Office of Health Review

Annual Report 2007/08

Statement of Compliance

HON. JIM McGINTY MLA
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 2008.

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

Date: 29 August 2008

Index - 2007/08 Office of Health Review Annual Report

1.0 Overview - Executive Summary

1.1 Executive Summary

The 2007/08 year was a significant one for the Office of Health Review, which saw us expanding our activity levels in our core functions as well as in our supporting business areas.

During the previous 12 months we have seen a large increase in the number of complaints lodged with us, reversing a downward trend and giving us the highest number of complaints since the agency began operations in 1996.

While we discuss the possible reasons for this rise in complaints in greater detail later in this report, I believe that one of the reasons for this increase in numbers is the increased visibility of the Office, and the confidence of providers to refer complainants on to us should their own dispute resolution process fail to deliver agreed outcomes.

We have continued with an education and relationship-building program during the year and it appears that the benefits from this work have been broad. For example, we have established a climate of trust amongst a number of major providers, which has a positive flow-on effect when we conciliate complaints with those providers, as well as the wider provider network.

As ever, the most important aspect in relationship building is the way we conduct ourselves when we are doing business, which for the most part means during the conciliation process. As an independent organisation we always endeavour to act impartially, and to guide parties towards conciliation, to reach an outcome that is agreed and accepted by both parties. I believe that the key reason we have improved our profile amongst providers and consumers over the past year has been our efficiency, impartiality and an ability to impart our conciliation skills.

One significant project that we undertook during the year was focussed on determining the actual provider of a service in a private hospital setting. This project was initiated because we had received a number of complaints against private hospitals where it was difficult for us to determine whether the service had been provided by an individual practitioner or an institution. Sometimes we found that neither party wanted to be identified as being the actual 'provider', which made conciliating the dispute difficult if not impossible. Since the project's completion we have been more readily able to determine the actual provider and in many cases this has made it more feasible to conciliate the complaint.

This year we facilitated important project work in the area of open disclosure. The process of open communication following an adverse event in health care is not a new concept, however the typical legal approach to adverse events and complaints has seen a tendency for health care providers to withdraw from communication for fear of litigation.

In recent years there has been a move to promote effective open communication that is now being backed by a number of international bodies and organisations. In April this year, the Australian Health Ministers endorsed and agreed to the implementation of an 'open disclosure' policy with the understanding that effective open communication has the potential to fundamentally improve the provision of health services.

In March, OHR facilitated a meeting of industry partners within the health, insurance and legal industries, as well as the tertiary sector, to form a collaborative research venture. The aim of this collaboration is to provide leadership and direction in identifying issues and prioritising areas of action around understanding and implementing open disclosure following an adverse event.

During the year we have developed and sustained a number of partnerships that have benefitted the conciliation process and other areas of our work. Our communications staff have engaged stakeholder representatives to participate in a number of projects, including a successful series of focus groups to provide us with consumers' and providers' insights and perspectives to aid the development of our service standards. We have also enlisted the aid and opinions of our stakeholders in the design and content of our publications, including our fact sheets, brochures and posters.

Executive Summary

The Office is fortunate to have a stable permanent workforce with the skills and dedication to effectively carry out our important work. During the year, we have successfully made a number of people in contract positions permanent members of staff.

Over the coming 12 months we plan to employ an Officer specifically to support Aboriginal complainants; and a Medical Officer on a part-time basis, to assist our conciliation staff and to engage in conciliation meetings with providers. The creation of these positions reflects the attention that we have been paying towards the development of specialist roles that can support our core functions of dispute resolution and overall service improvement.

The employment of a specialist legal officer has reaped positive benefits for the Office, including the drafted amendments to our enabling legislation and specific provisions of the Disability Services Act. If passed, these amendments will correct a number of discrepancies between the two Acts, while facilitating a change of name for our organisation to the Health and Disability Complaints Office. This change of name should markedly increase the visibility and profile of the Office as a dispute resolution body.

The coming year will provide us with both challenges and opportunities, which I am sure we will engage successfully.

Linley Anne Donaldson
DIRECTOR

OHR Director Anne Donaldson

1.2 Operational Structure

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

The Office of Health Review operates under the *Health Services (Conciliation and Review) Act 1995*. The Office also deals with complaints regarding disability services under Part 6 of the *Disability Services Act 1993*. The Office reports to the Minister for Health.

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

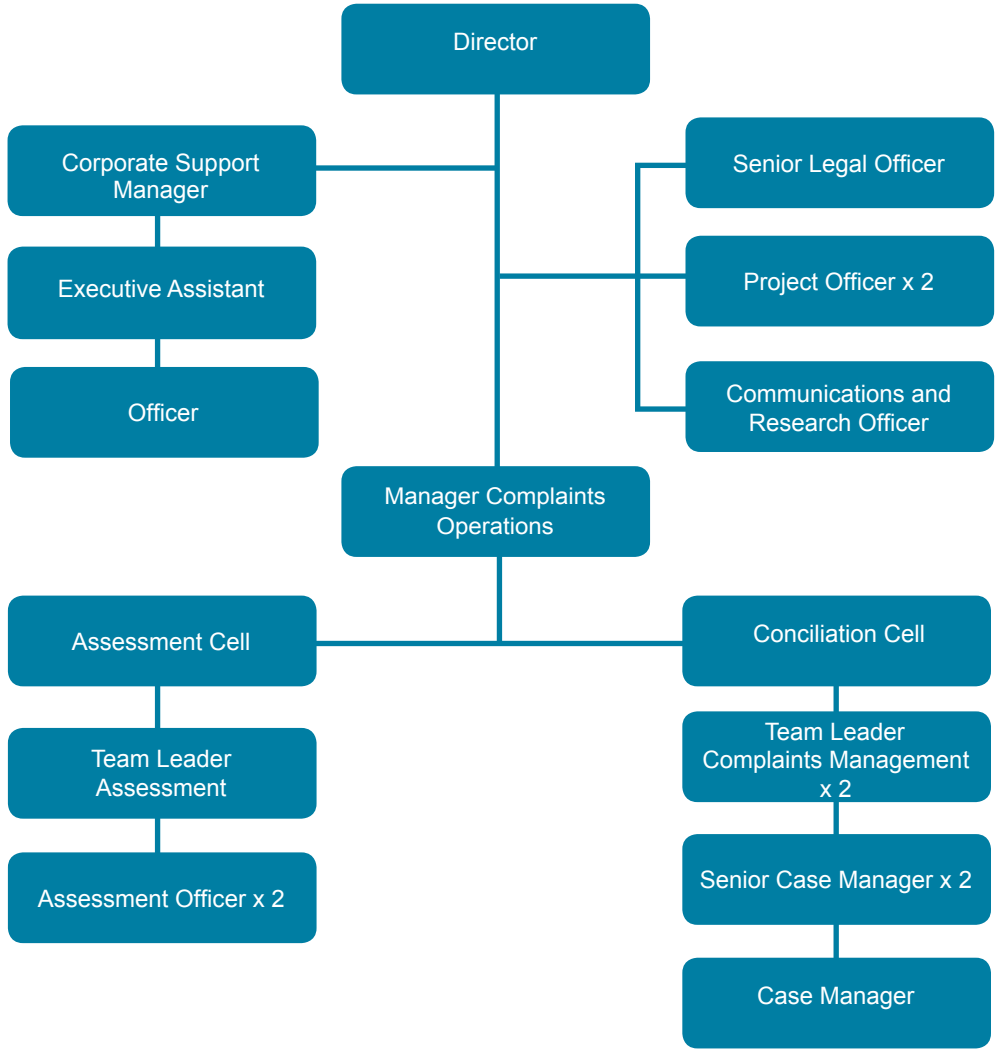
The Office also deals with complaints regarding a range of disability services including accommodation, therapy services, in-home support and respite services. OHR accepts disability complaints not only from complainants but also from a recognised advocate, or from a carer (within the context of the Carer's Charter under the *Carer's Recognition Act 2004*).

The Office works in a spirit of cooperation with both consumers and providers, encouraging disputing parties to reach an agreed outcome.

The Office aims 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 from complaints and providing appropriate feedback to providers and various bodies, such as registration boards and professional organisations.

While the Office hopes to help consumers and providers through assisting them to resolve their complaints, we also strive to empower consumers and providers by imparting to them, during the conciliation process, 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.

OHR Organisational Structure as at June 30 2008



Operational Structure

Being an office of less than 20 people, OHR is not able to support employees in non-core functions such as corporate services and information technology. The Office therefore has an agreement with the Health Department and the Health Corporate Network to provide the Office with human resources, supply, finance, reporting and business systems services, as well as information and communications technology support.

Staff training session

OHR publications

1.3 Performance Management Framework

1.3.1 Outcome Based Management Framework

The Department of Premier and Cabinet's framework for strategic management *Better Planning, Better Futures* outlines a number of goals and outcomes that government agencies are required to align with their own goals and outcomes. State Government agencies are also required to report on their own contribution to the outcomes outlined in the document.

The Office of Health Review has a range of functions related to the provision of health and disability services. While the Office carries out a specific range of functions, contributions are made to a number of goals and outcomes outlined in the strategic framework

Goal 1: Better Services
OHR contributes to the strategic outcome of an effective and coordinated public health service.

