and was living in group home managed by a non-government disability service provider – that her finances had been mismanaged and also that she was at risk of abuse by a family member.

After taking steps to ensure that the consumer was not in immediate danger, we commenced an investigation into the allegations. The investigations were complicated by family members having different perceptions of the care being provided. We obtained a written response from the provider, along with information about the protocols in place at the group home for handling the consumer's finances and for monitoring visits from her relatives and friends. The service provider conducted a detailed audit of the consumer's financial transactions which had been made on her behalf by authorised staff members, including payment requests made by members of her family. The outcome of this audit did not support the allegation of financial mismanagement, but did propose the development of improved guidelines for verifying and authorising expenditure on behalf of residents.

We were satisfied that the service provider had put in place protocols to ensure that family visits to the consumer were supervised by staff and that no incidents had been reported since the protocols were implemented. We advised the complainant that we were satisfied that the service provider had responded appropriately to her concerns and that the

protocols which were introduced should protect her sister's finances and her personal safety.

CASE STUDY – Application of the *Residential Tenancies Act* 1987

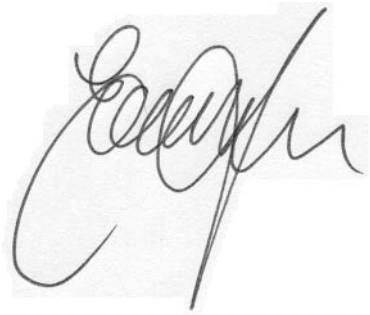
A young woman with an intellectual disability who was living in supported accommodation was involved in an incident with a co-tenant. The service provider, a public authority, asked the woman's father to immediately collect her from the shared house, and it soon became clear that she would be unable to return. The woman's mother complained about the manner of her daughter's removal from her accommodation and the absence of consideration of other options.

During our investigation, it was established that there had probably been a breach of the *Residential Tenancies Act* 1987 in the manner of the woman's removal from the house. There was, at the time, a signed tenancy agreement between the woman and the public authority. It appeared that the woman had not been given notice to quit the premises within the timeframes set down in the *Residential Tenancies Act* 1987. The outcome was a monetary settlement for the young woman, and an assurance that she would be considered for any future vacancies in supported accommodation.

This complaint raised an important issue of security of tenure for residents in supported accommodation.

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 302003.



Eamon Ryan
Director
ACCOUNTABLE AUTHORITY

29 August 2003

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
PERFORMANCE INDICATORS FOR THE YEAR ENDED JUNE 30, 2003

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, 2003.

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
December 1, 2003

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

Operational report

Outcome

To resolve complaints about health and disability services by providing systems for dealing with complaints and improving practices and actions of health and disability service providers.

Performance indicators

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 comparison figures are given.

Efficiency Indicators		**2002-2003**	**2001-2002**	**2000-2001**
a)	Cost per finalised complaint[2]	$639	$697	$646
b)	Number of days taken to finalise a complaint[3]	104 days	118 days	118 days
Effectiveness Indicators				
a)	Number of improvements in practices and actions taken by agencies/providers as a result of OHR recommendations	40	59	42
b)	Percentage of complaints finalised this year[4]	96%	104%[5]	99%

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 20 complainants requested an internal review. A senior staff member reviewed these files and made any further recommendations as necessary.

We also advise complainants and providers that they can complain to the Ombudsman if they are unhappy with the processes followed by this office. In 2002-2003 the Ombudsman's office received 9 complaints about the Office of Health Review, covering

[2] Based on the accrual costs for the period 1 July 2002 to 30 June 2003.
[3] Taken from the date of receipt of the complaint form to the date of closure of the file.
[4] The percentage of complaints closed reflects the overall effectiveness of the OHR in dealing with a complaint.
[5] 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.

30 different issues. None of these were sustained although one remained open as at 30th June 2003.

Enabling Legislation

The Office of Health Review exists by virtue of the *Health Services (Conciliation and Review) Act* 1995. We operate under this Act and also under the *Disability Services Act* 1993, which was amended in 1999 to bring complaints about disability services under 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 of the Office are specified in s10 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.

Ministerial and Parliamentary directives

Under s11 of the *Health Services (Conciliation and Review) Act* 1995 the Minister may give directions in writing to the Director with respect to the performance of the functions of the Director. No such directions were given during the year ending 30 June 2003.

