Office of Health Review

Annual Report 2008/09

'Creating strategic partnerships to promote safety and quality in health and disability services through dispute resolution'

Statement of Compliance

HON. DR KIM HAMES M.L.A.
MINISTER FOR HEALTH

In accordance with section 61 of the *Financial Management Act 2006*, we hereby submit for your information and presentation to Parliament, the Annual Report of the Office of Health Review for the financial year ended 30 June 2009.

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

Auditor General Act 2006;
Carers Recognition Act 2004;
Contaminated Sites Act 2003;
Disability Services Act 1993;
Electoral Act 1907;
Equal Opportunity act 1984;
Financial Management 2006;
Freedom of Information Act 1992;
Health Services (Conciliation and Review) Act 1995;
Industrial Relations Act 1979;
Minimum Conditions of Employment Act 1993;
Occupational Safety and Health Act 1984;
Public Sector Management Act 1994;
Salaries and Allowances Act 1994;
State Records Act 2000; and
Government and Ministerial Annual Reporting Policies.

Linley Anne Donaldson
DIRECTOR

7 September 2009

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Executive Summary

The 2008/09 year was a dynamic one for the Office of Health Review, which saw the establishment of some major projects and a continued commitment to effective dispute resolution for health and disability service consumers and providers.

Our main function of dispute resolution maintained the level of momentum that we had built up last year, with a similar number of complaints and enquiries coming into the Office. This resulted in the same level of activity across our Assessment and Conciliation Teams. A more streamlined process enabled us to generally resolve complaints more efficiently during the reporting year, as compared to those previous. We also managed several ongoing investigations during the year.

Throughout this report we have highlighted the importance of taking a fair, balanced approach to complaints. This is something that we strive for in dispute resolution as we are keenly aware of the impact that a complaint has on the consumer and the service provider. We have found that a resolution that is acceptable to both parties can leave all of those involved with a new sense of empowerment. Our vision is to promote this positive attitude towards dispute resolution to all the people that we deal with, be they a consumer or a provider.

As an agency that works closely with the public we endeavour to reach out to representative groups and organisations to improve our network coverage. Through the streamlining of the complaints management process we were able to develop our outreach program within established resources.

During the year we developed a strategic communications document with the aim of establishing different levels of engagement with a range of key stakeholders. In conjunction with our new strategic plan, this document will provide a blueprint for our business over the coming year.

The regional visits that we undertook during the year to Kalgoorlie and Geraldton offered us the opportunity to raise awareness of our Office and to meet with local health and disability service providers. We delivered a number of presentations to service providers regarding the prevention and handling of complaints. These liaison opportunities were beneficial and provided valuable guidance for OHR in understanding the options for creating meaningful dialogue with our regional stakeholder groups.

The proposed legislative amendments to the *Health Services (Conciliation and Review) Act 1995* and the *Disability Services Act 1993* were delayed in their passage through Parliament. The State Government election in September 2008 and subsequent suspension of Parliament led to delays. We are now hoping that the amendments will be passed by Parliament early in the 2009/10 year.

The amendments will enact a change in our name to the Health and Disability Services Complaints Office, which we feel will give us much more visibility and opportunities to improve our level of recognition. As well they will remove some inconsistencies between the processes for managing the resolution of health and disability complaints.

Staffing the Office provided some challenges and opportunities during the year. We saw the retirement of a long-standing corporate manager, which enabled a review of the position to place greater emphasis on corporate governance. We also developed a new recruitment strategy to enable us to streamline the employment of complaints management staff at short notice.

During the year our staff undertook substantial project work to support our main function of dispute resolution.

Our Legal Officer continued to work on the proposed legislative amendments, and also developed agreements between ourselves and some of our key stakeholders including the Medical Board and the State Coroner's Office. This work will underpin our future liaison with these organisations and provide a sound basis for future communication, resulting in many benefits for consumers and service providers.

The Open Disclosure research initiative has provided us with the opportunities for promoting systemic changes and brought together a range of industry

partners, who are now engaged in a project that is set to support the improved management of adverse health care events in Australia. It aims to promote better communication between service providers and consumers, and identify barriers to effective communication following an adverse event.

One exciting feature of the Open Disclosure project was the opportunity that we took to host a number of forums, which involved inviting an international expert in the field to speak to our WA audience in Perth and regionally by video link up.

Another significant project that was completed during the year was the work on our CRED database. The CRED database, which records all of the relevant information regarding consumer complaints, replaces our former database which was in danger of becoming unstable, and posing a significant risk to our business. CRED has given us improved access to complaint data and enabled greater analysis of complaint trends and identification of systemic issues.

I would like to acknowledge the help of the staff at the Information Technology branch of the Health Department in developing the database, which provided expertise and guidance during the planning, development and implementation phases of the system.

Training our staff has always been an important part of our business planning, as it enables them to develop a broad range of skills and competencies. During the year we provided staff with training across a range of areas including conciliation, freedom of information, project management and risk management. We are also in the process of applying for accreditation training for our conciliation staff, to facilitate a nationally recognised standard in mediation/ conciliation.

Finally, I would like to thank everyone at OHR for the excellent contribution that they have made during the year. Their resilience, vibrancy and flexibility have enabled OHR to continue making a positive contribution towards improving health and disability services for consumers and providers in Western Australia.

OHR Director Anne Donaldson

Our Vision, Mission and Planned Outcomes

Our Vision: Promoting leadership in effective communication

Our Mission: Creating strategic partnerships to promote safety and quality in health and disability services through dispute resolution

Our Planned Outcomes:

- Leadership and dialogue through engagement with stakeholders and communities
- Promoting research and development in effective communication and complaints management
- Quality service delivery

Operational Structure

The Office of Health Review (OHR) is an independent statutory authority. We are responsible for conciliating and investigating disputes between consumers and health and disability service providers in Western Australia and the Indian Ocean Territories.

Reporting to Parliament and the Minister for Health (for administrative functions), we operate under the legislative framework of the *Health Services (Conciliation and Review) Act 1995*. We also deal with complaints regarding disability services under Part 6 of the *Disability Services Act 1993*.

We are made up of three work groups. The majority of our staff are involved in complaint assessment, conciliation and investigation, which are our main functions. We have a legal, research and communications group which is involved in projects and programs that support the complaints functions of the Office. We also have a corporate executive group that leads and supports the Office as a whole. The Health Corporate Network provides us with some services, while we have an agreement with the Health Department to provide us with ICT support.

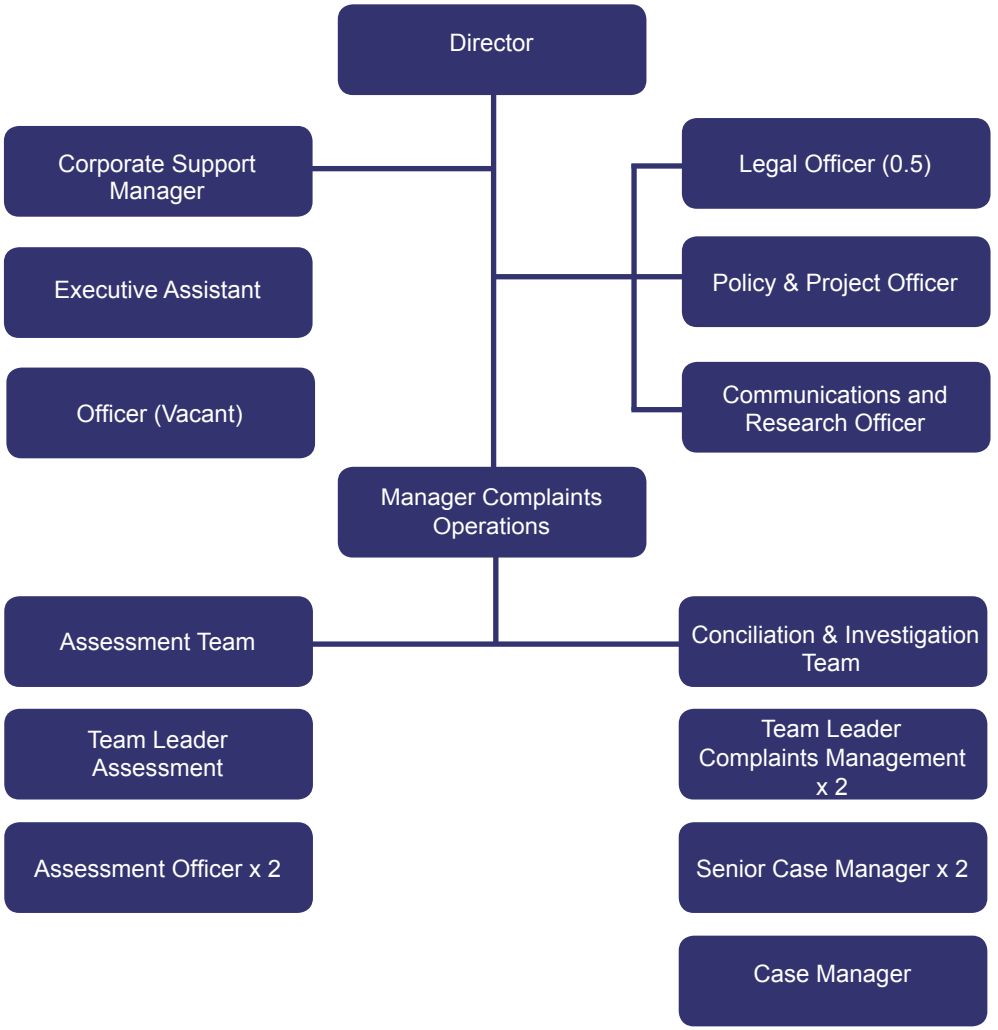
How We Operate

The Assessment team is the first point of contact for our clients, responsible for taking initial customer enquiries and identifying the key issues. The Assessment team determines whether the client's issues fit within the parameters of our legislation, and clarifies aspects and details of their complaint. The team also makes recommendations for future action or closure of the complaint.

We are mindful of the importance of being able to resolve issues for our clients efficiently. If we are not able to help people who contact our Office in the first instance, the Assessment team members are familiar with the range of services that assist people in different situations.

The Conciliation team is responsible for conciliating and investigating complaints referred to them by the Assessment team. Conciliation and investigation are complex processes that, among other activities, involve seeking, obtaining and reviewing information, convening conciliation meetings and making recommendations.

Office of Health Review structure as at 30 June 2009



The majority of complaints are dealt with via conciliation, with a small proportion going on to be investigated. When a matter is referred to investigation, our Director has a number of coercive powers under the Act including compelling a person's attendance in order to answer questions, and the ability to obtain a warrant to enter and inspect premises.

The health services that we deal with range across the various health professions such as medicine, dentistry and nursing, through to alternative health services, ambulance services and prison health services.

We also deal with complaints regarding a range of disability services including accommodation, therapy, in-home support and respite. We accept disability complaints not only from complainants but also from advocates and carers.

As an organisation, we endeavour to operate in a spirit of conciliation and cooperation with consumers and service providers, encouraging both parties to reach an agreed outcome. By doing this we aim to not only resolve consumer complaints but also to improve the overall quality of care delivered by health and disability service providers.

We do this by using the lessons learnt in our experiences with dispute resolution to provide feedback and information to providers and various bodies, such as registration boards and professional organisations.

While we hope to help consumers and providers by assisting them to resolve their disputes, we also strive to empower them during the conciliation process by conveying some of the dispute resolution methods and skills of our staff. This benefits both parties by equipping them with the skills necessary to deal with any similar issues that they may encounter in the future.

In order to be impartial and independent, we are mindful of the effect that complaints have on both parties involved in a dispute.

Performance Management Framework

In this section we are required to document links between Whole of Government goals and strategic outcomes and our work during the year. During 2008/09 we contributed to the following goals:

Financial and Economic responsibility

We aim to deliver services to the community in an efficient and cost-effective manner. During the year we were able to reduce the costs associated with conciliating each complaint (from the 2007/08 year), as well as the costs associated with delivering presentations to consumer and provider groups.

Outcomes Based Service Delivery

One of our main aims as an organisation is to improve the delivery of health and disability services through the resolution of complaints. We do this by providing feedback to providers in relation to the complaints that we deal with, and making suggestions and/or recommendations for improvement. This can be in relation to something relatively simple such as an administrative error, or something more complex like a systemic issue that has the potential to affect a large number of people.

Stronger Focus On the Regions

Our focus on the regions during the year was conducted through a number of avenues. These included:

Regional Visits

We visited Kalgoorlie and Geraldton as part of the Regional Access and Awareness Program that was facilitated by the State Ombudsman and included the Office of Public Sector Standards, the Freedom of Information Office and the Commonwealth Ombudsman.

During the regional visits we held presentations for local community groups and government agencies, convened complaint clinics for the local communities and met with key stakeholders such as staff from regional hospitals, disability services and prisons. Presentations on complaint handling were also held for service providers in Geraldton and Kalgoorlie.

Regional Conciliation Meetings

Face-to-face conciliation meetings are the preferred method of conciliation, and during the year we attended a number of conciliation meetings in regional centres. While holding meetings in regional areas involves extra time and expense, as an organisation we are willing to travel to regional areas for conciliation meetings as qualitative and quantitative analyses have shown that meetings conciliated in person lead to better outcomes for all parties.

Regional Involvement – Projects

During the year our work on the Open Disclosure project involved holding two presentations for health professionals, one of which was held in Bunbury at Edith Cowan University. The Bunbury presentation was well-attended by practitioners and other interested parties from the South-West.

Changes to Desired Outcomes, Services and Key Performance Indicators

Following advice from the Office of the Auditor General, we have changed some of our Performance Indicators from the 2007/08 year. These changes have been made so that our targets more accurately reflect those set out in our legislation.

Joint Delivery of Services and Co-contribution to Desired Outcomes

We did not co-deliver any of our services with other agencies during the year. However, we contribute to the desired outcomes of other agencies such as the WA Health Department and the Disability Services Commission by endeavouring to improve health and disability services through the methods described above in this section.

Agency Performance

Community Relations

Consulting, collaborating and building relationships with our stakeholders formed the basis of the year's community relations activities. As an organisation we value the benefits that good community relations brings to us and our stakeholders, and it is something that is practiced and embraced by all of our staff.

One of the highlights of the year was participating in the Regional Awareness and Accessibility Program facilitated by the State Ombudsman, which was also joined by the Commonwealth Ombudsman, the Freedom of Information Office and the Office of Public Sector Standards.

The program involved a number of staff visiting the regional centres of Kalgoorlie and Geraldton. The main events for the program included presentations to local government and community agencies, and complaint clinics that were set up to capture complaints from people living in the regions. We also used the time in the towns to go out and meet regional stakeholders such as hospital staff, disability services and prison health services, and we delivered presentations on complaint handling to local service providers.

In each town we also participated in some useful workshops with local Aboriginal people to discuss ways to improve accessibility to the collective agencies for them and their communities.

Participants at the RAAP meeting in Kalgoorlie, l-r Dr Ruth Shean (OPSSC), Anne Donaldson (OHR), Grace Grandia (FOI), Chris Field (State Ombudsman) and Sandra Pelham (Commowealth Ombudsman).

While presenting to other government agencies and community groups was useful, we found that the most successful activities involved going out and meeting our own specific stakeholder groups, and discussing any issues that they found important to them and their work.

The lessons that we learned from our experiences in Geraldton and Kalgoorlie will be carried over into the next visit which will take place in the Peel Region in the 2009/10 year.

A number of key publications were produced during the year, including our new Practice Standards and Service Standards, a compensation guide for consumers and a service provider's guide to resolving complaints. The production of these documents involved significant consultation with other organisations and interested parties. This was especially the case with the compensation guide, which has proven to be a valuable document for consumers who come to OHR seeking financial compensation as part of their resolution.

Our regular newsletter, *The Health Review*, has continued to be issued through our stakeholder database and has been well received. Requests have even been made for articles from the newsletter to be re-published in other publications. We also distributed a large number of brochures and posters to service providers and consumers.

We also continued to sustain our relationships with a number of organisations through the development of key projects. Our work in the field of Open Disclosure, which is based around promoting open communication between consumers and service providers, involved partnering with a number of stakeholders including representatives from the private, public and tertiary sectors. Discussion forums have also been held with representatives from agencies such as the Department of Corrective Services and the Inspector of Custodial Services.

The year was significant in terms of communications planning, a large part of which was underpinned by a revised strategic plan which will be implemented in the 2009/10 year. A significant stakeholder engagement plan was also developed during the year, which will be implemented in 2009/10.

Risk Management

During the year we developed a risk management policy, in consultation with Risk-Cover, to meet corporate governance guidelines for the State public sector. One area that we examined in particular was identifying potential or perceived conflicts of interest, something that is very important to us considering the confidentiality of our work.

In the 2009/10 year key staff members undertook training in risk management, which will ensure that we are aware of our responsibilities regarding identifying and controlling risk.

Christmas Island Hospital

The Indian Ocean Territories

In May 2004 we signed a service delivery agreement with the Commonwealth Government to provide our services to the populations of the Indian Ocean Territories; Christmas Island and the Cocos (Keeling) Islands. The island groups are non-self governing territories of Australia, administered from the Australian Capital Territory by the Commonwealth Attorney General's Department.

As part of our commitment to the territories, we try to visit each group on a bi-annual basis. One of our Team Leaders visited the Cocos-Keeling group during the year, and met with consumer representatives and service providers during the visit, including medical, nursing and dental practitioners, as well as members of the Cocos-Keeling Health Consultative Group.

We feel it is important for our representatives to go to the territories as they value the involvement and attention of a personal visit, and numerous opportunities arise to raise our profile among the communities. OHR will continue to honour its commitment to the territories with a visit during the coming year.