The Office does this by imparting dispute resolution skills to health and disability service providers during the conciliation process.

The Office is able to affect changes to policies and procedures as a result of the conciliation process. A complaint will often reveal an opportunity to improve a provider's established method of providing services. When this is the case, OHR will contact the provider and suggest that they consider changing the policy or procedure that may have led to the origins of the complaint.

OHR also has an educational role, where staff members conduct presentations for service providers regarding issues such as preventing complaints and how to handle complaints when they are made.

Goal 4: Regional Development
The Office deals with complaints from people across Western Australia, as well as the Indian Ocean Territories of Christmas Island and Cocos (Keeling) Islands.

While we are a Perth-based agency, we deal with regional complaints through a combination of communication methods including telephone, written correspondence, email and video conferencing. OHR staff members also conducted conciliation meetings in a number of regional centres during the year including Bunbury, Karratha and Geraldton.

Generally, the Office contributes to regional communities by improving regional health and disability services. We do this through conciliating complaints for consumers and service providers in the regions. Conciliating complaints for these groups not only resolves single issues but also equips both parties with resolution skills. In the case of regional providers, the feedback that they receive through the conciliation process enables them to improve their service provision, which in turn benefits the community.

Goal 5: Governance and Public Sector Improvement
As an independent statutory authority OHR contributes to the strategic outcome of a more accountable public sector by dealing with complaints relating to government health and disability service providers.

We are able to monitor incoming complaints regarding public health and disability services and to provide feedback to these providers. Complaint statistics regarding major teaching hospitals are also published annually in the *Annual Report*.

1.3.2 Changes to Outcome Based Management Framework

There were no changes made to OHR's outcome based management structures during the year. The Office continued to work with a five-year strategic plan that was developed in late 2006.

2.0 Agency Performance (Report on Operations)

Community relations

During the year the Office took part in a range of community relations activities to support the core functions of the Office.

A number of conciliation meetings were held in regional centres including Bunbury, Geraldton, Albany, Busselton and Karratha. The staff who visited the towns to participate in these meetings took the opportunity to conduct outreach activities within the community, which included meeting with providers and community groups.

The Office undertook advertising in a number of regional publications, including an Aboriginal newspaper, to promote the services we offer to people living in regional areas. The Office gained media coverage in regional publications and an OHR staff member gave a promotional interview on ABC local radio during a regional visit.

The Office also advertised in a number of languages on a community radio station to boost our profile among Western Australia's culturally and linguistically diverse populations.

A review of our publications took place during the year, which saw the launch of a new range of information brochures targeted at both consumers and providers. The brochures, which were re-written in consultation with a number of our stakeholder groups, are designed to provide clear, concise information about our services.

The Office also produced and distributed a number of other publications. Posters promoting the Office's services were distributed to a range of institutions. A compensation fact sheet was developed in response to a perceived need for some clarification regarding this issue amongst service providers and consumers. A guide to preventing and handling complaints was adapted from a document produced by the New South Wales Health Care Complaints Commission, after OHR had received requests from provider representatives for such a publication.

The Office continued to publish its quarterly newsletter *The Health Review* during the year. This publication has continued to be a valuable tool in promoting the Office to our stakeholders. The readership of the newsletter was significantly enhanced during the year following the development of a distribution list.

OHR publications

Agency Performance

Proposed legislation changes

During the year OHR's Senior Legal Officer worked on a project involving proposed amendments to the *Health Services (Conciliation and Review) Act 1995* and the *Disability Services Act 1993*.

This work follows on from the 2002 review of the Office that was conducted by the Minister for Health. The reasons for the recommendations were to make the resolution of complaints more efficient and to remove inconsistencies between the legislation and the process of dealing with complaints. In the review, of the 44 recommendations that were accepted, 18 require amendments to both Acts.

The proposed amendments relate to a number of areas contained in the legislation. These areas include consistency between the two Acts, time limits for providing responses and various sections concerning the acceptance and rejection of complaints.

The proposed amendments have been drafted and submitted to Parliamentary Counsel for consideration.

Complaints Database

During the year the Office continued work on the development of the new complaint database, CRED (Complaints Resolution Electronic Database), in conjunction with information technology staff from WA Health.

The new database was proposed because the Office's original database, RAEMOC, was becoming unstable and compared to contemporary products it had a limited range of functions and was difficult to use.

The Office initially underestimated the amount of work required to establish the new database. While we had hoped that the database would be implemented during the year, this was not possible. Implementation and further development of the database will continue during the next financial year.

Agency Performance

Systemic Issues Group

During the year a Systemic Issues Group was formed at the suggestion of an OHR staff member.

The group was developed to help ensure that complaints that appeared to indicate systemic problems or issues with particular service providers (or across provider groups) would be identified and dealt with in order to prevent their recurrence.

During the year the systemic issues group met regularly to examine complaint reports to determine whether any complaints revealed a systemic issue. These were then examined more closely and recommendations for action were made to the Director.

The activities of the group are indicative of the preventive role OHR has undertaken to support and contribute to the improvement of health and disability services.

Disability Services Training

In the previous financial year, the Office collaborated with National Disability Services (NDS) in seeking a funding grant through the Disability Services Commission. The grant was approved by the Commission, and was set aside to fund training for staff working in disability services.

After canvassing people working in the industry during 2007/08, it appeared that training in relation to preventing and handling customer complaints was the area in which most staff sought training.

NDS developed a series of workshops based around the theme of 'Managing Complaints in Disability Services.' Each workshop had a separate theme, which included complaint prevention, understanding needs, improving systems and dealing with difficult situations.

The workshops created significant interest within the disability services industry. Due to the success of the workshops, a similar series for regional locations has been suggested.

Agency Performance

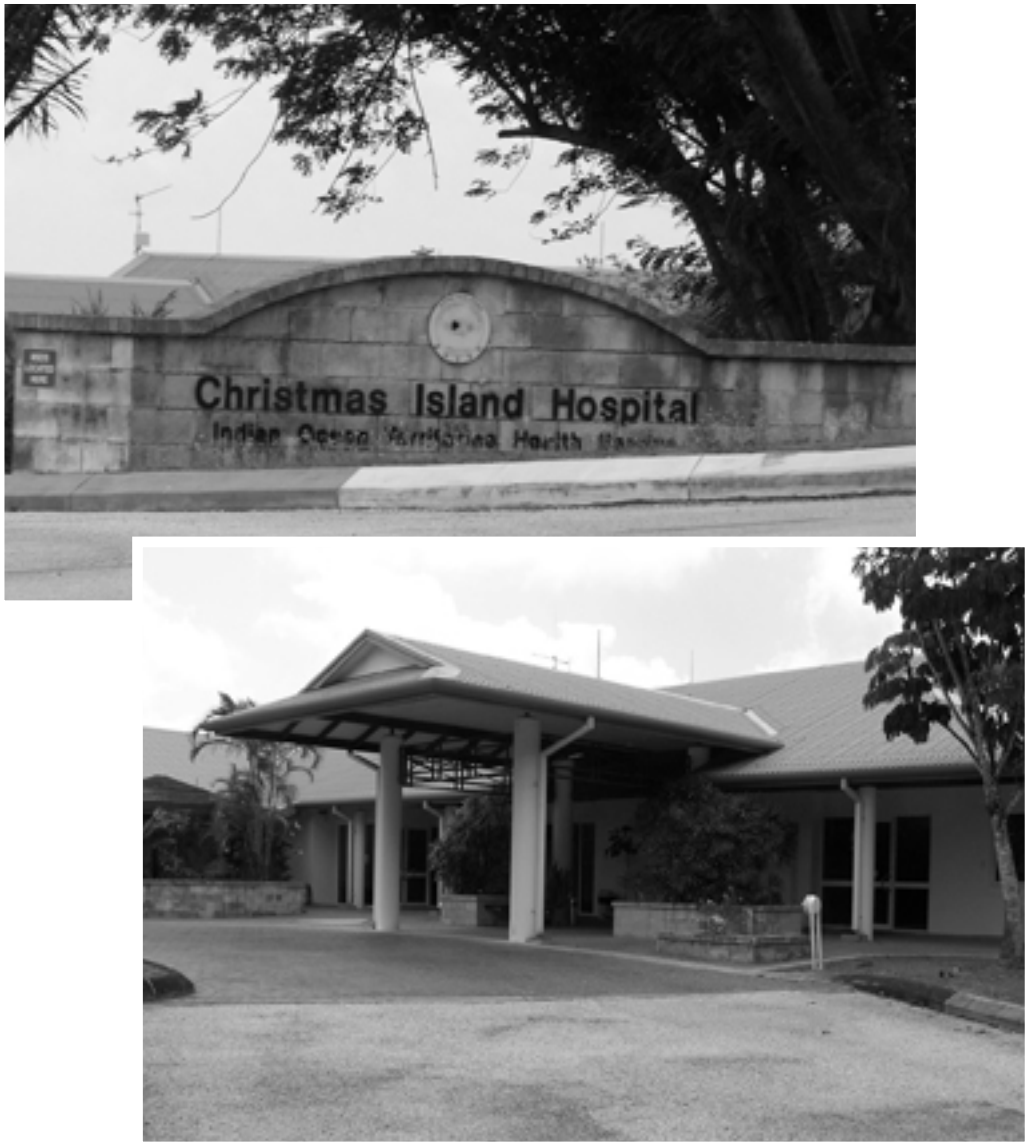
Indian Ocean Territories

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

OHR deals with complaints about health and disability services for residents of CKI and CI. Complaints can be received about services provided on CI and CKI and also services provided in Western Australia to people from both territories.

