Office of Health Review

ANNUAL REPORT

2004/2005

Record details on database

CAU: COMPLAINTS ASSESSMENT UNIT

Assess for compliance with legislation

Provide advice to consumers

Initiate contact with provider

Health & Disability Complaints

Obtain independent opinions

CIU: CONCILIATION INVESTIGATION UNIT

Gather & review relevant information

Research & report

Conduct investigations

OFFICE OF HEALTH REVIEW

Contact Details

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

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

Office Hours:
8am to 5pm Monday to Friday

Postal Address:
GPO Box B61
PERTH WA 6838

Telephone:
(08) 9323 0600

Freecall (Country WA only):
1800 813 583

Facsimile:
(08) 9221 3675

Email:
officehealthreview@health.wa.gov.au

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

Inside this Report

This report describes the functions and operations of the Office of Health Review and presents the financial statements and performance indicators for the year ending 30 June 2005. The report also provides information about our work and activities undertaken during the year in dealing with and resolving complaints about health and disability service providers.

Statement of Compliance

HON JIM McGINTY BA BJuris (Hons) LLB JP MLA
MINISTER FOR HEALTH

In accordance with Section 66 of the *Financial Administration and Audit Act 1985,* I am pleased to submit for your information and presentation to Parliament, the Annual Report of the Office of Health Review for the financial year ending 30 June 2005.

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

Disability Services Act 1993;

Electoral Act 1907;

Equal Opportunity Act 1984;

Financial Administration and Audit Act 1985;

Freedom of Information Act 1992;

Health Services (Conciliation and Review) Act 1995;

Public Sector Management Act 1994; and

Government and Ministerial Annual Reporting Policies.

Eamon Ryan
DIRECTOR

30 August 2005

HEALTH AND DISABILITY COMPLAINTS
Level 17, St Martins Tower, 44 St Georges Terrace, Perth, WA 6000 GPO Box B61, Perth, WA 6838
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2004/05 Annual Report Questionnaire

The content and presentation of our Annual Report was developed to meet your needs and requirements. We would be grateful if you would spend a few minutes responding to this questionnaire. We would also value any additional suggestions and comments you have, which may be relevant to the preparation of future Annual Reports.

You may respond by:

Completing the form and returning it to us at GPO Box B61, PERTH, WA 6838
OR
Telephoning your answers to this office on (08) 9323 0600 or
(country free call) 1800 813 583 and our staff will assist you
OR
e-mail to officehealthreview@health.wa.gov.au

Please rank the following statements, where
1 = Strongly Agree; 2 = Agree; 3 = Disagree and 4 = Strongly Disagree

Statement	1	2	3	4
The Annual Report was presented in a format that was easy to read.				
The content of the Annual Report was concise and easy to understand.				
The Annual Report contained sufficient information.				
The Annual Report highlighted the key issues of relevance about the Office of Health Review.				
Reading the Annual Report gave me a better understanding of the role and functions of the Office of Health Review.				
The graphs and tables were valuable in illustrating the content of the Annual Report.				
The Performance Indicators were useful in assessing the performance of the office.				
The Financial Statements were useful in understanding the financial position of the Office.				
The case studies were informative and interesting to read.				

What improvements/suggestions would you recommend for future Annual Reports?

Thank you for taking the time to complete this questionnaire.

Your feedback is invaluable to us and will be reviewed and used when preparing for future Annual Reports.

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Part 1:
An Introduction to the Office of Health Review

About us

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

We have 14 staff, 11 of whom are directly involved in the resolution of complaints. Our staff come from various backgrounds, including the clinical professions, law, investigation, conciliation, dispute resolution, complaints handling and management. As at 30 June 2005, we were in the process of recruiting an Information and Community Liaison Officer who will focus on raising the level of awareness in the community about the role and functions of our office.

Our mission

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

Our vision

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

In practice this means –

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

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

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

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

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

Our values

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

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

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

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

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

Courage
- Having the courage to stand up for the things we believe in.
- Having the courage to pursue issues that require action.
- Having the courage to make decisions in a difficult operating environment and being open and accountable for these decisions.

Our operating environment

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

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

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1 *Australian Bureau of Statistics <http://www.abs.gov.au>*
2 *Disability Services Commission Annual Report 2002-2003. <http://www.dsc.wa.gov.au>*
3 *Health Insurance Commission <http://hic.gov.au>*
4 *Australian Institute of Health and Welfare <http://www.aihw.gov.au>*

Functions of the Director

The *Health Services (Conciliation and Review) Act 1995* (the Health Services Act) and the *Disability Services Act 1993* (the Disability Services Act) sets out the functions of the Director.

Generally these functions include –

- To undertake the receipt, conciliation and investigation of complaints;
- To review and identify the causes of complaints;
- To take steps to bring to the notice of users and providers details of complaints procedures;
- 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 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 either act.

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

Guiding principles for the provision of health care

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

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

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

Principles and objectives relevant to the provision of disability services

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

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

Principles

- People with disabilities have the inherent right to respect for their human worth and dignity.
- People with disabilities, whatever the origin, nature, type or degree of disability, have the same basic human rights as other members of society and should be enabled to exercise those basic human rights.
- People with disabilities have the same rights as other members of society to realise their individual capacities for physical, social, emotional, intellectual and spiritual development.
- People with disabilities have the same right as other members of society to services which will support their attaining a reasonable quality of life in a way that also recognises the role and needs of their families and careers.
- People with disabilities have the same right as other members of society to participate in, direct and implement the decisions which affect their lives.
- People with disabilities have the same right as other members of society to receive services in a manner that results in the least restriction of their rights and opportunities.
- People with disabilities have the same right as other members of society to pursue any grievance concerning services.
- People with disabilities have the right to access the type of services and supports that they believe are most appropriate to meet their needs.
- People with disabilities who reside in rural and regional areas have a right, as far as is reasonable to expect, to have access to similar services provided to people with disabilities who reside in the metropolitan area.
- People with disabilities have a right to an environment free from neglect, abuse, intimidation and exploitation.

Objectives

- Programmes and services are to focus on achieving positive outcomes for people with disabilities, such as increased independence, employment opportunities and inclusion within the community.
- Programmes and services are to contribute to ensuring that the conditions of the every day life of people with disabilities are the same as, or as close as possible to, norms and patterns which are valued in the general community.
- Programmes and services are to be integrated with services generally available to members of the community.
- Programmes and services are to be tailored to meet the individual needs and goals of the people with disabilities receiving those programmes and services.
- Programmes and services are to be designed and administered so as to meet the needs of people with disabilities who experience additional barriers as a result of their age, gender, aboriginality, culturally or linguistically diverse backgrounds or geographic location.
- Programmes and services are to be designed and administered so as to promote recognition of the competence of, and enhance the community perception of, people with disabilities.
- Programmes and services are to be designed and administered so as to promote the participation of people with disabilities in the life of the local community through maximum physical, social, economic, emotional, intellectual and spiritual inclusion in the community.
- Programmes and services are to be designed and administered so as to ensure that no single organisation shall exercise control over all or most aspects of an individual's life.
- Service provider organisations, whether disability specific or generic, shall be accountable to those people with disabilities who use their services, the advocates of such people, the

State and the community generally for the provision of information from which the quality of their services can be judged.

- Programmes and services are to be designed and administered so as to provide opportunities for people with disabilities to reach goals and enjoy lifestyles which are valued by the community.
- Programmes and services are to be designed and administered so as to ensure that people with disabilities have access to advocacy support where necessary to ensure adequate participation in decision making about the services they receive or are seeking.
- Programmes and services are to be designed and administered so as to ensure that appropriate avenues exist for people with disabilities to raise, and have resolved, any grievances about services.
- Programmes and services are to be designed and implemented as part of local coordinated services systems and integrated with services generally available to members of the community. Public sector agencies are to develop, plan and deliver disability programmes and services in a coordinated and pro-active way.
- Programmes and services are to be designed and administered so as to respect the rights of people with disabilities to privacy and confidentiality.
- Programmes and services are to have regard for the benefits of activities that prevent the occurrence or worsening of disabilities and are to plan for the needs of such activities.
- Programmes and services are to be designed and implemented to –
  - consider the implications for the families and carers of people with disabilities;
  - recognise the demands on the families of people with disabilities; and
  - take into account the implications for, and demands on, the families and carers of people with disabilities.
- Programmes and services are to be designed and administered so as to –
  - provide people with disabilities with, and encourage them to make use of, ways of participating continually in the planning, operation and evaluation of services they receive; and
  - provide for people with disabilities to be consulted about the development of major policy, programme and operational changes.

Carers

The *Carers Recognition Act 2004* came into operation in January 2005 and sets out the Western Australian Carers Charter.

This Charter is set out below.

- Carers must be treated with respect and dignity.
- The role of carers must be recognised by including carers in the assessment, planning, delivery and review of services that impact on them and the role of carers.
- The views and needs of carers must be taken into account along with the views, needs and best interests of people receiving care when decisions are made that impact on carers and the role of carers.
- Complaints made by carers in relation to services that impact on them and the role of carers must be given due attention and consideration.

Carers can now complain to our office that an applicable organisation has failed to comply with the Carers Charter.

Part 2:
The Year in Review

Highlights

- Complaint numbers continue to be high with 1741 new complaints and 1802 closed complaints.
- Reduction in the number of active cases on hand from 353 at the commencement of the year to 308 at the end of the year. No significant backlog of old complaints.
- Prison complaint numbers remain high with a slight increase from last year to 365. Increase in complaints about health services in Casuarina Prison but a decrease in complaints about the women's prisons (Bandyup and Nyandi).
- Increased outreach activities this year, including a number undertaken with other complaint agencies (State Ombudsman, Commonwealth Ombudsman, and Freedom of Information Commissioner). These included exhibiting at the *WA on Show Expo*, the *Albany Show*, the *Wagin Woolorama*, and the *Northwest Expo*.
- As part of our service delivery obligations to provide a complaints mechanism for residents of the Indian Ocean Territories of Christmas Island and Cocos (Keeling) Island, the Director undertook a joint awareness visit to the Territories together with the Sate Ombudsman and the Commonwealth Ombudsman.
- Disability complaints continue to be a focus, increased from 28 last year to 41 this year. We held a very successful forum for disability services providers and advocacy groups in March 2005. From this forum a network for complaints officers is being established to share information and promote best practice in complaints handling.
- Results of efficiency and effectiveness performance indicators:

- Cost per finalised complaint.	$608	($650 in 03/04)
- Average number of days to finalise written complaints.	123	(122 in 03/04)
- Improvements in practices as a result of our recommendations.	47	(38 in 03/04)
- Percentage of complaints finalised this year.	86%	(83% in 03/04)

- Strong financial performance.
  - Delivered services within budget and with a small surplus from our allocated appropriations from the Government.
  - Reduced costs through collocation with other accountability agencies.
  - Reduced operational costs through reduction in the number of office vehicles and other savings.

Overview

This year was a period of considerable change within the Office. We continued with improvements to our internal process and we have made a number of significant changes to how we operate.

<u>Changes to how we operate</u>

Following the restructure of the Office into two teams, we faced a number of challenges through the year in refining our practices and procedures. However, we are now starting to see rewards for our efforts. Our Complaints Assessment Unit (CAU) and Conciliation Investigation Unit (CIU) are starting to function efficiently and effectively and we are confident that these changes

will allow us to deliver an improved performance and better outcomes. The two team approach has led to specialisation of knowledge and skills in our staff and improved internal processes for dealing with complaints.

We have seen some evidence of improvements in our performance based on our statistics and performance indicators this year and we view this as a positive endorsement of these changes.

Although we do not have a significant backlog of old complaints, one of our targets for next year is to significantly reduce the number of matters we have that are over 12 months old. As at 30 June 11.69% (36) of our current matters on hand were more than 12 months old. Hopefully, we will see continued improvements in both the quality and timeliness of our work and also the outcomes we are able to achieve.

Other improvements we have made this year have led to better documentation of our processes and a clear, concise and informative procedures manual for staff. We now undertake a more thorough assessment of complaints when they are received and put greater effort into the initial phase of the resolution process. This allows for early identification of those matters that are likely to require more complex work as part of the resolution process. We have improved the information we give to consumers and providers, leading to better clarity and understanding about our processes for resolving complaints. We also have a series of information sheets available for consumers and providers to assist in clarifying their options for resolution of their concerns.

During the year we undertook a review of how we categorise and record complaints when we receive them and also how we record closure categories and outcomes once matters have been finalised. The timing for implementation of these changes has been set for 1 July 2005, as this will allow for full year reporting next year. The focus of these changes was to record and report closure categories that better reflect the legislation we operate under and also the outcomes achieved rather than simply how matters were closed. These changes will also facilitate a meaningful review of, and improvements to, our performance indicators.

Our approach to resolving complaints is to deal with matters through the conciliation process set out in the legislation, with a focus on resolution and not retribution. However, where the conduct of any individual provider warrants scrutiny we have investigative powers available as well as referral powers to the relevant registration bodies. This year we made 11 formal referrals to registration boards.

As part of our process of continual improvement we have also set for ourselves an objective of achieving greater involvement of the consumer and provider in the dispute resolution process.

Specific strategies we have developed to achieve this include:

- Encouraging both consumers and providers to actively participate in the resolution process by seeking comments on the information gathered as the matter progresses;
- Seeking the comments and views of consumers and providers about our selection of independent experts and the information and advice being sought;and
- Seeking comments and views of consumers and providers about the information gathered, preliminary conclusions and proposed outcomes prior to finalisation of the matter.

We are confident that these strategies will result in better understanding and acceptance of what can reasonably be achieved for both consumers and providers.

Staff

During the year we lost several senior and experienced staff who left to pursue career opportunities elsewhere. It is important to acknowledge their efforts, in particular Ms Helen Shurven, who has made a significant contribution to the work of this Office. We wish Helen and each of the other staff well in the next phase of their careers. Although the loss of experienced staff is a big challenge for a small agency, the news is not all bad as it gives us an opportunity for renewal. We have recruited several new staff who bring to the Office a new perspective, different skills and varied experience.

Throughout the year we have continued with our efforts to train and develop our staff to improve their ability to deal with matters from the initial enquiry stage through to conciliation and investigation. This has included several staff obtaining formal qualifications in mediation and conciliation. Two more of our staff are scheduled to undertake formal training early in the new financial year and, ultimately, our objective is for all of our complaints staff who are involved in the conciliation and resolution of complaints to receive some formal training in mediation and conciliation. This objective is in addition to other training and development opportunities that arise throughout the year.

Our collocation with other accountability agencies has also allowed us to participate in joint staff training and development opportunities.

Outreach

During the year we noticed an increase in the number of requests for our staff to give presentations to community and provider groups about the role and functions of the Office in dealing with complaints about health and disability services.

These outreach activities included meeting with consumer and provider groups and participating in several community activities and forums to raise awareness about what we do. We also provided contributions to various health and disability newsletters and publications raising awareness about our role in resolving complaints. Several opportunities also arose for us to participate and contribute to professional seminars and conferences, including risk management, medico-legal issues, and safety and quality issues.

We are collocated with the State Ombudsman, the Freedom of Information Commissioner, the Public Sector Standards Commissioner and the Commonwealth Ombudsman. During the year we undertook a number of joint outreach activities with several of these agencies, the details of which are covered later in this report. Several of these opportunities would have been beyond our resources but were made possible by sharing costs with these other agencies.

As part of our service delivery obligations to provide a complaints service to the Indian Ocean Territories the Director, together with the Commonwealth Ombudsman and the State Ombudsman, undertook an outreach visit to Christmas Island and Cocos (Keeling) Islands.

We have also received approval to appoint an Information and Community Liaison Officer on a 12 month contact. This will allow us to develop a structured outreach program for next year.

Amendments to the legislation

On 15 December 2004 amendments to the Disability Services Act came into effect. Several of these amendments have removed inconsistencies between Part 6 of the Disability Services Act and the Health Services Act. We now have comparable powers and functions under both Acts.

On 1 January 2005 the *Carers Recognition Act 2004* came into effect and this contained a significant amendment to the Health Services Act to allow a "carer" to complain that an "applicable organisation" has failed to comply with the "Carers Charter", which is set out in Part 2 of the *Carers Recognition Act 2004*. We are currently part of a working group, consisting of representatives of the Department of Health, the Disability Services Commission and the Office of Seniors' Interests, to formulate reporting arrangements to ensure compliance with the relevant provisions of the *Carers Recognition Act 2004*.

Amendments to the Health Services Act arising from the Review of the Office are proposed and hopefully these will progress during the coming year.