Geraldton Hospital

Office Refurbishment

In the *2007/08 Annual Report* we noted that the creation of new offices on another floor within our building would allow refurbishment of the main office. This planned refurbishment took place during the year and has resulted in a more open-plan workplace, which is an improvement on the previous fit-out. The refurbishment has also allowed the creation of two new offices.

Legal Services

During the year our legal officer initiated and collaborated on a number of projects that support the work of the Office. The major projects have been documented below.

Office of the State Coroner (WA)

We met this year with the Office of the State Coroner to discuss opening up and developing greater communication between the two agencies. An information and exchange policy was drafted, which provides for the exchange of information when;

- one agency requests information reasonably necessary to assist that agency to carry out its functions relating to a matter within its jurisdiction or the disclosing agency becomes aware that the other agency has received a complaint and the information held by the disclosing agency would assist the other agency to carry out its functions, or,
- it is reasonably necessary to share information, regularly or in appropriate circumstances, in order for one or both of the agencies to carry out its or their functions in an efficient manner.

This agreement is currently in draft form.

Medical Board of Western Australia

We signed a Complaints Referral and Management Policy with the Western Australian Medical Board. The Policy sets out our obligations and those of the Board regarding the referral and future management of complaints against medical practitioners registered in Western Australia. The new policy and its consultation process have promoted communication between the two organisations.

Physiotherapists' Board of Western Australia

We are in the process of formulating a Complaints Referral and Management Policy with the Physiotherapists' Board of Western Australia. As with the Medical Board, we anticipate that this will promote communication with the Physiotherapists' Board and allow a more effective complaint handling process in instances where a complaint may be dealt with either or both agencies.

We are also working towards agreements with the other health boards in WA.

Proposed Amendments to the *Health Services (Conciliation and Review) Act 1995*

We are in the process of guiding the proposed amendments to the *Health Services (Conciliation and Review) Act 1995* through Parliament.

The proposed amendments are designed to streamline the resolution of health and disability complaints, with the introduction of a 'negotiated settlement' alternative to complaint resolution.

The amendments will also reduce inconsistencies between the Health Services Act and the *Disability Services Act 1993* in terms of the processes involved in complaint handling. Several proposed amendments to Part 6 of the Disability Services Act would ensure that people with disabilities have equal access to the complaints process. For instance, the time period for making a health complaint will be increased to two years, which is consistent with the time period for making a disability complaint.

We are also seeking to change our name, through the proposed amendments, to the Health and Disability Services Complaints Office. This change will better reflect our role as the principal health and disability services complaints agency in Western Australia. It will also help to make the Office more visible and therefore more accessible to consumers.

Guidelines for the interpretation of the *Health Services (Conciliation and Review) Act 1995*

Our legal officer is in the process of establishing guidelines for the interpretation of the Health Services Act. These guidelines aim to ensure that our decisions are consistent and transparent for the community and health providers.

Consumer Records Electronic Database (CRED)

Our legislation asks that we keep a register of complaints, and since our office was established we had been using the same electronic complaints database. The original application stored all the relevant information about a complaint, including details regarding the parties to the complaint and the actions that had taken place.

By the end of the 2006/07 year the database held almost 100,000 actions for the 15,053 different cases that had been entered on the system. This caused many problems for the program's operations, which were exacerbated by the reliance on an outdated platform. The database was not compatible with other systems used in the Office and did not offer a great level of functionality.

Our equivalent agency in Victoria had developed a new database based on more modern technology, which they shared with us. We then commissioned a programmer to finalise this program over the 2007/08 financial year and tailored it to suit our needs. This culminated in the successful launch and rollout of our new CRED database, and all new complaints were recorded on CRED from 1 July 2008.

One of our biggest goals in implementing the CRED database was to enhance our ability to evaluate our performance. An example of this was measuring the timeframes in which we deal with complaints. CRED gives us the ability to flag systemic issues, distinguish between paper or meeting based conciliations and capture the demography of our consumers and complainants.

CRED is also more secure than our previous database, and will help ensure that our office can continue to improve and offer our insights into the causes of complaints in the health and disability sectors to the community.

At the Open Disclosure Forum, l-r, Lyn David (Dept Health), Prof. Rick Iedema, Tom Gallagher MD, Anne Donaldson (OHR), Dr Christine Jorm (ACSQHC), Imogen Curtis (ACSQHC).

Open Disclosure Research Initiative

The Office of Health Review supports the open discussion with patients of health incidents that either result in harm, or have the potential to result in future harm. This practice is called 'Open Disclosure'.

Two years ago we brought together a group of industry partners from the health, legal and insurance industries to find the best way forward for implementing this practice in WA. Together this research collaboration has produced several literature reviews defining Open Disclosure and identifying the legal issues it may raise.

During the year we began a series of forums convened to present information about Open Disclosure and involve audiences in a discussion. The first were forums held in Perth and Bunbury that covered Open Disclosure from the perspectives of a psychology professor, a health consumer who had experienced an adverse event and an experienced Perth clinician. This also involved a panel discussion that included each presenter, with a representative from the insurance sector.

In May we brought United States academic and clinician Tom Gallagher MD to Perth in partnership with the Australian Commission on Safety and Quality in Health Care. Together with health communications expert Professor Rick Iedema, Mr Gallagher presented his perspectives regarding Open Disclosure to a large audience. The forum was video conferenced to several sites throughout regional W.A.

This year we have plans to arrange a further forum around the legal components of Open Disclosure, along with some other research activities agreed to by the industry partners.

This initiative has linked us in with a national research advancement in the area of managing adverse events in health care. Together the research partners have sponsored research papers, hosted forums and discussed common barriers to Open Disclosure implementation. Key themes for planning are legal issues and developing core skills related to difficult conversations.

A range of representatives have partnered with us in this initiative including the Department of Health, Ramsay Health Care, St John of God Health Care, RiskCover, MDA National, Health Consumers' Council, Australian Medical Association WA and Edith Cowan University. We have also been supported by the Australian Commission for Safety and Quality in Health Care, the Val Lishman Health Research Foundation and various individuals.

John Pintabona at the Perth Open Disclosure Community Forum

Complaints Management Report

Introduction

Each year we assist and support a wide range of stakeholders, from community members to providers, to move toward a resolution of issues that arise in the delivery of health and disability services.

Our legislation asks that we keep a register of complaints and this financial year we launched a new database, which allows us to review complaints data in a more effective manner than ever before.

This year we have divided the Complaints Management Report into four sections:

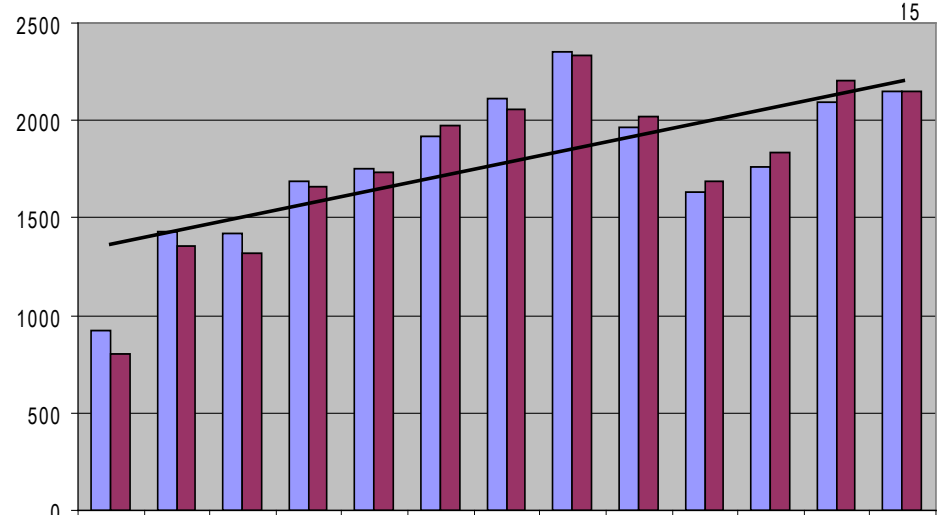
- Enquiry and assessment stage report
- Case management stage report
- Disability services complaints report
- Trend reports for:
    - Public hospitals
    - Prisoner complaints
    - Mental health services
    - Complainants and consumers.

Each enquiry coming into our office is different. Some issues are information-seeking in nature, and are dealt with at the enquiry stage. Other enquiries involve complex issues that need to be dealt with through conciliation.

This report will give information relating to each stage of our process and how we have performed.

In each annual report we compare the number of new and closed health and disability service related enquiries received since our office was established.

This year we have decided to include all of the enquiries that we received, not just the ones within our field of expertise. We do this to reflect every member of the public that we have assisted each year, as referring people to other organisations is one of our services. Earlier years have been updated with this information for accurate comparison.



	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
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

Graph 1 - Enquiries and complaints 1996/97 - 2008/09

The line on Graph 1 above represents the trend of new enquiries and complaints over time, indicating that contact with the public has increased steadily.

	2007/08	2008/09
Active enquiries and complaints as at 1 July	210	125
New enquiries and complaints received	1734	1732
Re-opened cases	25	15
Out-of-jurisdiction enquiries (closed)	358	419
Closed enquiries and complaints	1844	1731
Total enquiries and complaints handled	2327	2291
Active enquiries and complaints as at 30 June	125	141

Table 1 - Workload data 2007/08 - 2008/09

Table 1 above shows a comparison of our workload at 1 July for 2007/08 and 2008/09. It shows a similarity in workload between the two years.

Enquiry and Assessment Stage Report - Overview

The range of health and disability services can be complex and difficult for consumers to navigate. In many cases a person is unsure where to go to get the information they need and will contact us for advice.

Our Assessment Officers are familiar with the health and disability sectors and possess the knowledge to address the types of issues that come to us. If an Assessment Officer cannot assist a member of the public, they refer them to the appropriate body that can.

Any issue raised in relation to health or disability services is logged as a new case on our database. We do this to ensure that we have a field view of health and disability complaints on hand, which is useful for identifying trends and patterns.

A complaint moves from the enquiry to the assessment stage when we receive the complaint in writing and have all the necessary information to proceed. The assessment stage is where we evaluate the complaint to see whether it can be dealt with under our legislation.

The complainant must have made a reasonable attempt to resolve the health complaint directly with the provider before we can assess it. The reason that our legislation asks this is to give the service provider the opportunity to resolve the matter in the first instance.

We have found that some providers are very keen to address any issues as soon as they are made aware of them. By raising the matter with them directly, they have the opportunity to address the issue without delay, to the benefit of both parties.

We act quickly to support a member of the public where we can identify issues such as poor literacy, a linguistically or culturally diverse background or a reduced capacity to complain. This could mean making them aware of an appropriate advocacy service that could assist them to make their complaint, or arranging an interpreter service.

Case Study

A man complained to our office about a dental service he had received over a number of years. English was his second language and the issues he raised were complex.

As a result, we arranged an interpreter over the phone on two occasions. We also asked the man to come into our office, where we had arranged for an interpreter to be present. This allowed us to ensure we had enough information from the man in order to know how to proceed with his complaint. This ensured that he understood what was being said, and therefore was in a much better position to make a complaint.

Case Study

Our Assessment Officers received a number of telephone calls complaining that a medical practice was not releasing records after a doctor left. The callers implied that the medical practice was being deliberately obstructive by not releasing records. Eventually one caller gave us authorisation to contact the medical practice.

Apparently the doctor who left the surgery was refusing to allow the records to be sent to other doctors without him reviewing them first, which was delaying their release. The doctor threatened legal action if the medical practice did anything without his permission.

As a result of a call from the OHR, the medical practice obtained their own legal advice from their medical indemnifier. They were able to email the doctor giving him until a certain time the following day to collect the records or they would become the property of the practice.

The complaints were resolved when the doctor collected the files the following day from his former practice.

Active in enquiry stage as at 1 July	60
New enquiries	2151
Enquiry only (closed)	1389
Out-of-jurisdiction (closed)	419
Proceeded to assessment stage	343
Total handled at enquiry stage	2210
Active in enquiry stage as at 30 June	60

Table 2 - Enquiry stage workload data: 2008/09

Table 2 above indicates that our Assessment team dealt with a total of 2151 new enquiries. In most cases new enquiries are made by telephone. We are also able to handle enquiries made by letter, fax, email, through our website or in person.

Out-of-jurisdiction enquiries

This year there were 419 enquiries (19 per cent) that did not relate to health or disability service complaints. Our Assessment team refers people making this type of enquiry to another agency that can assist.

Some issues may on the surface appear to be health related, but other agencies are better able to assist. This is the case for issues such as faulty workmanship on a pair of glasses (DOCEP), food contamination (Environmental Health Officer in local shire), aged care (Department of Health and Ageing) or health insurance (Private Health Insurance Ombudsman).

Closed in enquiry and one-contact cases

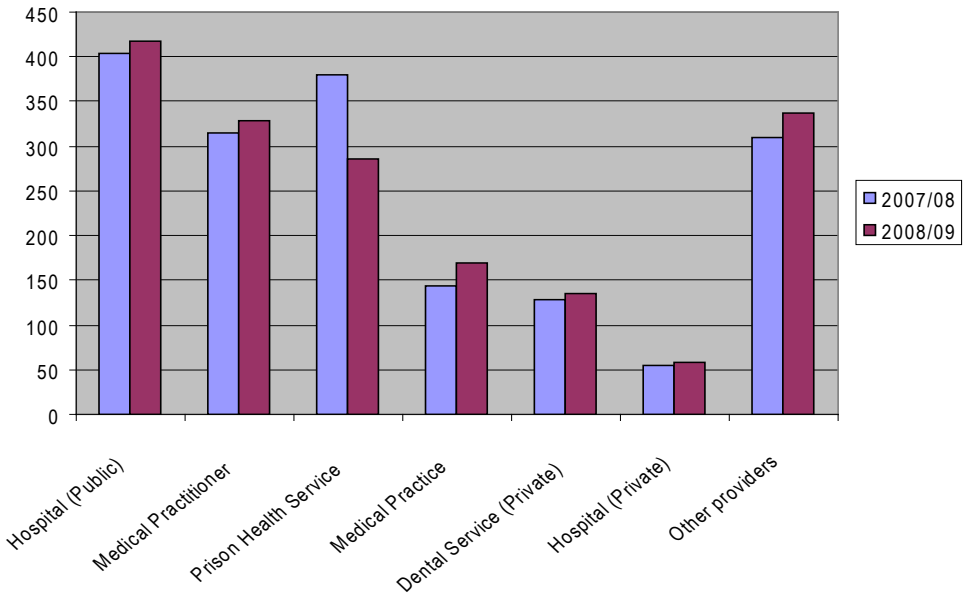
We find that some people contact us to discuss an event, rather than make a complaint. Once they have spoken to our Assessment Officers, they may not make a complaint because they have received the information that they were seeking.

In other cases, a potential complainant might not be able to make a complaint to us because their issue does not comply with our legislation. This would have been explained to them in their original contact with our Office. We would not expect cases like this to go beyond an enquiry.

At the end of the year, 1389 of the 1732 new health and disability complaint enquiries were closed in the enquiry stage. These files can be re-opened at any time, as long as they remain within our legislative timeframes. Should the complaint be submitted to our Office in writing or further contact made, the file would be re-opened.

Complaints regarding health and disability service providers

Typically the providers we receive the most complaints about are also the ones that service the most consumers. Graph 3 below indicates that the most common types of providers complained about in 2008/09 were public hospitals (417 complaints), medical practitioners (328 complaints) then prison health services (285 complaints).



Graph 2 - New complaints by provider: 2007/08 - 2008/09

While complaints against public hospitals and medical practitioners rose by 3.5 and 4.5 per cent respectively in 2008/09 compared with 2007/08, complaints against prison health services fell in the same period by 25 per cent. Complaints for medical practices increased 18 per cent, which is a significant change.

Issues raised by new complaints

When we receive a complaint or enquiry we aim to capture all of the issues raised, which we place in 18 broad categories. Some complainants raise more than one issue.This year almost 80 per cent of all issues raised related to the four most common complaint categories:

- Treatment (41 per cent)
- Access (14 per cent)
- Fees & costs (13 per cent)
- Communication & information (11 per cent).

Below we will explain what each of these issue categories mean, and what issues might present under each category.

Treatment

Treatment complaints are where a health treatment has been delayed, excessive, inadequate, unneccessarily painful, or if there was an unexpected outcome or complication.

This was our most common issue complaint category this year and was raised as an issue in 784 different complaints. In total there were 957 treatment issues recorded, as some complainants raised more than one issue.

Inadequate treatment	276
Unexpected treatment outcome/complications	211
Wrong/inappropriate treatment	143
Delay in treatment	82
Diagnosis	67
Excessive treatment	33
Rough and painful treatment	33
Inadequate consultation	32
Other	80
Total complaints with a treatment issue	**784**
Total treatment issues	**957**

Table 3 - Issues relating to treatment, 2008/09

Case Study

A consumer attended a dental clinic to repair the damage to a fixed partial denture, more commonly known as a ‘bridge’. A denture was fitted but the consumer was not happy with the appearance of the new denture, particularly in relation to the size and colour of the tooth.

The consumer wanted the teeth next to the denture to be re-enamelled and for the false tooth to be altered to match the other teeth. The consumer also asked for compensation and that the dentist pay for the treatment to be carried out at another clinic.

The provider was willing to enter into the conciliation process, however, they did not want to meet with the client. A paper based conciliation was selected as the way forward. During the conciliation process an independent opinion from a specialist consultant was obtained. They reported that the treatment was above the minimum standard expected from such a practitioner.

The provider offered to refund the cost of the consumer’s new bridge, but was unwilling to refund the cost of the initial consultation or temporary bridge. The consumer accepted this offer.

Access

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.

