THE HEALTH REVIEW
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Above: Geraldton Hospital

Regional Visit: Geraldton

OHR staff members visited Geraldton in July as part of the Regional Awareness and Accessibility Program facilitated by the State Ombudsman.

During the visit presentations and complaint clinics were held by OHR, the Ombudsman, the Office of Public Sector Standards and the Freedom of Information Commissioner.

The driving force behind the program is to improve access to OHR for our regional stakeholders and raise awareness of our agency and what we do. OHR officers also met with health and disability services staff during the visit, the next of which will be held in Mandurah in November.

Access to GPs an Issue

The Office of Health Review receives a large number of calls from people who have been refused service from a General Practitioner (GP).

The circumstances of refusal may vary. It could be that someone is new to an area and trying to find a GP, only to have a number of practices tell them that their doctors are not accepting new patients. Some people have been refused any further service due to a minor argument with their doctor or front-line staff.

Our current legislation does not allow us to accept complaints about a private practitioner refusing to provide a health service. A GP is considered a private business practitioner, and like any private business retains the right to refuse clients. Some people have also been told that they should find another doctor if there has been an altercation with the existing GP or their front office staff.

If people can't find or get access to a GP, often their only option is a public hospital out-patients clinic. (cont. next page)

Above: A 'hot topics' panel at the congress, l-r: Peter Condliffe, LEADR Chair Margaret Halsmith, Professor Nadja Alexander and Justice Jennifer Davies.

LEADR Congress 2009

During September OHR Director Anne Donaldson spoke at the LEADR Congress 2009 in Melbourne.

LEADR is an Australasian organisation that promotes and facilitates the use of dispute resolution processes including mediation (also known as alternative dispute resolution or ADR). OHR conciliation staff are currently planning to undertake LEADR accreditation as part of a professional development program.

The LEADR Congress involved a number of sessions based around the many facets and fundamental aspects of mediation and ADR such as negotiation, ethics, conflict and communication.

As processes that aim to circumscribe legal avenues such as the courts and legal action, mediation and alternative dispute resolution have much in common with the conciliation process practiced at OHR.

Ms Donaldson's presentation, Communication Matters in Health Care, was based around the importance of open communication in the health setting, particularly in relation to adverse events. The presentation also (cont. next page)

Welcome to the seventh edition of the Office of Health Review's newsletter, *The Health Review*. Any feedback or suggestions are welcome and can be sent to: mail@healthreview.wa.gov.au

(from previous page) It is often the case that the most popular GPs will have a busy practice, and as a result it may be difficult to schedule an appointment and long delays in the waiting room are likely.

Unfortunately, the shortage of GPs throughout Australia will apparently get worse, according to research published in the Medical Journal of Australia. Monash University's Dr Catherine Joyce and colleagues used simulation modelling and analysed recent industry trends that showed a steady increase in university medical places is needed to sustain Australia's medical workforce.

The research forecasts that while the total medical workforce will increase over the next few years, the GP workforce is likely to face chronic shortages. The findings also suggest that more doctors will move into specialist sectors, contributing to the decrease in the number of GPs. In response to current medical workforce shortages, five new medical schools have opened since 2000 and medical graduates are set to increase by 60 percent. However, a sudden growth in the nation's medical workforce may increase the risk of overcorrection.

The study suggested a smooth progression of workforce supply is needed to reduce the likelihood of extreme shortages or surpluses of medical staff. Other factors that need to be considered include the time-lag in training GPs, and the nature of the GP workforce, which is made up of an increasingly large number of female doctors working part-time. The average age of GPs is also increasing, suggesting that new graduates need to be encouraged into general practice.

Above: Anne Donaldson presenting at the congress

(from previous page) noted the rise of the patient safety movement and the increasing prevalence of litigation following an adverse event.

While the legal aspects of open disclosure are unclear and untested, Ms Donaldson noted that preparing patients for a possible adverse event may actually help to prevent litigation as long as patients are made aware of the risks and possible outcomes of procedures.

In a similar fashion, mediation, ADR and OHR's own conciliation model may promote open communication to resolve a complaint.

Ms Donaldson's presentation was part of a stimulating and entertaining program that made the congress a successful event for LEADR and all the attendees.

OHR 2008/09 Annual Report

The OHR 2008/09 Annual Report was recently tabled in Parliament, enabling us to release this important document to the public. This year the report responds to some new criteria in the field of occupational safety and health, as well as the State Government's strategic priorities.

As well as the required financial and accountability reporting, we have tried to give readers a broad overview of OHR's roles, objectives, planned outcomes and operational structure.

The most significant feature of the report is our analysis of the complaints that we have dealt with during the year.

The development of our new database has enabled us to produce a detailed complaints management report that includes an overview of our complaints process, trend analysis and a number of case studies (a summary of the complaints management report is presented on page four).