Feedback and complaints

Although we strive to achieve the best possible outcomes for both consumers and providers, it is a reality that we are not always able to achieve outcomes that are acceptable to the parties. It is also a reality that occasionally we may not get it right.

In recognition of this, we are receptive to feedback and criticism and genuinely consider issues of concern raised about how we operate. We have a number of internal processes available, which allow for concerns or criticisms to be considered.

During the course of dealing with a complaint individual case officers are encouraged to listen and respond to any concerns or issues raised by consumers or providers about how they are handling the matter.

We also have a process of internal review whereby a complainant or provider can approach the Director seeking to have an internal review of the outcome of their complaint. Usually this process involves an internal review of the file by a senior officer who, wherever possible, has had no prior involvement in the matter. The objective of the review is to consider:

- the issues raised by the consumer or provider in their request for review;
- the adequacy of the original enquiries undertaken and whether all relevant information was gathered and appropriately considered;
- whether reasonable conclusions have been reached and whether any other conclusions should be considered;
- whether sensible and workable outcomes have been achieved; and
- whether any further additional work should be undertaken on the matter.

A report and recommendations is then prepared for the Director and a detailed written explanation is provided setting out the outcome of the review. If more work is undertaken each of the parties is provided with a written explanation setting out the results of that additional work. Parties are also advised that they can approach the Ombudsman if they remain unhappy following the review. During the year we had 10 requests for an internal review.

Complainants and providers are also provided with information about the role of the Ombudsman in dealing with complaints about our processes and the administrative decisions we make in dealing with complaints. During the year there were 8 complaints to the Ombudsman about our work.

We also take into account the views of key stakeholders about how we operate. In fact several of the internal changes that we have made through the year have been in direct response to feedback from stakeholders. For example: we received feedback from several stakeholders that they would prefer more clarity and better understanding of the processes we use in resolving complaints. In response to this we have amended how we deal with complaints and also the written information we give to both consumers and providers about the resolution process and what they can expect from us.

Relationships

We are continuing to work on building and maintaining relationships with key stakeholders. This often involves regular meetings on general matters of interest or individual meetings on specific matters of concern.

We also attend and/or have membership of committees or forums which meet to discuss matters of interest, some of these include: the Health Complaints Coordinators Network, the Breast Screen Advisory Group, the People with Disabilities Advocacy Forum, the Medical Board Complaints Sub-Committee, and the Medical Defence Association Risk Management Consultative Group. We look to, wherever possible, have a systemic and strategic focus on matters arising from complaints and this is facilitated through such things as our membership of the Offender Health Council and our working relationships with the Department of Health – Office of Safety and Quality in Health Care, the Office of the Chief Psychiatrist, the Inspector of Custodial Services, the Ombudsman, the Disability Services Commission and the Department of Justice. We also work cooperatively with provider organisations and advocacy groups such as the Australian Dental Association, People with Disabilities and the Health Consumers' Council.

It is also important to acknowledge the enormous assistance we receive from individual providers who contribute to our work by providing independent opinions. The value of their contribution to how we resolve complaints cannot be emphasised enough and we are very grateful for their continued assistance.

Finally, it is important to acknowledge the hard work and dedication of our staff. Throughout the year we were faced with many challenges including, the loss of experienced staff, the significant reform process, and maintaining focus on our core business of complaint resolution. Without exception, all of our staff put in an enormous effort during the year to meet these challenges and I am very grateful for their efforts.

Eamon Ryan
DIRECTOR

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

In December 2003 the report containing recommendations following the review of our Office was tabled in Parliament by the Minister for Health. The Review focussed on the operations and effectiveness of our Office and made 47 recommendations. The Government accepted 44 of the 47 recommendations, including 3 that were accepted with amendments. The Minister directed that we implement the accepted recommendations.

In summary, the recommendations sought to:

- Remove inconsistencies between the legislation and processes for dealing with health and disability complaints;
- Make the process and reporting of complaints more efficient; and
- Raise awareness about the role and functions of the Office.

The full report of the Review is available on our website at http://www.healthreview.wa.gov.au.

There are 14 of the recommendations that require amendments to the legislation. Of the remaining recommendations only 5 have not been fully implemented.

The following sets out the progress we have made in implementing the recommendations.

Changes to the legislation

The following recommendations require changes to either the Disability Services Act or the Health Services Act: 3, 7, 8, 9, 11, 15, 16, 17, 18(ii), 19, 22, 27, 38 and 39.

Following consultation with relevant ministerial office staff and also the Disability Services Commission and the Department of Health, the necessary documents required to progress the drafting of the amendments to the legislation were prepared by us. At the request of the Minister for Health, these documents were sent to the Legal Services Directorate within the Department of Health, for comment and advice prior to the documents going before Cabinet for approval. Unfortunately, it appears that due to the heavy workload within the Legal Services Directorate, the provision of this advice has been delayed. We are working to progress this matter. Unfortunately, we do not have the specialist legal expertise in-house and have to rely on external advice and assistance to progress these changes.

Four of the recommendations required amendments to the Disability Services Act, specifically recommendations 36, 37, 38 and 39. Of these, recommendations 36 and 37 were included as part of the amendments to the Disability Services Act, which came into effect on 15 December 2004.

The progress we have made on the remaining 5 recommendations is set out below.

Lodging complaints on-line

Recommendation 13 related to modification of our web-site to allow for lodging of complaints on-line. In considering this recommendation we identified several other improvements we could make to our web-site. A redesign plan was developed and quotes obtained for the design work. A decision was made to work with the Department of Health Information Technology Branch to design and host our new web-site. A developmental web-site has been established. Unfortunately, the progress of this project was delayed when the officer responsible for this project left the office. This project is one of the immediate priorities for our Information and Community Liaison Officer, who is due to start with us in August 2005.

Key performance indicators

Recommendation 26 identified the need to develop a more comprehensive set of performance indicators. As part of this project we identified that there would have to be a significant change in how we record and report complaints data before we could meaningfully change our performance indicators. This process of change has been finalised and a series of new reporting categories will be used from 1 July 2005. We will now be able to work on finalising appropriate performance indicators. These will be based on data which measure how matters are resolved and the outcomes reached. We will work with the Office of the Auditor General and the Department of Treasury and Finance to ensure that our key performance indicators continue to meet our reporting obligations.

Strategic approach to data collection and reporting

Recommendations 31 and 32 related to us establishing a more strategic approach to complaints data and how we translate that data to shareholders.

Many of the internal changes we have made this year reflect a desire to facilitate a more strategic focus on complaints data.

One of the issues we identified is that our current complaints database is probably inadequate to meet our future needs.

We have spent some time this year looking at the complaints management systems used by other health complaints agencies. At this stage, it appears that the best option for us might be to continue working with the Department of Health, which is in the process of developing a complaints management system for use throughout the public health system. Obviously, if such a system could also accommodate our needs, especially in view of our broad jurisdiction in both the health and disability sector, then this would appear to be a sensible approach for us to follow.

In addition, the appointment of an Information and Community Liaison Officer will allow us to build relationships with special needs groups and develop strategies to improve how we can best meet their needs.

Performance management system

Recommendation 44 related to improving our performance management system. Several things have been done which have improved how we manage the performance of our staff. As

mentioned previously, we now have a two team structure within the office and, in addition to operational efficiencies, this has had an impact for our staff. This new structure allows for two senior staff to take on supervision and leadership responsibilities in managing and leading these teams. This in turn allows for more active mentoring of less experienced staff and improvements in monitoring of staff performance, providing feedback on individual performance and identification of training and development needs of staff.

Following the publication in October 2004 of the report on Compliance with Performance Management Standards by the Public Sector Standards Commissioner, Ms Maxine Murray, it is also our intention next year to implement a more formal performance management system for our staff. This will enhance the work we currently do in performance management and ensure our approach remains current and appropriate.

Significant achievements and changes made as a result of the recommendations arising from the Review.

Many of the recommendations that have been implemented have led to significant changes and improvements, including:

- Regular case management review after three months and thereafter every month until the matter is finalised.
- Formulation and publication of a set of core values, principles and vision for the Office. These core values and vision underpin the substance of what we do and guide us in our process of continual improvement.
- Routinely offering consumers assistance in making a complaint, including completing their complaint form. This offer is made at the first point of contact with the consumer, it is reiterated in the first letter that we send to consumers, and it is printed in several places on our complaints form.
- We now have a more clearly defined and structured process for capturing and recording statistics from complaints.
- We have refined our process for the assessment, acceptance and review of complaints when they are first received. We now have a more formalised process for acceptance of complaints and clarification of matters with the complainant.
- We also have a more thorough process for identifying and clarifying areas of ambiguity prior to forwarding complaints to providers seeking a response.
- Direct funding for the provision of a complaints mechanism under part 6 of the Disability Services Act is now part of our direct appropriation from Government.
- We held a forum for complaints staff from disability service providers in March of this year, which was a significant success. Arising from this forum a steering committee was formed to progress the establishment of a complaints network from disability service providers and advocacy groups, with a view to holding regular meetings to discuss matters of mutual interest and promote best practice in complaints handling.
- We have prepared information sheets for consumers and providers outlining the role and functions of the various Registration Boards.
- We have prepared information sheets about the various health and disability advocacy agencies and their contact details.
- We have identified that our staff require training and development to increase their skills in conciliation and several of our staff have obtained formal qualifications in mediation and conciliation.
- We are about to appoint an Information and Community Liaison Officer on a 12 month contract. This will allow us to develop and implement a structured outreach program.

- We hold regular meetings with the Inspector of Custodial Services and the Director of Health Services within the Department of Justice with a view to sharing information about the provision of health services in prisons. We also have ex-officio membership of the Offender Health Management Council, which is a peak strategic advisory body relevant to prisoner health issues.
- Before publishing our 2003/2004 Annual Report we undertook a significant process of consultation with a view to identifying how we could improve the value and quality of the information contained in our Annual Report. Feedback we received from a number of stakeholders was that the revised format and the provision of additional information in our 2004/2005 Annual Report was both informative and valuable to them.

The review of our office and other feedback from stakeholders has been the catalyst for a period of significant change in how we operate. We now have a culture which fosters continual improvement and encourages opportunities for feedback from stakeholders.

Part 4:
Functions of the Director

In this part we are reporting on our activities relevant to the specific functions of the Director as set out in both the Health Services Act and the Disability Services Act.

Although neither Act prioritises the specific functions, it is clear that our core business is the receipt, conciliation and investigation of complaints. As in previous years, we are reporting general statistical information about the complaints we received during the year and also specific statistical information relevant to health and disability complaints. We are also reporting activities undertaken to promote the other related functions of the Director.

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

CORE FUNCTION

The receipt, conciliation and investigation of complaints

Introduction

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

Our office is structured into two units to deal with the complaints we receive. Our Complaints Assessment Unit (CAU) deals with the initial phase of our complaints resolution process, including initial enquiries, analysis and recording of complaints on our computer system and making the initial contact with providers. Our Conciliation and Investigation Unit (CIU) deals with more complex conciliation and investigation matters that cannot be resolved by the CAU.

How do we resolve complaints?

The CAU is the first point of contact in the complaint resolution process. Their primary role is to assess the complaint for clarity and compliance with the legislation, identify the key issues to be addressed and give advice to consumers and providers to facilitate a timely and satisfactory resolution of issues. In doing this they:

- Respond to telephone enquiries from members of the public and service providers;
- Register all oral and written complaints on our complaints management system;
- Provide advice and assistance to resolve complaints;
- Assess new complaints and, where the complaint is accepted for conciliation or investigation, develop a plan to resolve the matter;
- Clarify details of the complaint as necessary;
- Contact the provider and facilitate communication between the parties;
- Assess the response received and other information gathered; and
- Make recommendations for further action or closure.

Should a resolution not be reached and the Complaints Manager or Director feels that resolution may be possible with more work by us, the complaint is referred to the CIU for further conciliation or investigation.
The role of the CIU, as conciliators and investigators, is to gather more information to assist resolution and to ensure fairness in terms of opportunity, natural justice, objectivity and testing

evidence through a process that shows diligence and integrity. The focus is on complaint resolution through a process of conciliation. Where a complaint is not suitable for conciliation a formal investigation is undertaken. As all complaints are complex and unique there is no one process that can be strictly followed. Our processes are sufficiently flexible to meet the needs of each case.

Generally the process involves:

- Reviewing the file and information obtained by the CAU;
- Initiating contact with all parties to confirm and clarify the complaint;
- Determining plan of action;
- Gathering additional information from appropriate sources;
- Forming a preliminary conclusion on the possibility of resolution, based on evidence obtained through records, statements, independent opinions and any other relevant information gathered during the process;
- Seeking the views of the parties on the possibility of resolution;
- Considering any response received and resolution options available;
- Preparing recommendation for the Director;
- Finalising and distributing conciliation report to all parties, including the relevant registration board, if required; and
- Providing detailed explanation to the parties on the outcome of the conciliation or investigation.

Overview of complaints we received this year

During 2004-2005 we received a total of 1741 new complaints and closed 1802 complaints. This represents a slight decrease in new complaints and a slight increase in closed complaints compared to last year.

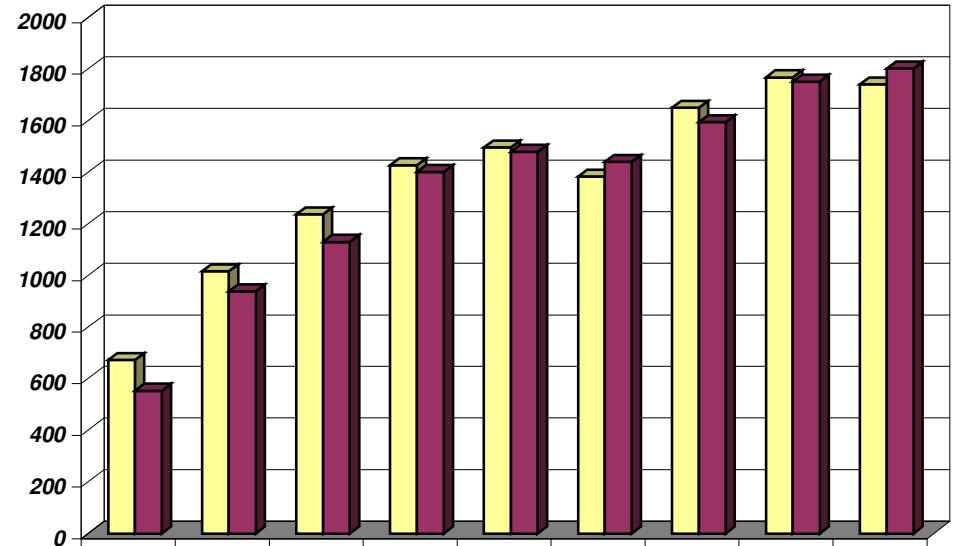
The following table gives a breakdown of new and closed health and disability complaints this year.

	New Complaints	Closed Complaints
Health Complaints	1700	1770
Disability Complaints	41	32
Total	1741	1802

Table 1: Health and Disability Complaints 2004/2005

Figure 1 below shows the trend over time of new and closed complaints.

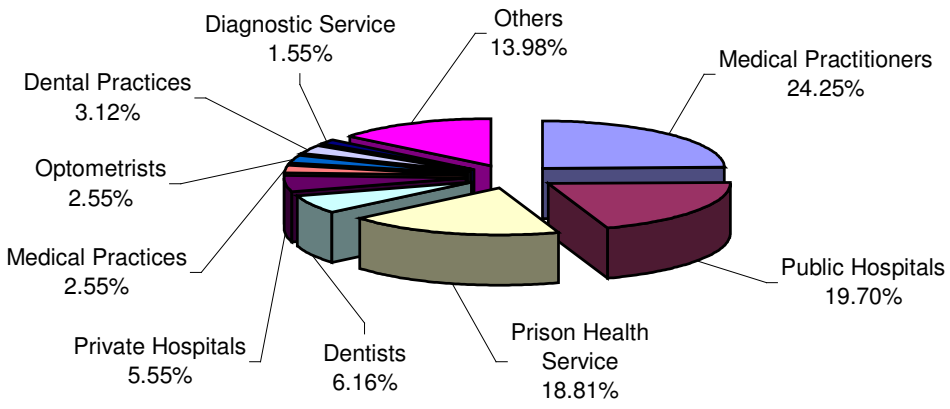
Figure 1 - New & Closed Complaints (1996/97 to 2004/05)



	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05
New	672	1016	1237	1427	1496	1383	1650	1768	1741
Closed	553	938	1130	1401	1479	1440	1594	1751	1802

Figure 2 below shows the complaints about Major Provider types in 2004/05.