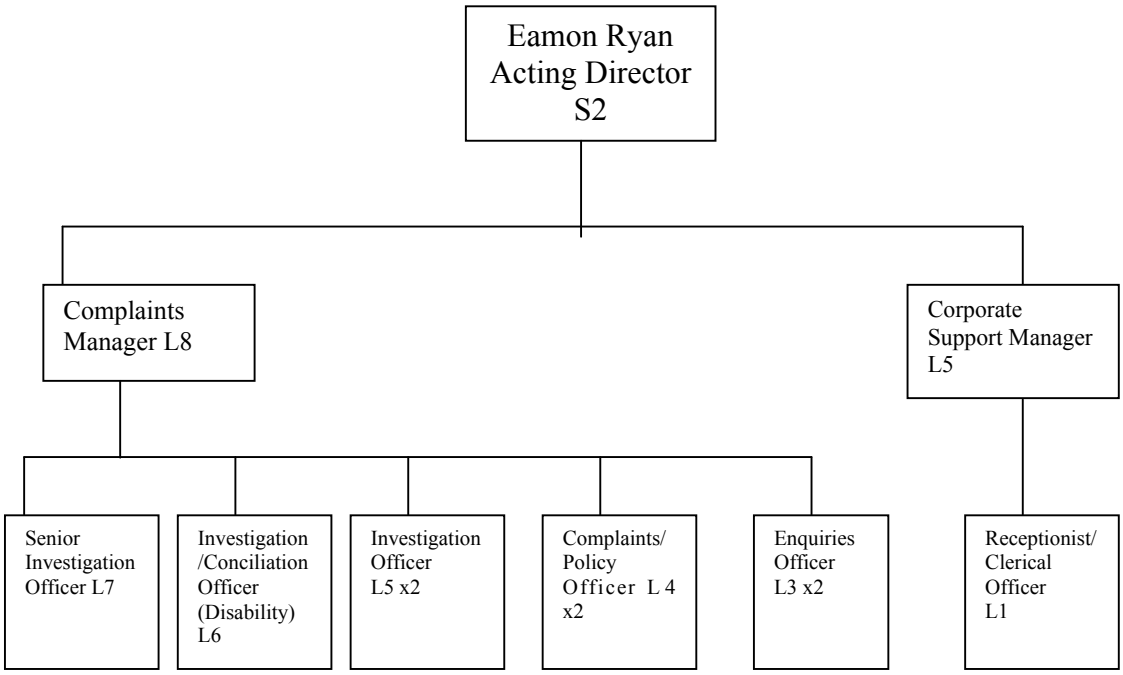
Under s56 of the Act, the Director may make reports to Parliament, or at the request of Parliament. No reports were requested or made during the year ending 2002-2003.

Administrative

Eamon Ryan was appointed as Director on an interim basis for 6 months in August 2002 and this appointment was extended for a further period of 6 months in February 2003.

The Office of Health Review had 12 full time staff at 30 June 2003. The staff bring together a variety of skills and experience which are drawn from legal, investigative, nursing, research, policy and administrative backgrounds.

Organisational Chart as of 30th June 2003



Research, Promotions and Publications

The Office of Health Review has not been directly involved in any formal research activities in 2002-2003. 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 distributed widely and are available on request. We also promote our activities through our website which is located at http://www.healthreview.wa.gov.au.

Staff participate in various activities to promote public awareness of the Office of Health Review. These include conferences, seminars, meetings and workshops which are relevant to the work we do. See Appendix A for a full list of such activities undertaken in 2002-2003.

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

During the year, the Minister for Health appointed a reference group to conduct a review of the operations and effectiveness of the Office as required in Section 79 of the *Health Services (Conciliation and Review) Act* 1995. The report by the reference groups is with the Minister for consideration. We expect that the report will make recommendations that may impact on the operations of the office.