There were 316 different complaints that raised an access issue, and in total 332 different access issues were raised.

Refusal to admit or treat	207
Service availability	70
Waiting lists	25
Access to facility	17
Access to subsidies	10
Remoteness of service	3
Total complaints with an access issue	**316**
Total access issues	**332**

Table 4 - Issues relating to access 2008/09

Case Study

A prisoner had been booked for the last phase of an assessment to determine whether they were eligible for a specialised medical treatment. The appointment was cancelled when the prisoner was transferred to another prison.

When the prisoner's medical record arrived at the new prison, the assessment paperwork had gone missing. The prisoner thought he would have to start the assessment over again to determine eligibility for the treatment. This caused the prisoner a great deal of anxiety, as he wished to receive the treatment as soon as possible.

After receiving the complaint in writing, we contacted the prison's internal complaints unit. Following an investigation, the prisoner's medical record was updated with the missing report and the health service reviewed why this had not occurred earlier.

The prison's complaints unit then advised that the prisoner did not need to start the assessment from the beginning. The medical appointment was scheduled as soon as one was available on the public waitlist. This partially resolved the prisoner's concerns and the complaint was closed.

Fees & Costs

The cost of health or disability services was an issue for 17 per cent of complaints in the 2008/09 year. Where this was cited as an issue it related to billing practices, cost of the treatment, or compliance with financial consent.

Billing practices	182
Cost of treatment	89
Financial consent	37
Total complaints with a fees and cost issue	**272**
Total fees and costs issues	**308**

Table 5 - Issues relating to fees and costs, 2008/09

Case Study

A consumer consulted a dental prosthetist for a replacement upper denture. The customer was a member of a private health fund and assumed that the provider was registered with her fund, making her eligible for a rebate.

After having the work completed, the customer's total costs came to $3400.00. While the customer did not have any complaint about the quality of the denture or the service provided, she felt that the provider should have made it known to her that they were not registered with her fund.

The consumer was seeking a refund of $1500, which is approximately what she would have received had she been entitled to a rebate through that provider. The provider made an ex-gratia payment of $1500.00 to resolve the matter, and also undertook to provide information to future patients about what funds he was registered with.

Communication & Information

Complaints in this category relate to concerns regarding the attitude/manner of a service provider, inadequate or incorrect information or special needs not being accommodated.

Attitude/manner	157
Inadequate information provided	50
Incorrect/misleading information provided	41
Special needs not accommodated	15
Total complaints with a communication and information issue	239
Total communication and information issues	263

Table 6 - Issues relating to communication and information, 2008/09

Average time taken to assess a complaint

Our legislation asks that we assess complaints within 28 days of their receipt. We can extend this period by a further 28 days if it is to the benefit of the parties. The date the complaint is actually received is measured from when we have the complaint in writing and have enough information to assess the complaint.

Once we have enough information to proceed, we then have 28 days to accept, reject, or refer the case. In some instances a 28-day extension is granted, when more time is needed to assess the details of the complaint.

For new complaints received this year that were assessed, the median number of days taken to assess was 24 days.

Accepted complaints at assessment stage

As at 30 June 2009, 45 complaints were still under assessment and 71 complaints had been accepted. Accepted complaints can be referred to either conciliation or investigation.

The file might also be closed after being accepted. For example, the complainant may decide to withdraw the matter, or the complainant and provider may resolve the complaint themselves.

Closed or resolved at assessment stage

Our Assessment Officers were able to resolve 22 complaints at the assessment stage. Another 13 complainants told us that they were able to resolve their complaint after we referred them back to their service provider.

Case Study

A young man with symptoms of erectile dysfunction visited a suburban clinic and agreed to an 18-month treatment contract with payments over that period. He used the treatment for approximately one month and found that he had gained no benefit and suffered minor side effects. The medication was adjusted, and he then began to feel mentally unwell.

After visiting his local General Practitioner, the man discovered that he had been prescribed an antidepressant. His doctor informed him that the antidepressant was available on standard prescription through the Pharmaceutical Benefits Scheme at a much lower cost than what he had been paying the clinic. A family member contacted us to seek assistance, as it was their belief that the man had not been given a proper consultation for the treatment provided. The complaint was resolved at the assessment level when the provider offered to cancel the payment plan.

Case management stage report - Overview

Once a complaint is accepted, it is assigned to a case manager, who reviews the file and makes a decision of how to proceed with the complaint. Where appropriate, the case manager will accept complaints into our conciliation process.

Conciliation is achieved either through organising a meeting between the complainant, provider and their representatives (meeting based); or by sending letters back and forth between parties (paper based). All information exchanged throughout conciliation is confidential and cannot be used or shared with external parties.

The issues within the complaint and the outcomes sought by the complainant will determine whether we would recommend a meeting or paper based conciliation. We will explain what this means in this section.

We must investigate all disability service complaints that do not reach agreement in conciliation. Typically we would consider the option of investigation when a significant health complaint:

- fails to reach agreement with the parties in conciliation,
- is not appropriate for conciliation, or,
- involves a significant issue that is in the public interest to investigate.

Between 1 July 2008 and 30 June 2009 there were 133 complaints handled by case managers.

Active with Case Managers as at 1 July 2008	72
New complaints allocated to case managers	61
Complaints closed by case managers	64
Complaints closed by case managers outside conciliation	38
Total complaints handled	133
Active with case managers as at 30 June 2009	31

Table 7 - Workload data, Case Management Stage.

Conciliated complaints

Case managers closed a total of 102 complaints this year, conciliating 64 complaints.

- 28 conciliations (44 per cent) were meeting based
- 36 conciliations (56 per cent) were paper based.

	Meeting based		Paper based	
Agreement or partial agreement reached	24	86%	14	39%
No agreement was reached	4	14%	22	61%
Complaints conciliated	28		36	

Table 8 - Success of conciliation by meeting or paper, 2008/09

As indicated in Table 8 above, more successful outcomes were achieved in complaints where a meeting was held when compared with paper based conciliation. This could be partly due to parties who are willing to meet being more amenable to conciliation and more likely to come to an agreement.

In any event, we encourage conciliation meetings as we have seen how positive they can be for the parties involved.

We would recommend a conciliation approach involving meetings for complaints were the key issues involved related to communication, providing an explanation, an expression of regret or apology.

Paper based conciliation is recommended where the issues involved relate to fees and costs, and also where the relationship has broken down to such an extent that a meeting is not favourable. In such cases it can be difficult to get the parties together to reach agreement on how the complaint could be resolved.

Case Study

Following a health crisis, a patient was taken to the emergency department of a public hospital. The patient felt that information regarding transfer arrangements and discharge was not made clear, advising our office they left the facility with a cannula in their arm and without agreed transport arrangements.

The patient was concerned with the manner of the staff, and believed that they had not been provided with appropriate training to deal with the patient's mental health needs effectively. After several attempts to resolve the matter with the hospital failed, the patient lodged a complaint with us.

A paper based conciliation approach allowed information to be shared between the parties, and agreement was reached. The health service apologised for the communication issues, and agreed that action was necessary in order to prevent another patient from being discharged with a cannula in place. They agreed to review their processes and use the patient's case as a learning experience for staff.

Time taken to conciliate a complaint

The time taken to measure a complaint is calculated from the day the complaint form was lodged, to when the complaint was closed.

The median time taken to conciliate for complaints closed this year was 168 days.

When reviewing the meeting or paper based approach, the median time taken to conciliate a complaint was:

- 177 days where a conciliation meeting was held.
- 150 days where it was paper based.

The median time taken to schedule a conciliation meeting was 130 days, indicating that much of the time taken in a meeting based conciliation approach is spent organising the meeting and preparing the parties beforehand.

Once the meeting was held, the median time the complaint remained open was 32 days. This shows that once the meeting is held, many cases are finalised quite quickly and in most cases (86 per cent) reach some level of agreement.

Paper based conciliation may appear to be a speedier avenue, but from what we observe the provider and the consumer appear to spend a considerable amount of time drafting letters and then waiting for a response. This waiting period accounts for a lot of the time needed to conciliate a complaint by paper.

Paper and meeting based conciliation approaches can both work very well in the appropriate circumstances. For a successful outcome to be achieved, all parties must have a willingness to want to reach an agreement.

Case Study

A woman contacted us to discuss her belief that her doctor was unprofessional and uncaring towards her during her pregnancy. She described how the doctor was not present during the birth, did not make arrangements for another doctor to be there, and she felt she was not given sufficient care after the birth of her son.

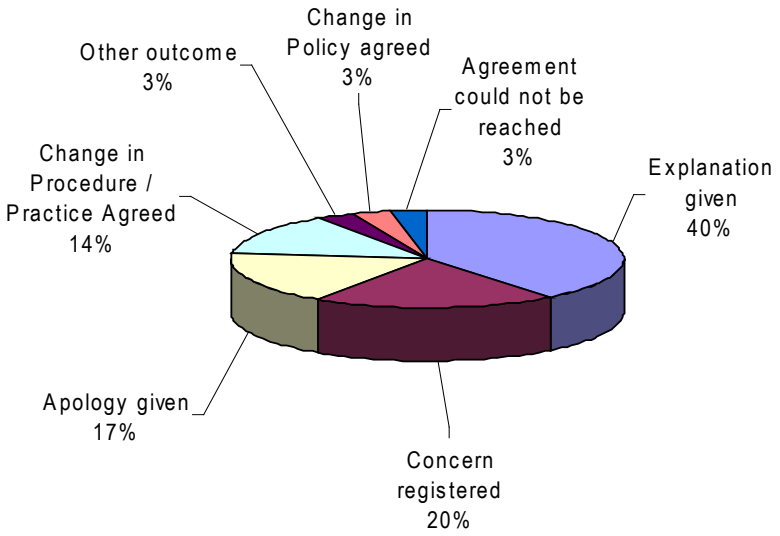
After assessing the complaint, we accepted it into a paper based conciliation as the woman did not want to meet with the doctor.

The conciliator met with the doctor to discuss the medical record. The doctor explained that he had missed the birth by ten minutes, but had arranged for another doctor to be present. He recalled that he had apologised to the patient at the time for missing the birth and thought that he had done everything he could to care for her and her son, visiting them daily. He put this explanation and apology in a substantial handwritten letter to his patient.

The woman had earlier expressed dissatisfaction that we could not discipline the doctor, and was not satisfied with the length of time taken for the doctor to respond to her issues. She could not be drawn back into the process to reach an agreement with the doctor, and the case was closed.

Outcomes achieved

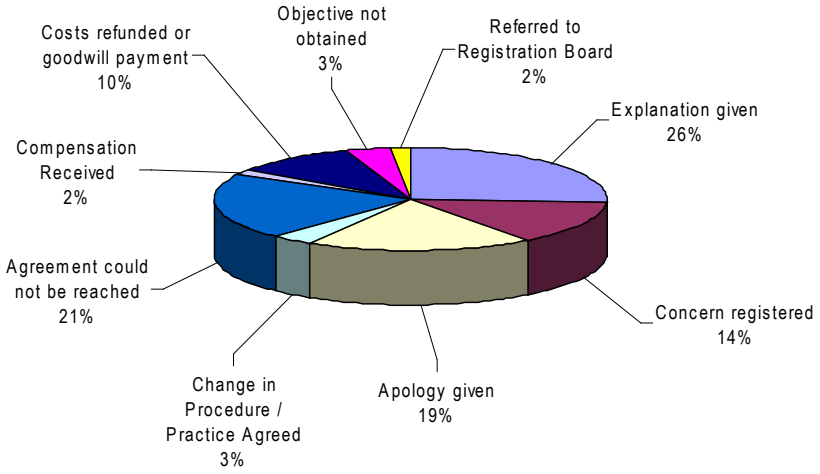
From the list of outcomes achieved for conciliated complaints, the most commonly achieved outcomes for all conciliated complaints was an explanation, concern registered, and an apology. The outcomes for meeting and paper based conciliation are compared in Graphs 4 and 5.



Graph 3 - Outcomes achieved for complaints conciliated by meeting, 2008/09

The outcomes achieved for each conciliation approach provide a similar insight to the issues involved in the complaints that were compared earlier. Notably, the paper based approach had more outcomes involving refunds as this is the route we encourage such a complaint to take.

It is also interesting to note that a greater proportion of outcomes where a meeting was involved achieved an explanation, or a change in procedure/practice or policy. Often when an individual complains they want to know what happened, and want to make sure this does not happen again to another person. A greater proportion of meeting based conciliations achieved this outcome this year than paper based conciliation.



Graph 4 - Outcomes achieved for complaints conciliated by paper, 2008/09

Case Study

A young woman who had a long history of severe asthma died during admission to a regional public hospital, while undergoing care for an acute asthma attack. The woman's family had multiple concerns relating to the treatment provided, and her father made a complaint.

A critical aspect of the case was the decision to not transfer the woman to a larger hospital with more sophisticated facilities. The family felt that if they had been consulted more, a different decision may have been made. While other factors were involved, from the regional hospital's point of view part of the issue related to the lack of available beds in the larger hospital.

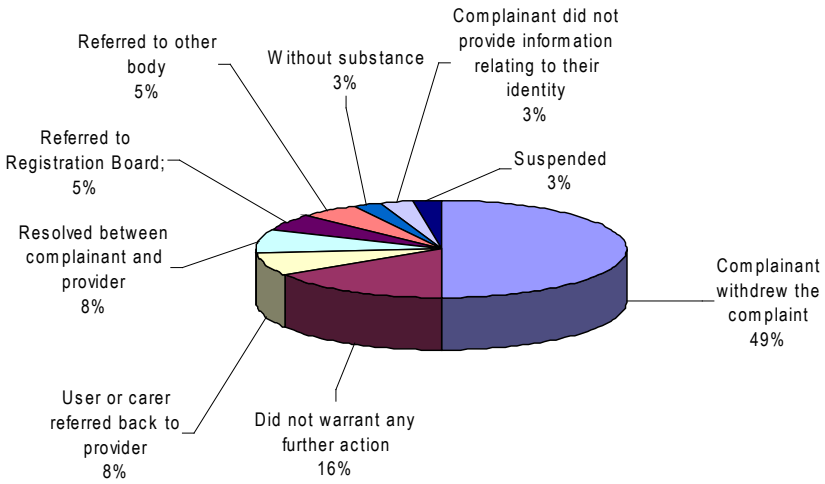
During the conciliation process, the representative from the regional hospital expressed deep regret for the distress and grief experienced by the family. The family was advised that as a result of their complaint the hospital was negotiating an agreement with the larger hospital to keep beds available for transfers. This would enable future transfers to occur with greater ease. This agreement was scheduled for enactment in 2009.

Case managed complaints that were not conciliated

Once a file has been allocated to a case manager, it might not proceed through to conciliation for a number of reasons, such as:

- the complaint was referred to another body
- the issue was resolved between the parties outside of our process
- the complaint was withdrawn.

This year case managers were assigned 38 complaints that were closed outside of conciliation. Almost half (19) were withdrawn, four were referred to other bodies, and three were resolved outside our process.



Graph 5 - Closure categories of non-conciliated case management complaints 2008/09

Investigations

Our investigations are a formal process prescribed by our legislation, and are typically reserved for the most serious health service complaints. All disability service complaints where agreement is not reached must be investigated.

The investigation is undertaken in order to determine whether the service provider was reasonable in providing or not providing the service. The case manager investigating the case makes recommendations for remedial action to the provider if found to be unreasonable. The provider must respond to these recommendations for remedial action.

There were six active investigations this year, including an investigation closed in 2007/08 that was active while the provider was reporting remedial actions taken. Five of the six investigations involved a complaint against a disability service.

This year one investigation was closed and the Director found that the provider had acted unreasonably in the manner in which they provided a disability service. The provider had been very cooperative and open throughout the process, and recommendations were made to prevent the reoccurrence of a similar issue. While closed, the investigation was still active as we reviewed the progress the provider was making to implement the recommendations.

When we investigate a complaint, it involves an intensive program of gathering information and evidence from all parties which can take a long time to complete.

The complaint closed this year was open in investigation 532 days. The average length of time taken to date to investigate the complaints active this year was 494 days.

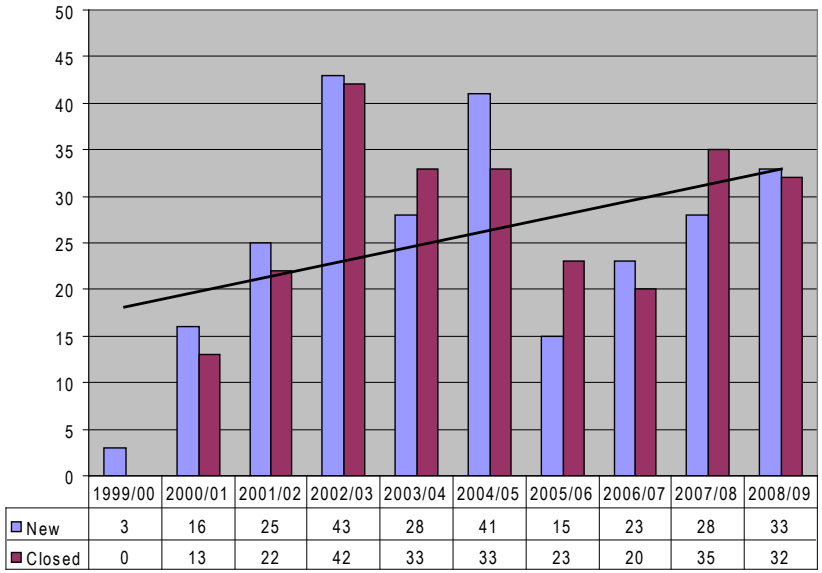
Disability Service Complaints Report

Since 1999 the Office of Health Review has accepted complaints about disability services under Part 6 of the *Disability Services Act 1993*. We thought that this year it would be timely to reflect on what has been achieved over ten years of dealing with disability service complaints.