Figure 2 - Major Provider Types 2004/05



Active complaints through the year

At the beginning of the year we had 353 active complaints on hand and by the end of the year this figure had been reduced to 308.

Active Complaints at 1/7/2005	353
New Complaints received during the year	1741
Total Complaints handled	2094
Complaints closed during the year	1802
Balance	292
Active Complaints as at 30/6/2005*	308

Table 2: Workload Data 2004/2005

[* Note: To avoid double counting we do not count as new complaints matters that were closed as at the end of the previous year but subsequently re-opened during the current year. Typically this involves matters where a written complaint was not received and the matter was closed in the previous financial year. However, if a written confirmation of the complaint is received after 1 July of the following financial year then the matter is re-opened and further work is undertaken. This explains why the number of active complaints on hand 308 is greater than 292.]

Distribution of active complaints

	2004-05	2003-04
Complaints Assessment Unit	227	175
Conciliation Investigation Unit	81	178
Total	308	353

Table 3: Active Complaints 2004/2005

Age analysis of active complaints

	2004-05	2003-04
0-3 months	210	211
3-6 months	32	65
6-9 months	15	28
9-12 months	15	17
12-18 months	21	20
18-24 months	10	9
Over 24 months	5	3
Total	308	353

Table 4: Age Analysis 2004/2005

It is important to note that during the year our workload includes those complaints that were active at the beginning of the year together with new complaints we received during the year and also matters that were re-opened from the previous year.

The data on active complaints reported above shows that we do not have a significant backlog of outstanding complaints. Some significant changes are evident from last year, particularly the reduction of the overall numbers of active complaints, notably in the more complex matters allocated to the CIU.

The data, however, does suggest that we need to focus our attention on those complaints that are over 12 months old. We have put in place strategies that will allow us to focus on older complaints. This includes re-allocation of some complaints and more active supervision and follow-up of older complaints. There are occasions where complaints take longer to resolve than we would like, but where we can improve timeliness we will direct our efforts towards this during the coming year.

Who complains to us?

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

Gender

Female	Male	Not Identified
43%	54%	3%
Table 5: Gender of Consumers		

Age of consumer*

Age Group	Percentage
Age 0-10	8%
Age 11-20	4%
Age 21-30	24%
Age 31-40	24%
Age 41-50	17%
Age 51-60	11%
Age 61-70	6%
Age 71 and Over	6%
Table 6: Age of Consumers	

[* Note: The consumer's date of birth was not disclosed in 1107 complaints. The above percentages are for the 634 consumers who provided this information.]

Geographical location

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

	2004-05	**2003-04**	**2002-03**
Metropolitan WA	72%	69%	72%
Rural/Regional WA	19%	18%	17%
Interstate/Overseas	0.2%	1%	0%
Unknown	9%	12%	11%
Table 7: Geographical Location of Consumers 2002-03 to 2004-05			

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

	2004-05	2003-04	2002-03
6200 - 6299	93	115	100
6300 - 6399	40	44	47
6400 - 6499	34	47	34
6500 - 6599	100	75	66
6600 - 6699	2	8	2
6700 - 6799	51	30	41
6800 - 6899	4	2	0

Table 8: Rural and Regional Consumers 2002-03 to 2004-05

Analysis of closed complaints

The following gives an overview of the cases we closed and the outcomes achieved during the year.

Enquiries

Each year we receive enquiries about issues which are clearly outside our jurisdiction, these include such things as enquiries about food standards or other public health issues. This year the CAU received approximately 500 calls about such issues. This figure does not include the large number of similar calls which are screened by our receptionist.

Oral complaints

During the year we closed 1078 oral complaints. This was 60% of the total number of complaints received. Oral complaints are a significant part of the work of the CAU. We only record as oral complaints those matters which, on initial assessment, are within our jurisdiction. If an oral complaint is not confirmed in writing then, under the Health Services Act and the Disability Services Act, it may be rejected by the Director.

In dealing with oral complaints, we provide the complainant with information and options for the resolution of their complaint. This includes written information about advocacy services and, where relevant, registration boards. Often this process may involve some simple work on our part, such as a telephone call to a provider aimed at assisting in the resolution of the complaint. We also encourage complainants to try to resolve the complaint with the provider in the first instance. Where they are unable to do so they can come back to us with their complaint.

Written complaints

Once a written complaint is received, it is assessed by CAU staff and a decision is made on whether to accept, reject, refer or close the complaint.

Complaints rejected 108

There are occasions where the receipt of a written complaint is the first contact we have with a complainant. There are also occasions where once the complaint is received in writing it becomes clear that we cannot accept it. This explains why a number of written complaints are

not accepted and are rejected or referred elsewhere. The following table shows the number of written complaints we received that were rejected and the reasons why they were not accepted.

Complaints Rejected	
The incident occurred more than 12 months before the complaint was made	27
The complaint did not allege an issue outlined in section 25 of the Act	19
The complaint was vexatious, trivial or without substance	1
The complaint did not warrant any further action	9
The complaint did not comply with the Act	5
The issue had already been determined by a court, industrial tribunal or registration board	16
The issue has already been dealt with under another written law or a law of the Commonwealth or by a court	1
The complainant did not provide sufficient information requested by the Director	29
Outside the jurisdiction of the Office and referred appropriately	1
Total number of complaints rejected:	**108**

Table 9: Written complaints Rejected 2004-05

Complaints referred 23

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

Complaints Referred	
Referred to a registration board	11
More appropriately handled by another body and referred elsewhere	12
Total number of complaints referred	**23**

Table 10: Written complaints referred 2004-05

Written complaints accepted 593

Of the remaining 593 written complaints, the following outcomes were achieved.

Written Complaints Accepted	
Resolved mainly or completely in favour of the complainant	105
Resolved partly in favour of the complainant	110
Complaint not upheld	286
Unable to be determined	34
Complaint withdrawn, lapsed or not pursued by the complainant	58
Total number of written complaints accepted:	**593**

Table 11: Written Complaints Accepted 2004-05

In every case a detailed written explanation of the outcome is provided to the complainant and the provider.

Total number of written complaints closed 724.

Analysis of closed health complaints in 2004-2005

In 2004/2005 we closed 1770 health complaints. The following analysis includes both oral and written health complaints. These figures represent the overall profile of health complaints we closed this year.

What provider types do consumers complaints about?
The complaints we receive are categorised by provider types. The following table shows the trend in complaints about the major provider types over the past three years.

Major provider types

	2004-05	2003-04	2002-03
Medial Practitioners	24%	25%	31%
Public Hospitals	20%	19%	21%
Prison Health Services	19%	20%	11%
Dentists	6%	5%	7%
Private Hospitals	6%	4%	4%
Medical Practices	3%	7%	7%
Dental Practices	2%	4%	4%

Table 12: Major Provider Types 2002-2003 to 2004-2005

Other provider types each accounted for less than 3% of closed complaints. A full list of complaints for each provider type is available at Appendix A.

The small change in complaints received about Medical Practices and Dental Practices probably reflects a change in how we categorise such complaints rather than a significant change in the actual number of complaints.

Medical Practitioners

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

	2004-05	2003-04	2002-03
General Practitioners	59%	45%	44%
Plastic/Cosmetic Surgeons	6%	3%	3%
General Surgeons	5%	5%	12%
Obstetricians/ Gynaecologists	5%	6%	8%
Psychiatrists	5%	7%	7%
Anaesthetists	4%	8%	5%
Orthopaedic Surgeons	3%	4%	5%

Table 13: Complaints about Medical Specialists

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

This year there was a noticeable rise (14%) in the number of complaints about General Practitioners. We could not identify any particular reason for this increase other than we received more complaints. There was nothing unusual in the types of issues raised in the complaints and the distribution of issue types was consistent with overall complaints about Medical Practitioners and complaints generally. Also, in comparison to previous years there was nothing of particular significance to explain the increase. The increase could possibly be explained by increased awareness about our Role or perhaps simply a statistical anomaly this year.

Another noticeable change this year was a 4% drop in complaints about Anaesthetists. Consistent with previous years complaints about costs remains the most significant issue in the complaints we receive about Anaesthetists, accounting for 72% of all complaints. This year the actual number of complaints about costs involving anaesthetists fell from 33 to 13.

There was an increase in the number of complaints we received about Plastic/Cosmetic Surgeons, 6% this year up from 3% last year. It is important to remember that the actual number of complaints is very small, with only 25 complaints in total. The majority of complaints were about treatment (20). Detailed analysis showed that almost all of these complaints involved issues relating to the outcome of the treatment with a significant number of consumers being unhappy with their appearance following treatment.

Public hospitals

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

	2004-05	**2003-04**	**2002-03**
General Medicine	34%	26%	29%
Psychiatry	21%	22%	16%
Emergency Departments	11%	17%	17%
General Surgery	5%	10%	8%
Obstetrics/ Gynaecology	5%	7%	5%
Paediatrics	5%	4%	2%
Table14: Complaints about Public Hospitals			

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

Issues

What issues do consumers complain about?

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

Issues	**%**
Treatment	51%
Access	16%
Cost	13%
Information	6%
Privacy	4%
Decision Making	3%
Other	7%

Table 15: Complaint Issues 2004-05

The three issues attracting the greatest number of complaints this financial year, as in previous years, were treatment, access and costs.

Do issues change over time?

	2004-05	**2003-04**	**2002-03**
Treatment	51%	50%	49%
Cost	13%	15%	15%
Access	16%	10%	11%
Information	6%	9%	9%
Privacy	4%	8%	7%
Decision Making	3%	3%	3%
Other	7%	5%	6%

Table 16: Comparison of Issue Type

This year there was a noticeable change of 6% in the number of complaints about access compared to last year.

Do the issues vary between provider types?

It is interesting to consider the main issues raised in all complaints compared to the issues raised about major provider types. This allows us to make an assessment of whether certain provider types draw a particular type of complaint.

	Treatment			Cost			Access			Information			Privacy		
	04-05	03-04	02-03	04-05	03-04	02-03	04-05	03-04	02-03	04-05	03-04	02-03	04-05	03-04	02-03
All Complaints	51%	50%	49%	13%	15%	15%	16%	10%	11%	6%	9%	9%	4%	8%	7%
Medical Practitioners	52%	43%	50%	16%	23%	17%	7%	5%	6%	9%	11%	11%	9%	13%	9%
Prison Health Services	48%	75%	69%	0%	0%	2%	34%	8%	9%	3%	2%	3%	2%	2%	3%
Public Hospitals	60%	50%	49%	5%	1%	2%	19%	22%	24%	7%	11%	10%	2%	7%	6%
Dentists	65%	61%	67%	23%	22%	23%	2%	1%	2%	4%	6%	4%	3%	3%	0%
Private Hospitals	54%	42%	41%	20%	30%	34%	10%	14%	6%	7%	5%	6%	1%	8%	5%

Table 17: Comparison of Issues and Provider Types

Caution is required when analysing this data, because in some cases the raw figures are low and may not have statistical significance.

Public hospital complaints and issue types

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

These figures have been grouped into teaching hospitals and non-teaching hospitals. The analysis looks at the numbers of complaints and the issues raised and allows comparison between similar facilities and also comparison to complaints received about all health services. We sought and received permission from the Acting Director-General of the Department of Health to provide the information in Tables 18 and 19 in an identified form. Of particular note is the very small number of complaints received about each public hospital relative to the high number of occasions of care they each provide. The existence of a well developed and publicised complaints management policy together with the availability of customer liaison offices in each facility no doubt contributes to many complaints and grievances being resolved at the service provider level.

Teaching hospitals

	Fremantle		King Edward		Princess Margaret		Royal Perth		Sir Charles Gairdner	
	04-05	03-04	04-05	03-04	04-05	03-04	04-05	03-04	04-05	03-04
Treatment	6	12	9	11	12	7	39	18	23	13
Access	3	6	1	2	3	3	13	10	3	9
Information	0	4	2	1	1	3	7	4	4	7
Privacy	1	1	1	2	0	1	1	5	0	1
Decision Making	0	0	1	0	1	0	4	0	1	2
Cost	0	0	0	0	0	0	2	0	2	1
Grievances	0	0	0	0	0	0	0	1	0	0
Other	1	0	0	0	0	0	1	2	0	2
TOTAL	**11**	**23**	**14**	**16**	**17**	**14**	**67**	**40**	**33**	**35**

Table 18: Teaching Hospitals - Issues

There has been a slight increase in complaints about Royal Perth from 40 to 67, but the base number is relatively low. At the same time complaints about Fremantle Hospital have fallen from 23 to 11.

Non-teaching hospitals

	Armadale		Bentley		Graylands		Osborne Park		Rockingham/ Kwinana		Swan Districts	
	04-05	03-04	04-05	03-04	04-05	03-04	04-05	03-04	04-05	03-04	04-05	03-04
Treatment	9	5	4	7	19	12	3	1	4	4	3	4
Access	5	3	1	0	0	3	1	2	0	2	3	2
Information	0	0	1	1	0	0	0	0	0	1	1	1
Privacy	0	0	0	2	1	2	0	0	0	0	0	0
Decision Making	0	1	0	0	3	2	0	0	0	0	1	0
Cost	0	0	1	0	0	0	0	0	0	0	0	0
Grievances	0	0	0	0	0	0	1	0	0	0	0	0
Other	0	0	0	1	0	2	0	0	0	0	0	0
TOTAL	**14**	**9**	**7**	**11**	**23**	**21**	**5**	**3**	**4**	**7**	**8**	**7**

Table 19: Non-teaching Hospitals - Issues

It is clear that the issues do not differ significantly between each facility. The major complaint issues raised consistently involve treatment and access, and this is consistent with previous years. This data also suggests that there is no one issue type of complaint that is a particular cause for concern in an individual facility. When dealing with individual complaints, if a potential systemic issue arises we, as part of the resolution process, provide information to the Office of Safety and Quality within the Department of Health with a view to promoting system-wide learning and improvements from individual complaints.

As one would expect, the above data is consistent with the contention that the number of complaints received about individual hospitals should reflect the size of the individual facility and the number of patients they see and the services they deliver.

Mental health complaints

The number of complaints about mental health services have generally remained similar to last year. This year we received a total of 128 complaints about public and private mental health services, slightly fewer than last year's figure of 134. Of the 128 complaints received this year, 98 complaints were received about public mental health services, 68 of these involved in-patient mental health services and 30 involved community mental health services. There were 30 complaints received about private mental health services, 22 of these were about private mental health practitioners and 8 were about private in-patient mental health services.

This year 66% of the mental health complaints were not confirmed in writing and this is slightly higher than the average for all complaints received.

	Treatment	Cost	Access	Information	Decision Making	Privacy
All complaints	51%	13%	16%	6%	3%	4%
Public Mental Health Services	68%	0%	7%	6%	15%	4%
Private Mental Health Services	48%	10%	12%	9%	14%	7%

Table 20: Comparison of public and private mental health complaints 2004-2005

Access to mental health services continues to be an issue raised in complaints. Several of the complaints we received this year involving access issues were from people who felt that family members should be cared for as an in-patient as opposed to living in the community. Another issue arising from these complaints related to access to after hours mental health services.

In dealing with mental health complaints we recognise the significant disadvantage that people who experience mental illness face in making a complaint. When we receive contact or enquiries about mental health issues we routinely provide information about advocacy and support services that are available to mental health consumers and their carers and families. In particular referrals are made to the Mental Health Law Centre, the Council of Official Visitors, the Health Consumers' Council, the Mental Health Review Board, and the Office of the Chief Psychiatrist.

We also work closely with the Office of the Chief Psychiatrist in relation to broader mental health issues and on matters arising from individual complaints. This relationship is important to us because of the role of the Chief Psychiatrist in safeguarding the standards of care and supporting service improvements.

Prison complaints

Introduction

Prison complaints continue to be a significant part of our work. We are able to accept complaints from prisoners about the provision of health services in both public and private prisons in Western Australia.

This year we received 365 health complaints from prisoners, slightly more than last year (337).

Complaints

	2004-05	2003-04	2002-03
New complaints	365	337	180
Closed Complaints	339	342	161

Table 21: Prison complaint numbers

Issues in closed complaints

	2004-05	2003-04	2002-03
Treatment	48%	80%	78%
Access	34%	7%	7%
Policy/Administration	8%	8%	7%
Other	10%	5%	8%

Table 22: Issues in closed prison complaints

It is important to note that the statistical information provided here is an overview of the complaints profile involving the complaints we receive about prison health service and the issues prisoners raised in complaints. Our focus is on resolution of complaints and in that regard the following outcomes were achieved.

Outcomes

We closed 339 prison health complaints this year. Of these, 8% were resolved mainly or partly in favour of consumer (for example, the service was obtained or an explanation given) and 31% were not upheld.