Feedback from Complaints

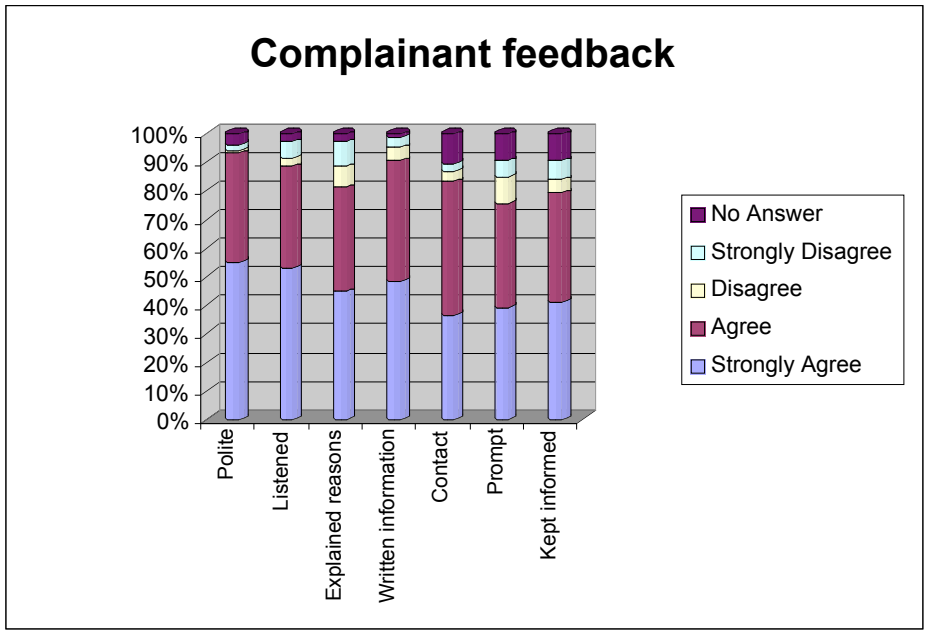
At the conclusion of each written complaint, a client survey form is sent to both the complainant and provider seeking their feedback on the process. It is often the case that an individual complainant or provider is unhappy with the specific outcome of a complaint, but we find that these surveys are useful in measuring how satisfied they are with the processes we followed and the manner of our staff.

Our clients are asked to indicate whether they strongly agree, agree, disagree or strongly disagree with a series of statements about the Office. Specifically, whether the staff were polite, whether they listened, whether the reasons for decision were explained, whether the written information was easy to understand, whether it was easy to contact the office, whether staff were prompt in responding to letters and telephone calls and whether staff kept the client informed of the progress of the matter.

We also ask two yes or no questions about whether the client was satisfied with the outcome of the complaint, and whether they were satisfied that the matter was dealt with in an unbiased way.

This year we received 111 provider responses and 107 complainant responses. This is a return rate of approximately 15%, which is probably too low for the sample to be statistically valid. However, the responses received are invaluable feedback for us.