During the year, a senior OHR staff member visited Christmas Island. The visit provided the opportunity to meet with health and disability service providers, local government officials and community representatives. At these meetings, the OHR staff member sought to raise the profile of the Office and inform people about our roles. The local providers and consumers also discussed various issues related to the provision of services on the island.

The Office is planning to send a staff member to the Cocos (Keeling) Islands early in the next financial year to engage in similar outreach activities.



Christmas Island Hospital

Agency Performance

Development of Procedures Manual

The Office has continued to develop our procedures manual, a document that sets out the procedures involved in the conciliation of health and disability service complaints.

The manual is an active document which is continually updated to reflect the evolutionary nature of our work in dispute resolution through conciliation.

Development of the manual undertaken during the year included alterations to reflect the Office's new Service Standards.

New office space

As a result of a small increase in staff numbers during the year, OHR looked at opportunities for expanding our accommodation.

Due to an extreme shortage of office space within the central business district, the only option was to take up an additional tenancy within the current premises. This space, which is on a different floor to the main office, now houses OHR's conciliation staff.

While housing staff in two separate areas was not the preferred option, measures have been taken to maintain communication between staff members. The relocation of staff will also allow the Office to consider refurbishing the main office.

Graduate Program Officer

In October, OHR successfully attracted a Graduate Officer from the WA Health Department's 2007 Graduate Development Program (GDP). The graduate chose OHR's diverse and challenging range of projects from over 50 other opportunities offered to the program members for their final placements for the year.

The four-month placement centered on writing service standards for the Office. The contracted Officer has since become a permanent member of staff.

OHR Service Standards

During the year OHR developed Service Standards that incorporate published prinicipals and values relating to how OHR operates and interacts with consumers, providers and other groups.

The standards aim to codify the expectations that consumers, providers and internal staff have from OHR.

In developing the standards, the Office consulted with representatives from health and disability providers, consumers, insurance and other industry groups. This identified what information was needed, and how the standards could be crafted to meet the expectations of our stakeholders.

These key areas of feedback contributed to the standards, and related to the importance of OHR being timely, impartial, conciliatory, confidential and accessible to all parties.

The service standards provide a benchmark against which the office can now review its own performance.

Senior Legal Officer

The Senior Legal Officer who joined the Office in the previous financial year continued with a number of projects relating to the legal aspects of OHR's business. This included working on proposed amendments to OHR's enabling legislation, and the drafting of consumer information regarding issues such as compensation.

Following the Senior Legal Officer's appointment, a series of meetings were held between representatives from OHR, the Health Consumers' Council and a number of Perth legal firms.

These meetings were held in response to a number of situations occurring where complainants seeking financial compensation had been advised that they might wish to seek independent legal advice. Having done so, some of these individuals had incurred a large fee for initial consultations.

Agency Performance

OHR and the Health Consumers' Council felt that that some form of material should be developed to educate consumers about financial compensation, particularly about the likelihood of success and what needs to be established before proceeding with legal action.

In response, OHR prepared a non-legal information fact sheet regarding claims for financial compensation, which is available from the Office's web site.

The Health Consumers' Council and a number of Perth legal practitioners developed a legal clinic, where complainants who are seeking financial compensation can discuss their complaint with a lawyer in an initial consultation, at no cost. The main purpose of the initial consultation is to determine whether the complainant has suitable grounds for making a claim.

A successful trial run of the clinic saw it operating on a monthly basis, open to complainants who had been referred by the Health Consumers' Council and OHR. The Health Consumers' Council and the legal practitioners who worked pro bono are currently discussing future plans for the clinic.

Undergraduate Work Placement

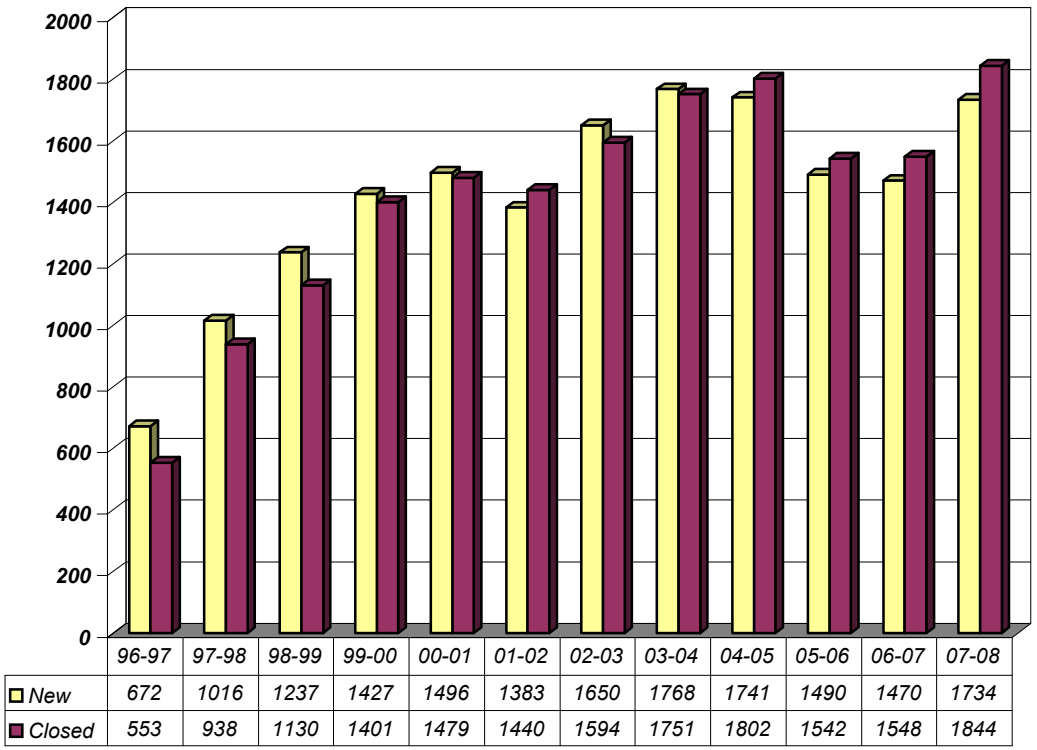
During the year the Office attracted a university student to complete a 90-hour internship as part of Notre Dame University's undergraduate work placement program.

Working closely with the Senior Legal Officer, the student participated in and managed a number of projects. The student's main role was to assist the Senior Legal Officer develop a Memorandum of Understanding between OHR and the Medical Board.

The contribution made by the student was significant and has encouraged the Office to continue its relationship with higher education institutions in Western Australia. OHR thanks Notre Dame University for this opportunity.

Agency Performance - Complaints Management Report

Graph 1: New and Closed Complaints 1996-2008



	96-97	97-98	98-99	99-00	00-01	01-02	02-03	03-04	04-05	05-06	06-07	07-08
New	672	1016	1237	1427	1496	1383	1650	1768	1741	1490	1470	1734
Closed	553	938	1130	1401	1479	1440	1594	1751	1802	1542	1548	1844

In the last financial year OHR received 1734 new complaints relating to health and disability services and finalised 1844. We have closed more cases this year than in any other year since we were created, increasing 19% since last year. In the same period new complaints have increased 18%.

The number of complaints open on 1 July 2007 was 210, with 125 open on 30 June 2008.

OHR has two teams working on the resolution of health and disability complaints – the Assessment Team and the Complaints Management Team. The Assessment Team undertakes initial assessment of the enquiry, and where appropriate passes the complaint on to the Complaints Management Team. Of the 125 complaints open on 30 June 2008, 80 were sitting with the Assessment Team and 40 with the Complaints Management Team.

Table 1: Workload Data 2006/07 to 2007/08

	2006/07	2007/08
Active complaints 1 July	268	210
New complaints received during the year	1470	1734
Total complaints handled	1738	1944
Complaints closed during the year	1548	1844
Balance	190	100
Re-opened cases	20	25
Active complaints 30 June	210	125

The Assessment Team

The Assessment Team takes phone calls about new complaints, receives complaint forms, and gathers all the information that is necessary for a complaint to be assessed.

The role of the Assessment Team will change for the first three months of the next financial year. In addition to gathering the information together needed to assess a complaint, the team will also trial the role of contacting the provider, and recommending whether to accept, reject or refer the complaint.

This change will allow us to reduce the time taken to assess a complaint, and to better facilitate the handover of information to the Complaints Management Team.

We look forward to the change and will report on the outcome in next year's *Annual Report*.

In 2007/08 we created the Assessment Team Leader position and have been developing this role in relation to the team's processes. The Team Leader has:

- supported our decision-making processes,
- represented the interests of the team at internal and external meetings,
- supervised the two other Assessment Officers, and,
- taken part in refining practices and procedures.

Agency Performance - Complaints Management Report

Complaints Management Team

Many of the enquiries initially made to the Assessment Team are either resolved through providing information, or referring the complainant to the provider to discuss the matter directly.

Where complaints have not been resolved they are referred to the Complaints Management Team.