40% of these complaints were oral complaints which were rejected because the complaint was not confirmed in writing.

Just over 3% of complaints received were not within the jurisdiction of this Office and were referred to another appropriate agency, such as the Ombudsman.

Resolving complaints

As we saw last year there appears to be an unmet need for immediate advocacy for prisoners to deal with health issues. Many of the complaints we receive relate to matters that need to be addressed quickly such as access to a medical practitioner or medication. This year we continued to provide prisoners with options which may assist them to resolve their concerns. These include, encouraging them to approach the health service staff directly with their concerns, to use the peer support person as an advocate, or to use the internal grievance process.

Analysis of complaints for each prison

We sought and obtained consent from the Director General of the Department of Justice to report complaints about specific prisons this financial year. Of the 365 new complaints received this financial year, the following is a breakdown of complaints received about each prison. This data represents the issues raised in complaints we received and reflect the types of concerns prisoners have about their health care within the prison. The data does not reflect whether or not the complaint was ultimately resolved in favour of the complainant.

	Total Number of Complaints		**2004-05 Issues**					
	2003-04	**2004-05**	Treatment	Access	Cost	Administrative Practice	Privacy	Other
Acacia	81	96	47	32	2	7	3	5
Albany	5	5	5	0	0	0	0	0
Bandyup	33	17	7	6	0	3	0	1
Boronia Pre Release Centre	0	1	0	0	0	1	0	0
Rangeview	1	0	0	0	0	0	0	0
Broome	3	0	0	0	0	0	0	0
Bunbury	9	14	5	7	0	0	0	2
Casuarina	60	100	48	35	0	13	1	3
Department of Justice	0	1	0	0	0	0	0	1
Eastern Goldfields	1	2	1	0	0	1	0	0
Greenough	5	15	5	5	0	4	0	1
Hakea	99	102	43	46	0	4	2	7
Karnet	10	7	4	2	0	1	0	0
Nyandi	18	0	0	0	0	0	0	0
Roebourne	3	2	0	1	0	1	0	0
Wooroloo	9	3	2	1	0	0	0	0
Total	**337**	**365**	**167**	**135**	**2**	**35**	**6**	**20**

Table 23: Complaint issues for each prison

Two features are noticeable from the number of complaints received this year. Firstly, the number of complaints from prisoners at Casuarina Prison rose from 60 last year to 100 this

year. Secondly, the number of complaints received from women prisoners fell this year. Complaints from Bandyup Prison fell from 33 to 17 and Nyandi Prison fell from 18 to 0.

Complaints about access have changed significantly this year and some of this change is due to changes in how we record complaints about access and treatment issues. Analysis of complaints about access showed that the issues complained about involved access to medication (41%), medical appointments (35%), dental services (14%), and specialist services (10%). Complaints about access to medical appointments are often resolved through direct contact with health service staff. Our experience shows that complaints about access to medication and dental services require more work by us to resolve. Medication issues are not uncommon particularly where there is conflict between what the prisoner was prescribed in the community before coming to prison and the medication that is prescribed in the prison. Tradability of some medications is often an issue that arises in such complaints. Many of these complaints are matters that would benefit from the availability of a prison health advocate.

Access to dental services in prisons is also a significant issue. There appears to be a significant problem with providing dental services in some prisons. We are aware of work being undertaken by the Health Services Directorate within the Department of Justice to address this problem. However, it is clear that the problem is a cause of a significant number of complaints and enquiries we receive and it should be resolved as a matter of priority.

We have a very good working relationship with staff in each of the Prisons Health Service and the Office of the Director of Health Services. The Director and Complaints Manager meet regularly with the Director of Health Services and staff from the Office of the Inspector of Custodial Services. We have also been invited to participate as a member of the Inspection Team for the proposed inspection of the Acacia Prison.

RELATED FUNCTIONS

As stated previously, our core function is the receipt, conciliation and investigation of complaints. There are also a number of related functions, which we pursue throughout the year. The activities we undertook in relation to each of these are set out below.

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

There are a number of things we do throughout the year to fulfil this function, including regular liaison with key stakeholder groups on general issues and also dealing with providers on specific complaints.

Communication and documentation

As in previous years a significant contributing factor in the complaints we deal with involve issues around communication and documentation. Almost without exception there is some element of communication and/or documentation involved in the complaints we receive regardless of which broad category they fall within. This issue is something that we have emphasised continuously in the past and it continues to be a significant issue. Given our previous coverage of this issue there was some temptation not to cover this issue in detail again this year. However, at the risk of repetition this issue is so important that it cannot, in our view, be emphasised enough. It is a matter that we raise in all of our presentations and discussions with provider groups.

In our 2001/2002 Annual Report the issue of communication was raised regarding informed consent and informed financial consent. In that report we noted that some providers do not make much effort to ensure that their patients are fully informed about the nature, effect and risks of treatment proposed and that often consent is not fully obtained for all procedures undertaken. In addition, we noted that data from complaints suggested that some providers failed in their duty to provide sufficient information about the cost involved in their treatment to allow the consumer to make an informed decision.

In our 2002/2003 Annual Report, the importance of good record keeping was highlighted and that data from complaints we received showed that the standard of record keeping was often below what one should reasonably expect.

In our 2003/2004 Annual Report, we again highlighted the issues of communication and record keeping as a significant contributing factor to complaints. In that report we pointed to a variety of information available about the need for good communication and documentation.

It has been apparent again this year that these issues continue to be a significant contributing factor to the complaints we received.

There are a number of things we do through the year that aim to address these issues and improve practices. Whenever we are invited to speak to providers or groups of providers these issues are always highlighted as areas that require improvement. It has also been addressed by us at various conferences and seminars for both providers and consumers. For example: these issues were reinforced in the theme of a poster presentation by us at the 2nd Australasian Conference on Safety and Quality in Health Care which was held in Canberra in 2004. The

theme of this presentation was the importance of good communication and documentation and how this can reduce or minimise the significant causes of complaint.

In addition to addressing this issue from the broader perspective as mentioned above, we also deal with it in resolving individual complaints. Poor communication or inadequate documentation arises in individual complaints and it is often an issue identified by our independent advisers. Comments along the lines of "the records, while appearing complete, are not always easily legible" (Independent Adviser June 2005) are not uncommon. Where we have such concerns, we deal with them on a case by case basis. This often involves providing specific feedback to the provider and making recommendations for improvement. This year we have also referred a number of matters to the relevant registration board where the standard of documentation has been significantly lacking.

During the year we also raised the issue on a broader systemic level with several of the colleges and professional associations and also the Office of Safety and Quality within the Department of Health. The objective of this is to provide feedback into the system about this issue as a means of raising awareness with providers and provider groups about the need for continued efforts to improve the standard of communication and documentation.

Given the human factor, it is probably unrealistic to expect that in every case communication and documentation will be perfect. Nevertheless, this is a goal that providers should strive to achieve.

We believe that the situation can improve and there are a number of things which individual providers and provider groups can do that would have an impact. The advantages for providers are the potential to reduce complaints, an improvement in the standard and quality of care provided and significant benefits from a risk management perspective.

There are a number of the things we think could be done which would lead to improvements in this area. These include:

- Individual providers taking responsibility for improving the standard of their communication and documentation;
- Providers recognising and accepting that as a means of reducing complaints high standards of communication and documentation are just as important as high standards of skill and care;
- Supervisors, managers and senior executives in large provider groups (including both public and private providers) must continually reinforce the need for high standards of communication and documentation. This can be achieved by having adequate policies and procedures in place, through active performance oversight and supervision, and in response to specific issues of concern raised in complaints;
- Trainers and educators also have a role to play in reinforcing the need for high standards of communication and documentation. This issue is one that needs to be reinforced continually in undergraduate, post graduate and continuing training to encourage individual providers to achieve and maintain high standards in this area; and
- Administrators and managers also have a responsibility to ensure that there are high standards of communication and documentation within the facilities they operate. This includes taking responsibility for dealing with situations where the standard of communication and documentation falls below an acceptable standard.

There are a number of useful reference sources available for providers to seek advice and assistance on this issue. Information and advice is available from various colleges and professional associations, indemnity insurers, safety and quality bodies (such as the Office of Safety and Quality and the Australian Council for Safety and Quality in Health Care) and complaints bodies (eg the Office of Health Review and the State Ombudsman).

Complaints about Anaesthetists

As previously stated, we noticed a 4% drop in complaints about Anaesthetists this year. Complaints about costs remained the most significant issue in these complaints, accounting for 72% of all complaints. This year, however, the actual number of complaints about costs involving Anaesthetists fell from 33 to 13.

Last year we reported on the research we had undertaken on how following best practice in providing information on costs could reduce the number of complaints received about this issue. The results of this research were made available to key stakeholders. Hopefully, the fall in these complaints is a result of better practice by anaesthetists relating to the information they give to their patients about costs. What is clear, as we reported last year, our research shows that anaesthetists (and indeed all providers) who provide clear information about fees, encourage discussion of their fees and provide a written quote or estimate before providing treatment are far less likely to draw complaints.

Complaints about Plastic/Cosmetic Surgeons

Another noticeable factor from complaints data this year was an increase in the number of complaints we received about Plastic/Cosmetic Surgeons, and while it is important to remember that the actual number of complaints is very small, with only 25 complaints in total, there are some lessons from these complaints. The majority of these complaints were about treatment and analysis showed that almost all of these complaints involved issues relating to the outcome of the treatment with a significant number of consumers being unhappy with their post-operative appearance.

Leaving aside the question of the standard of clinical skill involved, there are a number of things that providers can do to reduce the incidence of such complaints. These include:

- Discussing the treatment in detail with the consumer. These discussions should cover risks, benefits, side effects, outcomes and realistic expectations. This will help to ensure that the consumer gives informed consent;
- Providing details about the cost of treatment and all likely charges, including alerting the consumer to the likelihood of additional anaesthetist, hospital and other charges. This will help to ensure that the consumer gives informed financial consent;
- Providing written information to the consumer to take away and read. This gives the consumer time to consider the treatment and seek clarification of any concerns they may have;
- Where appropriate, taking pre and post operative photographs (obviously with the consumers consent); and
- Ensuring the consumer has realistic expectations about what the treatment can achieve.

This information formed the basis of a presentation we recently gave to a provider group who specialises in cosmetic procedures.

To take steps to bring to the notice of users and providers details of complaints procedures under the Act.
To cause information about the work of the Office to be published from time to time.

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

As in previous years, these activities range from the distribution of brochures and complaint forms, speaking about our role at provider and consumer seminars and conferences, participating in committees or working groups, and providing media comment on issues of public interest.

During the year we undertook a number of community outreach activities which were targeted at raising public awareness about our office particularly in regional centres.

As part of our service delivery obligations to provide a complaints service to the Indian Ocean Territories of Christmas Island (CI) and Cocos Keeling Islands (CKI) we undertook an outreach visit to the Territories.

The Director, Eamon Ryan, undertook this outreach visit to CKI and CI together with the State Ombudsman, Ms Deirdre O'Donnell, and the Commonwealth Ombudsman, Professor John McMillan. We met with community representatives, Local Government officers, Commonwealth Government officers, health service staff and individual residents. We also set aside time to meet residents to accept complaints.

The visit was worthwhile and proved to be an excellent opportunity to raise awareness with the residents of CKI and CI about the role and functions of each agency. Over the next few months we are going to develop brochures specifically for the different community groups on both CKI and CI.

Several community outreach initiatives were undertaken together with the State Ombudsman, the Freedom of Information Commissioner and the Commonwealth Ombudsman. These initiatives arose from us being collocated with these agencies and also the Public Sector Standards Commissioner.

These community outreach activities included:

<u>WA On Show Expo – 27 to 31 August 2004</u>

This was a major showcase event to mark the opening of the Perth Convention Centre.

We were one of the many exhibitors at the Expo. This outreach activity was undertaken together with the State Ombudsman, the Freedom of Information Commissioner and the Commonwealth Ombudsman.

It was an enormously successful event which was attended by a record number of visitors. We distributed brochures, complaint forms, information sheets and promotional material throughout the five days of the Expo. Our staff were available throughout the Expo to meet members of the public and answer questions about our role and functions in dealing with complaints.

This was also a very positive experience for us as it was the first joint community outreach activity conducted with the other collocated agencies. The success of the event was a model for subsequent outreach activities. It also allowed us to participate in an event that otherwise would have been beyond our resources.

Albany Show and Trade Exhibition – 12 & 13 November 2004

This was a joint community outreach activity undertaken with the Commonwealth Ombudsman, the State Ombudsman and the Freedom of Information Commissioner.

Posters detailing the types of matters that each of the agencies can deal with were on display and brochures and information sheets were made available for members of the public. A free raffle of local produce was successfully used to attract people to the exhibit. To enter the raffle a simple question about the agencies had to be answered. Staff members at the exhibit assisted people to complete the entry form and at the same time they were able to tell them about the work done by each agency. Four hundred and forty raffle tickets were completed. We were also able to have longer discussions about specific problems or issues people wanted to discuss. This activity has led to a significant increase in awareness of the roles of each of the agencies involved.

People were also given a package of brochures (from each agency) and promotional material that provided information and contact details.

Staff from the agencies who attended were interviewed on the local community radio station which was broadcasting from the Show. These broadcasts went to air on each day of the Show and were a great opportunity to explain the role of each agency and provide contact details.

An advertisement was also placed in the official program published by the local newspaper. The program was included with newspapers which were distributed to 14,000 households in and around the Albany region. In addition, further copies of the program were available at the Show entrances.

Other outreach activities undertaken in Albany
Several outreach activities beyond the Albany Show were also undertaken. Meetings were arranged with the Director of Nursing and Quality Manager at Albany Regional Hospital, the Supervisor of Local Area Coordinators for disability services and the Director of Nursing at the Albany Regional Prison. Again a package of information tailored to suit the needs of each provider was made available.

Wagin Woolorama – 11 & 12 March 2005

This was a joint outreach activity undertaken with the Commonwealth Ombudsman and the State Ombudsman.

Overall the show attracted over 24 000 people from the region. Brochures, complaint forms and promotional material were distributed to visitors who attended our exhibit.

A free raffle of local produce was again used to encourage visitors to our exhibit. This was a very successful strategy and it gave staff from each of the agencies an opportunity to tell people about our role and functions.

Staff from each of the agencies were also interviewed on the local radio station and spoke about the respective roles of each agency and provided contact details.

Unfortunately, due to the logistics of the event no outreach activities beyond the show were possible.

Northwest Expo – 7 & 8 May 2005

This was a joint outreach activity undertaken with the Commonwealth Ombudsman.

The Expo attracted approximately 8000 visitors from the region. Throughout the Expo we had the opportunity to speak with many visitors about the role and functions of our office.

We distributed pamphlets, complaint forms, information sheets and promotional material to visitors.

Other outreach activities undertaken in Broome
Outreach activities beyond the Expo were also undertaken. These included meeting with representatives of the local service providers, the local Mental Health Services, the Regional Health Service, the Local Hospital, the Prison Health Service, the Aboriginal Medical Service, several community groups and the local Area Coordinator for Disability Services. A package of information was also made available to each of these groups.

We also took the opportunity to meet with a complainant who lives in the area to further discuss issues regarding their complaint.

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

There are a number of things we do to address this function. In dealing with individual complaints, we regularly provide feedback to providers on ways to improve their complaints handling procedures.

During the year we also gave a number of presentations to provider groups and practice staff in provider organisations, dealing with promoting better practice in complaints handling. We also look for opportunities to promote this issue from a more systemic perspective.

When asked to speak to provider groups about the role of our office and dealing with complaints we always include discussion on complaints management and how to improve complaints handling.

There are a number of useful publications available that we refer to which can be used by providers as a resource for promoting best practice. Some of these include:

- Better Practice Guidelines on Complaints Management for Health Care Services – July 2004, available at http://www.safetyandquality.org/articles/Action/complaintfact.pdf
- Australian Standard, Complaints Handling, AS4269:1995, available for purchase from Standards Australia at www.standards.com.au
- Good Practice Guide for Effective Complaint Handling, Commonwealth Ombudsman, available at www.comb.gov.au/publications

- The Ombudsman's Guidelines for conducting administrative investigations, WA Ombudsman, available at www.ombudsman.wa.gov.au

We also have been a member of the Hospital Complaints Co-ordinators Network since its inception. This network consists of complaints and customer liaison staff from public and private health providers (mostly hospitals). Membership also includes consumer advocacy groups and more recently a representative from the Prison Health Service. The network is currently reviewing the Department of Health Complaints Management Policy and we are providing input into that work. This network also generates opportunities for us to visit individual provider organisations to promote the work of the office and increase best practice in complaints handling.