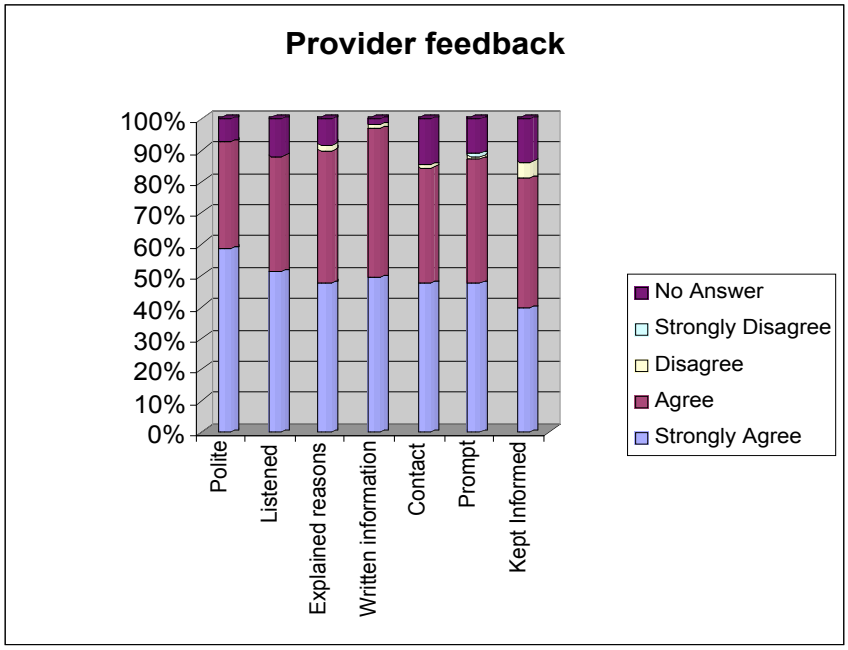
Complainant responses



It is interesting to compare these figures to the responses to the "yes and no" questions at the end of the survey. Only 54% of complainants indicated that they were satisfied with the outcome of the complaint. However, 75% of complainants indicated that they agreed that the complaint was dealt with in an unbiased way. These figures, viewed alongside the responses to questions about how we handled the complaint, suggest that while complainants may not feel that the outcome achieved was what they were seeking, they

do acknowledge that the process we followed was appropriate and that our staff dealt with the matter well.

Provider responses



In terms of overall satisfaction, 97% of providers stated that they were satisfied with the outcome of the complaint, and 99% were satisfied that the complaint was dealt with in an unbiased way.

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 for their consideration.

Some of the comments this year included:

COMPLAINANTS:

"I would like to thank everyone for the helpful way we were treated. It was first class. My wife and myself are grateful for what you have done. Thank you."

"Employ in-house medicos who can understand basic medical terminology"

"The staff were extremely helpful with all my questions and queries. Thank you all so much".

"More staff would be of assistance – however, the staff were highly professional and assisted at all times in progressing my complaint."

"I found some of your outcomes to not quite be true, but was basically happy with the rest of the findings".

"In relation to my complaint, your department has been a mediator and has sat on the fence. There are issues that require addressing within the health system and this will not be done by departments sitting on the fence".

PROVIDERS:

"I was happy with outcome, and the investigation was prompt"

"Many thanks for resolving this".

"In my opinion the office is consumer biased and needs to revise its operations so it is fair"

"Very impressed by the professionalism and the depth of investigation"

"System appeared to work well in this circumstance. Unenviable job, trying to balance the equation".

"From a clinicians viewpoint attempting to improve our service delivery in an increasingly complex environment, I have valued the approach taken by the office in addressing those difficult issues in a manner which allows for equitable outcomes for both parties".

What we do with feedback

Information obtained from these feedback forms has led to a number of improvements in the way we do our work. Our Complaints Manager now routinely reviews all active files over 200 days old to ensure that the action being taken is on track and appropriate. It is an opportunity for advice to be given to staff at this time to recommend ways of bringing the matter to a timely conclusion. The Complaints Manager also has regular individual case meetings with case officers to ensure that any matters of concern are raised and dealt with. These initiatives have improved our timeliness in dealing with complaints.

We also ensure that all parties to a complaint are aware at the beginning of the process of their right to request an internal review and their right to complain to the Ombudsman if they are unhappy with the outcome or the way we handled the complaint.

One challenge for the future which is identified by this information is the discrepancy between providers overall satisfaction with the outcome and whether we handled the complaint in an unbiased manner compared to the same results from complainants. Understandably, complainants are likely to be unhappy with the outcome if we do not achieve what they expect. We probably need to do more work in the area of reality testing and managing the expectations of complainants throughout the process of handling complaints.

Statutory Report

Reports on Customer Group Outcomes

Disability Service Plan Outcomes

All staff continue to implement the Disability Service Plan which identifies potential barriers for people with disabilities in accessing our services and looks at ways of overcoming these barriers. All of our publications, including our brochures, are available in braille or on audiotape, and this information is available on our website. Our specialist disability investigation officer also provides all staff with information and support generally and specifically when they are dealing with a complaint from a person with a disability.

Equal Employment Opportunity Outcomes

Of the 12 staff employed at the Office on 30th June 2003, 10 were women. Women occupy 75% of senior positions in the office. Two main ethnic groups are represented within our staff. We have identified that we do not have staff with disabilities, staff from indigenous backgrounds or staff under 25. Future recruitment campaigns will include statements encouraging applications from within these groups.

Cultural and Language Services Outcomes

The Office has a language services strategy that we follow. Where appropriate, staff use independent and qualified interpreters and translators when liaising with clients from culturally and linguistically diverse backgrounds. Our multilingual guides have been sent to a number of health services. The Office has a representative on the Multicultural Access Contact Officers' Network which is run by the Multicultural Access Unit within the Department of Health. Membership of this network provides our staff with strategies, support and information which we use when dealing with complaints from people from culturally and linguistically diverse backgrounds.