The Complaints Management Team is made up of seven Case Managers. They assess the complaint to see whether it is suitable for conciliation or investigation.

The Complaints Process

Enquiry stage

The Assessment Team initially assess our complaints to determine if they fall within our legislation. To do this we need the complaint in writing and an indication that the complainant has attempted to address the matter directly with their provider. If making a complaint about a disability service, the consumer does not need to contact the provider.

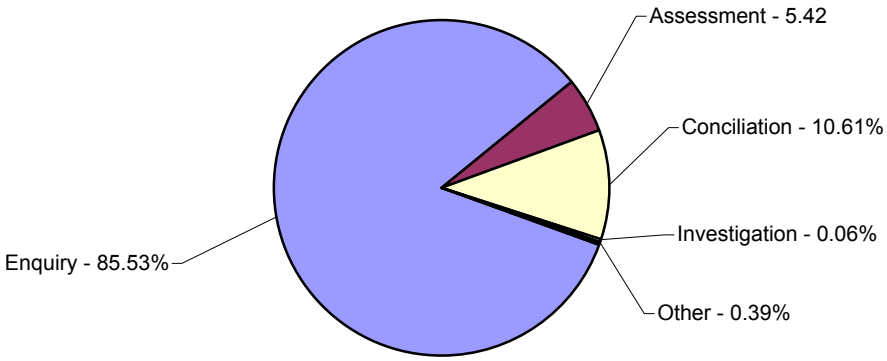
If we consider that a person may find it difficult to return to the provider we can refer them to an advocate for assistance.

In cases when we refer a complainant to the provider, the complaint may be quickly resolved between the two parties without our assistance. We have identified that we need to work with providers and consumer stakeholders to understand what factors encourage early resolution, and what may inhibit it.

After referring a complainant back to the provider, we have a policy of contacting people after 6 weeks to enquire how they progressed.

If the grievance remains after a reasonable attempt has been made to resolve the complaint with the provider, we can reassess the complaint to see whether it can be accepted. Complaints can be closed at any stage in our process. In 2007/08, 85.6% of complaints were closed at enquiry.

Graph 2: Health Complaints Closed at Each Stage



OHR Case studies: *Throughout this report we have included a number of case studies that we hope give a human element to our reporting and statistics. We have tried to omit any information that could be used to identify any of the parties involved. Some minor details have been altered to preserve confidentiality.*

Case study

An elderly man underwent a routine surgical procedure at a private hospital. Following the treatment, he was left to clean himself unassisted by the hospital staff and was very dissatisfied.

He called OHR to discuss whether he should pay the gap that remained outstanding to the hospital because he was unhappy with the care provided. An Assessment Officer referred him back to the hospital to seek a resolution. After making contact with the Patient Liaison Officer at the hospital, they quickly agreed that it should never have happened. They cancelled the outstanding account and apologised to the patient.

Agency Performance - Complaints Management Report

Informal referrals to other agencies and services

In addition to playing a key role in processing the 1734 new complaints made last year, the Assessment Team received 358 calls that did not relate to health service complaints. These callers may have wanted general information or needed to be directed to another agency.

A sample of the agencies callers have been referred to over the past year is detailed below. In many cases more than one agency was suggested to the caller, however, only the first one listed for each enquiry is recorded in the table.

Table 2: Callers referred to other agencies

Agency	Referrals
WA Health Department	33
Environmental Health Officer, Local Council	20
Local Council	24
DoCEP	22
State Ombudsman	17
Minister for Health	9
Private Health Insurance Ombudsman	8
Federal Privacy Commissioner	7
General Practitioner	6
Health Consumers' Council	6
Legal advice	6
Department of Health and Ageing	5
Disability Services Commission	5
Medicare	5
Other	175
Total	358

Enquiries about health issues, not health services

A number of enquiries the Assessment Team receives relate to health issues, but OHR only deals with professional health service issues. Examples of issues we cannot deal with include food safety and environmental health problems such as pollution.

Over 30 enquiries were recorded last year reporting food safety breaches, or incidents of food poisoning. While food safety is a health issue, it is not a complaint about a health service provider and therefore not in OHR's jurisdiction. Assessment Officers refer these callers to the Environmental Health Officer in the local council of where the incident occurred for further action. Reportable food poisoning outbreaks are also referred to WA Health.

Health service complaints not appropriate for OHR

From time to time we get complaints that may relate to a health service but another organisation can address the issues within the complaint. For example, where a complaint about a health service appears to be solely a contractual matter we may refer the complaint to DOCEP - although we can and do deal with this sometimes.

These types of complaints commonly occur in national health franchises that follow a 'business' model, whereby patients agree to a contract for health services provided over a set period of time. Often these involve considerable sums of money, and contracts are agreed to over the phone.

Vulnerable patients may not fully understand or realise the terms of a contract they sign and may not understand that such a treatment plan is binding. As a result, we frequently get complaints relating to the contractual arrangements between the consumer and provider in this type of health business.

In some cases, medications are dispensed over the phone by health franchises without an in-person consultation. This can have disastrous consequences for callers who are not given a correct explanation of the treatment and its associated risks, nor given the opportunity to provide their medical history. We can deal with complaints that relate to this type of treatment.

Agency Performance - Complaints Management Report

Instead of consulting a health care business, a better solution for patients may be to consult a general practitioner who can point them in the direction of good quality information at a much lower cost. A GP can also ensure that they have understood the medical history of the patient and offer an appropriate treatment.

OHR publications

Case Study

A man called a nationally franchised company that advertises impotency treatments for advice of how to overcome premature ejaculation.

He had a phone consultation with a doctor and was recommended a course of tablets. He asked about any possible side effects and the doctor was able to outline three possible adverse reactions. He paid over $1400.00 for the treatment.

After receiving the script he later looked up the drug on the Internet. He found out the tablets were a tricyclic anti-depressant. This presented a great issue for the man as his employer did not allow staff to take such medications due to the high-risk nature of his workplace. He would have been unable to work had he commenced the treament. Furthermore, the side effects he discovered online were more serious than what he was told over the phone.

The man felt he would not have agreed to the treatment if he had been given enough information. Subsequently he made a complaint to OHR after raising his concerns with the company and being refused a refund. We accepted the complaint and referred the matter to conciliation. Following contact with the business, they refunded $1024.00 to the consumer.

Agency Performance - Complaints Management Report

Spotlight on: General Practitioners

There are shortages of GPs across both the metropolitan and country areas. For this reason access to appointments can be difficult and many people cannot see a GP.

Compounding this shortage is that GPs are entitled to decide who they will see. They provide a private service and clinics operate as small businesses. GPs are able to choose who to see, what to charge, and who to turn away. They do not have to treat an urgent patient, nor even a long-term patient who has been with them for many years.

For most patients this may never be an issue, however, where there has been a breakdown in the relationship between a patient and a GP there is no obligation for treatment. This is further exacerbated in rural areas where there may only be one GP in the district. Where the relationship cannot be restored the patient may have to present to the local public hospital for their future health needs. This puts more pressure on hospitals.

When we receive a complaint about a GP, the Assessment Team determine whether we are able to proceed, and to what extent on the issues that have been raised. OHR may not often be able to assist complaints relating to access or fees. We can only accept complaints about a private health service where the provider has acted unreasonably in providing a health service. We can, however, take complaints about public providers who have refused to provide a service.

General practitioners attracted 55.4% of complaints about medical practitioners received last year by specialty, however, this figure is tempered somewhat by the volume of people who see GPs each day. In many cases they are the first point of entry for consumers when moving through the health system.

Case Study

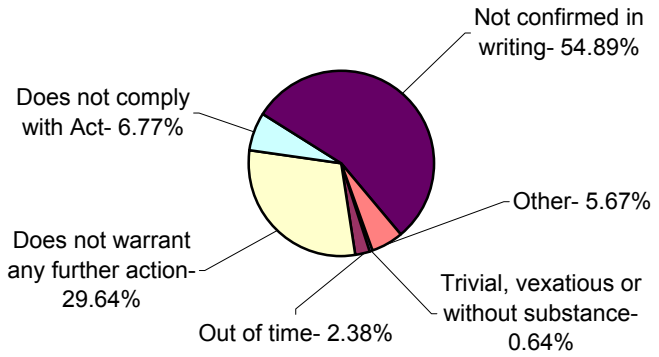
A complainant approached OHR, dissatisfied with treatment provided by several staff at a private medical practice. The relationship between the complainant and the practice had deteriorated to the point that a conciliation meeting was not something the provider felt comfortable participating in.

The provider expressed a sense of grievance that this office was dealing with the matter at all as in their view it did not have any substance.

However after further discussions with the case manager, a written response was provided via the provider's legal representative, which included an apology to the complainant. This did resolve the matter for the complainant however the provider was left with the sense that the matter should not have been accepted into our processes.

Agency Performance - Complaints Management Report

Graph 3: Complaints - Rejected 2007/08



Accepting, rejecting and referring complaints

When we receive all the information needed to assess a complaint we decide whether to accept, reject or refer the matter.

Rejecting complaints

1093 new complaints made to us this year were rejected for a variety of reasons. Most of the rejected complaints:

- had not been confirmed in writing
- did not warrant any further action, or
- involved an incident that occurred too long ago.