The number of enquiries and complaints related to disability services that we deal with over the past ten years has, on average, slightly increased each year.

While following a similar pathway to health service complaints, disability complaints differ in three key ways. According to the legislation, a consumer of a disability service:

- does not need to complain to their service provider before making a complaint to us;
- can complain about an issue up to 24 months after it occurs, instead of 12 months as for health service complaints; and,
- has their complaint automatically investigated if the issue cannot be resolved in conciliation.



	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
New	3	16	25	43	28	41	15	23	28	33
Closed	0	13	22	42	33	33	23	20	35	32

Graph 6 - New and closed disability service complaints and enquiries: 1999/00 to 2008/09.

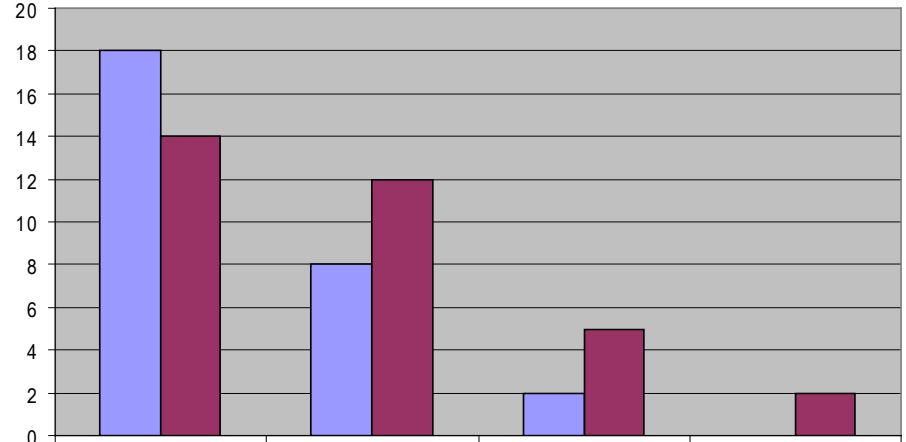
Active complaints as at 1 July 2008	4
New enquiries and complaints received	33
Total number enquiries and complaints handled	37
Number of enquiries and complaints closed	32
Active complaints as at 30 June 2009	5

Table 9 - Disability Workload data, 2008/09

New enquiries and open complaints

As Table 10 above indicates, we received 33 new enquiries that related to disability service complaints in 2008/09, five more than the year before. Of these 33 new enquiries, seven complaints were submitted in writing to be assessed under our legislation, 25 were closed at the enquiry stage, and one is currently open. There were five complaints open as at 30 June 2009, with four under investigation and one complaint in the enquiry stage.

Enquiries and complaints were made about non-government service providers, the Disability Services Commission and public authorities. Two consumers did not wish to name their provider.



	Non-government service provider (not for profit)	Disability Services Commission	Public authority	Anonymous
2007/08	18	8	2	0
2008/09	14	12	5	2

Graph 7 - New disability service complaints by provider type: 2008/09.

Enquiries relating to the Disability Services Commission increased by 50 per cent, but this only represents a small increase from eight enquiries in 2007/08 to 12 enquiries in 2008/09. Enquires against non-government service providers fell by 22 per cent, representing a fall from 18 enquiries to 14.

Number of enquiries and complaints finalised

During 2008/09 we closed 32 disability enquiries and complaints. This included seven complaints that were submitted in writing and 25 closed in the enquiry stage.

Complaints finalised

The reasons for a complaint leaving the enquiry stage include the complaint being progressed to the assessment stage of our process, or if the complaint has been closed. If a complaint is closed because we did not receive a written follow-up, the complaint can be reopened at any time, if the complainant wishes.

Did not return to make a complaint	19	59%
Proceeded to assessment	7	22%
Remained anonymous	2	6%
Does not warrant further action	2	6%
Did not provide requested information	1	3%
Does not comply with Act	1	3%
Total complaints finalised	32	

Table 10 - Outcome of finalised disability service complaints, 2008/09

Once a complaint is made in writing, it moves to the assessment stage to see if it can be accepted under our legislation. The outcome of the seven complaints that proceeded to the assessment stage is charted below.

Does not comply with the Act	2	29%
Deferred	2	29%
Withdrawn	1	14%
Does not warrant any further action	1	14%
Conciliation complete - settlement reached	1	14%
Total complaints assessed	7	

Table 11 - Outcome of assessed disability service complaints, 2008/09.

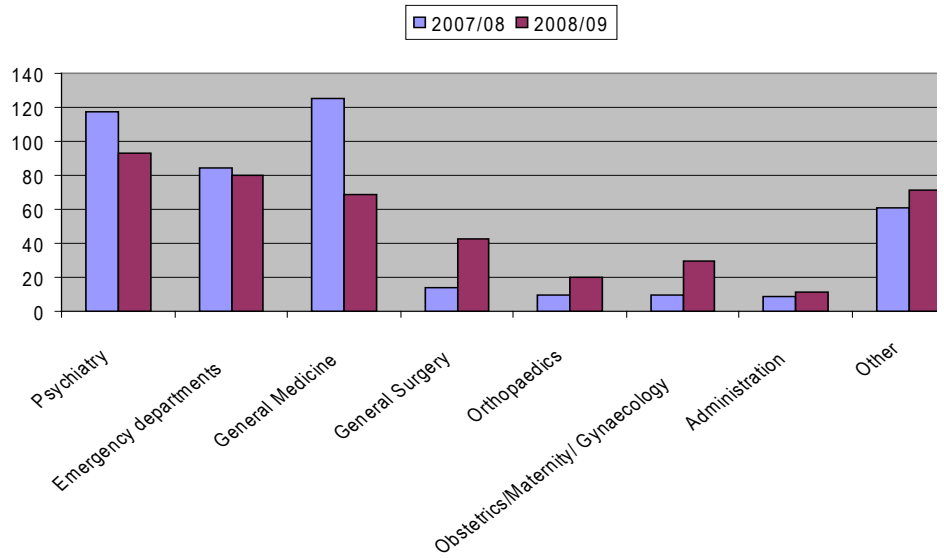
We defer dealing with complaints that are being dealt with under another written law, a law of the Commonwealth or by a court. This is because we cannot proceed with a complaint if the issues at hand have already been determined by a court or tribunal. At the conclusion of the issue being reviewed, we are able to revisit the complaint and determine whether it is possible to continue.

When a complaint is closed because it does not require any further action, this can often mean that some other way has been used to find a resolution.

Trend Reports

Public Hospitals

There were 417 new complaints made about public hospitals in 2008/09, down three per cent from the 430 complaints recorded over 2007/08.



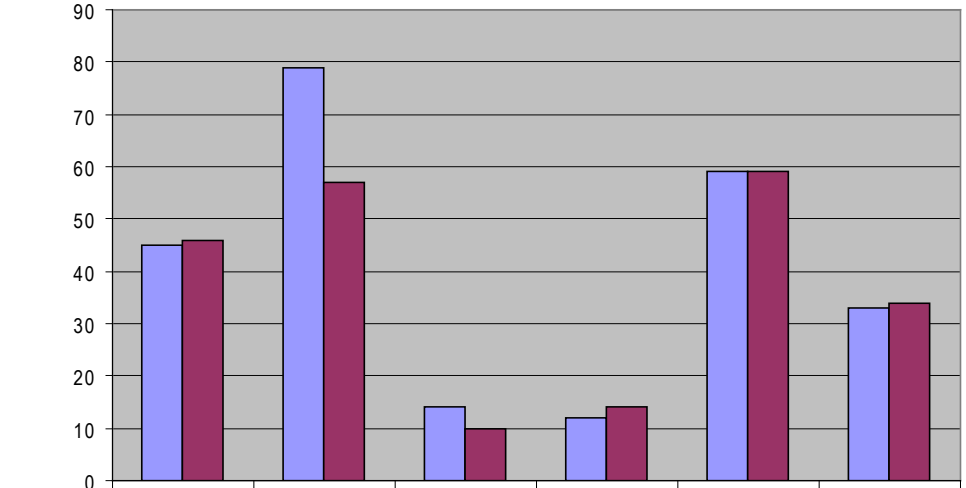
Graph 8 - Public hospital complaints by specialty, 2007/08 - 2008/09.

Compared with the previous year, complaints decreased over 2008/09 for emergency departments, psychiatric and general medicine specialties. Over the same period, complaints increased for general, orthopaedic, and obstetrics/maternity/gynaecological surgery.

Teaching Hospitals

As teaching hospitals service the greatest number of patients, it is to be expected that most of our public hospital complaints relate to that group. In our experience, teaching hospitals are effective in their management of complaints and are often successful at resolving complaints quickly with the patient.

Complaints against teaching hospitals decreased nine per cent, from 242 complaints in 2007/08 to 220 this year.



	Sir Charles Gairdner Hospital	Royal Perth Hospital	Princess Margaret Hospital for	King Edward Memorial Hospital for	Fremantle Hospital*	Graylands Hospital**
2007/08	45	79	14	12	59	33
2008/09	46	57	10	14	59	34

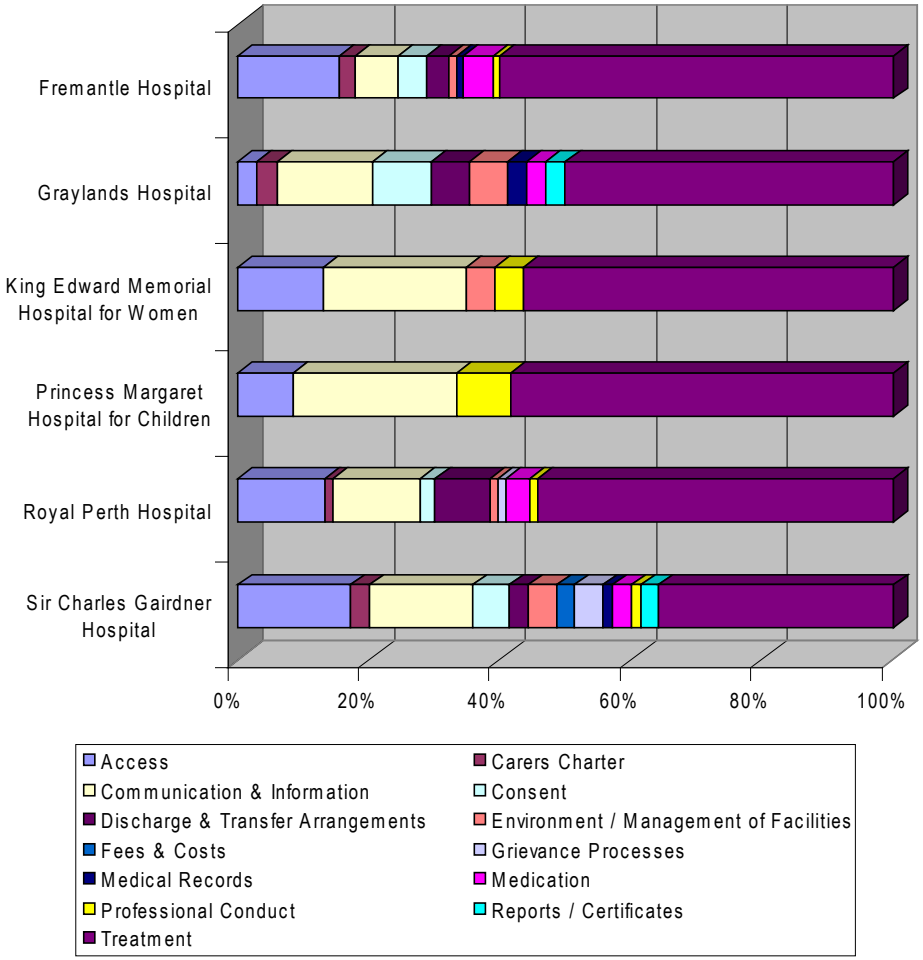
Graph 9 - Teaching hospital complaints, 2007/08 - 2008/09.

**Last year we reported that Fremantle Hospital had 38 complaints over 2007/08, but this did not include Alma Street Mental Health Centre or Kaleeya Hospital which are part of the campus. The 07/08 total has been updated.*

*** Only one complaint against Graylands Hospital was reported last year due to a database error.*

Royal Perth Hospital experienced a significant decrease in complaints made to us, with 22 fewer complaints made this year. Complaints against Fremantle Hospital marginally decreased, by seven per cent. Sir Charles Gairdner Hospital, King Edward Memorial Hospital for Women, Graylands Hospital and Princess Margaret Hospital did not experience a significant change.

The issues raised in all teaching hospital complaints are charted below as a proportion of the overall issues lodged with us for that service. This graph allows each teaching hospital to be compared, despite the differing volumes of complaints made. The most common complaint issue for all teaching hospitals is the treatment provided. Sir Charles Gairdner Hospital has the smallest proportion of issues raised related to treatment (36 per cent), while Fremantle Hospital has the highest



Graph 10 - Issue categories raised in teaching hospital complaints, 2008/09.

(60 per cent). The next most common issue category is access. This was a significant issue at Fremantle Hospital (16 per cent) and Sir Charles Gairdner Hospital (17 per cent), but not proportionally for Graylands Hospital or Princess Margaret Hospital for Children.

Communication & information was a significant complaint category issue for King Edward Memorial Hospital for Women (22 per cent) and Princess Margaret Hospital for Children (25 per cent), but not for Fremantle Hospital (seven per cent).

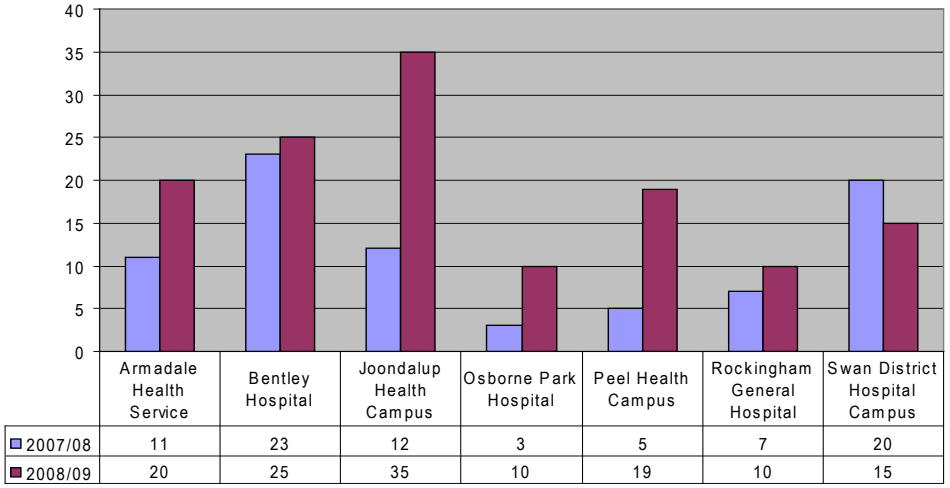
Royal Perth Hospital had a much larger incidence of complaints relating to discharge and transfer arrangements in proportion to other complaints made (eight per cent) but this still only represented a small number of issues.

Compared with other teaching hospitals, Graylands Hospital has a much higher proportion of issues raised in complaints relating to consent (nine per cent) and grievance processes (four per cent).

Non-teaching public hospitals - metropolitan area

This report relates to complaints that we recorded for non-teaching public hospitals in the metropolitan area. While the Peel Health Campus is outside the metropolitan area, the population and growth in Peel and its proximity to Perth has prompted us to include it in this report.

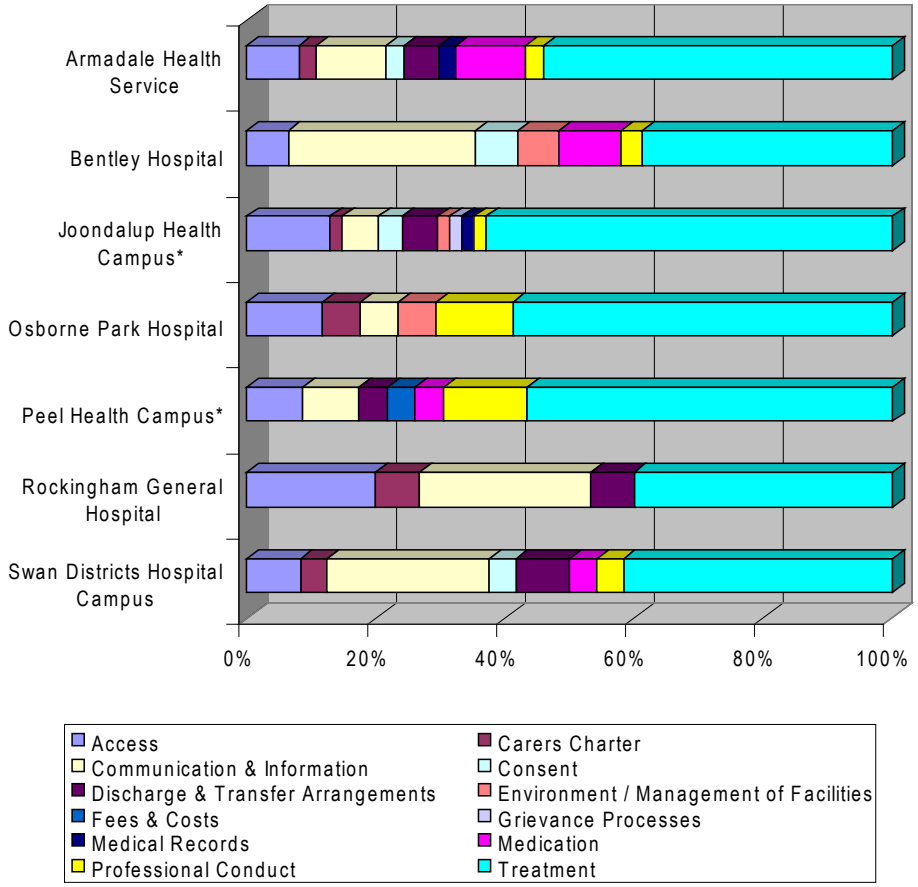
Both Peel Health Campus and Joondalup Health Campus include public and private hospital facilities. Complaints recorded here for both services aims to involve publicly provided services.