We are also working with investigation staff from the Medical Board in a series of meetings to improve how each of our organisations handle complaints.

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

No inquiries covering broader issues of health care were undertaken during the 2004-2005 financial year.

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

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

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

We have a series of information sheets for consumers and providers covering topics such as:
- Complaints to registration boards and the role and function of each board;
- The guiding principles for the provision of health services and the principles and objectives relevant to disability services;
- Health advocacy and information services; and
- Disability advocacy and information services.

Our CAU staff also routinely provide consumers and providers with advice and information about our processes and other options for dealing with complaints.

Our CAU staff have access to various resources and information about other avenues available for dealing with complaints. They maintain regular contact with other complaints agencies, advocacy agencies and registration boards to determine questions about jurisdiction and to ensure that consumers have a variety of options and are able to pursue their concerns with the most appropriate agency.

Part 5:
Disability Complaints

Our jurisdiction to accept complaints about disability service providers is contained in Part 6 of the Disability Services Act.

Disability complaints receive particular attention within the Office. For most of the year we had an officer allocated to disability complaints who has broad experience in the disability sector. We will continue with our focus on disability complaints in the coming year.

The actual number of complaints received remains relatively small in comparison to health complaints but this year we did see an increase in the number of new complaints received.

Analysis of disability complaints

How many complaints do we receive?

We received 41 new disability complaints in 2004/2005 and closed 32 complaints. Twelve of the new complaints were confirmed in writing.

Table 24 below shows the trend of complaint numbers over the past four years.

	2004-05	**2003-04**	**2002-03**	**2001-02**
New Complaints	41	28	43	24
Closed Complaints	32	33	42	23

Table 24: New and closed complaints 2001-02 to 2004-05

At the end of the financial year 14 complaints remained open. Five of these complaints have been accepted for conciliation and 9 complaints are currently being assessed or we are awaiting further information from the complainant before they can be assessed. Each complaint that we receive is assessed by our CAU staff to ensure that the complaint is a matter we can deal with under the Disability Services Act.

Table 25 below shows the workload for disability complaints handled during the year.

Number of complaints carried forward from previous year:	5
New complaints received 2004-2005:	41
Total number handled 2004-2005:	46
Number of complaints closed 2004-2005:	32
Complaints on hand 30 June 2005:	14

Table 25: Workload data 2004-05

What provider types do people complain about?

Of the complaints received this year, 27 were about non-government service providers and 14 were about the Disability Services Commission. Table 26 below shows the trend in complaints about different provider types over the past four years.

	2004-05	2003-04	2002-03	2001-02
Non government service provider	27	13	22	17
Disability Services Commission	14	11	16	5
Public authority	0	3	2	2
Not identified/Other	0	1	3	0

Table 26: Provider Types 2000-01 to 2004-05

Who complains?

The majority of complaints were made by parents or relatives of adult consumers and this is consistent with previous years. Only 2 complaints were made by people with disabilities acting on their own behalf. Table 27 below shows who made complaints this year.

Parent/Relative of adult consumer	20
Advocate of adult consumer	12
Parent of minor consumer	7
Consumer	2

Table 27: Complaints about disability services 2004-05

What issues do they complain about?

The majority of complaints (16) were about service quality. The remaining complaints were spread evenly over several other issue types. Table 28 below shows the trend in issue types over the past two years.

	2004-05	2003-04
Service Quality	16	18
Service Eligibility	5	2
Staff Conduct	5	1
Communication	3	1
Funding or Not Making a Grant	3	2
Service Withdrawn	3	0
Policy	2	1
Service Delayed	1	0
Service Reduced	1	0
Cost	1	0
No Issue Identified	1	0
Privacy/Confidentiality	0	2
Service Refused	0	1

Table 28: Disability complaint issues 2004-05 and 2003-04

What outcomes do we achieve?

This year we closed 32 disability complaints and the outcomes achieved for each of these are shown in table 29 below.

Resolved mainly in favour of complainant	2
Resolved partly in favour of complainant	4
Complaint not upheld	2
Unable to be determined	2
Complaint withdrawn or lapsed or not pursued by complainant	2
The Director has made a decision to reject a complaint as per s.37*	20

Table 29: Outcomes of closed disability complaints 2004-05

[* Note: These complaints are oral complaints which were not confirmed in writing as required under the Disability Services Act and thus were rejected by the Director.]

Why are some disability complaints are not confirmed in writing?

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

As in previous years, in an effort to determine why many complainants do not proceed with their complaint and confirm it in writing, each complainant was contacted by telephone or in writing after their initial contact with this office to see why they did not pursue their complaint with us. Half of the people we contacted said they had been able to resolve the matter with the service provider. Other reasons given were:

- They had been too busy to follow up the complaint;
- They did not want to pursue the matter;
- They had obtained advocacy assistance; or
- They had sought other options for resolution.

Only two complainants could not be contacted or did not respond.

Disability Complaints – the Year in Review

Complaint numbers

As mentioned above, consistent with previous years the number of complaints we received about disability services is relatively small in comparison to the number of complaints we received about health services. Discussions with our colleagues in other Australian States and Territories and also in New Zealand suggest that a similar trend in relatively low complaint numbers about disability services is also evident.

It is not possible to state categorically the reasons why the number of disability complaints we receive is relatively low.

However, it does appear that the existence in Western Australia of well developed complaint resolution processes at the service provider level results in a significant number of complaints and grievances being resolved at that level. Our follow up of complainants who do not proceed with a written complaint to us supports this contention. It is also fair to acknowledge that the Disability Services Commission plays an active and important role in developing these processes and promoting the resolution of complaints and grievances at the service provider level. Where complaints cannot be resolved at this level they should be referred to this office.

Another possible reason is a reluctance to complain on the part of some recipients of disability services. From our discussions with advocacy groups and service providers, it appears that some recipients of disability services, or their carers or advocates, may be reluctant to complain for fear of either losing their service or suffering some other form of retribution arising from the fact that a complaint has been made. In this regard section 47 of the Disability Services Act provides protection to ensure that people are not penalised because of complaining. Although we have not seen any specific examples of this kind of behaviour, we would be concerned if we received such an allegation and would vigorously pursue a complaint about this issue. Whenever possible, we do reassure complainants about the protection available under the Act.

This issue was one of many issues discussed at a recent forum we held for service providers, which was attended by representatives of the Disability Services Commission, other disability service providers and also advocacy groups. From these discussions there appeared to be a good understanding and appreciation of this issue and a genuine commitment to do as much as possible to ensure that those who wish to complain can do so without fear of loss of service or other forms of reprisal.

Individuals who may have concerns about this issue are encouraged to contact us for advice and assistance, such advice can be provided anonymously.

Disability forum and complaints network

In March 2005 we held a very successful forum for complaints officers within disability service provider organisations. This was one of the initiatives to arise from the review of our Office. One of the outcomes of the forum was an agreement to form a complaints network comprising representatives from disability service provider organisations, advocacy groups, the Disability Service Commission and this Office with the view to sharing information and improving the standard of complaints handling.

Significant progress has already been made towards the establishment of this network. It was particularly pleasing that the idea has been embraced so positively by all concerned. We view this as a very positive and beneficial step towards improving the overall quality of service delivery to people with disabilities.

Community outreach

We are about to appoint an Information and Community Liaison Officer for a twelve month fixed term. This was one of the recommendations arising from the review of our Office, however, at the time the report was considered by Government, the allocation of additional resources to fund this initiative was not possible. We received approval to proceed with a proposal to fund this project internally for a period of twelve months. The objective of the project is to develop and implement a targeted outreach program for both the health and disability community. The objective to raise awareness within the community about the role and functions of this Office. It is also hoped to be able to measure the effectiveness of this outreach program and evaluate the success or otherwise of the project.

We are confident that during the next twelve months we will be able to improve our profile significantly within the disability community. Whether this translates into an increase in complaint numbers remains to be seen.

Amendments to the Disability Services Act

In December 2004 amendments to the Disability Services Act came into effect. There was a number of quite significant changes relevant to the work we do. These included:

- Specifying the functions of the Director under Part 6 of the Act;
- Specifying the Director's relationship with the Minister, including that the Minister may:
  - give directions to the Director;
  - have access to information; and
  - refer matters for investigation;
- Providing the Director with the power to lay a report before each House of Parliament on any matter arising from an individual complaint or an investigation, or in relation to the performance of the Director's functions under the Act; and
- Providing for a referral at any time by either House of Parliament, or any committee of either or both Houses, of any matter relating to the provision of disability services or a particular disability service that the House or Committee considers should be investigated.

These changes remove many of the inconsistencies that existed between the Health Services Act and the Disability Services Act.

Independent review process for unsuccessful applicants for service eligibility

During the year we made recommendations to the Disability Services Commission that consideration should be given to the introduction of a process that would allow for an independent review mechanism for unsuccessful applicants for service eligibility. This recommendation arose from two complaints that we finalised during the year.

The Disability Services Commission accepted these recommendations and has made substantial progress in developing a policy to establish an appeals process for eligibility decisions. We were pleased to be given an opportunity to provide comment on the draft policy.

Once this policy is finalised and implemented we are confident that it will be a significant improvement for people who have been unsuccessful in their application for service eligibility to seek a review of that decision.

Care plans

The importance of having a written care plan that is agreed to by the parties cannot be emphasised enough. These plans provide for a clear understanding of the care to be provided to the person who receives the disability service. The kinds of matters that a care plan can and should cover is as diverse as the range of services that are provided to people with disabilities.

Care plans facilitate a clear understanding of the nature and type of services that are to be provided. They can and should cover the roles of carers, the level of care to be provided, the standards of the service to be provided, who will be involved in the care and what services will be provided.

A number of cases we handled during the year emphasised the need for care plans. The absence of a care plan or a care plan that was not readily available contributed to misunderstandings, breakdowns in communication and essential relationships and, ultimately, complaints. In one case the family of the person receiving care did not have an up-to-date care plan and were unsure about the level of care being given to their adult son. In this case, the absence of a care plan led to confusion about services to be provided, particularly, when casual carers had been engaged to provide support. This example emphasises the need for service providers and people with disabilities, and/or their families or carers, to agree on a written care plan before the service is commenced and for the plan to be available, particularly for casual carers engaged to provide care for the individual.

Care plans should also be reviewed regularly to ensure that they remain current. This is because care needs can change over time and also the level of funding to support the provision of care often changes. Regular review and updating ensures the plan remains current and is a reliable guide for carers.

Part 6:
Case Studies – Health and Disability

HEALTH CASE STUDIES

Case Study - Wrong information

A woman complained that a private radiology provider had refused to provide her with diagnostic films and the accompanying report when she requested them. The woman said that the staff told her that the x-ray and report would be sent to her referring doctor who would inform her of the result of the radiology studies. The woman wanted access to all of her present and future records from the radiology provider.

The response from the radiology practice included an apology to the woman because she had been given wrong information about access to her records. The provider advised that in relation to uncomplicated tests, their policy was to provide the patient with a choice of waiting for the results, having the films delivered to the referring doctor, or returning later to collect the results. They stated that for more complicated tests, they deliver the report and films to the referring doctor or the patient may return later to collect them. According to the provider, if the report is abnormal, it is their practice to contact the referring doctor to find out if he/she wants the patient to return immediately. They advised that the report is then forwarded to the doctor to deliver the results to the patient in a clinical context.

Enquires were made with the Office of the Federal Privacy Commissioner who administers the *Privacy Act 2001*. The advice received confirmed that, if requested, records should be made available to the patient (there were some exceptions, for example where access would pose a threat to life or health). They also advised that providing the records within 30 days was generally considered acceptable.

A copy of the radiology provider's policy in relation to patients accessing their studies and results was obtained by us. The information contained in the policy was not consistent with their response or with current privacy legislation. These concerns were provided to the radiology practice and they advised that they would amend their procedures to comply with the *Privacy Act 2001*. They advised that access to all reports, including those with abnormal results, will be provided to patients if requested to do so.

As a result of this complaint, the complainant was given access to her records and the radiology provider has reviewed and updated their privacy policy to reflect current privacy legislation.

Case Study – Inadequate pain relief in labour

A woman complained about the adequacy of the pain relief she was given during labour. She requested and received an epidural early on in the labour. Following insertion of the epidural, she received six 'top ups' which did not relieve her pain. Close to 5 hours from when she first complained of pain, it was decided that the epidural was not sited correctly and a second epidural was inserted and pain relief medication was administered with positive effect.

The first response to the complaint from the health service did not deal with the issue of the delay in responding to the failed epidural, except to say that the doctor was in theatre until

4:00am and therefore unable to assist. However, this was not a helpful explanation, as the woman did not start to complain of pain until 4:15am.

Independent advice was provided to us by an anaesthetist who works in obstetrics. The adviser stated that the delay in responding to the failed epidural was "disappointing and unacceptable". This independent advice was sent to both the complainant and to the provider and they were each asked to respond to the advice and offer suggestions to resolve the matter. A response was received from the provider, but it did not adequately address the issues. The provider was contacted again for a more complete response and we suggested that they should consider a reduction of the fees as a means to resolving the matter. The health service subsequently refused to reduce the fee as a way of resolving the matter.

Information was then provided to the CEO of the hospital regarding the ineffectiveness of the first epidural and the lack of other pain relief measures being given. A final response was received from the provider advising that they were simply not willing to waive any of the fees as a means of resolving the matter. The outcome sought by the woman was a reduction in the fee charged and we were unable to achieve that for her. The woman remained dissatisfied with the response from health service to her concerns but was appreciative of our efforts to resolve the matter. This was a disappointing outcome to the complaint, which, in our view, could have been resolved by the provider offering a reasonable compromise.

Case Study – Wrong procedure number documented

A woman complained that her husband had received an account for theatre costs for a surgical procedure that was two thousand dollars more than the estimate used when he had given financial consent for the admission. She advised that her objective in raising her concern was to have the outstanding account fee reduced.

The hospital responded with an apology and an offer of a 10% discount on the outstanding account. We established that the reason why the patient was given the incorrect fee estimate was because the incorrect procedure number was written on the patient fee estimate form. An estimate was given for a procedure number 30571 which is an open appendicectomy, and the patient had given consent to his surgeon to have the procedure performed laparoscopically, which is number 30572. We were unable to determine whether the mistake was due to an error made by hospital staff or by the surgeon's office staff giving the wrong information to the hospital.

The matter was resolved when the complainant accepted the hospital's offer of 10% discount on the outstanding account. Feedback was given to the hospital suggesting that they document the name of the procedure along with the procedure number when obtaining financial consent to avoid this type of confusion in the future.

Case Study - Provider proactive in resolving complaint

A woman complained that she had tried to seek mental health services in a regional area and was told that there were no services available for her. She complained to us about being denied services and also about the manner of the nurse who provided her with the information.

A copy of the complaint was sent to the Regional Director of the Health Service and it was then forwarded to the Manager of the Mental Health Service. The Manager arranged to meet with

the woman to discuss her concerns. The outcome of this meeting was that a plan was prepared for the women to receive ongoing mental health care from a visiting psychiatrist and the nurse involved was also made aware of how her manner was perceived by the complainant. This intervention by the health service led to a timely resolution of the woman's concerns.

Case Study – Problems after dental treatment

A woman complained about a public dental health provider. She said that after receiving treatment she experienced headaches and continual moderate to severe pain in her jaw. She also said her jaw locked from time to time and she could only eat soft or processed foods. A subsequent provider arranged for her to have a MRI assessment, which revealed a bulking of the discs situated in the Temporo-Mandibular Joint (TMJ). The subsequent provider said the problem with the TMJ was associated with a pre-existing condition, and the dental treatment may have exacerbated the problem. Although this matter was not resolved in favour of the woman, a recommendation was made to the provider that all patients undergoing treatment should be informed that problems with the TMJ could be a complication arising from treatment. The provider responded by saying that such complications were rare but, nevertheless, they agreed that patients undergoing treatment where the jaw must be held open for long periods of time and those who had a pre-disposition for problems with their TMJ would be informed of such a potential complication.