Complaints made to us cannot relate to issues occurring more than 12 months previously for health services, or 24 months for disability services, unless there are exceptional circumstances.

It is of concern to us how many complaints are not confirmed in writing. This could indicate that the complainant has decided, for whatever reason, not to proceed with the complaint. However, it could also indicate that they have difficulty in completing the form or expressing what has occurred in writing.

To address this issue of equity we actively promote the use of advocates when we identify that a complainant may have an issue with literacy, including where English is not their first language. Ensuring that we are accessible is part of our Service Standards and we will continue to monitor this situation over the next year.

Sometimes there are circumstances where a complaint may be vexatious. One example is matters that arise in response to family law court rulings. One partner may want to complain about not getting access to medical records or medications prescribed to a child when in the custody of the other parent. They then may want to make a complaint about the clinician who is caught in the middle of the dispute.

A medical practitioner may be caught between their obligation of giving medical records to the parent who had custody at that time, and the unclear legal issues if disclosing it to the other. Either way, they would be entering into the dispute on some level.

In cases like this we would be likely to reject the complaint on the grounds that it is vexatious, and advise the complainant to see their family law solicitor.

We reject very few complaints each year on the basis that they are vexatious or trivial, with 4 recorded this year. We are careful of how we use these categories to reject a complaint because a complaint is never trivial to the person making it.

Agency Performance - Complaints Management Report

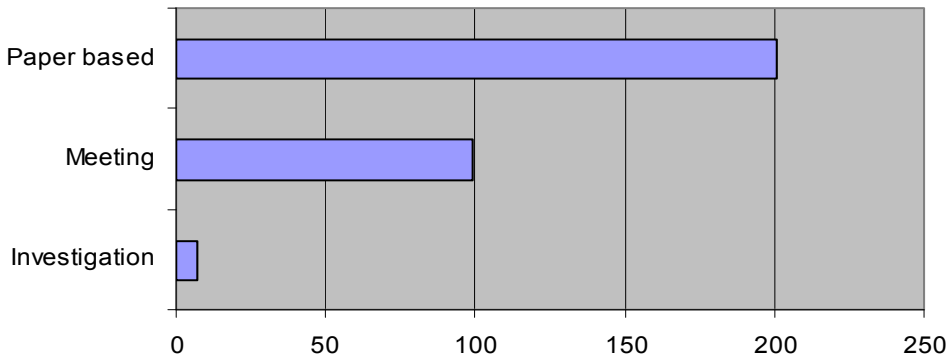
Referring complaints
As detailed earlier, we informally refer many callers at the enquiry stage to other agencies. Within our legislation we also are able to make formal referrals. Last year we formally referred 14 new complaints to other agencies, 4 of these to registration boards. This category is where we have received a complaint in writing that appears to fall within our jurisdiction but is better dealt with by another body.

Accepting complaints
Complaints we can assist with usually involve a consumer of a health or disability service who believes that the provider has been unreasonable in the manner of providing a health or disability service. A representative or carer of the consumer can also make a complaint.

A staff workshop was convened to assess our progress in the 2007 calendar year. As part of this, we analysed how we approached accepted complaints. We reviewed whether accepted complaints were:

- conciliated by paper
- conciliated through meetings, or,
- investigated.

Graph 4: Approach for Accepted Complaints



In the past year there have been four active investigations. Three of these concern disability service complaints. This is explained by our legislation, as under part 6 of the *Disability Services Act 1993* we must investigate when conciliation has failed. The *Health Services (Conciliation and Review) Act 1996* leaves this decision to the Director in the case of health service complaints.

Complaints in most instances are referred for conciliation. The focus of the agency is on a flexible, open process to facilitate and expedite discussions between provider and complainant, and conciliation can provide this.

As an alternate dispute resolution process conciliation is protected. Its confidentiality provisions prohibit information from the conciliation process being used in any legal proceedings.

It has been brought to our attention this year that when we say we 'accept' a complaint it may be creating the impression that we endorse the material within that complaint. We have appreciated this feedback because we had not previously considered how accepting a complaint would appear to the parties involved in a complaint.

When we accept a complaint, we are accepting it into our process. We are an impartial third party to the complaint and act between each party to find some common ground to resolve the issues as they stand. Our role within this is not to endorse one view over another, rather we provide an opportunity for those views to be shared.

There are times when we accept a complaint where a provider does not believe that this was the correct course of action, however, we must accept complaints that fall within the bounds of our legislation.

Agency Performance - Complaints Management Report

A conciliation process can either occur through meetings, or letters, or a combination of both. When used appropriately each approach can effectively bring about the resolution of a complaint.

Paper based conciliation

Our analysis shows that the majority of complaints were conciliated on paper in 2007. This reflects the fact that some cases do not generally require a meeting, particularly those involving a refund. We have proposed changes to our legislation to add a stage called 'negotiated settlement' which would cover complaints such as these.

A provider may prefer a paper based conciliation model because it appears to be less time consuming than attending a meeting, however many underestimate the steps involved. They must first draft the correspondence, check the accuracy of the facts, and obtain an appropriate level of clearance from superiors before finalising the document. This can take a long time and that can impact on the ability to resolve the complaint.

We may recommend paper based conciliation for more straightforward issues. Even where paper based conciliation is the recommended course of action there can be misunderstandings that arise from the indirect mode of communication.

All the same, paper based conciliation can be highly effective for many issues. In most cases a private practitioner will conciliate this way.

Case Study: Paper Based Conciliation

A woman complained that there had been no follow up after a surgical procedure. She reported not having recovered from the surgery and suffering a number of ongoing complications that she felt had contributed to the breakdown of her relationship with her partner. The specialist concerned was advised by her insurer not to meet with the complainant, so the matter was conciliated via letters.

The specialist provided a written response but it did not fully address the issues in the complaint. Further discussion between the case manager and provider were necessary to ensure that the response was amended to cover all the matters raised in the complaint. The resulting delay in providing a written response may have been part of the reason the complainant withdrew from the process and did not contact this office to confirm that the provider's response had addressed the matter for her.

Case Study: Paper Based Conciliation

A patient had attempted to negotiate a refund directly with the provider. When unsuccessful, she made a complaint to our office for a refund that was more comprehensive than what she had originally requested from the provider. Relations between the two parties had deteriorated prior to the complaint being made to this office and conciliation was therefore conducted on paper.

After further discussions, an independent opinion was suggested as a way forward. This opinion did not alter the matter at all and the initial refund was still on the table at the end of this process. However, confusions arose between the parties about what a 'full refund' meant and to add to this, the provider requested a deed of release at the end of the process.

Meetings often provide a more interactive mode of communication to ensure that all matters are discussed in detail and can help prevent any misunderstandings. As there had not been this opportunity for the parties to meet, by the end of the process they were both confused and frustrated. Eventually the refund amount was clarified in a deed of release.

Agency Performance - Complaints Management Report

Spotlight on: Private Practitioners and Private Hospitals

A complainant who has an issue with the care provided at a private hospital may experience both a conciliation meeting and a paper-based process when resolving their issue. This is because issues relating to nursing care would need to be conciliated with the hospital, while clinical issues would be conciliated with the private practitioner. Private health sites are typically very open to the conciliation process, but private medical practitioners are generally not able to meet with complainants. This is often because it contravenes advice from their insurers.

We have concerns about the perceptions of the complainant when a hospital is open and willing to meet, yet the practitioner is not. This can sometimes create the impression that the practitioner is disinterested in comparison to the hospital, fuelling an environment of suspicion that can work against conciliation. While this dual process can be an unwieldy process for all parties, it is the compromise solution offered to respond to the hospital's contracting arrangements.

The dual system still allows the practitioner to have a voice within the conciliation process and offer their views on the issue, and they can do this with the support of the insurer. We would prefer private practitioners being able to attend a conciliation meeting when appropriate, but are working to understand this issue better from the perspective of practitioners and insurers.

At any stage either party are still able to meet with the Case Manager to assist bring about the resolution of the matter, no matter which avenue they have selected. Case Managers can offer their insight into the complaint and encourage conciliation as they are well placed to understand where the barriers for resolution might lie with each party.

Conciliation conducted through meetings

A meeting based conciliation model can quickly bring about a resolution of matters that have become entrenched and address the human element within the issues. Where possible, and appropriate, we aim to hold conciliation meetings.

A facilitated face-to-face meeting can give both parties the opportunity to engage in a discussion and see the issues from another perspective. When parties feel listened to they are often more receptive to the other person's point of view.

Conciliation meetings are particularly effective when there has been bereavement. We dealt with a number of complaints related to deceased people during the year.

We are becoming more aware of the importance of separating the grief in a complaint from the grievance so that the parties can deal appropriately with each component. The opportunity to have a meeting can assist families where there has been a death, even a long time after the event.

Public and private hospitals have tended to embrace the conciliation model, and there have been a number of very positive outcomes. Hospitals are able to provide appropriate personnel to manage a complaint and to attend the meeting on the day.

We find that pre-conciliation meetings are an effective way of sorting through the issues that each party would like to raise at the joint meeting, and can assist in a more effective conciliation meeting.

There are times when a conciliation meeting can fail to foster an effective dialogue between the parties, causing distress or offence. In some cases this can irreparably damage the ability of the complaint to be resolved.