	Armadale Health Service	Bentley Hospital	Joondalup Health Campus	Osborne Park Hospital	Peel Health Campus	Rockingham General Hospital	Swan District Hospital Campus
2007/08	11	23	12	3	5	7	20
2008/09	20	25	35	10	19	10	15

Graph 11 - Non-teaching hospital complaints (metro), 2007/08 - 2008/09

The large increases in some of these providers - particularly Peel Health Campus and Joondalup Health Campus - might be related to changes in our databases, as well as name changes for each of these services that have occurred across the periods documented.



Graph 12 - Issues raised in non-teaching public hospital (metro) complaints, 2008/09

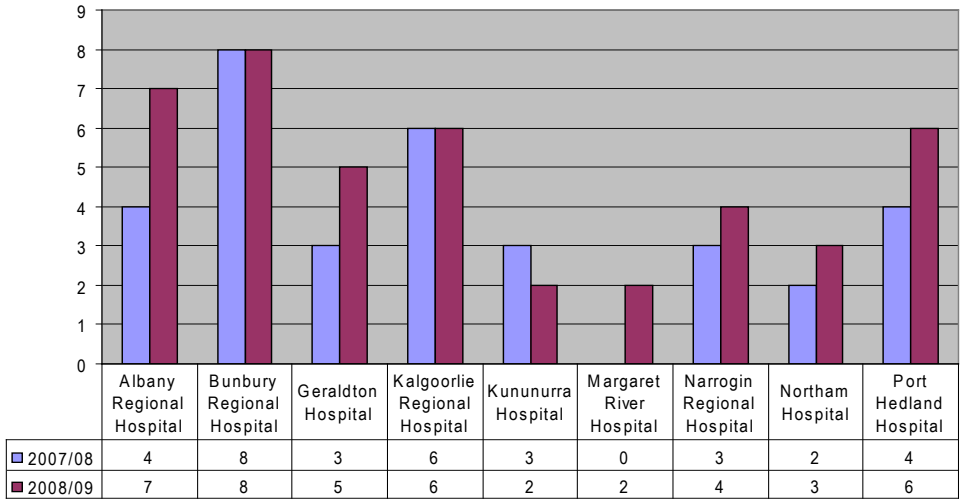
Like teaching hospitals, the non-teaching public hospitals in the metropolitan area have a high proportion of complaint issues relating to treatment. The provider with the smallest proportion of issues relating to treatment is Bentley Hospital (39 per cent), while Joondalup Health Campus had the greatest proportion (63 per cent).

These non-teaching public hospitals had a larger proportion overall of issues relating to communication & information than to access. This year Bentley Hospital had the highest proportion of communication and information related issues (29 per cent), while Joondalup Health Campus and Osborne Park Hospital shared the smallest proportion (six per cent). Access was a proportionally greater issue at Rockingham General Hospital (20 per cent), while it was a lesser issue for Bentley Hospital (six per cent).

Rockingham General Hospital had the higher proportion of issues relating to the Carers Charter (seven per cent) not only when compared to other non-teaching hospitals, but teaching hospitals as well. Osborne Park Hospital also had a higher than average proportion of issues relating to the Carers Charter (six per cent).

Non-teaching public hospitals - rural and regional Western Australia

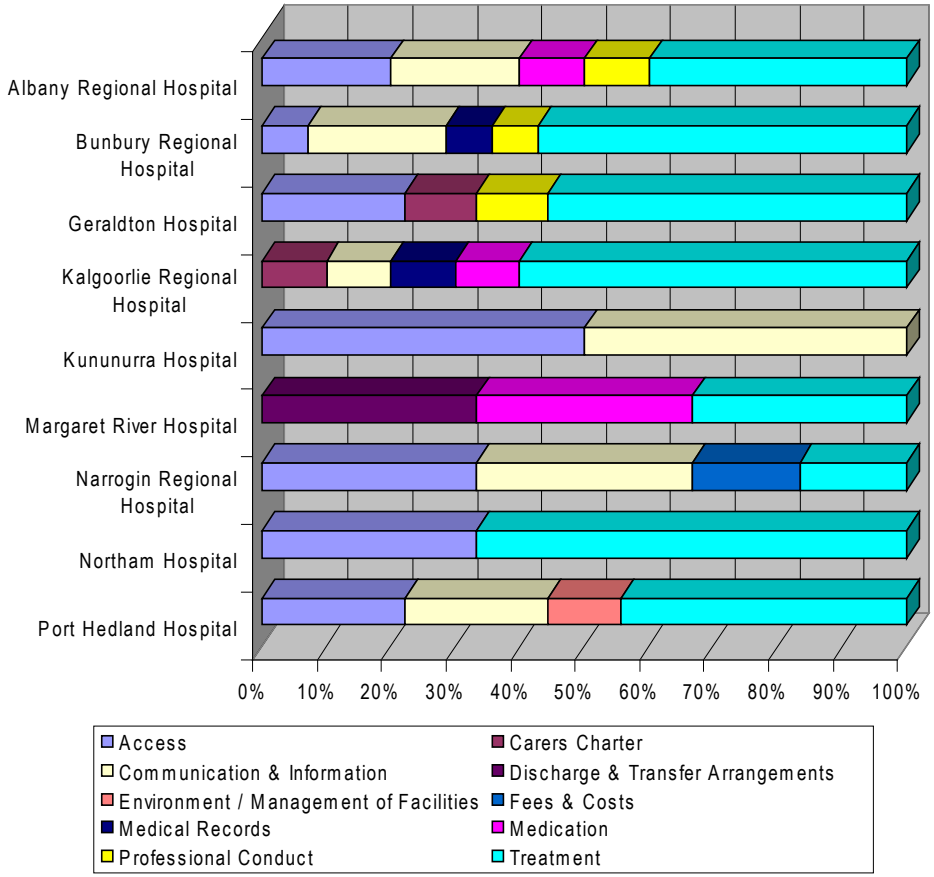
This report relates to complaint issues made against public hospitals in rural and regional Western Australia.



	Albany Regional Hospital	Bunbury Regional Hospital	Geraldton Hospital	Kalgoorlie Regional Hospital	Kununurra Hospital	Margaret River Hospital	Narrogin Regional Hospital	Northam Hospital	Port Hedland Hospital
2007/08	4	8	3	6	3	0	3	2	4
2008/09	7	8	5	6	2	2	4	3	6

Graph 13 - Non-teaching hospital complaints - rural and regional WA, 2007/08 - 2008/09

As indicated in Graph 14, we received a low number of complaints regarding these providers. However, the issues raised can still give an insight into opportunities for service improvement.



Graph 14 - Issues raised in non-teaching (rural and regional) public hospital complaints

Owing to the smaller number of issues raised it is more difficult to point to trends with the rural and regional hospitals. Nevertheless it is interesting to observe that despite the fewer number of issues, the proportion is very similar to larger metropolitan public hospitals.

Prisoner Complaints Report

Prisoner complaints are dealt with by our Assessment team, who aim to conciliate complaints directly with prison health staff. This is achieved through the Department of Corrective Service's complaint mechanism, ACCESS. As with other complaints about health services, a prisoner must make a reasonable attempt to first resolve the complaint with the prison.

This year there were 296 new complaints made about the health services provided at prisons in 2008/09, which is 22 per cent fewer than last year. In the same period we closed 287 complaints, 27 per cent fewer than the year before.

This decline is even more significant when looking at the number of complaints received in writing. While we received 43 per cent of prison complaints in writing over 2007/08, this year we received just 29 per cent. This could indicate that the prisons are successfully identifying and addressing the causes of complaints, however further work needs to be done to understand the reason for this reduction.

We will continue to meet with prison health staff to find the best way that we can deal with complaints made by prisoners.

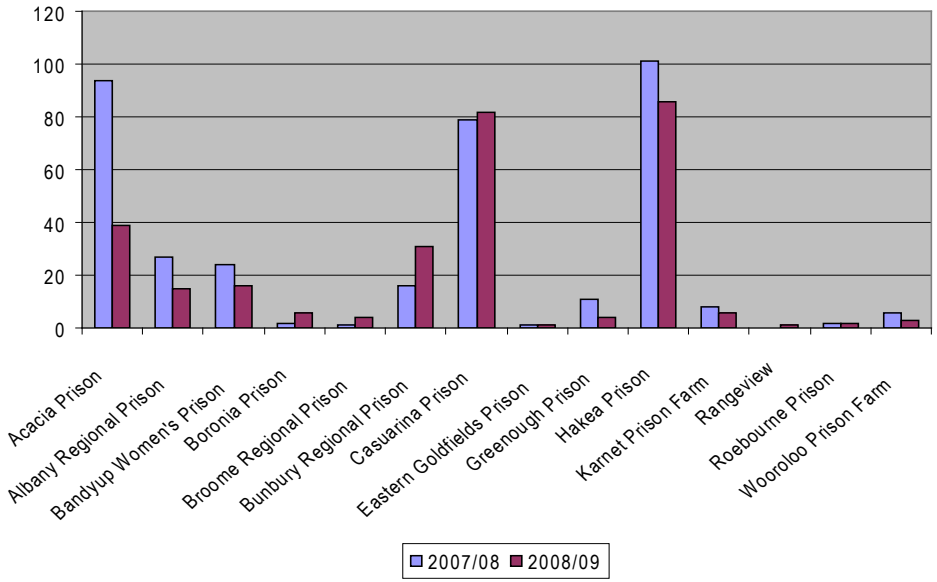
Issues

The most common issue categories for prisoner complaints was treatment and access, both with 125 issues raised, and then medication with 67 issues lodged. Often more than one issue was raised in a complaint. Refusal to admit or treat a prisoner was the most common issue and was raised in 88 prison complaints. This was followed by inadequate treatment (57 complaints), then delay in treatment (31 complaints).

We have experienced significant falls in total complaints from Acacia Prison and Hakea Prison, with reductions of 59 and 15 per cent respectively.

Conciliated prison complaints

There were five complaints resolved between the complainant and provider, and 24 complaints resolved by our Assessment team.



Graph 15 - Prison complaint numbers, 2007/08 - 2008/09.

This year we conciliated complaints made against Acacia Prison, Albany Regional Prison, Bunbury Regional Prison, Casuarina Regional Prison, and Hakea Prison. Conciliated complaints took an average of 114 days to finalise from when we received their complaint in writing.

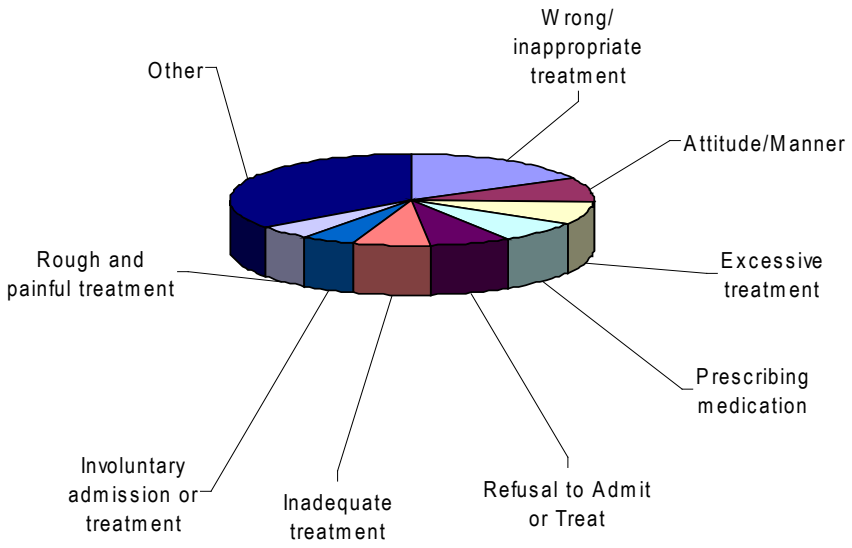
For the prison complaints that were conciliated, 19 (79 per cent) were able to reach either full or partial agreement. This is a positive outcome for the prisoner, and highlights the responsiveness of the prison health service to address these issues.

Notably, one hundred per cent of complaints conciliated at Albany Regional Prison (4) and Casuarina Prison (7) were able to reach some level of agreement. This was a good outcome for both prisons.

Mental Health Report

We received 125 new complaints and enquiries relating to mental health services this year, a 30 per cent reduction on the 179 received the previous year.

The issue for which we received the most complaints was wrong/inappropriate treatment being provided, which was raised in 22 per cent of mental health service complaints. The next most common issues were the attitude/manner of the service (11 per cent) and excessive treatment (10 per cent).



Graph 16 - Mental health services complaint issues, 2008/09.

Complainants and consumers report

We record demographic information about our consumers in our new database, such as:

- Gender
- Age
- Postcode
- Primary language spoken
- Ethnicity.

We also ask people when they make an enquiry where they found out about us, and how their enquiry was first made.

Age

We recorded the age of 817 consumers and 668 complainants making an enquiry to us over 2008/09.

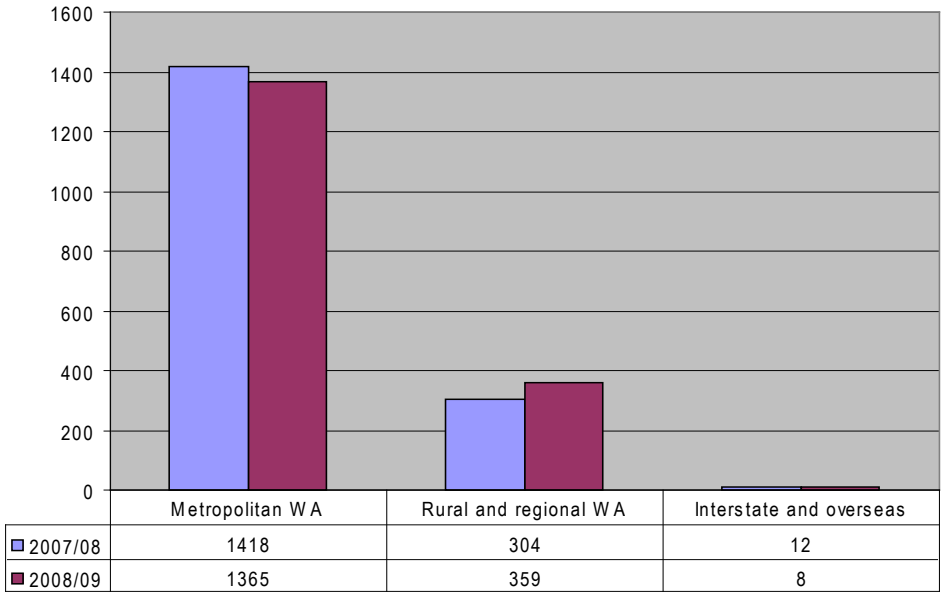
Age range	Consumers	Complainants
0 -14	65	0
15 - 24	78	38
25 - 34	153	133
35 - 44	126	128
45 - 54	129	149
55 - 64	103	106
65 - 74	88	74
75+	75	40
Total	817	668

Table 12 - Age range of consumers and complainants.

The location of consumers

We use the postcode of the consumer of the health or disability service to gauge our awareness across the state. Postcodes were recorded for all 1732 consumers involved in the new enquiries we received this year.

If an address is not specified, our new database sets their postcode automatically to 6000. On our previous database there was no default, so where we did not record a post code in 2007/08 we have reset this to 6000.



Graph 17 - Metropolitan and regional consumers 2008/09.

This year the number of metropolitan consumers involved in our complaints reduced by four per cent, while at the same time consumers in regional and remote areas increased 18 per cent.

Consumers from rural and regional Western Australia

The distribution of our consumers across the regional and remote areas of the states is broken down in the table on the folllowing page.

		2007/08	2008/09
6200 - 6299	South West	100	136
6300 - 6399	Southern	50	62
6400 - 6499	South East	38	42
6500 - 6599	Mid West	84	68
6600 - 6699	Central	5	3
6700 - 6799	North	27	48
	Total	304	359

Table 13 - Complaints involving consumers from rural and regional WA 2007/08, 2008/09.

The biggest increase in complaints came from consumers in the South West region of Western Australia, with an increase of 36 per cent, and the North West, where complaints increased by 78 per cent. Consumers in the South and South East regions also increased 24 and 11 per cent respectively.

Aboriginal consumers and complainants

We recorded eleven new enquiries in the last year that were made by, or on behalf of, Aboriginal people. There may have been more but we only gather the data where the individuals wish to identify themselves as an Aboriginal or Torres Strait Islander.

As at 30 June 2009:

- six complaints had been submitted in writing
- one had been closed in conciliation with a settlement reached (with an outcome or explanation given, and change in procedure/ practice agreed)
- three remain open.

We are concerned that we are not assisting a number of Aboriginal people in the community who may want the opportunity to resolve an issue with a health or disability service.

In response to this concern, we have used our two regional visits this year to meet with local Aboriginal communities around Kalgoorlie and Geraldton. We have sought to increase awareness of our office, and how we can help.

In 2009/10 we will be reviewing further ways we can become more accessible to Aboriginal people, and will report on the success of the Geraldton visit.

Significant Issues and Trends

The Office encountered a number of issues that impacted on our operations and performance during the year, which also have the potential to affect us during the coming year.