The report also features sections on the work undertaken in other areas and projects including community relations, risk management, legal services and open disclosure. To view the report online, go to the OHR web site here. Hard copies can be requested by phoning 9323 0607.

OHR Case Study

In each edition of *The Health Review*, we like to bring our readers case studies of issues we have dealt with that show the results we have achieved through conciliating complaints.

We recently completed an investigation into a complaint made against a disability service provider. The complaint related to the provision of care for a child who has a dual diagnosis of autism and an intellectual disability.

The complainant came to our Office because she felt that her son's respite service had been withdrawn unfairly. The child had attended the respite service for one-two days per month for around a year when his mother was told that the service could not be provided any longer due to the risk of injury to other children.

The child's mother felt that the provider had been unreasonable because, in her view, the provider had withdrawn the service without regard for the family, and she also felt that a large provider should be able to provide a respite service for children with high needs, as well as those with slight to moderate needs

The child's mother also felt that the service should have catered more to her child's needs, rather than the child having to fit within the parameters of the service being offered.

The mother had hoped that by coming to OHR the respite service could have been reinstated, with independent monitoring to ensure that the service being provided met her child's needs.

A conciliation meeting was held soon after we received the complaint. At the meeting, the child's mother noted the concerns she brought to us.

The provider's representatives claimed that their organisation was not suited to the provision of services to children with autism, and that they were primarily resourced towards providing services for children with intellectual disabilities.

The mother noted at the meeting that the provider cared for other children with autism and that the provider was aware at the time of offering the respite service the provider was aware of the child's dual diagnosis.

However, the provider felt that they did not have the resources to support the child and that the child had on a number of occasions caused physical harm to other children. The provider had tried to better accommodate the child by moving him to other facilities, but this was unsuccessful. The provider was unwilling to offer any further care to the child for these reasons.

The conciliation was not resolved to the satisfaction of the complainant. As our legislation dictates, the complaint then moved into the investigation phase. The focus of the investigation was to determine whether the provider acted unreasonably in denying access to its respite program. The terms of reference included whether the provider acted unreasonably by failing to implement a management plan for the child to remain in respite.

The investigation process was comprehensive and took some time to complete. It involved a number of meetings with the provider's representatives, independent psychologists and the child's mother, as well as the review of a large amount of information regarding the provider's policies.

The investigation concluded that the provider had not acted unreasonably in regards to the issues that had been raised. The reasons for this finding were that the provider had tried to implement strategies to modify the child's behaviour, and the service had been withdrawn in accordance with the provider's Entry and Exit Policy.

While the investigation reached these conclusions regarding the provider's actions, our staff member who conducted the investigation felt that there were some issues that could be addressed to improve the provider's services.

One of the most important issues was that the provider may have known that their service was not suitable for the child during their assessment but felt pressured to offer a place anyway. We made a number of suggestions to the provider, including that they:

- Review their processes regarding the provision of information to and making assessments of potential clients.
- Review the notices sent to clients upon the termination of services.
- Review their incident reporting process to ensure greater accuracy.

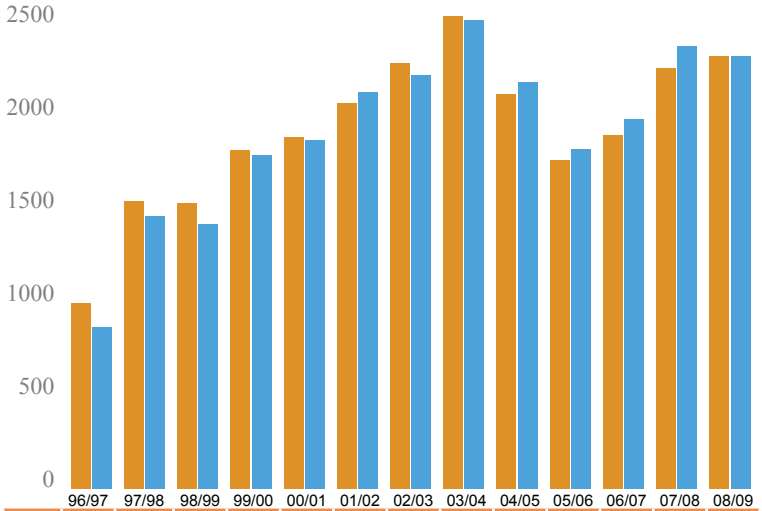
The provider gave us a comprehensive response to these suggestions, noting that the organisation had made a number of changes to its polices and procedures regarding each of the areas for which we sought a response.

In this case, we were not able to resolve the complainant's issues to their satisfaction. Conciliation failed to achieve the outcome that the complainant sought, and the subsequent investigation confirmed in our view that the provider had acted reasonably. However, as noted above, we felt that there were some areas where the provider could have improved or altered their procedures. It is hoped that by making these changes the chances of anyone in the future going through the same negative experiences as the complainant and her child will be reduced.