We attempt to prepare each party for a conciliation meeting in an effort to prevent such a situation from occurring. However the dynamics on the day will determine whether a matter can be discussed in a way that is beneficial. Often a conciliation meeting is not practicable for parties because they live too far apart. Where uniting the parties at a common place is not possible, we offer teleconferencing in an attempt to facilitate the communication between parties.

Agency Performance - Complaints Management Report

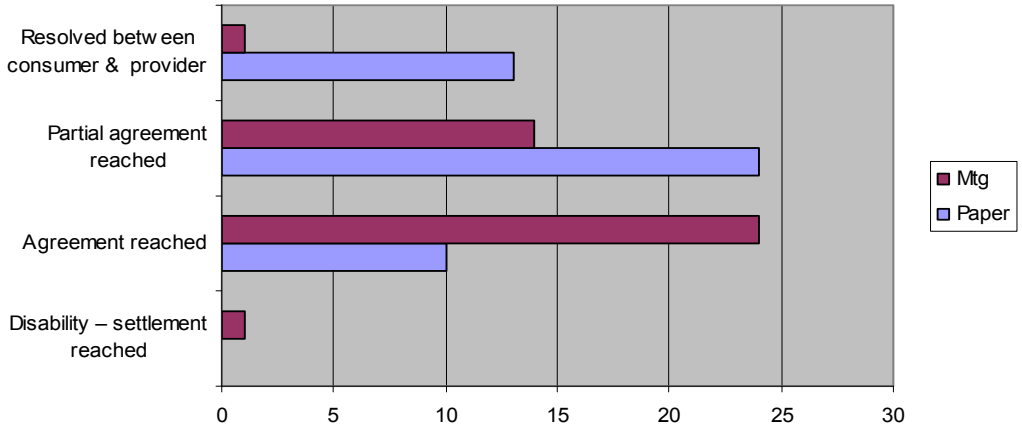
Comparing paper and meeting based conciliations

In the 2007 calendar year there were significantly more cases where complete agreement was reached through a meeting, than through paper-based conciliation.

This could either indicate meetings are a more effective means of resolving a complaint, or that parties who are wiling to meet may be more willing to come to an agreement. There may also be other factors at play we have not considered.

In any event both models offer a means of resolution of the issues. Service providers agreed to a change in procedure or practice in 30 of the complaints that were closed last year.

Graph 5: Agreements Reached in Paper and Meeting Based Conciliations



Compensation

Many complainants continue to put compensation forward as an outcome they are seeking. This means we must in some way acknowledge the issue, but negotiating a settlement for the complainant is not our role.

Generally we can offer the complainant the opportunity to ask the provider for information on how they can independently pursue compensation and clarify the process followed. It is our preference that the compensation process, and not compensation itself, remains an agenda item at conciliation meetings where requested. In a few cases a provider will consider dealing with compensation within our process, and was an outcome in five complaints last year.

Many providers have concerns regarding how compensation can be factored into conciliation meeting discussions. Many view that by virtue of having compensation on the agenda it can violate the conciliatory spirit of the meeting.

However, where providers are willing to discuss the process of how the complainant might pursue compensation, it can encourage the sense that the communication lines are open and help restore the trust between the parties. This facilitates conciliation of the other issues on the table.

Regardless of what has occurred, however, various studies suggest that patients are less likely to sue a physician if an error is openly acknowledged and explained. Failure to achieve these outcomes can be what motivates some people to take legal action.

A conciliation meeting that is conducted openly can be an alternative to legal action, and not its precursor. There is evidence around the world that effectively communicating with patients can reduce the number and cost of claims for compensation - a conciliation meeting provides a forum that encourages effective communication to occur.

Agency Performance - Complaints Management Report

In 2007/08 we spoke about this issue to the CEO Forum, the leadership group of the WA Health Department. Headed by Acting Director General Peter Flett, the group agreed that a consistent approach was needed across all public hospitals in relation to the way compensation is addressed in a conciliation meeting. 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 next financial year.

Refunds

Complaints in which a complainant is seeking a refund for services that did not meet their expectations are generally appropriate for our conciliation process. If a refund was the only outcome desired by the complainant then we may recommend a paper-based conciliation model.

Refunds are frequently requested from people that are not satisfied with a health or disability service for which they have paid.

In other cases, refunds are sought when someone does not believe they have given their informed financial consent for a procedure. This means that they were not aware of the costs involved with the procedure prior to it being performed.

Informed consent

We received a number of complaints where a patient does not believe they consented to a procedure, or were not given enough information to understand the risks involved. To avoid misunderstandings, it is essential that clinicians explain procedures fully to patients, ensure they are aware of the risks, and record the conversation in the medical notes.

As the provider and complainant may have different recollections of any discussions taking place, a good record can help to guide conciliation of the issue. Consent discussions are not always recorded in medical notes and we have noticed this can cause some issues for the provider when dealing with a complaint.

Informed financial consent

As well as ensuring that a patient understands the treatment and the risks involved, it is also important that they are aware of the costs involved in treatment.This is a common issue in private hospitals because different aspects of the care provided are billed by different parts of the system and it is not always possible to foresee the costs involved. There may be costs from the specialist, anaesthetist, pharmacy, hospital room, as well as prosthesis costs for any surgical items required.

The complainant may think they are aware of all the costs incurred, only to receive an additional invoice.

The added complication of private health insurance and gap charges exacerbates the issue of informed financial consent. Many private health providers are knowledgeable about health funds and may feel comfortable discussing the likely gap with the patient. They may also be able to match components of the treatment, such as the prosthesis selected, to what is covered by the patient’s policy.

While this can be very helpful to patients, it remains the patient’s responsibility to determine what is covered by their insurance and how much they will be out of pocket. Complaints about gap fees are more common in some specialties. We find that gap payments and out of pocket expenses are frequently an issue in radiology. Complainants report sometimes not being aware of costs at the time of ordering tests.

A leading radiological provider has discussed this issue with us, and they suggested Medicare rebates for procedures could be contributing to the amount of complaints we receive in this area. Medicare reported that rebates have not increased in this area for many years. In addition it is often the changing patient status, such as from inpatient to day patient, when the rebate reduces and an unexpected fee may arise.

Autopsies

The issue of autopsy has arisen in a number of enquiries and complaints. It is a very difficult situation in which to make decisions relating to whether or not to request or consent to an autopsy. The absence of an autopsy can leave unanswered questions for family members.

The facilities of hospitals in being able to offer this service will vary, and a shortage of pathologists can make waiting times quite long. This situation can be further compounded in smaller hospitals that do not have a morgue.

In some cases complaints have been handled within the health organisation by a number of case managers and a paper based approach implemented. Some of these complaints when referred to OHR have been resolved through the use of face-to-face conciliation meetings.

Dentures

A denture is a prosthesis composed of artificial teeth bonded to plastic gumwork, supported in the mouth by a plastic or metal base. It is not a like-for-like replacement for patient's natural teeth- it is an artificial prosthesis which acts as a substitute to having missing teeth.

We deal with many complaints about dentures, and have identified the issues in this area as being:

- difficulties in adapting to a new prosthesis (restoring function, appearance and speech),
- emotional and/or psychological issues attached to the loss of teeth and having to wear dentures
- varying ability to manage a denture
- dealing with an elderly and potentially vulnerable demographic
- significant costs involved, and,
- in some cases poorly constructed dentures.

Every mouth is different in shape and function and every patient's ability to manage a denture will be individual. For this reason, every complaint we deal with about dentures must be looked at on an individual basis. Some complaints about the standard of the denture are upheld, but in any event complaints in this area are difficult to deal with because the suitability of a denture can be subjective.

When it comes to dentures, communication is crucial. The provider must clearly define with the patient what can and cannot be achieved at the outset. From there, they must be prepared to be involved in an ongoing process of managing the expectations of the patient.

Case Study: Resolved denture complaint

A woman attended a private dental service to have a denture made after all her teeth were taken out. She then experienced problems with the denture and returned to the provider without success. The outcome of conciliation was that it was agreed that the denture was not made to an adequate standard and that it would be re-made at no cost. Furthermore, it was agreed that the denture would be used as a training exercise for junior staff to avoid the same complaint recurring.

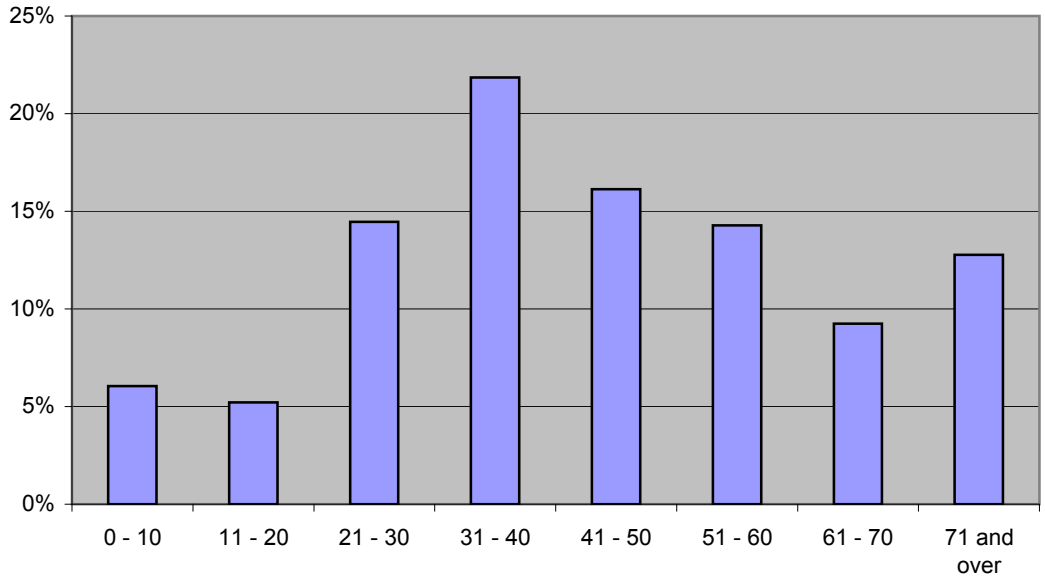
Case Study: Resolved denture complaint

A woman was concerned that the bottom denture she had been given did not fit, and was unusable. She acknowledged that the provider had tried very hard to alter the denture to suit her, however she still could not use the denture and did not feel that it was fair that she had to pay for a product that she could not use.