Youth Outcomes

The Office does not have a specific strategy targeting young people. Parents complain on behalf of children, however, we can, and often do, investigate complaints about health and disability services on receipt of a complaint from a young person. There is no age restriction on making a complaint to the Office.

Information Statement

The Office operates under strict statutory confidentiality requirements, reflecting the type of work we undertake. 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) can access information on their file by applying to the office. The Office is also subject to the *Freedom of Information Act* 1992.

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 information gathered as part of our enquiries, including responses from other parties and copies of records from health providers. The office also maintains administrative files relevant to the operation of the office.

There were 14 requests for access to information under the *Freedom of Information Act* 1992 in the 2002-2003 financial year, all of which related to personal information. 11 requests were finalised within the financial year. Three requests were made towards the end of the year and will be completed in the 2003-2004 financial year. Of the 11 finalised requests, seven were granted full access and three were granted edited access. Access was deferred in one matter. There were no reviews or amendments and no charges were raised for access to information. The average time taken to process each application was ten days.

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.

Statement of compliance with Public Sector Standards

Compliance with Human Resource Management Standards

The Office of Health Review has complied with the Public Sector Standards in Human Resource Management. No applications were made for breach of standards review in 2002-2003.

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.

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 2002-2003. There were no such expenses incurred this year.

Waste Paper Recycling

The Office of Health Review uses a free paper recycling service provided by the building managers. We also have a shredder for the purposes of recycling paper containing confidential information.

Energy Smart Government Policy

The Office of Health Review has fewer than 25 FTE's and, as such, we are not required to report on this matter.

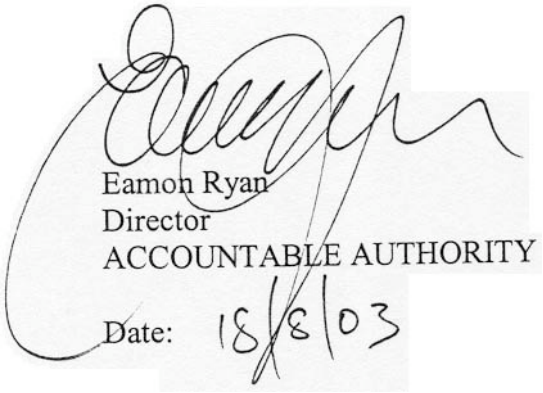
Evaluations

There were no evaluations undertaken in 2002-2003.

CERTIFICATION OF FINANCIAL STATEMENTS

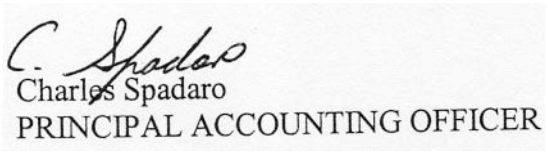
The accompanying financial statements of the Office of Health Review have been prepared in compliance with the provisions of the *Financial Administration and Audit Act* 1985 from proper accounts and records to present fairly the financial transactions for the twelve months ending 30 June 2003 and the financial position as at 30 June 2003.

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
Director
ACCOUNTABLE AUTHORITY

Date: 18/8/03



Charles Spadaro
PRINCIPAL ACCOUNTING OFFICER

Date: 14-8-03

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
FINANCIAL STATEMENTS FOR THE YEAR ENDED JUNE 30, 2003

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, 2003 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
December 1, 2003

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 2003

	Note	2003 $	2002 $
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses	2	706,663	689,266
External Services	20	17,072	32,056
Repairs, maintenance and consumable equipment expense	20	123,673	111,982
Depreciation expense	3	14,798	17,058
Other expenses from ordinary activities	4	156,842	153,548
Total cost of services		1,019,048	1,003,910
NET COST OF SERVICES		1,019,048	1,003,910
Revenues from State Government			
Output appropriations	5	1,009,783	983,000
Resources received free of charge	6	22,824	20,083
Total revenues from State Government		1,032,607	1,003,083
Change in net assets		**13,559**	**(827)**
Net initial adjustments on adoption of AASB 102B "Employee Benefits"	12	(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 the WA State Government as owners.		**11,791**	**(827)**