Complaint Statistics 2008/09

In our recent Annual Report we published complaint statistics for the 2008/09 year. Given that the annual data provides a good overall view of our activities during the year, we will look at some of the annual statistics in this section instead of the usual quarterly data.

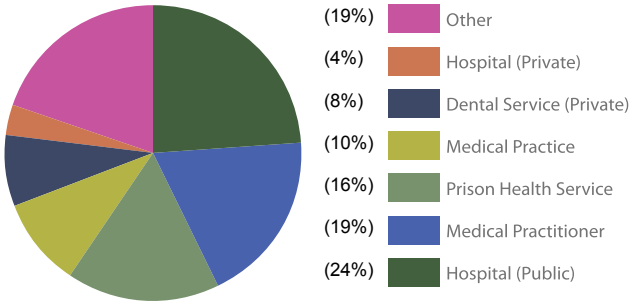
We began our analysis in the annual report by looking at the total number of new and closed enquiries and complaints since our inception in 1996. The graph below indicates a generally upward trend of increased public demand:



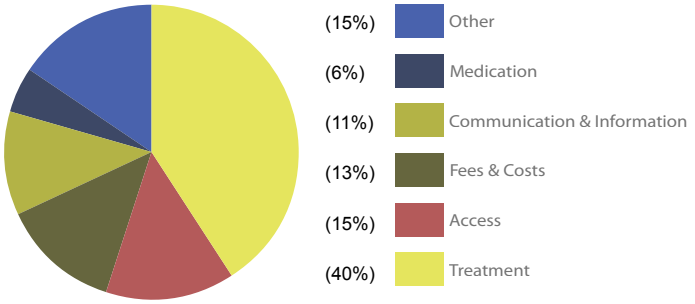
	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09
New	922	1432	1422	1685	1749	1917	2115	2350	1961	1635	1759	2092	2151
Closed	803	1354	1315	1659	1732	1974	2059	2333	2022	1687	1837	2202	2150

As the graph above shows, the number of incoming enquiries and closed complaints between 2007/08 and 2008/09 remained comparable. Its is also encouraging to note that the incoming contacts have steadily recovered from a low in 2005/06, where contact dropped fairly dramatically following a high in 2003/04.

The categories of providers that we received complaints about during the year are indicated in the graph below. Typically the providers we receive the most complaints about are also the ones that service the most consumers. As the graph shows, the provider types that we received the most complaints about in 2008/09 were public hospitals, medical practitioners and prison health services.



Above: Complaints by Provider, 2008/09

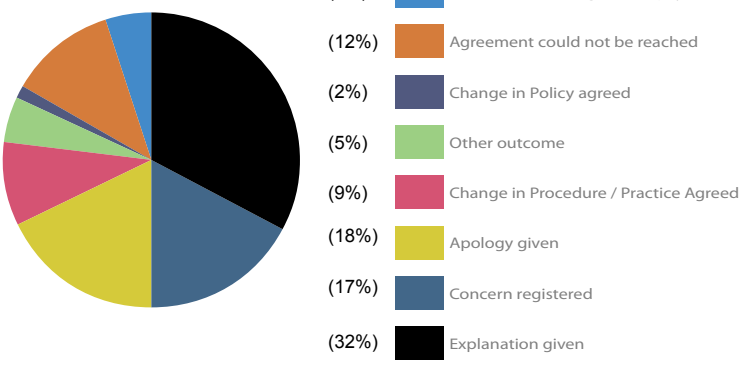


Above: Complaint Issues, 2008/09

The graph above shows that the most common complaint issues received during the year related to treatment, access, fees and costs and communication/information. We will look at each of these categories to provide some clarification:

- **Treatment** complaints are where a health treatment has been delayed, excessive, inadequate, unneccessarily painful, or if there was an unexpected outcome or complication.
- An enquiry or complaint involving **access** to health or disability services could involve access to a service facility, subsidies, a refusal to admit or treat, or the availability of a service. Complaints about waiting lists are also fundamentally an access issue.
- The **cost** of health or disability services relates to billing practices, cost of the treatment or compliance with financial consent.
- Complaints about **communication and information** relate to concerns regarding the attitude/manner of a service provider, inadequate or incorrect information or special needs not being accommodated.

The most important factor regarding any complaint that we receive is achieving a good outcome for the people involved. This may occur at any stage in the process. For example, our Assessment Team may resolve an enquiry simply by providing quality information or by referring someone to the appropriate organisation. In the graph below, we have shown the results achieved by the conciliation team during the year. As indicated, the most common outcomes included an explanation being given, concern registered, an apology being given and a change in procedure/practice agreed.



Above: Conciliation Outcomes, 2008/09

The **Office of Health Review** is an independent State Government agency established to deal with complaints about health and disability services.

Our mission: To improve health and disability services through the impartial resolution of complaints.

For more information about the office, please visit our web site at: **www.healthreview.wa.gov.au**

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