A conciliation meeting was held, and as a result an independent opinion was sought. On the basis of the opinion, the provider agreed to refund the complainant for a mutually agreed amount which both parties felt reflected the cost of the bottom denture.

Agency Performance - Complaints Management Report

Graph 6: Age of Complainants



Complaint Trends and Analysis

Who makes complaints to us?

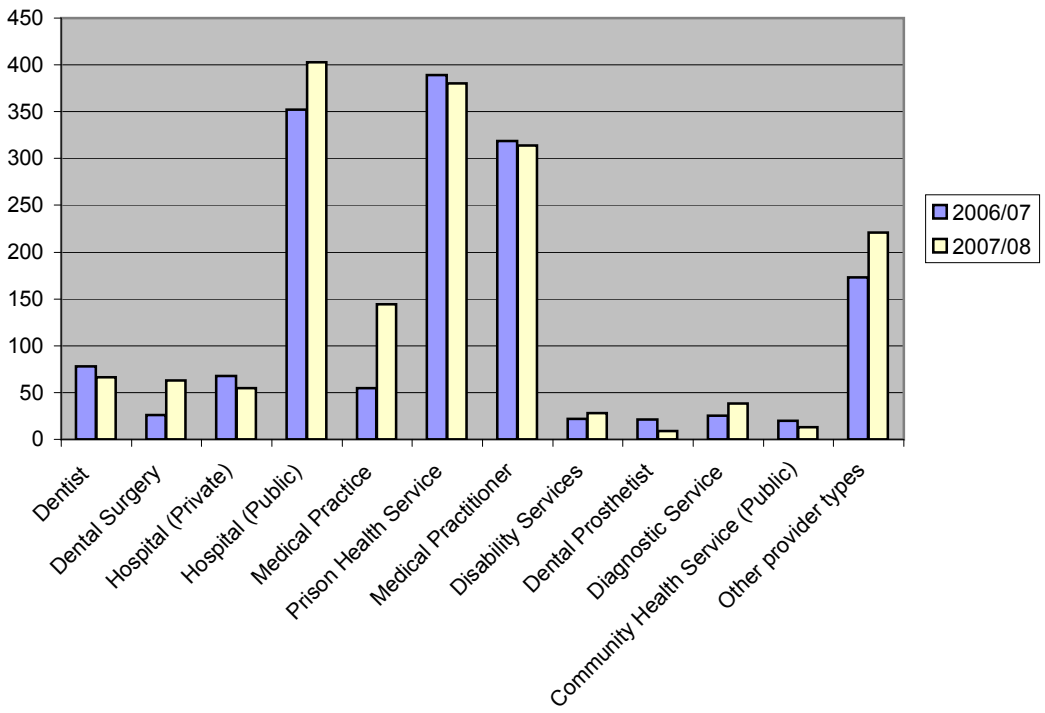
Of the new complaints made to us last year, 48.2% were from female complainants and 50.2% were from males. Gender was not recorded for the remaining 1.7% complainants.

We recorded the complainants' ages from 594 of the new complaints received. The results are listed above, with the 31-40 year old age bracket the most represented group.

What services do people complain about?

We receive complaints about many different types of service providers, the most common categories being public hospitals and prisons. The high number of patients treated each year in such facilities can assist to explain this. While complaints overall have increased, there is variation among service providers for the trend experienced. Even within similar fields there is variation. For example complaints about public hospitals increased 14.5% in the last year, while complaints about private hospitals declined 19%.

Graph 7: New Complaints by Service Provider



There is also a variation in the trend for complaints about dental services, but this is most likely due to a change in our processes. In the last year we have done some work around defining "who is the provider" as detailed in another section. This has led us to change the way we categorise complaints about dental services.

These process changes could account for the vast differences in the two-year trend for complaints about dentists (reduced 20%), dental surgeries (increased 142%) and dental prosthetists (reduced 52%). When we review the complaints over the past two years for these three dental service types, the overall trend in the area is a 10% increase.

For this reason, the categories of medical practitioner (262% increase) and medical practice (1.6% reduction) are also more meaningful when combined. Together they experienced a 22.4% increase in complaints.

Agency Performance - Complaints Management Report

Updating Procedures

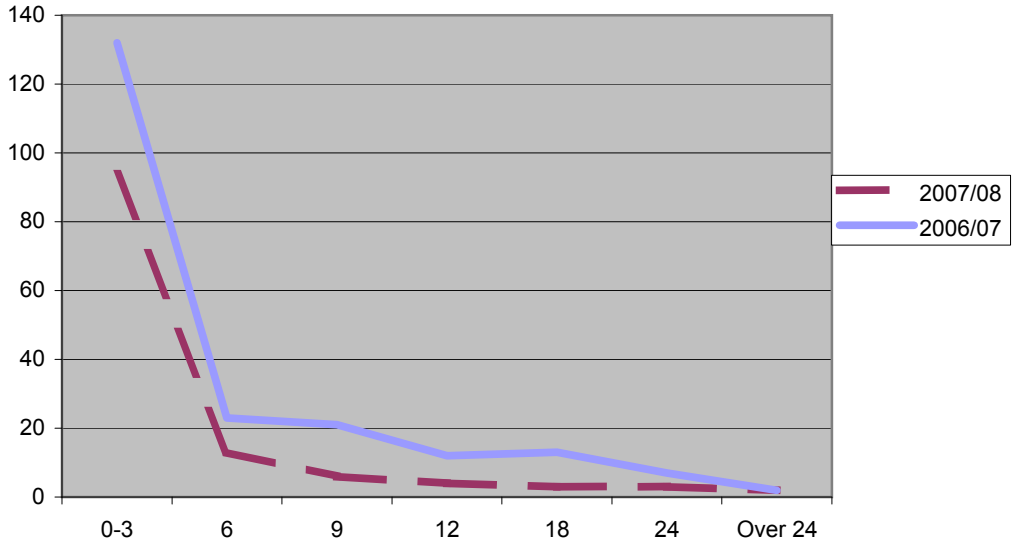
The Office continues to enhance and improve its procedures, updating our Procedure Manuals to reflect this.

There has been a focus on reviewing older cases to ensure that they are completed in a timely manner. As a general reflection the longer a complaint is allowed to continue, the more entrenched it can become and the more difficult the resolution of the issues involved. This is not satisfactory to either party.

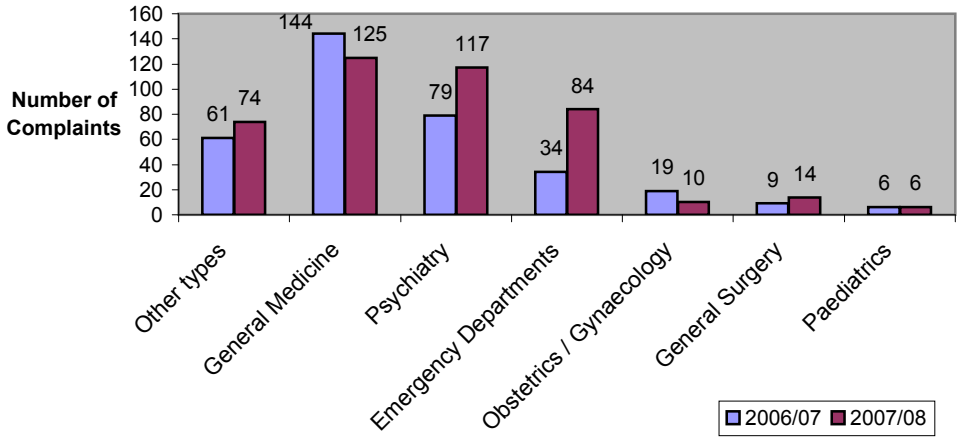
Age of Active Complaints

In the reporting period we have closed 110 more complaints than we have opened, and there are 65% fewer cases older than 12 months in 2007/08 than 2006/07.

Graph 8: Age of Complaints (months)



Graph 9: Number of Public Hospital Complaints by Specialty 2006/07 - 2007/08



Public Hospitals

Public hospitals continue to be supportive of the Office of Health Review. We collaborate well with staff to bring about mutually agreeable outcomes where possible for both parties.