As a dispute conciliation body, complaints are the core function of our Office. Over the past few years, the number of complaints lodged has remained steady. However, this is subject to change according to the community's needs.

As an organisation, we need to be flexible to meet increased consumer demand. We have therefore trained a number of our staff to take enquiries and complaints should incoming contacts significantly increase and our Assessment team require support.

During the year we worked to progress proposed amendments to the *Health Services (Conciliation and Review) Act 1995* and the *Disability Services Act 1993*. However, the State election and subsequent suspension of Parliament impeded significantly on the timetable that we had planned. It was hoped that the amendments would be approved by Parliament during the year, however this should now take place during the 2009/10 year.

It is worth noting that the increased visibility of the Office when we change names to the Health and Disability Services Complaints Office (dependent on the proposed legislation) could also lead to a higher number of incoming complaints and enquiries.

Sometimes we encounter a degree of reluctance from providers in the private sector to engage in conciliation. This can be challenging for our staff and complainants as it gives little hope of achieving a resolution. We cannot compel providers to engage in conciliation, and this can result in some frustration for complainants seeking a resolution.

We try to counter any reluctance to engage in our process by building confidence in our Office amongst the providers that we do deal with. We do this by remaining professional, independent and impartial, and by engaging empathetically with both parties in a dispute.

As a small agency with a large jurisdiction, reaching a wide audience of consumers and providers is a constant challenge. While we have established a relationship with many of the larger providers, such as public hospitals, we are mindful of the benefits of being accessible to consumers and being recognised by providers.

We often face the challenge of dealing with complaints from rural and regional areas. We have found that the conciliation process usually benefits from face-to-face communication, and sometimes send staff members to regional areas to hold conciliation meetings or use video conferencing facilities.

Regional visits have the added benefit of opportunities for community outreach activities. It is not always feasible to hold regional conciliation meetings, however if we can involve other benefits for the community we try to accommodate our regional stakeholders by doing so.

What we said we would do/What we did

What we said we would do in 2008/09	What we did
Plan to employ an Officer specifically to support Aboriginal complainants.	A proposal has been developed for this position and will be actioned once sufficient funding is available.
Employ a Medical Officer on a part-time basis, to assist our conciliation staff and to engage in conciliation meetings with providers.	This will be actioned once sufficient funding is available.
Submit proposed legislative amendments to Parliament - to correct a number of discrepancies between the two Acts, while facilitating a change of name for our organisation to the Health and Disability Services Complaints Office.	Due to the State Government election being held in October 2008 and the resulting suspension of Parliament, the proposed amendments were restricted from any progression into the new year. It is hoped that the amendments will be passed through during the 2009/10 year.
Implementation and further development of the CRED database.	The data base went live in July 08 and since that time it has been closely monitored to address implementation problems, and where required modifications made.
Send a staff member to the Cocos (Keeling) Islands early in the next financial year to engage in similar outreach activities.	A staff member visited the Cocos (Keeling) Islands at the beginning of the year – see report on page 10.
Consider refurbishing the main office.	Refurbishment of the main office took place during the year – see page 11.
Look at ways of dealing with low literacy levels amongst complainants.	OHR promotes consumers using advocates where necessary. In addition interpreters are engaged where English is not the spoken language, or if AUSLAN interpreters are required.
In 2007/08 we spoke about compensation to the CEO Forum, the leadership group of the WA Health Department. An outcome of the meeting was a suggestion that we to speak to the Clinical Directors of each hospital to develop such a protocol. We will report on the outcome of these talks in 2008/09.	OHR met with public hospital Medical Directors late 2008 to discuss issues related to compensation. The outcome was an agreed set of facts sheets. In addition, the Medical Directors from the teaching hospitals meet regularly to review their processes and claims.
We have received no complaints from prisoners at either the Nyandi or Rangeview prisons. We will continue to look closely at this issue next year.	This situation was monitored. We understand that Nyandi prison has closed. Rangeview is a juvenile facility and historically we rarely receive complaints. The Inspector of Custodial Services reports that the level of care for inmates is very good, which may be why we don't receive complaints regarding the services at this facility.
We will review ways of providing a service that takes greater consideration of the needs of mental health consumers during the coming year.	The Assessment team concentrated their efforts during the year to assist people with mental health issues, spending more time with this group of consumers and liaising with other agencies such as the Office of the Chief Psychiatrist, the Council of Official Visitors and the Health Consumers' Council to achieve the best results.
Greater qualitative and quantitative analyses of data.	The new complaints data base provides opportunities for greater qualitative and quantitative analysis of data, which is reflected in this report.
'Prescribing' providers in accordance with Section 75 of the Act. This will be done in consultation with providers, and we will work with prescribed providers in establishing reporting formats.	The initial stages of this project began late in the year and will continue into 2009/10.
The efficiency and effectiveness of OHR's recordkeeping training will be evaluated in the next financial year.	This took place and the training program was found to be beneficial (see page 62). Further online training was undertaken by a number of our staff members.

Independent Audit Opinion

Auditor General

INDEPENDENT AUDIT OPINION

To the Parliament of Western Australia

OFFICE OF HEALTH REVIEW
FINANCIAL STATEMENTS AND KEY PERFORMANCE INDICATORS
FOR THE YEAR ENDED 30 JUNE 2009

I have audited the accounts, financial statements, controls and key performance indicators of the Office of Health Review.

The financial statements comprise the Balance Sheet as at 30 June 2009, and the Income Statement, Statement of Changes in Equity and Cash Flow Statement for the year then ended, a summary of significant accounting policies and other explanatory Notes.

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

Director's Responsibility for the Financial Statements and Key Performance Indicators
The Director is responsible for keeping proper accounts, and the preparation and fair presentation of the financial statements in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions, and the key performance indicators. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of the financial statements and key performance indicators that are free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; making accounting estimates that are reasonable in the circumstances; and complying with the Financial Management Act 2006 and other relevant written law.

Summary of my Role
As required by the Auditor General Act 2006, my responsibility is to express an opinion on the financial statements, controls and key performance indicators based on my audit. This was done by testing selected samples of the audit evidence. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion. Further information on my audit approach is provided in my audit practice statement. Refer www.audit.wa.gov.au/pubs/AuditPracStatement.pdf.

An audit does not guarantee that every amount and disclosure in the financial statements and key performance indicators 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 and key performance indicators.

Office of Health Review
Financial Statements and Key Performance Indicators for the year ended 30 June 2009

Audit Opinion
In my opinion,

(i) the financial statements are based on proper accounts and present fairly the financial position of the Office of Health Review at 30 June 2009 and its financial performance and cash flows for the year ended on that date. They are in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Treasurer's Instructions;

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

(iii) the key performance indicators of the Office are relevant and appropriate to help users assess the Office's performance and fairly represent the indicated performance for the year ended 30 June 2009.

COLIN MURPHY
AUDITOR GENERAL
14 September 2009

Disclosures and Legal Compliance - Certification of Financial Statements

OFFICE OF HEALTH REVIEW

CERTIFICATION OF FINANCIAL STATEMENTS

I hereby certify that the financial statements of the Office of Health Review have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper amounts and records to present fairly the financial transactions for the financial year ending 30 June 2009 and financial position as at 30 June 2009.

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.

Edward Lee CPA
CHIEF FINANCE OFFICER

Date: 7 September 2009

Linley Anne Donaldson
DIRECTOR
ACCOUNTABLE AUTHORITY

Date: 7 September 2009

Financial Statements

Office of Health Review

Income Statement

For the year ended 30th June 2009

	Note	2009 $	2008 $
COST OF SERVICES			
Expenses			
Employee benefits expense	6	1,408,712	1,355,532
External services	7	8,650	8,673
Depreciation expense	8	3,085	3,577
Repairs, maintenance and consumable equipment	9	26,683	43,651
Other expenses	10	392,324	351,085
Total cost of services		**1,839,454**	**1,762,518**
INCOME			
Revenue			
Recoveries and other revenues	11	21,915	36,915
Total revenue		21,915	36,915
Total income other than income from State Government		**21,915**	**36,915**
NET COST OF SERVICES		**1,817,539**	**1,725,603**
INCOME FROM STATE GOVERNMENT			
Service appropriations	12	1,715,946	1,613,000
Resources received free of charge	13	17,067	4,643
Total income from State Government		**1,733,013**	**1,617,643**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(84,526)**	**(107,960)**

The Income Statement should be read in conjunction with the notes to the financial statements.

Balance Sheet

As at 30th June 2009

	Note	2009	2008
ASSETS		**$**	**$**
Current Assets			
Cash and cash equivalents	14	318,095	421,006
Other current assets	15	100	-
Total Current Assets		318,195	421,006
Non-Current Assets			
Plant and equipment	16	6,522	9,607
Total Non-Current Assets		6,522	9,607
Total Assets		**324,717**	**430,613**
LIABILITIES			
Current Liabilities			
Payables	18	80,134	74,319
Provisions	19	264,005	288,588
Total Current Liabilities		344,139	362,907
Non-Current Liabilities			
Provisions	19	20,756	23,358
Total Non-Current Liabilities		20,756	23,358
Total Liabilities		**364,895**	**386,265**
NET ASSETS		**(40,178)**	**44,348**
EQUITY			
Accumulated surplus/(deficiency)	20	(40,178)	44,348
TOTAL EQUITY		**(40,178)**	**44,348**

The Balance Sheet should be read in conjunction with the notes to the financial statements.

Statement of Changes in Equity

For the year ended 30th June 2009

	Note	2009 $	2008 $
Balance of equity at start of period		44,348	152,308
ACCUMULATED SURPLUS / (DEFICIENCY)	20		
Balance at start of period		44,348	152,308
Surplus/(deficit) for the period		(84,526)	(107,960)
Balance at end of period		**(40,178)**	**44,348**
Balance of equity at end of period		**(40,178)**	**44,348**
Total income and expense for the period		(84,526)	(107,960)

The Statement of Changes in Equity should be read in conjunction with the notes to the financial statements.

Cash Flow Statement

For the year ended 30th June 2009

	Note	2009 $ Inflows (Outflows)	2008 $ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		1,715,946	1,613,000
Net cash provided by State Government		1,715,946	1,613,000
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(401,010)	(374,786)
Employee benefits		(1,439,762)	(1,346,585)
Receipts			
Recoveries and other receipts		21,915	36,915
Net cash used in operating activities	21b	(1,818,857)	(1,684,456)
Net decrease in cash and cash equivalents		(102,911)	(71,456)
Cash and cash equivalents at the beginning of period		421,006	492,462
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	21a	318,095	421,006

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

Notes to the Financial Statements

For the year ended 30th June 2009

Note 1 Australian equivalents to International Financial Reporting Standards

General

The Authority's financial statements for the year ended 30 June 2009 have been prepared in accordance with Australian equivalents to International Financial Reporting Standards (AIFRS), which comprise a Framework for the Preparation and Presentation of Financial Statements (the Framework) and Australian Accounting Standards (including the Australian Accounting Interpretations).

In preparing these financial statements the Authority has adopted, where relevant to its operations, new and revised Standards and Interpretations from their operative dates as issued by the Australian Accounting Standards Board (AASB) and formerly the Urgent Issues Group (UIG).

Early adoption of standards

The Authority cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. No Standards and Interpretations that have been issued or amended but are not yet effective have been early adopted by the Authority for the annual reporting period ended 30 June 2009.

Note 2 Summary of significant accounting policies

(a) General Statement

The financial statements constitute a general purpose financial report which has been prepared in accordance with the Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board 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 Management Act and the Treasurer's instructions are legislative provisions governing the preparation of financial statements and take precedence over the Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board.

Where modification is required and has a material or significant financial effect upon the reported results, details of that modification and the resulting financial effect are disclosed in the notes to the financial statements.

(b) Basis of Preparation

The financial statements have been prepared on the accrual basis of accounting using the historical cost convention.

The accounting policies adopted in the preparation of the financial statements have been consistently applied throughout all periods presented unless otherwise stated.

The financial statements are presented in Australian dollars and all values are rounded to the nearest dollar ($).

The judgements that have been made in the process of applying the Authority's accounting policies that have the most significant effect on the amounts recognised in the financial statements are disclosed at note 3 'Judgements made by management in applying accounting policies'.

The key assumptions made concerning the future, and other key sources of estimation uncertainty at the balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are disclosed at note 4 'Key sources of estimation uncertainty'.

(c) Income

Revenue recognition

Revenue is measured at the fair value of consideration received or receivable. Revenue is recognised as follows:

Service Appropriations
Service Appropriations are recognised as revenues at nominal value 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 to the bank account or credited to the holding account held at Treasury (See note 12 'Service appropriations').

Grants, donations, gifts and other non-reciprocal contributions
Revenue is recognised at fair value when the Authority obtains control over the assets comprising the contributions, usually when cash is received.

Other non-reciprocal contributions that are not contributions by owners are recognised at their fair value. Contributions of services are only recognised when a fair value can be reliably determined and the services would be purchased if not donated.

Where contributions recognised as revenues during the reporting period were obtained on the condition that they be expended in a particular manner or used over a particular period, and those conditions were undischarged as at the balance sheet date, the nature of, and amounts pertaining to, those undischarged conditions are disclosed in the notes.

Gains

Gains may be realised or unrealised and are usually recognised on a net basis. These include gains arising on the disposal of non-current assets.

(d) Plant and Equipment

Capitalisation/Expensing of assets
Items of plant and equipment costing $5,000 or more are recognised as assets and the cost of utilising assets is expensed (depreciated) over their useful lives. Items of plant and equipment costing less than $5,000 are immediately expensed direct to the Income Statement (other than where they form part of a group of similar items which are significant in total).

Initial recognition and measurement
All items of plant and equipment are initially recognised at cost.

For items of plant and equipment acquired at no cost or for nominal cost, the cost is their fair value at the date of acquisition.

Subsequent measurement
All items of plant and equipment are stated at historical cost less accumulated depreciation and accumulated impairment losses.

Depreciation
All non-current assets having a limited useful life are systematically depreciated over their estimated useful lives in a manner that reflects the consumption of their future economic benefits.

In order to apply this policy the following methods are utilised :

* Plant and equipment - diminishing value with a straight line switch

Under the diminishing value with a straight line switch method, the cost amounts of the assets are allocated on average on a diminishing value basis over the first half of their useful lives and a straight line basis for the second half of their useful lives.

The assets' useful lives are reviewed annually. Expected useful lives for each class of depreciable asset are:

Computer equipment	5 years
Other plant and equipment	10 years

(e) Impairment of Assets

Plant and equipment are tested for any indication of impairment at each balance sheet date. Where there is an indication of impairment, the recoverable amount is estimated. Where the recoverable amount is less than the carrying amount, the asset is considered impaired and is written down to the recoverable amount and an impairment loss is recognised. As the Authority is a not-for-profit entity, unless an asset has been identified as a surplus asset, the recoverable amount is the higher of an asset's fair value less costs to sell and depreciated replacement cost.

The risk of impairment is generally limited to circumstances where an asset's depreciation is materially understated, where the replacement cost is falling or where there is a significant change in useful life. Each relevant class of assets is reviewed annually to verify that the accumulated depreciation/amortisation reflects the level of consumption or expiration of asset's future economic benefits and to evaluate any impairment risk from falling replacement costs.

The recoverable amount of assets identified as surplus assets is the higher of fair value less costs to sell and the present value of future cash flows expected to be derived from the asset. Surplus assets carried at fair value have no risk of material impairment where fair value is determined by reference to market-based evidence. Where fair value is determined by reference to depreciated replacement cost, surplus assets are at risk of impairment and the recoverable amount is measured. Surplus assets at cost are tested for indications of impairment at each balance sheet date.

(f) Non-current Assets Classified as Held for Sale

Non-current assets held for sale are recognised at the lower of carrying amount and fair value less costs to sell and are presented separately from other assets in the Balance Sheet. Assets classified as held for sale are not depreciated or amortised.

(g) Leases

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases.

Operating lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased items.

(h) Financial Instruments

In addition to cash, the Authority has two categories of financial instrument:
- Loans and receivables; and
- Financial liabilities measured at amortised cost.

These have been disaggregated into the following classes:

Financial Assets
* Cash and cash equivalents

Financial Liabilities
* Payables

Initial recognition and measurement of financial instruments is at fair value which normally equates to the transaction cost or the face value. Subsequent measurement is at amortised cost using the effective interest method.

The fair value of short-term receivables and payables is the transaction cost or the face value because there is no interest rate applicable and subsequent measurement is not required as the effect of discounting is not material.

(i) Cash and Cash Equivalents

For the purpose of the Cash Flow Statement, cash and cash equivalent (and restricted cash and cash equivalent) assets comprise cash on hand and short-term deposits with original maturities of three months or less that are readily convertible to a known amount of cash and which are subject to insignificant risk of changes in value.

(j) Accrued Salaries

Accrued salaries (see note 18 'Payables') represent the amount due to employees but unpaid at the end of the financial year, as the pay date for the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Authority considers the carrying amount of accrued salaries to be equivalent to its net fair value.

(k) Receivables

Receivables are recognised and carried at original invoice amount less an allowance for any uncollectible amounts (i.e. impairment). The collectability of receivables is reviewed on an ongoing basis and any receivables identified as uncollectible are written-off. The allowance for uncollectible amounts (doubtful debts) is raised when there is objective evidence that the Authority will not be able to collect the debts.

The carrying amount is equivalent to fair value as it is due for settlement within 30 days from the date of recognition. (See note 2(h) 'Financial instruments')

(l) Payables

Payables are recognised at the amounts payable when the Authority becomes obliged to make future payments as a result of a purchase of assets or services. The carrying amount is equivalent to fair value as they are generally settled within 30 days. See note 2(h) 'Financial instruments and note 18 'Payables'.