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 2003

	Note	2003 $	2002 $
CURRENT ASSETS			
Cash assets	7	455,708	453,144
Total current assets		455,708	453,144
NON-CURRENT ASSETS			
Property, plant and equipment	8	38,422	53,221
Total non-current assets		38,422	53,221
Total Assets		**494,130**	**506,365**
CURRENT LIABILITIES			
Payables	9	4,356	16,063
Provisions	10	85,135	80,799
Other liabilities	11	16,367	18,234
Total current liabilities		105,858	115,096
NON CURRENT LIABILITIES			
Provisions	10	47,570	62,358
		47,570	62,358
Total Liabilities		**153,428**	**177,454**
Net Assets		**340,702**	**328,911**
EQUITY			
Accumulated surplus / (deficiency)	12	340,702	328,911
Total Equity		**340,702**	**328,911**

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 2003

	Note	2003 $ Inflows (Outflows)	2002 $ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Output appropriations		1,009,783	983,000
Net cash provided by State Government		1,009,783	983,000
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(349,429)	(307,794)
Employee costs		(657,790)	(594,823)
Receipts			
GST receipts on sales		-	(1,350)
Other receipts		-	(7,200)
Net cash (used in) / provided by operating activities	13(b)	(1,007,219)	(911,167)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets	8	-	(7,201)
Net cash (used in) / Net increase / (decrease) in cash held		-	(7,201)
Net increase / (decrease) in cash held		2,564	64,632
Cash assets at the beginning of the financial year		453,144	388,512
CASH ASSETS AT THE END OF THE FINANCIAL YEAR	13(a)	455,708	453,144

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

Notes to the Financial Statements
For the year ended 30th June 2003

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.

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.

(b) 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.

(c) Depreciation of Non-Current Asset

All non-current assets 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 assets are:

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

(d) 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.

(e) 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.

(f) 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 exists.

(g) 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.

(h) Accrued Salaries

Accrued salaries 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.

(i) 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 Pension Scheme, a defined benefits pension scheme now closed to new members, or 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 either of these schemes 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 Pension Scheme is unfunded and the liability for future payments is provided for at reporting date.

The unfunded employer's liability in respect of the pre-transfer benefit for employees who transferred from the Pension Scheme to the Gold State Superannuation Scheme is assumed by the Treasurer. A revenue "Liabilities assumed by the Treasurer" equivalent to the change in this unfunded liability is recognised in the Statement of Financial Performance.

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.

Deferred Salary Scheme

With the written agreement of the Office of Health Review, an employee may elect to receive, over a four-year period, 80% of the salary they would otherwise be entitled to receive. On completion of the fourth year, an employee will be entitled to 12 months leave and will receive an amount equal to 80% of the salary they were otherwise entitled to in the fourth year of deferment. An employee may withdraw from this scheme prior to completing a four-year period by written notice. The employee will receive a lump sum payment of salary forgone to that time.

The liability for deferred salary scheme represents the amount which the Office of Health Review is obliged to pay to the employees participating in the deferred salary scheme. The liability has been calculated on current remuneration rates in respect of services provided by the employees up to the reporting date and includes related on-costs.

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.

(j) 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.

(k) 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.

(l) Comparative Figures

Comparative figures are, where appropriate, reclassified so as to be comparative with the figures presented in the current reporting period.

(m) 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 OHR gains control of appropriated funds at the time those funds are deposited into the Office's bank account or credited to the holding account held at the Department of Treasury and Finance.

Note 2 Employee expenses

	2003 $	2002 $
Salaries and wages (i)	640,740	635,747
Superannuation	65,923	53,519
	706,663	689,266

(i) These employee expenses include 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 10.

Note 3 Depreciation expense

	2003 $	2002 $
Computer equipment and software	10,704	12,846
Furniture and fittings	1,019	1,137
Other plant and equipment	3,075	3,075
	14,798	17,058

Note 4 Other expenses from ordinary activities

	2003 $	2002 $
Workers compensation insurance	7,583	6,006
Staff related expenses	39,781	25,759
Motor vehicle expenses	2,248	4,753
Insurance	9,068	7,478
Communications	17,642	19,512
Printing and stationery	8,945	14,402
Audit fees – external	11,000	11,000
Other	60,575	64,638
	156,842	153,548

Note 5 Output appropriations

	2003 $	2002 $
Appropriation revenue received during the year:		
Output appropriations	1,009,783	983,000

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 6 Resources received free of charge

Resources received free of charge has been determined on the basis of the following estimates provided by agencies.