Case Study – Dental caps

A woman complained about treatment she had with a private dentist to have caps placed on her front teeth. She said that the dentist had twice replaced the caps on her teeth but they were still not the right contour and the colour did not match her other teeth. She also said that the caps had began to give off an offensive odour after a few weeks. The woman attempted to resolve the complaint directly with the dentist and, initially, he had agreed to refund the fees he had charged. However, the dentist did not follow through with this agreement and the woman eventually approached us for help. Our initial attempts to obtain a response from the dentist were unsuccessful. There were difficulties in making contact with the dentist who did not return phone messages or respond to any correspondence from this office. We commenced a formal investigation and issued a notice requiring the production of the woman's dental records. The dentist then spoke to the case officer and agreed to respond to OHR written requests for information. Following receipt of the response and a report from a subsequent provider, which suggested that the original work was unsatisfactory, the case officer met with the dentist to discuss the matter. As a result of this discussion, the dentist agreed to refund the fees paid by the woman. This outcome was accepted by the woman and the case was resolved to her satisfaction.

Case Study – No school nurse

A woman complained that her daughter, who is an unstable insulin dependent diabetic, was unable to go to school for a week because there was no school nurse on duty. The woman said her daughter was being discriminated against, as she was the only child who could not attend school during this time. Following our review of the matter, we established that a breakdown in communication had occurred between the Community Health Service and the Education Department. It appeared that the school nurse had been withdrawn but a breakdown in communication caused a delay in a replacement nurse being allocated. Our involvement prompted a review of the policies and procedures aimed at ensuring better communication

between the Health Service and the Department to prevent similar occurrences. A written apology and explanation from the Chief Executive Officer of the Health Service was also given to the complainant, which assisted in resolving this matter to her satisfaction.

Case Study – Missed diagnosis

A man complained that following a fall at home he presented at a small country hospital. The duty doctor suggested that the pain in his ankle was only a sprain and he prescribed analgesics and strapped the ankle. However, 3 days later the swelling had increased and the man was in considerable pain. He presented to his usual GP who arranged for x-rays to be taken and the man was diagnosed with a fractured fibula, which was broken in two places. The man was seeking an explanation and an apology. Our enquiries led to a response from the health service concerned with a written apology from the doctor and an explanation for what had happened. The matter was resolved to the satisfaction of the man.

Case Study – Follow up of test results

A woman complained about a health service she received from a GP. She said that the GP did not alert her to the results of blood tests and, consequently, there was a delay in her having appropriate treatment for an infection. The woman said that the delay in the treatment may have jeopardised her health. Our review of the matter could not resolve what had actually happened because some of the GPs at the medical centre used the computerised medical record system and others did not. There was no cross referencing between the written and computerised system which may have led to the GP who saw her not being aware of test results. Also, the administrative staff who were responsible for recording contact with clients about abnormal tests results did not retain the documentation once all clients had been contacted. A recommendation was made by us suggesting that a cross referencing system be put in place between the computer records and the hard-copy records and also create a telephone logging system to record details of follow up calls with test results, including recording who had been contacted, the number called, the time of call, and whether the client had made an appointment for follow up. Although we could not resolve the issues in dispute in this case, we were able to recommend improvements to avoid a similar situation arising in the future.

Case Study – Pethidine for migraine

A woman complained following her attending a medical centre to seek treatment for a migraine. Her usual doctor normally prescribed Pethidine as a treatment, but on this occasion another doctor prescribed an alternative medication and she appeared to experience a negative reaction to this. The woman said that she was not advised of the nature of the drug or its potential side effects before administration and, therefore, was not given a choice.

The doctor's recollection of the consultation was that he had discussed the nature of treatment and that consent had been informed. There was, however, no entry in the medical record to demonstrate this and because of this, it was not possible to satisfactorily resolve this issue.

The independent advice we received was that treatment of a migraine with Pethidine was not contemporary practice as there are issues of dependency and also Pethidine had been shown not to treat the underlying cause of the migraine.

This case highlights two problems with communication. The first is that the lack of an adequate entry in the medical record made it difficult to resolve this issue. The second is that within the same medical practice doctors appeared to be applying different protocols for treating a migraine. Although it is a matter for individual clinical judgement, this was confusing for the patient who had expected to secure her usual treatment.

We recommended that with regard to entries in the medical records the RACGP Standards of Practice should be followed to ensure that the practice meets the required standard, namely: "adequate medical records are essential for maintaining continuity of care, professional development and medico-legal protection", and also "patient medical records contain sufficient information to identify the patient and to document assessment, management, progress and outcomes." It was also suggested that the clinical staff of the practice should discuss our independent advice and consider a protocol in line with those generally followed in Emergency Departments, where it is made known that opioids will not be given as first line treatment for migraine.

Case Study – Procedure by Gynaecologist

A man complained on behalf of his wife, who was in her early 40s, about a procedure performed by a gynaecologist. The complainant and his wife did not have English as their first language. They complained that they did not understand the information provided to them during a pre-operative consultation and therefore they had not given informed consent to the procedure.

In response to the complaint the gynaecologist said that he told the patient that she required the removal of her left ovary because he had found cysts covering the ovary during a tubal ligation. He also said that she had told him that she suffered from heavy periods and he had recommended the removal of her uterus to treat this problem. He felt her husband understood the gynaecological concepts and that his wife had chosen him as her interpreter.

During the surgery the gynaecologist discovered that the right ovary was also covered by cysts so he decided to remove both ovaries and the uterus. The woman said she did not know she had consented to a full hysterectomy and was upset that she now needed to take hormone replacement therapy.

This complaint raised two issues namely:

- Informed consent and whether an independent interpreter should have been engaged to ensure the patient obtained all the relevant information; and
- Whether the gynaecologist should have removed the right ovary without first consulting the patient or trying other treatment options.

Independent expert advice obtained by us indicated that there was no urgency to remove the right ovary and the gynaecologist could have left the ovary in situ and then discussed his findings and other possible treatment options with the patient. In relation to the issue of informed consent, advice we received was that generally it was in a doctor's best interest to ensure that an independent interpreter and not a family member is used to ensure information is being interpreted accurately.

This information was provided to the parties who agreed to proceed with the conciliation to see if they could reach agreement on a financial settlement. The complainant and his wife prepared their own submission without independent legal advice, notwithstanding our encouragement to

seek legal advice on the matter. Their claim was for a very large sum and it was necessary for us to work with them to progress meaningful discussions between the parties.

After further discussions and reality testing of the submissions made by both the complainant and the provider it did not look like agreement was possible. Eventually, however, the provider, though his insurer, increased their offer and the parties agreed to settle the matter.

DISABILITY CASE STUDIES

Case Study – Appeal of an eligibility decision

We received a complaint from a woman who said that the Disability Services Commission (DSC) had refused to register her adult son as having an intellectual disability and therefore he was ineligible for funding and services from the DSC. During the course of our enquiries we established that the man had been assessed for eligibility on three separate occasions and on each occasion it was determined that he was ineligible because his intellectual disability was not manifest before the age of 18. This complex complaint identified two key issues. The first was whether the DSC's criteria for assessing eligibility was reasonable and second, was whether in this particular case the application was thoroughly and fairly considered.

In dealing with the first issue, considerable research was undertaken to consider the criteria used in Western Australia compared to that used in other States. It appeared from those enquiries that the definition of intellectual disability used by the DSC was consistent with the standard international definition and therefore the current eligibility criteria based on that definition was reasonable.

With regard to the second issue, it appeared that some information of early IQ testing prior to the man turning 18 may not have been available to the Review Committee in making the eligibility decision in this matter. Following discussion with the DSC it appeared they were reluctant to commission a full independent review of the eligibility decision. However, they agreed to forward the test results to a private psychologist with a view to obtaining an opinion as to the reliance the DSC might have on this evidence in making a judgement about whether or not the man had an intellectual disability that fell within the standard definition. The parents accepted this as a reasonable outcome of their complaint.

In addition, we also recommended to the DSC that they should develop an independent appeals process for unsuccessful applicants for eligibility funding. This recommendation was accepted and considerable work has already been done by the DSC on developing and implementing a policy for such an appeals process.

Case Study – Care plan

A woman complained on behalf of her adult child that the quality of care provided to her daughter by a non-government organisation was unacceptable. The incidents highlighted in the complaint were situations where the care was provided by casual carers engaged when her daughter's usual carer was either rostered off or on leave. During the course of this complaint we dealt with a number of specific issues that the complainant had raised as examples to support that the care was below the acceptable standard.

Following a review of the provider's response it became apparent that the organisation providing the relief carers did not have an up to date care plan or any formal means of recording and reporting day to day care provided by the carer. We recommended that the provider should not accept new clients unless they had a current written care plan. A written care plan assists the provider in engaging suitably trained relief carers and developing procedures to ensure that care is appropriately designed and delivered. We also recommended that they introduce of a system of regular written reports, including incident reports, which would enable effective monitoring of the standard of service delivered and resolving any issues of concern as they arise.

Part 7:
Customer Feedback and Complaints

Consumer and provider feedback

Following closure of each written complaint, a client survey form is sent to the complainant and provider inviting comment on the way in which the complaints resolution process was handled by us. This year we received 150 provider responses and 97 complainant responses. (Last year we received 126 provider responses and 100 complainant responses). Most respondents choose to remain anonymous and in several cases not all of the questions were answered.

The results from the surveys we received this year are set out below.

Complainant responses (97)

Question	Strongly Agree	Agree	Disagree	Strongly Disagree	No Answer
The staff were polite	73%	26%	1%	0%	0%
The staff listened to what I had to say	70%	27%	2%	1%	0%
The reasons for decisions were clearly explained	55%	37%	2%	1%	4%
The written information provided was easy to understand	54%	38%	1%	1%	6%
I found it easy to make contact with the office	58%	33%	5%	2%	1%
The staff were prompt in responding to my letters and phone calls	52%	34%	7%	4%	2%
I was kept informed of the progress of the complaint	50%	37%	8%	3%	1%

Table 30: Complaint Satisfaction

Provider responses (150)

Question	Strongly Agree	Agree	Disagree	Strongly Disagree	No Answer
The staff were polite	57%	29%	1%	0%	13%
The staff listened to what I had to say	55%	28%	2%	0%	15%
The reasons for decisions were clearly explained	52%	36%	2%	1%	9%
The written information provided was easy to understand	46%	46%	3%	0%	5%
I found it easy to make contact with the office	43%	38%	1%	1%	17%
The staff were prompt in responding to my letters and phone calls	40%	43%	6%	1%	10%
I was kept informed of the progress of the complaint	39%	46%	10%	1%	4%

Table 31: Provider Satisfaction

Outcomes*

		Yes	No	Number of responses
I was satisfied with the outcome of the complaint	Complainant	60%	37%	94
	Provider	89%	3%	138
I was satisfied that the complaint was dealt with in an unbiased manner	Complainant	76%	14%	88
	Provider	86%	3%	134

Table 32: Satisfaction with outcomes

*[*Note: Not all respondents answered these questions and the figures shown are a percentage of total respondents.]*

In addition to answering the specific questions set out above we also receive subjective comments from consumers and providers. Some of these are set out below.

Consumers

"I was very impressed with the follow up and follow through. I don't think anyone could expect any more."

"In our opinion OHR is run by courteous staff very efficiently."

"The process is extremely slow, ie too much time is given to the other party to respond."

"A prompt and professional service."

"I feel the office did not try hard enough to substantiate my complaint."

"I didn't expect a solution just some answers."

Providers

"Thank you, you continue to provide a useful service."

"The reply/response took a very long time to arrive and therefore many sleepless nights."

"I recommend a review of processing complaints whereby complaints need to be substantiated prior to contact with provider."

"A surprisingly very fair and objective service."

"I have always found the Office of Health Review staff to be very helpful polite and fair."

"I was very impressed by the whole process. I am only sorry that the claimant strung out the process and did not proceed to conciliation at the end of it."

"Overall outcome I suggest a scale rather than a yes/no, to take into account the extent satisfied. More realistic."

We are currently reviewing the process we use to obtain feedback, including the content of the survey we use and the timing of when we seek feedback. The review will consider whether the feedback we are seeking is appropriate and relevant to what we do. Our experience suggests that many individuals choose not to complete the survey form and we are looking for a way to encourage more people to respond. We are also considering whether there is a better way to survey major providers, such as public hospitals, rather than sending a survey form for each complaint. We recognise how crucial it is that surveys are designed to capture the views of all participants in the resolution process.

Complaints

Internal review

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 financial year there were 10 requests for an internal review.

In 9 of these cases the review resulted in the confirmation of the original outcome. In the remaining case, it was the provider who requested the review. While the reviewer did not disagree with the original outcome achieved by the case officer she addressed issues which had not been fully covered by the case officer and provided information that had not previously been given to the parties. This review therefore resulted in a more detailed explanation being given to both parties.

Ombudsman review

We also advise complainants and providers that they can complain to the Ombudsman if they are unhappy with the processes we followed. In 2004-2005 the Ombudsman received 8 new complaints about the Office of Health Review, and they finalised 8 complaints with the following outcomes:

Complaint withdrawn or not proceeded with	1
Discretion exercised	1
Referral back to the OHR	1
Not sustained	4
Sustained partly	1

In the matter that was sustained partly, the Ombudsman expressed the view that we could have pursued in more detail one aspect of the original complaint. We acknowledged this and wrote to both the complainant and the provider apologising for this oversight. The oversight, however, did not alter the final outcome of the original complaint to this office.

As at 30 June 2005 the Ombudsman had 4 complaints on hand about the Office of Health Review.

Part 8: Reporting

INDIAN OCEAN TERRITORIES

Performance report

In May 2004 we signed a service delivery arrangement with the Commonwealth Government to provide a complaints mechanism for residents of the Indian Ocean Territories of Christmas Island (CI) and Cocos (Keeling) Islands (CKI).

Status of services

The services we provide are in response to complaints about health or disability services from residents on CKI or CI. Complaints can be received about services provided on CI or CKI and also services provided in Western Australia on behalf of the Indian Ocean Territories Health Service.

The cost of us providing this service is fully recoverable from the Commonwealth.

Activities during the year

Outreach

During the year the Director, Eamon Ryan, undertook an outreach visit to CKI and CI together with the State Ombudsman, Ms Deirdre O'Donnell, and the Commonwealth Ombudsman, Professor John McMillan. We met with community representatives, Local Government officers, Commonwealth Government officers, health service staff and individual residents. We also set aside time to meet residents to accept complaints.

The visit was worthwhile and proved to be an excellent opportunity to raise awareness with the residents of CKI and CI about the role and functions of each agency.

Over the next few months we are going to develop brochures specifically for the different community groups on both CKI and CI.

From these visits it appears that there were few complaints about the health and disability services that are currently being delivered on CKI and CI. However, there were concerns raised about access to some services, such as breast screening for women and also assistance for travel to Western Australia for medical treatment. These community concerns were fed back to the Health Services Manager, who advised that they were taking steps to address these concerns.

Complaints

During the year we received two complaints about health services on CI. One complaint raised concerns about how the health service had responded to the complainant's health issues and the other was about a treatment issue. Both complaints were reviewed by us and eventually were not upheld. A detailed explanation setting out the reasons for this outcome was provided to the complainant and also the health service. We are currently conducting an internal review of one of these cases following a request for such from the complainant.

Costs:

Case 1	$ 622.00
Case 2	$ 460.00
Awareness visit	$7,671.00
Administration	$ 182.00
Total cost of services	$8,935.00

Performance indicators:

Cost per finalised complaint	$631.00*
Average time to close	488 days
Recommendations for improvement	NIL
Percentage of complaints finalised	100%

[* Note – does not include cost of the awareness visit.]

Future issues

We propose to continue with outreach activities for residents or CKI and CI by providing brochures which, once developed, will be distributed widely within the community and to community groups and the health services.

STATUTORY REPORT

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

GOAL 1 – People and communities

Agency specific reporting

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

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

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

We are in the process of appointing an Information and Community Liaison Officer for a period of 12 months. The role of this position will be to develop and co-ordinate the implementation of a community outreach program. This activity will be a significant means for us to meet this goal.

Obligatory reporting

Disability Access and Inclusion Service Plan outcomes

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

All of our publications, including our brochures, are available in braille or on audiotape, and are available on our website.

We are also in the process of establishing a complaints network for disability service providers and advocacy groups. This will enhance our ability to seek advice from the disability community to ensure our services remain relevant and appropriate for people with disabilities.

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

Cultural diversity and language services outcomes

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

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

Youth outcomes

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

GOAL 2 – The economy

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

GOAL 3 – The environment

Obligatory reporting

Waste paper recycling

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

Energy Smart Government Policy

Given that we have fewer than 25 staff we are not required to report on this issue. However, as part of our collocation with other agencies, we adopt strategies to minimise energy use, including minimising the use of lighting where possible. During the year we also decided to dispose of one office vehicle which we determined was not fully utilised.

GOAL 4 – The regions

Obligatory reporting

Regional Development Policy

Outcomes:

- Government decision making is based on a thorough understanding of regional issues.
- Effective government service delivery.
- Effective health service delivery.