(m) Provisions

Provisions are liabilities of uncertain timing or amount and are recognised where there is a present legal or constructive obligation as a result of a past event and when the outflow of resources embodying economic benefits is probable and a reliable estimate can be made of the amount of the obligation. Provisions are reviewed at each balance sheet date. See note 19 ‘Provisions’.

Provisions - Employee Benefits

Annual Leave and Long Service Leave
The liability for annual and long service leave expected to be settled within 12 months after the balance sheet date is recognised and measured at the undiscounted amounts expected to be paid when the liabilities are settled. Annual and long service leave expected to be settled more than 12 months after the balance sheet date is measured at the present value of amounts expected to be paid when the liabilities are settled. Leave liabilities are in respect of services provided by employees up to the balance sheet date.

When assessing expected future payments consideration is given to expected future wage and salary levels including non-salary components such as employer superannuation contributions. In addition, the long service leave liability also considers the experience of employee departures and periods of service.

The expected future payments are discounted using market yields at the balance sheet date on national government bonds with terms to maturity that match, as closely as possible, the estimated future cash outflows.

All annual leave and unconditional long service leave provisions are classified as current liabilities as the Authority does not have an unconditional right to defer settlement of the liability for at least 12 months after the balance sheet date.

Sick Leave
Liabilities for sick leave are recognised when it is probable that sick leave paid in the future will be greater than the entitlement that will accrue in the future.

Past history indicates that on average, sick leave taken each reporting period is less than the entitlement accrued. This is expected to continue in future periods. Accordingly, it is unlikely that existing accumulated entitlements will be used by employees and no liability for unused sick leave entitlements is recognised. As sick leave is non-vesting, an expense is recognised in the Income Statement for this leave as it is taken.

Superannuation
The Government Employees Superannuation Board (GESB) administers the following superannuation schemes.

Employees may contribute to the Pension Scheme, a defined benefit pension scheme now closed to new members or the Gold State Superannuation Scheme (GSS), a defined benefit lump sum scheme also closed to new members.

The Authority does not have any current employees who are members of the Pension or the GSS Schemes.

Employees commencing employment prior to 16 April 2007 who were not members of either the Pension or the GSS Schemes became non-contributory members of the West State Superannuation Scheme (WSS). Employees commencing employment on or after 16 April 2007 became members of the GESB Super Scheme (GESBS). Both of these schemes are accumulation schemes. The Authority makes concurrent contributions to GESB on behalf of employees in compliance with the Commonwealth Government's Superannuation Guarantee (Administration) Act 1992. These contributions extinguish the liability for superannuation charges in respect of the WSS and GESBS Schemes.

(See also note 2(n) 'Superannuation Expense')

(m) Provisions (continued)

(ii) Provisions - Other

Employment on-costs
Employment on-costs, including workers' compensation insurance, are not employee benefits and are recognised separately as liabilities and expenses when the employment to which they relate has occurred. Employment oncosts are included as part of 'Other expenses' and are not included as part of the Authority's 'Employee benefits expense'. Any related liability is included in 'Employment on-costs provision'. (See note 10 'Other expenses' and note 19 'Provisions'.)

(n) Superannuation Expense

The following elements are included in calculating the superannuation expense in the Income Statement:

Defined contribution plans - Employer contributions paid to the GSS (concurrent contributions), the West State Superannuation Scheme (WSS), and the GESB Super Scheme (GESBS).

Defined benefit plans - The Authority does not have any current employees who are the members of the defined benefit plans.

The GSS Scheme is a defined benefit scheme for the purposes of employees and whole-of-government reporting. However, apart from the transfer benefit, it is a defined contribution plan for agency purposes because the concurrent contributions (defined contributions) made by the agency to GESB extinguishes the agency's obligations to the related superannuation liability.

(o) Resources Received Free of Charge or for Nominal Cost

Resources received free of charge or for nominal cost that can be reliably measured are recognised as income and as assets or expenses as appropriate, at fair value.

(p) Comparative Figures

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

Note 3 Judgements made by management in applying accounting policies

Judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

The judgements that have been made in the process of applying accounting policies that have the most significant effect on the amounts recognised in the financial statements include:

Employee benfits provisions
An average turnover rate for employees has been used to estimate the amount of non-current liability for long service leave. This turnover rate is representative of the Health public authorities in general.

Note 4 Key sources of estimation uncertainty

The key estimates and assumptions made concerning the future, and other key sources of estimation uncertainty at the balance sheet date that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year include:

Employee benefits provision

In estimating the non-current long service leave liabilities, employees are assumed to leave the Authority each year on account of resignation or retirement at 10.6%. This assumption was based on an analysis of the turnover rates exhibited by employees over a period of five years. Employees with leave benefits to which they are fully entitled are assumed to take all available leave uniformly over the following five years or to age 65 if earlier.

Note 5 Disclosure of changes in accounting policy and estimates

Initial application of an Australian Accounting Standard

The Authority has applied the following Australian Accounting Standards and Australian Accounting Interpretations effective for annual reporting periods beginning on or after 1 July 2008 that impacted on the Authority:

Review of AAS 27 'Financial Reporting by Local Governments', AAS 29 'Financial Reporting by Government Departments' and AAS 31 'Financial Reporting by Governments'. The AASB has made the following pronouncements from its short term review of AAS 27, AAS 29 and AAS 31:

AASB 1004 'Contributions';

AASB 2007-9 'Amendments to Australian Accounting Standards arising from the review of AASs 27, 29 and 31 [AASB 3, AASB 5, AASB 8, AASB 101, AASB 114, AASB 116, AASB 127 & AASB 137];and

Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities'.

The existing requirements in AAS 27, AAS 29 and AAS 31 have been transferred to the above new and revised topic-based Standards and Interpretation. These requirements remain substantively unchanged. AASB 1050, AASB 1051 and AASB 1052 do not apply to Statutory Authorities. The other Standards and Interpretation make some modifications to disclosures and provide additional guidance, otherwise there is no financial impact.

Note 5 Disclosure of changes in accounting policy and estimates (continued)

The following Australian Accounting Standards and Interpretations are not applicable to the Authority as they have no impact or do not apply to not-for-profit entities:

AASB Standards and Interpretations	
1048	'Interpretation and Application of Standards' (issued September 2008)
1049	'Whole of Government and General Government Sector Financial Reporting' (revised - October 2007)
1050	'Administered Items'
1051	'Land Under Roads'
1052	'Disaggregated Disclosures';
2007-2	'Amendments to Australian Accounting Standards arising from AASB Interpretation 12 [AASB 1, AASB 117, AASB 118, AASB 120, AASB 121, AASB 127, AASB 131 & AASB 139]' – paragraphs 1- 8
2008-10	'Amendments to Australian Accounting Standards – Reclassification of Financial Assets [AASB 7 & AASB 139]'
2008-12	'Amendments to Australian Accounting Standards – Reclassification of Financial Assets – Effective Date and Transition [AASB 7, AASB 139 & AASB 2008-10]'
2009-3	Amendments to Australian Accounting Standards – Embedded Derivatives [AASB 139 & Interpretation 9]
Interpretation 4	'Determining whether an Arrangement contains a Lease' (revised – February 2007)
Interpretation 12	'Service Concession Arrangements'
Interpretation 13	'Customer Loyalty Programmes'
Interpretation 14	AASB 119 - The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their
Interpretation 129	'Service Concession Arrangements: Disclosures'

Future impact of Australian Accounting Standards not yet operative

The Authority cannot early adopt an Australian Accounting Standard or Australian Accounting Interpretation unless specifically permitted by Treasurer's Instruction 1101 'Application of Australian Accounting Standards and Other Pronouncements'. Consequently, the Authority has not applied the following Australian Accounting Standards and Australian Accounting Interpretations that have been issued and which may impact the Authority but are not yet effective. Where applicable, the Authority plans to apply these Standards and Interpretations from their application date:

Title	Operative for reporting periods beginning on/after
AASB 101 'Presentation of Financial Statements' (September 2007). This Standard has been revised and will change the structure of the financial statements. These changes will require that owner changes in equity are presented separately from non-owner changes in equity. The Authority does not expect any financial impact when the Standard is first applied.	1 January 2009
AASB 2008-13 'Amendments to Australian Accounting Standards arising from AASB Interpretation 17 – Distributions of Non-cash Assets to Owners [AASB 5 & AASB 110]'. This Standard amends AASB 5 'Non-current Assets Held for Sale and Discontinued Operations' in respect of the classification, presentation and measurement of non-current assets held for distribution to owners in their capacity as owners. This may impact on the presentation and classification of Crown land held by the Authority where the Crown land is to be sold by the Authority for Planning and Infrastructure. The Authority does not expect any financial impact when the Standard is first applied prospectively.	1 July 2009
AASB 2009-2 'Amendments to Australian Accounting Standards – Improving Disclosures about Financial Instruments [AASB 4, AASB 7, AASB 1023 & AASB 1038]'. This Standard amends AASB 7 and will require enhanced disclosures about fair value measurements and liquidity risk with respect to financial instruments. The Department does not expect any financial impact when the Standard is first applied.	1 January 2009

	2009	2008
Note 6 Employee benefits expense	**$**	**$**
Salaries and wages (a)	1,148,373	1,025,456
Superannuation - defined contribution plans (b)	111,590	113,144
Annual leave and time off in lieu leave (c)	96,538	109,757
Long service leave (c)	52,211	107,175
	1,408,712	1,355,532

(a) Includes the value of the fringe benefit to the employees. The fringe benefits tax component is included at note 10 'Other expenses'.

(b) Defined contribution plans include West State, Gold State and GESB Super Scheme (contributions paid).

(c) Includes a superannuation contribution component.

Employment on-costs expense is included at note 10 'Other expenses'. The employment on-costs liability is included at note 19 'Provisions'.

Note 7 External services

Fuel, light and power	3,519	3,811
Food supplies	633	1,039
Purchase of other external services	4,498	3,823
	8,650	8,673

Note 8 Depreciation expense

Depreciation		
Computer equipment	2,031	2,031
Other plant and equipment	1,054	1,546
	3,085	3,577

Note 9 Repairs, maintenance and consumable equipment

Repairs and maintenance	6,914	4,759
Consumable equipment	19,769	38,892
	26,683	43,651

Note 10 Other expenses

Communications	37,734	43,114
Computer services	8,817	6,227
Employment on-costs (a)	43,451	27,707
Insurance	574	-
Legal expenses	17,067	4,643
Motor vehicle expenses	2,903	2,015
Operating lease expenses	179,617	143,907
Printing and stationery	11,303	17,297
Purchase of external services	57,192	63,964
Audit fees	17,000	16,500
External consulting fees	-	7,123
Other	16,666	18,588
	392,324	351,085

(a) Includes staff development and transport costs. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 19 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Note 11 Recoveries and other revenues

Recoveries	21,915	36,726
Other	-	189
	21,915	36,915

Note 12 Service appropriations	**2009 $**	**2008 $**
Appropriation revenue received during the year:		
Service appropriations	1,715,946	1,613,000

Service appropriations are accrual amounts reflecting the net cost of services delivered. The appropriation revenue comprises a cash component and a receivable (asset). The receivable (holding account) comprises the depreciation expense for the year and any agreed increase in leave liability during the year.

Note 13 Resources received free of charge

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

State Solicitor's Office	17,067	4,643

Where assets or services have been received free of charge or for nominal cost, the Authority recognises revenues equivalent to the fair value of the assets and/or the fair value of those services that can be reliably measured and which would have been purchased if they were not donated, and those fair values shall be recognised as assets or expenses, as applicable. Where the contribution of assets or services are in the nature of contributions by owners, the Authority makes an adjustment direct to equity.

Note 14 Cash and cash equivalents

Cash on hand	400	400
Cash at bank	317,695	420,606
	318,095	421,006

Note 15 Other current assets

Prepayments	100	-

Note 16 Plant and equipment

Computer equipment		
At cost	19,989	19,989
Accumulated depreciation	(19,055)	(17,024)
	934	2,965
Other plant and equipment		
At cost	25,766	25,766
Accumulated depreciation	(20,178)	(19,124)
	5,588	6,642
Total of plant and equipment	6,522	9,607

Reconciliations

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

Computer equipment		
Carrying amount at start of year	2,965	4,996
Depreciation	(2,031)	(2,031)
Carrying amount at end of year	934	2,965
Other plant and equipment		
Carrying amount at start of year	6,642	8,188
Depreciation	(1,054)	(1,546)
Carrying amount at end of year	5,588	6,642
Total plant and equipment		
Carrying amount at start of year	9,607	13,184
Depreciation	(3,085)	(3,577)
Carrying amount at end of year	6,522	9,607

Note 17 Impairment of Assets

There were no indications of impairment to plant and equipment at 30 June 2009.

The Authority held no goodwill with an indefinite useful life during the reporting period.

All surplus assets at 30 June 2009 have either been classified as assets held for sale or written off.

Note 18 Payables	2009 $	2008 $
Current		
Trade creditors	15,112	41,086
Accrued expenses	40,132	4,478
Accrued salaries	24,890	28,755
	80,134	74,319

(See also note 2(l) 'Payables' and note 28 'Financial instruments')

Note 19 Provisions		
Current		
Employee benefits provision		
Annual leave (a)	82,203	108,733
Time off in lieu leave (a)	135	-
Long service leave (b)	181,667	179,855
	264,005	288,588
Non-current		
Employee benefits provision		
Long service leave (b)	20,756	23,358
Total Provisions	284,761	311,946

(a) Annual leave liabilities and time off in lieu leave liabilities have been classified as current as there is no unconditional right to defer settlement for at least 12 months after balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	58,345	108,733
More than 12 months after balance sheet date	23,993	-
	82,338	108,733

(b) Long service leave liabilities have been classified as current where there is no unconditional right to defer settlement for at least 12 months after balance sheet date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of balance sheet date	46,337	93,141
More than 12 months after balance sheet date	156,086	110,072
	202,423	203,213

Note 20 Accumulated surplus/(deficiency)

Balance at start of year	44,348	152,308
Result for the period	(84,526)	(107,960)
Balance at end of year	(40,178)	44,348

Note 21 Notes to the Cash Flow Statement

a) **Reconciliation of cash**

Cash assets at the end of the financial year as shown in the Cash Flow Statement is reconciled to the related items in the Balance Sheet as follows:

Cash and cash equivalents (see note 14)	318,095	421,006

	2009	2008
	$	$
b) **Reconciliation of net cost of services to net cash flows used in operating activities**		
Net cash used in operating activities (Cash Flow Statement)	(1,818,857)	(1,684,456)
Increase/(decrease) in assets:		
Prepayments	100	-
Decrease/(increase) in liabilities:		
Payables	(5,815)	(46,542)
Current provisions	24,583	(8,116)
Non-current provisions	2,602	21,731
Non-cash items:		
Depreciation expense (note 8)	(3,085)	(3,577)
Resources received free of charge (note 13)	(17,067)	(4,643)
Net cost of services (Income Statement)	(1,817,539)	(1,725,603)

At the balance sheet date, the Authority had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

Note 22 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:

	2009	2008
$190,001 - $200,000	-	1
$270,000 - $280,000	1	-
Total	1	1

	$	$
The total remuneration of members of the Accountable Authority is:	278,842	193,930

The total remuneration includes the superannuation expense incurred by the Authority in respect of members of the members of the Accountable Authority.

Note 23 Remuneration of auditor

Remuneration payable to the Auditor General in respect to the audit for the current financial year is as follows:

Auditing the accounts, financial statements and performance indicators	18,500	17,000

Note 24 Commitments

a) **Operating lease commitments:**
Commitments in relation to non-cancellable leases contracted for at the balance sheet date but not recognised in the financial statements, are payable as follows:

Within 1 year	157,263	152,260
Later than 1 year, and not later than 5 years	314,526	456,780
	471,789	609,040

The operating lease commitments are all inclusive of GST.

b) **Other expenditure commitments:**
There were no other expenditure commitments as at 30th June 2009.

Note 25 Contingent liabilities and contingent assets

At the balance sheet date, the Authority is not aware of any contingent liabilities or contingent assets.

Note 26 Events occurring after balance sheet date

There were no events occurring after the balance sheet date which had significant financial effects on these financial statements.

Note 27 Explanatory Statement

(A) Significant variances between actual results for 2008 and 2009

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	2009 Actual $	2008 Actual $	Variance $
Expenses				
Employee benefits expense		1,408,712	1,355,532	53,180
External services		8,650	8,673	(23)
Depreciation expense	(a)	3,085	3,577	(492)
Repairs, maintenance and consumable equipment	(b)	26,683	43,651	(16,968)
Other expenses	(c)	392,324	351,085	41,239
Income				
Recoveries and other revenues	(d)	21,915	36,915	(15,000)
Service appropriations	(e)	1,715,946	1,613,000	102,946
Resources received free of charge	(f)	17,067	4,643	12,424

(a) Depreciation expense
Two items of equipment were fully depreciated in the last financial year (2008-09).

(b) Repairs, maintenance and consumable equipment
Last year's expenses in consumable equipment were higher due to the purchase of computer equipment.

(c) Other expenses
The increase is largely due to the additional operating lease expenses and the engagement of consultants to develop the complaints database.

(d) Recoveries and other revenues
The decrease in recoveries has predominately resulted from a lower number of staff seconded to other government agencies during this financial year.

(e) Service appropriations
Increased Service Appropriations reflect an increased Net Cost of Service.

(f) Resources received free of charge
Increased number of legal matters for which advice was received from the State Solicitor's Office.

(B) Significant variations between estimates and actual results for 2009

Significant variations between the estimates and actual results for income and expenses as detailed below. Significant variations are considered to be those greater than 10% of the budget estimates.