	2003 $	2002 $
Office of the Auditor General		
- Audit services	11,000	11,000
Other		
- Crown Solicitors Office	11,824	9,083
	22,824	20,083

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.

Note 7 Cash assets

	2003 $	2002 $
Cash on hand	400	400
Cash at bank – general	455,308	452,744
	455,708	453,144

Note 8 Property, plant and equipment

	2003 $	2002 $
Computer equipment and software		
At cost	76,710	76,711
Accumulated depreciation	(62,512)	(51,808)
	14,198	24,903
Furniture and fittings		
At cost	18,074	18,074
Accumulated depreciation	(5,009)	(3,990)
	13,065	14,084
Other plant and equipment		
At cost	35,269	35,269
Accumulated depreciation	(24,110)	(21,035)
	11,159	14,234
Total of property, plant and equipment	38,422	53,221

Payments for non-current assets

Payments were made for purchases of non-current assets during the reporting period as follows:

Paid as cash by the Office of Health Review from output appropriations	-	7,201
Gross payments for purchases of non-current assets	-	7,201

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.

	2003 $
Computer equipment and software	
Carrying amount at start of year	24,903
Additions	-
Disposals	-
Depreciation	(10,704)
Write-off of assets	-
Carrying amount at end of year	-
	14,198
Furniture and fittings	
Carrying amount at start of year	14,084
Additions	-
Disposals	-
Depreciation	(1,019)
Write-off of assets	-
Carrying amount at end of year	-
	13,065
Other plant and equipment	
Carrying amount at start of year	14,234
Additions	-
Disposals	-
Depreciation	(3,075)
Write-off of assets	-
Carrying amount at end of year	11,159
Total property, plant and equipment	
Carrying amount at start of year	53,221
Additions	-
Disposals	-
Revaluation increments / (decrements)	-
Depreciation	(14,798)
Write-off of assets	-
Carrying amount at end of year	38,422

Note 9 Payables

	2003 $	2002 $
Creditors and accruals	4,356	16,063

Note 10 Provisions

	2003 $	2002 $
Current liabilities:		
Annual leave	51,395	64,794
Long service leave	29,290	14,516
Deferred salary scheme	-	-
Superannuation	4,450	1,489
	85,135	80,799
Non-current liabilities:		
Long service leave	47,570	62,358
Deferred salary scheme	-	-
Superannuation	-	-
	47,570	62,358
Total employee benefit liabilities	132,705	143,157

(i) 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.

(ii) The superannuation liability has been established from data supplied by the Government Employees Superannuation Board.

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

Note 11 Other liabilities

	2003 $	2002 $
Accrued salaries	16,367	18,234

Note 12 Equity

	2003 $	2002 $
Accumulated Surplus		
Balance at beginning of the year	328,911	329,738
Change in net assets	13,559	(827)
Net initial adjustments on adoption of AASB 1028 "Employee Benefits"	(1,768)	-
Balance at end of the year	340,702	328,911

Note 13 Notes to the statement of cash flows

	2003 $	2002 $
(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 7)	455,708	453,144
	455,708	453,144
(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)	(1,007,219)	(911,167)
Decrease / (increase) in liabilities:		
Payables	11,707	(14,561)
Accrued salaries	1,867	(2,453)
Provisions	10,452	(38,588)
Non-cash items:		
Depreciation expense	(14,798)	(17,058)
Resources received free of charge	(22,824)	(20,083)
Other	1,767	-
Net cost of services (Statement of Financial Performance)	(1,019,048)	(1,003,910)

Note 14 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 fees, salaries, superannuation and other benefits for the financial year, fall within the following bands are:	2003	2002
$40,001 - $50,000	1	-
$130,001- $140,000	1	-
$150,001- $160,000	-	1
Total	2	1
	$	$
The total remuneration of senior officers is:	182,993	158,866

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 members of the OHR are members of the Pension Scheme.