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

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

We are a small office and, therefore, it is not practical to have a regional office. However, occasionally we are able to attend regional areas to meet with staff or complainants and, when we do so, we take the opportunity to promote our services to health and disability providers, consumers and advocacy groups in the region. This year we participated in three major regional events: The Albany Expo, the Wagin Woolarama and the Northwest Expo. These community outreach activities were undertaken with other accountability agencies collocated with us and were very successful. We also used these opportunities to meet with representatives and key stakeholders in those regional areas. These activities are covered in greater detail earlier in this report.

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

GOAL 5 – Governance

Agency specific reporting

Coordinated, integrated high quality service delivery to the community

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

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

We are collocated with the State Ombudsman, the Commonwealth Ombudsman, the Office of the Public Sector Standards Commissioner and the Freedom of Information Commissioner. This has provided a single entry point for members of the public, improved access to complaints mechanisms, a better understanding of how each agency operates and timely referral of matters between these agencies. Sharing services has also led to a reduction in resources used by each of the collocated agencies and the opportunity for us to conduct joint outreach activities.

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

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

Partnerships with the private sector are also a vital part of the work we do. We have good working relationships with many professional associations and various professional colleges regarding specific complaints and more general matters of interest.

We also have good working and referral relationships with advocacy organisations such as People with Disabilities and the Health Consumers' Council. Staff members also attend various community forums and use these opportunities to link into community networks.

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

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

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

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

Obligatory reporting

Equal employment opportunity outcomes

During the year 11 of the 13 staff employed by us were women. Women occupy 75% of senior positions in the office. Two main ethnic groups are represented within our staff.

All of our recruitment campaigns actively encourage applications from people with disabilities, young people or people from indigenous backgrounds.

Evaluations

There were no evaluations undertaken in 2004-2005.

Information statement

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

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

Freedom of Information statistics 2004-2005

Freedom of Information requests this year:	14
Number relating to personal information:	14
Number relating to non-personal information:	0
Number of requests finalised this year:	14
Granted full access:	6
Granted edited access:	6
Access refused:	0
Access deferred	2
Referred to another agency:	0
Number of reviews:	0
Requests for amendment of personal information: (amended fully in accordance with application)	1
Average time taken to process each application:	32 days
Charges raised for access to information:	0
Requests received from the media:	0

Enquiries about access to information under the *Freedom of Information Act* can be made to the Complaints Manager, Office of Health Review, GPO Box B61, Perth 6838 or (08) 9323 0600 and country free call on 1800 813 583.

The Office has brochures, complaint forms, information sheets 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 will also shortly be available on our re-designed website. Documents are available free of charge.

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

Report on Record Keeping Plans

We have an agreement with the Department of Health to be included as part of their Record Keeping Plan, this is part of the ongoing provision of corporate support we receive from the Department. The Department of Health's Record Keeping Plan was approved by the State Records Commission on the 15th July 2004. The Department has developed a business classification scheme and retention and disposal authority as part of the compliance process and intends to progressively implement these across the portfolio in conjunction with an electronic document and records management system over the next three years. The Department's intranet facility, to which we have access, addresses employee roles and responsibilities in regard to their compliance with the organisation Record Keeping Plan.

The efficiency and effectiveness of our record keeping system has not been evaluated, however, we intend to conduct such a review during 2007.

All staff are regularly reminded of our standard record keeping processes, both in relation to the complaints database and hard copies of information. New staff are given specific training in the area of maintaining and updating complaint files and records. Because we are such a small agency it is not necessary to conduct a formal review of the efficiency and effectiveness of our

record keeping training programmes. Compliance with our record keeping process is monitored through regular review by supervisors and mangers.

Compliance with Public Sector Standards and Ethical Codes

- Compliance with Human Resource Management Standards

The Office of Health Review has complied with the Public Sector Standards in Human Resource Management. All recruitment and selection processes are reviewed by the Department of Health, Human Resources Directorate. No applications were made for breach of standards review in 2004/2005.

- Compliance with Codes of Ethics and Codes of Conduct

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

Public Interest Disclosures

We have appointed a senior officer to be the Public Interest Disclosure Officer. Internal public interest disclosure procedures and information were developed and circulated to all staff.

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

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

Corruption prevention

In our work we encourage and expect the highest standards of ethical conduct by our staff. We do this by reinforcing and modelling such standards of behaviour. New staff on induction are informed of their performance obligations in this area. Copies of our Code of Conduct and the Public Sector Code of Ethics are included in our Procedures Manual, a copy of which is given to each new staff member.

In addition, each new staff member is required to undergo a criminal record screening check and take an oath or make an affirmation regarding faithful and impartial performance of duties and confidentially.

During the upcoming year we are going to review our Risk Management Policy and Code of Conduct to ensure that particular emphasis is placed on prevention of corruption and misconduct.

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 2004 – 2005. There were no such expenses incurred this year.

OPERATIONAL REPORT

General matters

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

Enabling legislation

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

Mission statement

We are committed to making health and disability services better through the impartial resolution of complaints. More information about our vision and values is set out earlier in this report.

Operations

The functions of the Director are specified in both of the Health Services Act and the Disability Services Act.

Generally, 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 people with disabilities, service providers, users and providers details of complaints procedures;
- 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 or care of people with disabilities 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 people with disabilities on the making of complaints, and to users on the making of complaints to registration boards; and
    - (ii) advice to users and people with disabilities as to other avenues available for dealing with complaints.

Administrative

Eamon Ryan was appointed as Acting Director in August 2002. This appointment continues until September 2005.

The position of Director is to be advertised and filled early in the new financial year.

The Office of Health Review has the equivalent of 13 fulltime permanent staff members.

We also have one fixed term (12 months) contract position, an Information and Community Liaison Officer. We have recruited a person to fill this position for a period of 12 months commencing in August 2005.

Research, promotions and publications

The Office of Health Review has not been directly involved in any formal research activities in 2004-2005. However, we have commented on, or made submissions to, various research projects being conducted elsewhere.

We promote our Office through brochures and complaint forms that are widely distributed and available on request. Staff participate in various activities to promote public awareness of our Office and some of those activities have been highlighted earlier in this report.

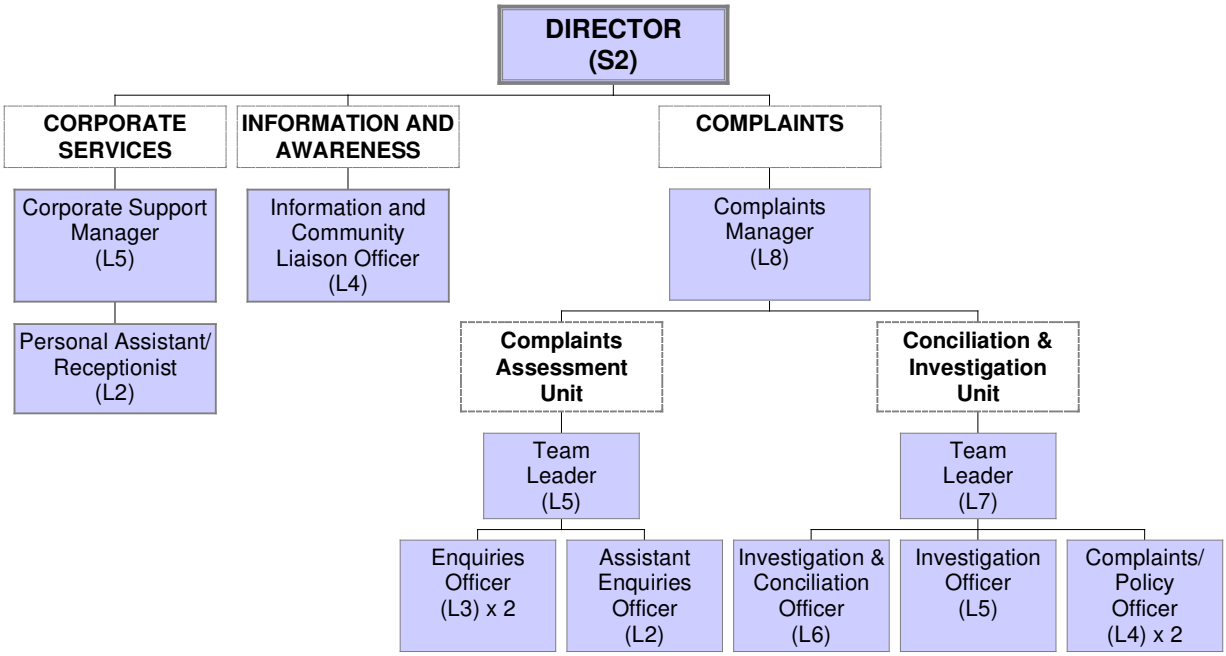
Declaration of Interest

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

Subsequent events

There are no events that have occurred between 30 June 2005 and the tabling of this report which may impact on operations.

Office of Health Review - Organisational Chart as at 30 June 2005

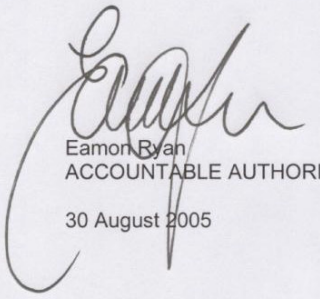


Certification of Performance Indicators

OFFICE OF HEALTH REVIEW

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 30 June 2005.



Eamon Ryan
ACCOUNTABLE AUTHORITY

30 August 2005

Independent Audit Opinion

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
PERFORMANCE INDICATORS FOR THE YEAR ENDED 30 JUNE 2005

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 30 June 2005.

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
11 November 2005

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

Performance Indicators

During the year we have made a number of internal changes. These include changes to our operational structure as well as how we deal with complaints. Because these changes affected how we deal with complaints it was considered prudent to delay finalisation of the review of our key performance indicators. This will now be undertaken during the coming year.

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

Efficiency Indicators	**2004-05**	**2003-04**	**2002-03**	**2001-02**
a) Cost per finalised complaint[11]	$608	$650	$639	$697
b) Number of days taken to finalise a complaint[12]	123 days	122 days	104 days	118 days

Effectiveness Indicators	**2004-05**	**2003-04**	**2002-03**	**2001-02**
a) Number of improvements in practices and actions taken by agencies/providers as a result of OHR recommendations[13]	47	38	40	59
b) Percentage of complaints finalised this year[14]	86%	83%[15]	96%	104%[16]

Additional information to assist in understanding the above performance indicators

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

Workload data as at 30 June 2005

Complaints on hand 1 July 2004	353
New complaints received	1741
Total complaints handled during the year	2094
Less complaints closed	1802
Balance	292
Complaints actually on hand 30 June 2005*	308

** To avoid double counting we do not count as new complaints matters that were closed as at the end of the previous year but subsequently re-opened during the current year. This explains why the number of active complaints on hand is greater than 292.*

---

[11] *Based on the accrual costs for the period 1 July 2004 to 30 June 2005.*

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

[13] *Many of these improvements are implemented over time, for example, where changes in policies require consultation prior to implementation. As at 30 June 2005 39 of these recommendations have been implemented, the remaining 8 are being followed up by us.*

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

[15] *In 2003/2004 we changed the way that this figure was reported. In previous years, the figure was taken as closed complaints as a percentage of new complaints. This year and in subsequent years, this figure represents closed complaints as a percentage of all complaints handled in the year.*

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

Age analysis of active complaints at the end of the year

0-3 months	210
3-6 months	32
6-9 months	15
9-12 months	15
12-18 months	21
18-24 months	10
Over 24 months	5
Total	308

Other indicators

Internal review

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 financial year there were 10 requests for an internal review.

Ombudsman review

We also advise complainants and providers that they can complain to the Ombudsman if they are unhappy with the processes we followed. In 2004-2005 the Ombudsman received 8 new complaints about the Office of Health Review, and they finalised 8 complaints.

As at 30 June 2005 the Ombudsman had 4 complaints on hand about the Office of Health Review.

Certification of Financial Statements

OFFICE OF HEALTH REVIEW

FINANCIAL STATEMENTS

CERTIFICATION OF FINANCIAL STATEMENTS

The accompanying financial statements of the Office of Health Review have been prepared in compliance with the provisions of the *Financial Administration and Audit Act 1985* from proper accounts and records to present fairly the financial transactions for the financial year ending 30 June 2005 and the financial position as at 30 June 2005.

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

Eamon Ryan
ACCOUNTABLE AUTHORITY

30 August 2005

Charles Spadaro
PRINCIPAL ACCOUNTING OFFICER

30 August 2005

AUDITOR **GENERAL**

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2005

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 30 June 2005 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
11 November 2005

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 2005

	Note	2005	2004
		$	$
COST OF SERVICES			
Expenses from Ordinary Activities			
Employee expenses	2	838,014	853,468
External Services	3	27,015	28,457
Depreciation expense	4	13,735	10,848
Carrying amount of non-current assets disposed of	5(a)	2,908	2,141
Other expenses from ordinary activities	6	234,482	244,896
Total cost of services		1,116,154	1,139,810
Revenues from Ordinary Activities			
Revenue from operating activities			
Commonwealth grants and contributions	7	20,410	0
Other revenues from operating activities	8	580	1,296
Revenue from non-operating activities			
Proceeds from disposal of non-current assets	5(b)	100	1,000
Total revenues from ordinary activities		21,090	2,296
NET COST OF SERVICES		**1,095,064**	**1,137,514**
Revenues from State Government			
Service appropriation	9	1,197,000	1,036,000
Resources received free of charge	10	4,556	15,550
Total revenues from State Government		**1,201,556**	**1,051,550**
CHANGE IN NET ASSETS		**106,492**	**(85,964)**
Total changes in equity other than those resulting from transactions with WA State Government as owners		**106,492**	**(85,964)**

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
For the year ended 30th June 2005

	Note	2005 $	2004 $
CURRENT ASSETS			
Cash assets	11	451,015	418,803
Receivables	12	16,726	5,902
Total current assets		467,741	424,705
NON-CURRENT ASSETS			
Plant and equipment	13	47,491	25,434
Total non-current assets		47.491	25,434
Total assets		**515,232**	**450,139**
CURRENT LIABILITIES			
Payables	14	0	2,569
Provisions	15	134,555	112,844
Other liabilities	16	0	33,420
Total current liabilities		134,555	148,833
NON-CURRENT LIABILITIES			
Provisions	15	19,447	46,568
Total non-current liabilities		19,447	46,568
Total liabilities		**154,002**	**195,401**
NET ASSETS		**361,230**	**254,738**
EQUITY			
Accumulated surplus / (deficiency)	17	361,230	254,738
TOTAL EQUITY		**361,230**	**254,738**

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 2005

	Note	2005 $	2004 $
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriation		1,197,000	1,036,000
Net cash provided by State Government		1,197,000	1,036,000
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(275,689)	(260,138)
Employee costs		(871,479)	(815,074)
Receipts			
Commonwealth grants and contributions		20,410	0
Other receipts		570	1,307
Net cash (used in) / provided by operating activities	18(b)	(1,126,188)	(1,073,905)
CASH FLOWS FROM INVESTING ACTIVITIES			
Payments for purchase of non-current assets		(38,700)	0
Proceeds from disposal of non-current assets	5	100	1,000
Net Cash (used in) / provided by investing activities		(38,600)	1,000
Net increase / (decrease) in cash held		32,212	(36,905)
Cash assets at the beginning of the financial year		418,803	455,708
CASH ASSETS AT THE END OF THE FINANCIAL YEAR	18(a)	451,015	418,803

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 2005

Note 1 Significant accounting policies

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

(a) General Statement

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

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

(b) Basis of Accounting

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

(c) Service Appropriation

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

(d) Acquisitions of Assets

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

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

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

(e) Plant and Equipment

Depreciation of Non-Current Assets

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

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

Computer equipment	5 to 10 years
Furniture and fittings	5 to 15 years
Other plant and equipment	5 to 15 years

(f) Leases

The Authority 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 Authority has no contractual obligations under finance leases.

(g) Cash

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

(h) Receivables

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

(i) Payables

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

(j) Accrued Salaries

Accrued salaries (refer note 16) represent the amount due to staff but unpaid at the end of the financial year when the end of the last pay period for that financial year does not coincide with the end of the financial year. The Authority considers the carrying amount approximates net fair value.

(k) Employee Benefits

Annual Leave

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

Long Service Leave

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

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

Superannuation

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

The superannuation expense comprises the employer contributions paid to the Gold State Superannuation Scheme and the West State Superannuation Scheme.

The Authority is funded for employer contributions in respect of the Gold State Superannuation Scheme and the West State Superannuation Scheme. The liabilities for superannuation charges under these schemes are extinguished by payment of employer contributions to the GESB.