	Note	2009 Actual $	2009 Estimates $	Variance $
Operating expenses				
Employee benefits expense		1,408,712	1,288,231	120,481
Other goods and services	(a)	430,742	367,769	62,973
Total expenses		1,839,454	1,656,000	183,454
Less: Revenues	(b)	(21,915)	-	(21,915)
Net cost of services		1,817,539	1,656,000	161,539

(a) Other goods and services
Additional expenses were incurred in the leasing of office premises and the engagement of consultants to develop the complaints database.

(b) Revenues
The Authority has received revenue from the Attorney General's Department for work done for Christmas Island.

Note 28 Financial instruments

a) **Financial risk management objectives and policies**

Financial instruments held by the Authority are cash and cash equivalents and payables. The Authority has limited exposure to financial risks. The Authority's overall risk management program focuses on managing the risks identified below.

Credit risk
Credit risk arises when there is the possibility of the Authority's receivables defaulting on their contractual obligations resulting in financial loss to the Authority.

The maximum exposure to credit risk at balance sheet date in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any provisions for impairment.

Credit risk associated with the Authority's financial assets is minimal because the debtors are predominately government bodies.

Liquidity risk
Liquidity risk arises when the Authority is unable to meet its financial obligations as they fall due. The Authority is exposed to liquidity risk through its trading in the normal course of operations.

The Authority has appropriate procedures to manage cash flows including drawdowns of appropriations by monitoring forecast cash flows to ensure that sufficient funds are available to meet its commitments.

Market risk
The Authority does not trade in foreign currency and is not materially exposed to other price risks.

The authority is not exposed to interest rate risk because cash and cash equivalents are non-interest bearing.

b) In addition to cash, the carrying amounts of each of the following categories of financial assets and financial liabilities at the balance sheet date are as follows :

	2009 $	2008 $
Financial Assets		
Cash and cash equivalents	318,095	421,006
Financial Liabilities		
Financial liabilities measured at amortised cost	80,134	74,319

c) **Financial Instrument disclosures**

Credit Risk and Interest Rate Risk Exposures
The following tables disclose the Authority's maximum exposure to credit risk, interest rate exposures and the ageing analysis of financial assets. The Authority's maximum exposure to credit risk at the balance sheet date is the carrying amount of financial assets as shown below. The table discloses the ageing of financial assets that are past due but not impaired and impaired financial assets. The table is based on information provided to senior management of the Authority.

The Authority does not hold any collateral as security or other credit enhancements relating to the financial assets it holds.

The Authority does not hold any financial assets that had to have their terms renegotiated that would have otherwise resulted in them being past due or impaired.

Interest rate exposures of financial assets

	Weighted average effective interest rate %	Carrying amount $	Interest rate exposure: Variable interest rate $	Interest rate exposure: Non-interest bearing $
Financial Assets				
2009				
Cash and cash equivalents	-	318,095	-	318,095
		318,095	-	318,095
2008				
Cash and cash equivalents	-	421,006	-	421,006
		421,006	-	421,006

c) **Financial Instrument disclosures (continued)**

Liquidity Risk

The following table details the contractual maturity analysis for financial liabilities. The contractual maturity amounts are representative of the undiscounted amounts at the balance sheet date. The table includes both interest and principal cash flows. An adjustment has been made where material.

Interest rate exposures and maturity analysis of financial liabilities

	Weighted average effective interest rate %	Carrying amount $	Interest rate exposure: Variable interest rate $	Interest rate exposure: Non-interest bearing $	Maturity dates: Up to 3 months $
Financial Liabilities					
2009					
Payables	-	80,134	-	80,134	80,134
		80,134	-	80,134	80,134
2008					
Payables	-	74,319	-	74,319	74,319
		74,319	-	74,319	74,319

The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities.

Estimates of Expenditure

The following estimates of expenditure for the year 2009-10 are prepared on an accrual accounting basis.

The estimates are required under Section 40(2) of the *Financial Management Act 2006* and by Treasury Instructions from the Department of Treasury and Finance.

The following Estimates of Expenditure for the 2009-10 year do not form part of the preceding audited financial statements.

Revenue	**2009-10**
Revenues from Government	$1,672,000

Key Performance Indicators

OFFICE OF HEALTH REVIEW

CERTIFICATION OF KEY PERFORMANCE INDICATORS

I hereby certify that the performance indicators are based on proper records, are relevant and appropriate for assisting users to assess the Office of Health Review's performance and fairly represent the performance of the Office of Health Review for the financial year ended 30 June 2009.

Linley Anne Donaldson
DIRECTOR
ACCOUNTABLE AUTHORITY

Date: 7 September 2009

The Office of Health Review has produced Key Effectiveness and Efficiency Indicators for 2008-2009. These Indicators link directly to the two key services provided by the Office, being:

Service 1: Assessment, conciliation and investigation of complaints.
Service 2: Education and training in prevention and resolution of complaints.

Information relating to the measurement of the OHR's performance against the indicators is described below:

Key Effectiveness Indicator

The Key Effectiveness Indicator relates to improvement to the provision of services. The number of recommendations made by OHR for improvements to practises and agreed actions for the implementation by agencies and providers (1) is demonstrated below:

2007/08	2008/09
30	45

Table 14 - Number of recommendations

Key Efficiency Indicators

The Key Efficiency Indicators relate to the OHR's two key services.

Service 1: Assessment, conciliation and investigation of complaints

	2007/08	2008/09
(1) Average cost per finalised complaint (2)	$816.50	$725.53
(2) Average length of time to finalise a complaint (3)	87.8 days	68 days

Table 15- Key Efficiency Indicators for OHR's key services

There is a requirement for the OHR to report on the percentage of complaints finalised within set timeframes, however due to database limitations we have not been able to produce this data to date. Recently a new and improved database has been implemented that will enable the OHR to report within these timeframes in 2009/10.

This year the overall percentage of written complaints greater than 12 months was reduced to 2.6 per cent which was an improvement from the 5.4 per cent of complaints greater than 12 months in 2007/08. Next year the OHR will strive to achieve an overall reduction in the number of written complaints greater than 12 months to 2 per cent.

The time taken to finalise written complaints is captured in the table below:

	2007/08	2008/09
0 to 3 months	448	366
3 to 6 months	64	43
6 to 9 months	24	15
9 to 12 months	18	13
12 to 18 months	19	3
18 to 24 months	6	6
24 months and over	7	3
Total written complaints:	586	449

Table 16 - Time taken to finalise written complaints (4)

Service 2: Education and training in prevention and resolution of complaints

The education/training and consultation sessions for 2008-2009 can be broken down into the following two groups:

Group 1 (cost for the development, production and distribution of information: ($91,807.43)

- Pamphlets (a total of 4171 leaflets were sent out throughout the year);
- Four quarterly newsletters were developed and sent to more than 200 organisations;
- Seven new publications were developed, including a Compensation Fact Sheet, a Providers Guide to Dealing with Complaints and Service Standards Brochures.

Group 2 (Presentations, Consultations and Networking Sessions): ($165,850.90)

- Presentations to stakeholders (25 presentations)
- Stakeholder consultations (47)
- Networking sessions (34).

	2007/08	2008/09
(1) Average cost per education/training and consultation (see Group 2 listed above) (5)	$2406.00	$1564.63

Table 17 - Average cost per education/training session

Throughout the year the OHR delivered 25 presentations which were tailored to the requirements of specific community groups in order to raise awareness of our Office and the services we provide both to consumers and providers (6).

Presentations (25)	24%
Health groups 17 Disability groups 1 Prisons 1 Regional 5 Insurance 1	
Consultations (47)	44%
Health groups 37 Disability groups 2 Government Agencies 4 Insurance 2 Tertiary Institutions 2	
Networking (34)	32%
Health groups 19 Disability groups 1 Government Agencies 11 Insurance 1 Tertiary Institutions 1 Advocacy groups 1	

Table 18 - Proportions of stakeholder engagements

These presentations comprise a variety of groups including:

- Public and private sector agencies;
- Metropolitan and rural WA agencies; and
- Regulatory groups and professional associations.

Notes:

1. The OHR supports recommendations for improved practises by agencies and providers through agreement to implement change. There were 24 conciliated cases that had a total of 45 recommendations. Of this total, 26 recommendations were implemented, one recommendation was not agreed to by the provider and 18 are in progress to be implemented. The progress for implementation of each of the recommendations will be monitored by OHR in 2009/10 as part of the continuous improvement process.
2. Based on the accrual costs for the 2008/2009 year, for direct staff costs and overheads in complaint resolution.
3. 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.
4. The introduction of the new database has changed the way in which data is recorded and this has resulted in the apparent reduction of written complaints in 2008/09.
5. Based on staff time and overheads to provide education, training, consultation and information sessions, divided by the number of presentations.
6. OHR undertook two regional visits to communities within Western Australia, which included a total of five presentations. The Office also conducted presentations on Open Disclosure in the metropolitan area, one of which included a video linkup which targeted a large number of stakeholders and one presentation in a Regional Centre.

Other Financial Disclosures

Ministerial Directives

We did not receive any Ministerial Directives during the year.

Pricing Policies of Services Provided

We do not charge for any of the services we provide.

Capital Works

We did not undertake any capital works during the year.

Employment, Industrial Relations and Worker's Compensation

As at 30 June 2009, we employed 15 people, 4 of whom were part-time employees. All of our employees are public servants.

Employee Category	Numbers of staff as at 30 June	
	2007/08	2008/09
Full-time permanent	12	9
Full-time contract	1	3
Part-time permanent	4	5
Part-time contract	1	1
Total	18	18

Table 19 - Staffing 2007/08 - 2008/09

During the year recruitment became a focus for us at OHR, prompted by the retirement of a long standing staff member, a senior staff member taking maternity leave and another embarking on a secondment.

Many vacancies were filled by acting staff members. To develop stability within the organisation, a full recruitment process for each of these positions took place. In previous years recruitment, agencies had been called upon to assist us with the recruitment process. However, after negotiations with the Health Corporate Network a procedure manual and a streamlining of recruitment processes was developed in-house. This initiative resulted in a more cost-effective and efficient recruitment process that benefits the Office and prospective employees.

We are looking to the future in terms of recruitment, and considering the dynamics of the job market a more targeted approach to recruitment is likely to take place in the future.

Our workforce did not make any compensation claims during the year. While we are a low-risk workplace, care was taken to prevent occupational injuries and illnesses. A small number of staff members took extended sick leave to recover from non-work related medical issues.

There were no significant industrial relations events during the year.

Governance disclosure regarding potential conflicts of interest

(i) Shares in a Statutory Authority
While we are a statutory authority, the Office has no shares for senior officers to hold.

(ii) Shares in Subsidiary Bodies
We do not have any subsidiary bodies.

(iii) Interests in Contracts by Senior Officers
There were no declarations of interest in any existing or proposed contracts by our senior officers in 2008-09.

(iv) Benefits to Senior Officers through Contracts
This is not applicable as none of our senior officers have received any benefits through any contract with our suppliers.

(v) Insurance Premiums to Indemnify Directors
This is not applicable as we do not have any directors as defined in Part 3 of the *Statutory Corporations (Liability of Directors) Act 1996*.

Other Legal Requirements

Advertising (Electoral Act 1907 S175ZE)

We are required to report on expenditure incurred during the year in relation to advertising agencies, market research organisations, polling organisations and media advertising organisations. As the table below indicates, in 2008/09 we engaged in a small amount of print advertising to promote our services to the public:

Market research	0
Polling	0
Advertising (non salary vacancies)	1446.07
Direct mail organisations	0
Media advertising organisations	0
Total	1446.07

Table 20 - Advertising and marketing expenditure.

Disability Access and Inclusion Plan Outcomes

Being a dispute resolution agency dealing with complaints against disability service providers, we are keenly aware of the requirements of people with disabilities and the need to make our services accessible.

We are easily contactable through a range of customer-friendly media including telephone, TTY machine, fax, email and SMS. Our publications, which we aim to write in plain English, are available in a number of formats and other languages on request. The OHR web site features a wide range of information, including all of our current publications in electronic format.

We use a shared reception area that is spacious and wheelchair accessible. Our building also has an elevator designed for wheelchair use and the ground floor is at street level for easy access.

Complaints made to us regarding disability services are given special consideration. For example, our legislation does not compel complainants to resolve their complaint with their service provider in the first instance. Disability service complainants are given 24 months to make a complaint regarding a service. Disability service complaints are also investigated by a senior member of staff if the complainant is not satisfied with the outcomes of the conciliation process.

At any event we hold accessibility is a key consideration. For example, a focus group for people with disabilities was held in a conference room on our reception floor, which is more easily accessed than our main accommodation.

Our proposed amendments to the Health Services and Disability Services Acts also support access and inclusion for people with disabilities. The proposed name change to ‘Health and Disability Services Complaints Office’ should greatly enhance our visibility as an agency that deals with complaints about disability services, especially when compared to our current title. The proposed amendments will also remove some inconsistencies between the two Acts, to ensure equal access for all of our complainants.

Compliance with Public Sector Standards and Ethical Codes

We have a Code of Conduct based on the Code developed by the Office of Public Sector Standards. The Code has been discussed in general meetings, hard copies have been circulated amongst staff and an electronic version is available on our intranet. Staff members are also required to sign a letter stating that they have received and read the Code.

In 2008/09 we were not faced with any compliance issues regarding public sector standards, the WA Code of Ethics or our own Code of Conduct.

Recordkeeping Plans

The recordkeeping plan that we developed in 2006/07 has been evaluated since its introduction on an ongoing basis and has proven to be a sound and effective system for managing and retrieving corporate information.

Our staff members were trained in the new recordkeeping system following its introduction. The training has proven to be effective in informing staff of their responsibilities in regards to compliance with the recordkeeping plan and state legislation. New staff members are familiarised with the plan through the induction process, and a refresher course for all staff has been planned for the coming year. Our staff members have also recently undertaken online record keeping awareness training provided by the Department of Health.

Corruption Prevention

We are strongly aware of the need to maintain a culture of confidentiality, transparency and accountability. This is especially important considering the nature of our work. A range of policies and initiatives designed to prevent, identify and manage misconduct and corruption have been adopted, including the following:

- OHR Code of Conduct
- Confidentiality Policy
- Conflict of Interest Guidelines
- Risk Management Policy
- Training and education for Public Interest Disclosure officers

Our staff members have been made aware of these policies and initiatives in meetings and through the induction process. The policies are also available for viewing and downloading on our intranet. Staff have also attended education sessions provided by the Corruption and Crime Commission, and been supplied with publications regarding the prevention of misconduct.

In addition to being required to abide by the Code of Conduct, our staff members take an oath stating that they will faithfully and impartially perform their duties, and that they will not divulge any information they receive except in accordance with the governing legislation.
Identifying risks to corporate governance, preventing corruption and misconduct and identifying and managing conflicts of interest will continue to be a priority for us in our organisation.

Occupational Safety and Health

We are committed to the management of workplace injuries and the provision of a safe and healthy work place for employees, contractors and visitors.

Our policies regarding occupational health and safety and injury management were developed in consultation with staff members and are available for viewing on our intranet.

We aim to maintain a ‘zero harm’ workplace free of injury and occupational hazards, where any risk is identified, reported and rectified as soon as possible. Employees are able to raise any occupational health and safety matter directly with the Director or the Business Manager. Occupational Health and Safety issues can also be raised and discussed through a formal mechanism at regular staff meetings.

In accordance with the injury management requirements of the Worker’s Compensation and Injury Management Act 1981, we retain an injury management process designed to respond to any worker’s compensation claims efficiently and with due care, and to ensure that injured workers can stay at work or return at the earliest appropriate time. This policy is available for our staff to view on our intranet. A return to work program has also been developed in accordance with the above Act.

Indicator	2008/09
Number of fatalities	0
Lost time injury/disease incidence rate	0
Lost time injury severity rate	0
Percentage of injured workers returned to work within 28 weeks	n/a
Percentage of managers trained in occupational safety, health and injury management responsibilities	16%

Table 21 - Occupational safety, health and injury management statistics.

In accordance with requirements, a self-evaluation of our occupational safety and health management systems (with a summary of findings) has been conducted.

Appendices

Functions and Powers of the Director [Health Services (Conciliation and Review) Act 1995 Section 10 (1)].

10. Functions and powers of Director

(1) The functions of the Director are;

(a) to undertake the receipt, conciliation and investigation of complaints under Part 3 and to perform any other function vested in the Director by this Act or another written law;

(b) to review and identify the causes of complaints, and to suggest ways of removing and minimizing those causes and bringing them to the notice of the public;

(c) to take steps to bring to the notice of users and providers details of complaints procedures under this Act;

(d) to assist providers in developing and improving complaints procedures and the training of staff in handling complaints;

(e) with the approval of the Minister, to inquire into broader issues of health care arising out of complaints received;

(f) subject to subsection (4), to cause information about the work of the Office to be published from time to time; and

(g) 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; and

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

Registration Boards

Chiropractors Registration Board under the *Chiropractor's Act 1964*.

Dental Board of Western Australia under the *Dental Act 1939*.

Medical Board under the *Medical Act 1894*.

Nurses Board of Western Australia under the *Nurses Act 1992*.

Occupational Therapists Registration Board of Western Australia under the *Occupational Therapists Registration Act 1980*.

Optometrists Registration Board under the *Optometrists Act 1940*.

Osteopaths Registration Board under the *Osteopaths Act 1997*.

Pharmaceutical Council of Western Australia under the *Pharmacy Act 1964*.

Physiotherapists Registration Board under the *Physiotherapists Act 1950*.

Podiatrists Registration Board under the *Podiatrists Registration Act 1984*.

Psychologists Board of Western Australia under the *Psychologists Registration Act 1976*.

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

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