	2003 $	2002 $
Note 15 Commitments for Expenditure		
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	119,897	121,036
Later than one year, and not later than five years	254,216	472,061
Later than five years	-	-
	374,113	593,097

Note 16 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 17 Events occurring after reporting date

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

Note 18 Related bodies

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

Note 19 Affiliated bodies

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

Note 20 Explanatory statement

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

	2003 $	2002 $	Variation $
External Services The variance due to additional costs for rental being reported in 2002 figures.	17,072	32,056	(14,984)
Repairs, maintenance and consumable equipment expense The variance is due to increases in lease and repairs and maintenance costs.	123,673	111,982	11,691

(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.

There are no significant variations between estimate and actual results.

Note 21 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 2003			
Financial Assets			
Cash assets	0.0%	455,708	455,708
		455,708	455,708
Financial Liabilities			
Payables	0.0%	4,356	4,356
Accrued Expenses	0.0%	16,367	16,367
		20,723	20,723
Net financial assets / (liabilities)		434,985	434,985

(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.

Estimates of Expenditure for 2003/2004

The following Estimates of Expenditure for the year 2003/2004 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 2003/2004 do not form part of the preceding audited financial statements.

Revenue	**2003/2004**
Consolidated Fund	$1 049 565

APPENDIX A: OUTREACH, COMMUNITY AWARENESS, TRAINING AND DEVELOPMENT AND OTHER INVOLVEMENT

In the 2002-2003 financial year, the Office has participated in or been represented on the following forums and committees:

Committees
- Department of Health, Multicultural Access Contact Officers' Network
- Health Complaints Coordinators' Network
- Human Rights and Social Justice Sub-Committee of the WA Association for Mental Health
- Breastscreen Consumer Reference Group
- Reference Group for the Review of the Mental Health Act
- Watch on Health (Ministerial Advisory Committee)
- Offender Health Council (Joint Committee of the Departments of Justice and Health)
- Australia and New Zealand Council of Health Complaints Commissioners
- Medical Defence Association Risk Consultative Committee
- Medical Board Complaints Sub-Committee

Forums
- "Didyaknow" – a forum for people with disabilities
- Disability Services Commission Accommodation Support Funding Forum
- People with Disabilities Safeguards Forum
- People with Disabilities Advocacy Forums
- Forum on Ageing and Disability
- Disability Forum on Purchasing Agreements
- Disability and Welfare Forum
- National Administrative Law Forum

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

Conferences/Seminars
- Paper presented at 4th National Health Complaints Conference (Canberra)
- Papers presented at 3rd National Complaint and Consumer Liaison Conference (Perth)

Presentations/Meetings
- Presentation at training session for volunteers of the Mental Health Law Centre
- Presentation to final year Physiotherapy students at Curtin University
- Meeting with parents of children with autism
- Presentation to Disability Services Commission Country Forum
- Meeting with Disability Services Commission Health Resource and Consultancy Team
- Presentation to Royal College of Anaesthetists Conference
- Consumer and Provider consultation meetings on the Open Disclosure Project
- Presentation to the Chiropractors Association
- Presentation at Health, Ageing and Disability Forum

Staff have also attended the following training seminars and conferences:

- Complaints Handling training.
- Inside Government, the Legislative Framework.
- Prevention and Management of Stress Related Disability.
- Basic Statistics training.
- Excellence in the First Time Manager.
- Administrative Assistants Conference 2003.
- Public Policy – a practical approach.
- Health Complaints Training.
- Infection Control Seminar.
- WA Civil and Administrative Review Tribunal Seminar.
- Complaints Handling Lessons for WA Government Agencies.
- Insurance Law Seminar.
- Service Provider Training (Office of the Public Advocate).
- Fundamentals of Writing.
- Effective Staff Selection Skills.
- Workplace Grievance Officer Training.
- Advanced Training for Government Decision-Makers.
- Securing Government – eGovernment – the way forward.
- Department of Premier and Cabinet Executive Seminar Series.
- Beyond the Enterprise – Australian Organisation for Quality
- Ethics and Leadership Seminar.
- Making Excellence Happen Seminar.
- Strategic Financial Management Seminar.
- Media Speaking Skills.
- Public Interest Disclosure Bill Seminar.
- Hidden Costs – Bullying in the WA Workplace.
- Handling Employee Performance Problems.