Employee benefit on-costs

Employee benefit on-costs are recognised and included in employee benefit liabilities and costs when the employee benefits to which they relate are recognised as liabilities and expenses. (See Notes 2 and 15)

(l) Revenue Recognition

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

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

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

(n) Comparative Figures

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

		2005 $	2004 $
Note 2	**Employee expenses**		
	Salaries and wages (i)	729,420	746,145
	Superannuation	66,906	64,360
	Other related expenses	41,688	42,964
		838,014	853,469

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

The related on-costs liability is included in employee benefit liabilities at Note 15.

Note 3	**External Services**		
	Domestic charges	10	32
	Fuel, light and power	3,424	3,390
	Food supplies	1,504	1,077
	Purchase of external services	22,077	23,957
		27,015	28,456
Note 4	**Depreciation expense**		
	Computer equipment	9,687	6,824
	Furniture and fittings	761	948
	Other plant and equipment	3,287	3,075
		13,735	10,847

Notes to the Financial Statements
For the year ended 30th June 2005

			2005 $	2004 $
Note 5	**Net gain / (loss) on disposal of non-current assets**			
	(a)	Carrying amount of non-current assets disposed	(2,908)	(2,141)
	(b)	Proceeds from disposal of non-current assets	100	1,000
	(c)	Gain / (Loss) on disposal of non-current assets:		
		Furniture and fittings	30	(1,141)
		Other plant and equipment	(2,838)	0
			(2,808)	(1,141)
Note 6	**Other expenses from ordinary activities**			
	Motor vehicle expenses		3,507	1,333
	Insurance		8,529	10,951
	Communications		20,764	22,378
	Printing and stationery		19,835	12,682
	Audit Fees - external		12,500	0
	Repairs, maintenance and consumable equipment expense		19,367	24,796
	Rental accommodation expense		84,731	99,960
	Other		65,249	72,796
			234,482	244,896
Note 7	**Grants and contributions**			
	Commonwealth grants and contributions			
	Grant for provision of health and disability complaint services		20,410	0
			20,410	0
Note 8	**Other revenues from ordinary activities**			
	Revenue from operating activities			
	Other		580	1,296
Note 9	**Service appropriation**			
	Appropriation revenue received during the year:			
	Service appropriation		1,197,000	1,036,000

Service appropriations are accrual amounts reflecting the full cost of services 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.

		2005 $	2004 $
Note 10	**Resources received free of charge**		
	Resources received free of charge has been determined on the basis of the following estimates provided by agencies.		
	- State Solicitor's Office	4,556	15,550
		4,556	15,550
	Where assets or services have been received free of charge or for nominal consideration, the Authority recognises revenues (except where the contribution of assets or services is in the nature of contributions by owners, in which case the Authority 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 11	**Cash assets**		
	Cash on hand	400	400
	Cash at bank	450,615	418,403
		451,015	418,803
Note 12	**Receivables**		
	Accounts receivable	16,726	5,902
		16,726	5,902
Note 13	**Plant and equipment**		
	Computer equipment		
	At cost	66,204	76,711
	Accumulated depreciation	(41,917)	(69,337)
		24,287	7,374
	Furniture and fittings		
	At cost	14,129	14,129
	Accumulated depreciation	(4,884)	(4,153)
		9,245	9,976
	Other plant and equipment		
	At cost	29,779	35,269
	Accumulated depreciation	(15,820)	(27,185)
		13,959	8,084
	Total of plant and equipment	47,491	25,434

Reconciliations

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

	2005 $
Computer equipment	
Carrying amount at start of year	7,374
Additions	26,600
Depreciation	(9,687)
Carrying amount at end of year	24,287
Furniture and fittings	
Carrying amount at start of year	9,976
Disposals	30
Depreciation	(761)
Carrying amount at end of year	9,245
Other plant and equipment	
Carrying amount at start of year	8,084
Additions	12,100
Disposals	(2,938)
Depreciation	(3,287)
Carrying amount at end of year	13,959
Total plant and equipment	
Carrying amount at start of year	25,434
Additions	38,700
Disposals	(2,908)
Depreciation	(13,735)
Carrying amount at end of year	47,491

		2005 $	2004 $
Note 14	**Payables**		
	Creditors and accruals	0	2,569
		0	2,569
Note 15	**Provisions**		
	Current liabilities:		
	Annual leave	56,879	59,650
	Long service leave	77,402	51,033
	Superannuation	274	2,161
		134,555	112,844
	Non-current liabilities:		
	Long service leave	19,447	46,568
		19,447	46,568
	Total employee benefit liabilities	154,002	159,412

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

The Authority considers the carrying amount of employee benefits approximates the net fair value.

		2005 $	2004 $
Note 16	**Other liabilities**		
	Accrued salaries	0	33,420
		0	33,420
Note 17	**Accumulated surplus / (deficiency)**		
	Balance at beginning of the year	254,738	340,702
	Change in net assets	106,492	(85,964)
	Balance at end of the year	361,230	254,738
Note 18	**Notes to the statement of cash flows**		
	(a) **Reconciliation of cash**		
	Cash assets at the end of the financial year as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:		
	Cash assets (Refer Note 11)	451,015	418,803
		451,015	418,803
	(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)	(1,126,188)	(1,073,905)
	Increase / (decrease) in assets:		
	Receivables	10,824	5,902
	Decrease / (increase) in liabilities:		
	Payables	2,569	1,787
	Accrued salaries	33,420	(17,053)
	Provisions	5,410	(26,707)
	Non-cash items:		
	Depreciation expense	(13,735)	(10,848)
	Net gain / (loss) from disposal of non-current assets	(2,808)	(1,141)
	Resources received free of charge	(4,556)	(15,550)
	Net cost of services (Statement of Financial Performance)	(1,095,064)	(1,137,514)

		2005 $	2004 $

Note 19 Remuneration of members of the accountable authority and senior officers

Remuneration of members of the accountable authority

The number of members of the Accountable Authority, whose total of fees, salaries, superannuation and other benefits for the financial year, fall within the following bands are:

	2005	2004
$140,001 - $150,000	0	1
$160,001 - $170,000	1	0
Total	1	1

	$	$
The total remuneration of senior officers is:	164,822	149,147

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

The Senior Officer presently employed is not a member of the Pension Scheme.

Note 20 Remuneration of Auditor

Remuneration to the Auditor General for the financial year is as follows:

Auditing the accounts, financial statements and performance Indicators	13,500	12,500

Note 21 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	87,410	114,757
Later than one year, and not later than five years	87,410	229,514
	174,820	344,271

Note 22 Contingent liabilities and contingent assets

At the reporting date, the Authority is not aware of any contingent liabilities and contingent assets.

Note 23 Events occurring after reporting date

International Financial Reporting Standards

For reporting periods beginning on or after 1 July 2005, the Authority must comply with Australia equivalents to International Financial Reporting Standards (AIFRS) as issued by the Australia Accounting Standards Board. The potential impact of adopting AIFRS are detailed in Note 26 to the financial statements.

Note 24 Related bodies

The Authority had no related bodies during the reporting period.

Note 25 Affiliated bodies

The Authority had no affiliated bodies during the reporting period.

Note 26 Impact of Adopting Australian Equivalents to International Financial Reporting Standards

For reporting periods beginning on or after 1 July 2005, the Authority must comply with the Australian equivalents to International Financial Reporting Standards (AIFRS) as issued by the Australian Accounting Standard Board.

This financial report has been prepared in accordance with Australian accounting standards and other financial reporting requirements (Australian GAAP) applicable for the reporting periods ended 30 June 2005.

The impact of transition to AIFRS, including the transitional adjustments disclosed in the reconciliations from current Australian GAAP and AIFRS, are based on AIFRS standards that the Authority expects to be in place, when preparing the first complete AIFRS financial report (being the year ending 30 June 2006). Only a complete set of financial statements and notes together with comparative balances can provide a true and fair presentation of the Authority's financial position, financial performance and cash flows in accordance with AIFRS. This note provides only a summary, therefore, further disclosure and explanations will be required in the first complete AIFRS financial report for a true and fair view to be presented under AIFRS.

Revisions to the selection and application of the AIFRS accounting policies may be required as a result of:

(i) changes in financial reporting requirements that are relevant to the Authority's first complete AIFRS financial report arising from new or revised accounting standards or interpretations issued by the Australian Accounting Standards Board subsequent to the preparation of the 30 June 2005 financial report;

(ii) additional guidance on the application of AIFRS in a particular industry or to a particular transaction.

The rules for the first time adoption of AIFRS are set out in AASB 1 "First Time Adoption of Australian Equivalents to International Financial Reporting Standards". In general, AIFRS accounting policies must be applied retrospectively to determine the opening AIFRS balance sheet as at transition date, being 1 July 2004. The Standard allows a number of exemptions to this general principle to assist in the transition to reporting under AIFRS.

Reconciliation of Equity

The following table sets out the expected adjustments to the statement of financial position for the AIFRS comparative period balance sheet as at 30 June 2005

	AGAAP 30 June 2005	Transition Impact	AIFRS 30 June 2005
	$	$	$
Statement of Financial Position			
Cash assets	450,615	0	450,615
Receivables	17,126	0	17,126
Total current assets	467,741	0	467,741
Property, plant and equipment	47,491	0	47,491
Total non-current assets	47,491	0	47,491
Total assets	515,232	0	515,232
Provisions	134,555	(1,488)	133,067
Total current liabilities	134,555	(1,488)	133,067
Provisions	19,447	0	19,447
Total non-current liabilities	19,447	0	19,447
Total liabilities	154,002	(1,488)	152,514
NET ASSETS	361,230	1,488	362,718
Accumulated surplus / (deficiency)	361,230	1,488	362,718
TOTAL EQUITY	361,230	1,488	362,718

Reconciliation of net cost of services for the financial year ended 30 June 2005

The following table sets out the expected adjustments to the statement of financial performance for the year ended 30 June 2005

	AGAAP 30 June 2005	Transition Impact	AIFRS 30 June 2005
	$	$	$
Statement of Financial Performance			
Employee expenses	838,014	251	838,265
External services	27,015	0	27,015
Depreciation expense	13,735	0	13,735
Carrying amount of non-current assets disposed of	2,908	(2,908)	0
Net loss (gain) on sale of non-current assets	0	2,808	2,808
Other expenses from ordinary activities	234,482	0	234,482
Total Cost of Services	1,116,154	151	1,116,305
Total revenues from ordinary activities	21,090	(100)	20,990
NET COST OF SERVICES	1,095,064	251	1,095,315

Summary of impact on transition to AIFRS on accumulated surplus/(deficiency)

Accumulated surplus/(deficiency) as at 1 July 2004 under AGAAP	254,738
AIFRS reconciliation	
Adjustments in respect of the Employee benefits provisions	1,740
Accumulated surplus/(deficiency) as at 1 July 2004under AIFRS	256,478

Changes in accounting policies

The significant changes in accounting policies expected to be adopted in preparing the AIFRS reconciliations are set out below:

(a) Plant and Equipment

Under AIFRS the gain or loss on the disposal of plant and equipment will be recognised on a net basis as a gain or loss rather than separately recognising the consideration received as revenue. An amount of $100 is expected to be reclassified from revenue to expenses for the financial year ended 30 June 2005.

(b) Employee Benefits

Under current Australian GAAP, all annual leave and vesting long service leave are measured at nominal amounts. Under AIFRS, all employee benefits that fall due after 12 months are measured at the present value.

The adjustment to recognise the long-term employee benefits at present value is expected to reduce the liability by $1,739 as at 1 July 2004 and $1,488 as at 30 June 2005 and to increase the accumulated surplus by $1,739 as at 1 July 2004. For the financial year ended 30 June 2005, employee benefits expense is expected to increase by $251.

Note 27 Financial instruments

(a) **Interest rate risk exposure**

The following table details the Authority's exposure to interest rate risk as at the reporting date:

	Weighted average effective interest rate %	$	Non interest bearing
As at 30th June 2005			
Financial Assets			
Cash assets	0.0%		450,615
Receivables	0.0%		16,726
			467,341
Net financial assets / (liabilities)			467,341

(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 maximum exposure to credit risk.

(c) **Net fair values**

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

Note 28 Explanatory Statement

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

Reasons for significant variations between actual results with the corresponding items of the preceding reporting period are detailed below. Significant variations are those greater than 10% or that are 4% or more of the current year's Total Cost of Services.

	Note	2005 Actual $	2004 Actual $	Variance $
Statement of Financial Performance – Expenses				
Employee expenses		838,014	853,468	(15,454)
External Services		27,015	28,457	(1,442)
Depreciation expense	(a)	13,735	10,848	2,887
Carrying amount of non-current assets disposed of		2,908	2,141	767
Other expenses from ordinary activities		234,482	244,896	(10,414)
Statement of Financial Performance – Revenues				
Commonwealth grants and contributions	(b)	20,410	0	20,410
Other revenues from operating activities		580	1,296	(716)
Proceeds from disposal of non-current assets	(c)	100	1,000	(900)
Service appropriation	(d)	1,197,000	1,036,000	161,000
Resources received free of charge	(e)	4,556	15,550	(10,994)

(a) Depreciation expense
Replacement of 10 computer desktops and servers has increased the depreciation expense in 2004-05.

(b) Commonwealth grants and contributions
Funding of $20,410 received from the Commonwealth Department of Transport and Regional Services in accordance with the Service Delivery Agreement for services to the Christmas and Cocos Islands for 2004-05.

(c) Proceeds from disposal of non-current assets
Disposal of old computers and/trade-in of a photocopier.

(d) Service appropriation
$8,000 additional cash appropriation received for salaries.

(e) Resources received free of charge
Legal advice obtained from the State Solicitors' Office has decreased in 2004-2005.

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

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

	Note	2005 Actual $	2004 Actual $	Variance $
Operating expenses				
Employee expenses		838,014	866,220	(28,206)
Other goods and services	(a)	278,140	330,780	(52,640)
Total expenses from ordinary activities		1,116,154	1,197,000	(80,846)
Less: Revenues from ordinary activities		(21,090)	(20,410)	(680)
Net cost of services		1,095,064	1,176,590	(81,526)

(a) Other goods and services
Two critical savings in the operational expenditure were identified:
1. Office accommodation expense was reduced as a result of the government's collocation agencies initiative.
2. Management's decision to cancel the lease of a vehicle in January 2005.

Estimates of Expenditure for 2005-2006

The following Estimates of Expenditure for the year 2005-2006 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 Department of Treasury and Finance.

The following Estimates of Expenditure for the year 2005-2006 do not form part of the preceding audited financial statements.

Revenue	**2005/2006**
Consolidated Fund	$1,223,000

Appendix A:
Number of Complaints for Each Provider Type

	Number of complaints	Percentage of all health complaints
Acupuncturist	1	0.06%
Aged Care Hostel	4	0.22%
Alternative Health Service	2	0.11%
Alternative Health Therapist	9	0.50%
Ambulance Service	13	0.72%
Anonymous Individual Provider	1	0.06%
Chiropractor	12	0.67%
Community Health Service (Private)	20	1.11%
Community Health Service (Public)	26	1.44%
Counsellor	3	0.17%
Dental Hygienist	1	0.06%
Dental Prosthetist	12	0.67%
Dental Surgery	44	2.44%
Dentist	111	6.16%
Detention Centre	2	0.11%
Diagnostic Service	28	1.55%
Disability Services	32	1.78%
Government Department	12	0.67%
Hearing Service	9	0.50%
Hospital (Private)	100	5.55%
Hospital (Public)	355	19.70%
Locum Service	1	0.06%
Masseur	1	0.06%
Medical Practice	46	2.55%
Medical Practitioner	437	24.25%
Mental Health Service (Non Hospital)	31	1.72%
Naturopath	2	0.11%
Nurse (Registered)	2	0.11%
Nursing Home	11	0.61%
Optical Service	14	0.78%
Optometrist	46	2.55%
Other	8	0.44%
Pharmacist	11	0.61%
Physiotherapist	6	0.33%
Physiotherapy / Hydrotherapy	3	0.17%
Podiatrist / Chiropodist	2	0.11%
Prison Health Service	339	18.81%
Private Primary Health Care Service	1	0.06%
Prosthetist / Orthotist	2	0.11%
Psychologist	11	0.61%
Public Dental Service	22	1.22%
Retail Pharmacy	5	0.28%
Social Worker	1	0.06%
Speech Therapist / Speech Pathologist	2	0.11%
Therapeutic Councillor	1	0.06%
Grand Total	**1802**	**100.00%**

Table 33: Complaint numbers for provider types