Public hospitals are highly represented in the complaints we receive with 23.2% of new complaints in 2007/08. However this figure represents 430 complaints, a very small percentage of the thousands of patients treated each year in our public hospitals. This low complaint rate could be explained by many factors. One may be that we only receive a small proportion of complaints that are raised internally with the hospital. Internal hospital complaints systems are often very effective in addressing patients' grievances.

As a result, many complaints are able to be resolved early without our involvement. When the public hospital and patient are not able to reach agreement, the patient can complain to us. Complaints that we receive about public hospitals relate mostly to the general medicine or psychiatry specialties. Complaints regarding General Medicine in public hospitals have declined by 13% over the last two years. In the same period, complaints about Emergency Departments and Psychiatry have increased 247% and

Agency Performance - Complaints Management Report

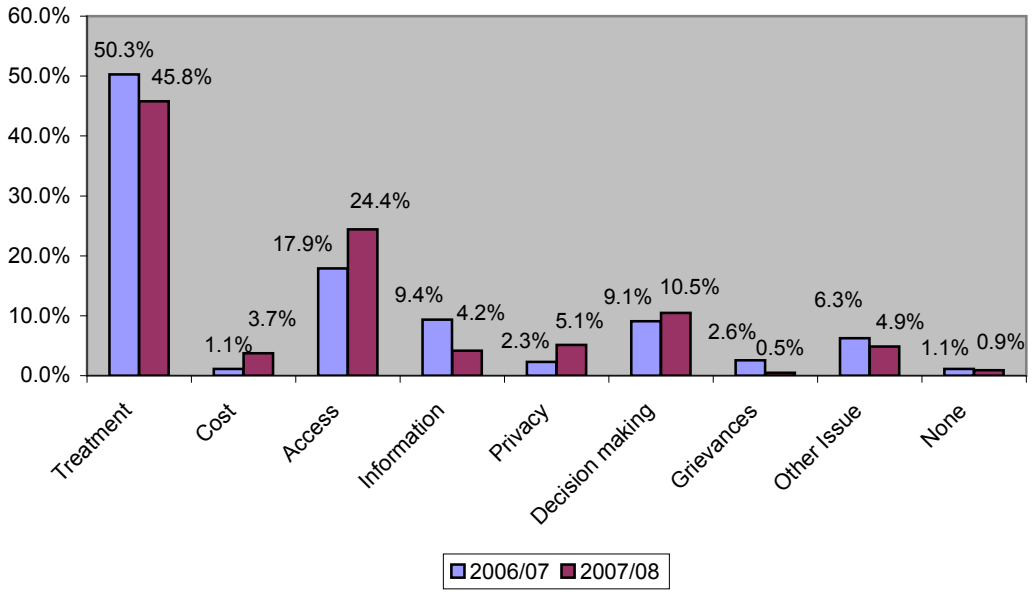
148% respectively. These large increases indicate more work is needed for us to understand why we are receiving so many more complaints this year when compared with other specialties.

Within each specialty, we categorise complaints to understand where the main issues lie. The major issues reported to us related to treatment, cost, access, information and privacy. Of these, the treatment itself accounted for almost half of all complaints.

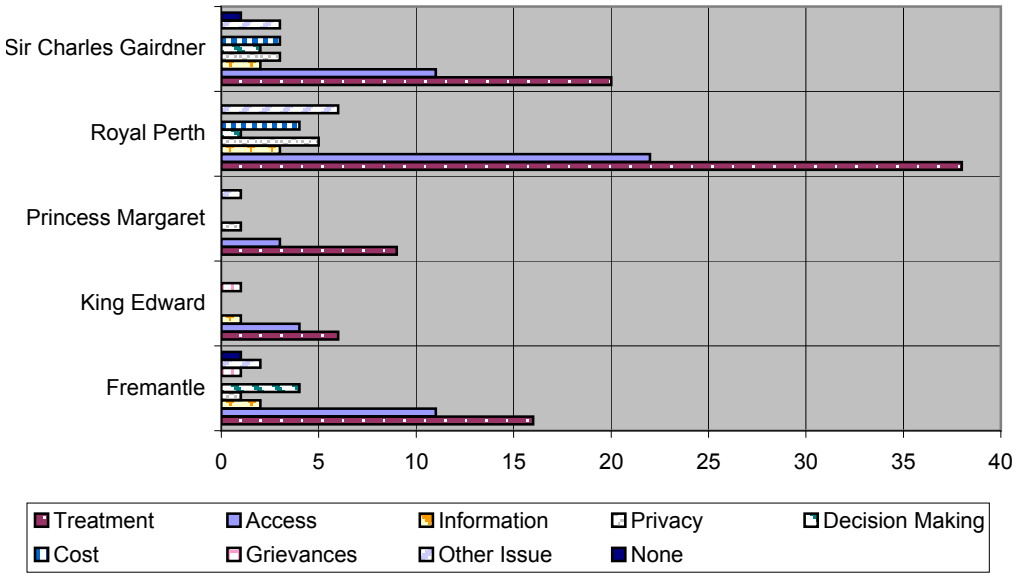
Complaints relating to privacy have more than doubled over the past two reporting periods, while complaints relating to information have reduced by half.

The number of complaints in these areas is compared (below, right and overleaf)) at each major teaching and non-teaching hospital in Western Australia. **Note:** The high proportion of complaints received regarding Royal Perth, Sir Charles Gairdener and Fremantle Hospitals should be taken into context, as these hospitals deal with the greatest number of admissions.

Graph 10: Major Issue Types for Public Hospitals 2006/07 and 2007/08



Graph 11: Teaching Hospitals and Major Issue Types

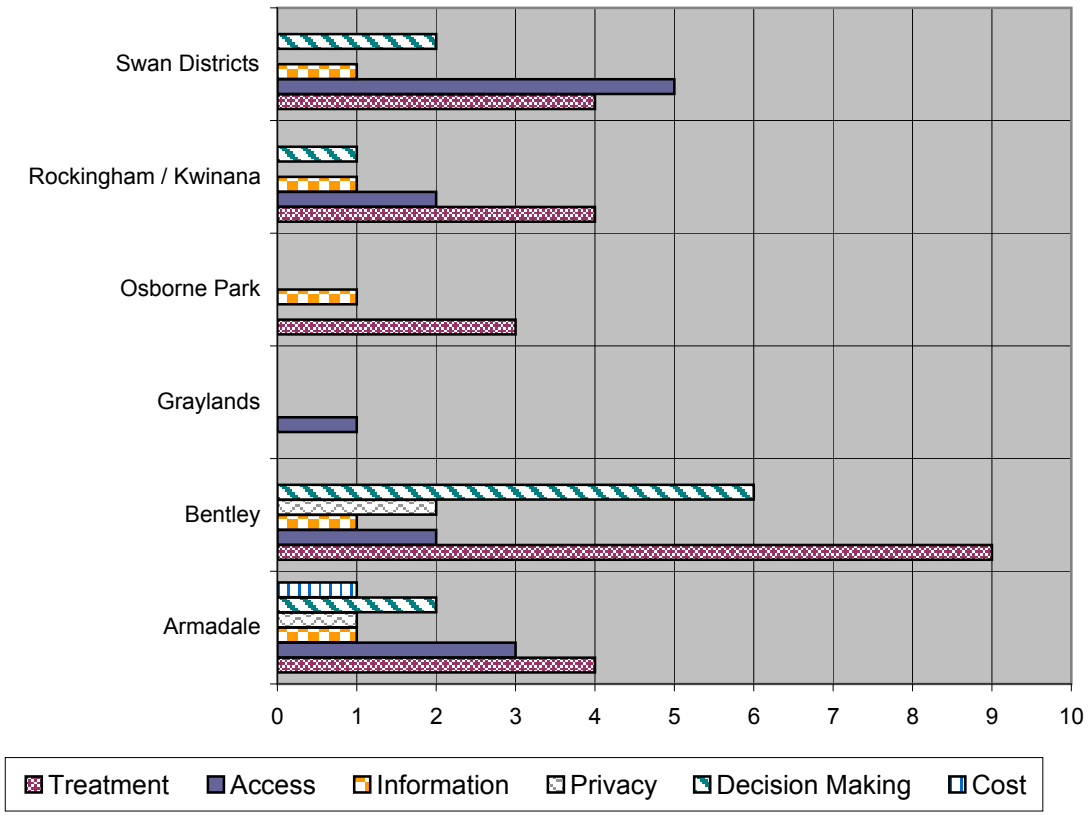


Case study

A patient had been in and out of hospital over seven months. Midway through this period, the agreement between the radiology provider and private insurer changed. While radiology costs were initially covered, the change meant that the patient became liable for gap fees. She was not made aware of this prior to arranging further radiological treatments. The radiological company offered a partial refund that was rejected by the complainant. Further negotiation reduced the account fees.

Agency Performance - Complaints Management Report

Graph 12: Non-Teaching Hospitals and Major Issue Types



One of OHR's community posters

As the graph above indicates, non-teaching hospitals experienced:

- almost double the number of complaints about decision-making (19.3%) and information (8.8%) than the average for public hospitals (10.5% and 4.2% respectively), and
- half the complaints about cost (1.8%, compared to the 3.7% average for public hospitals).

Case study

A complaint had been received in February 2006 relating to informed financial consent for a dental procedure. It had been dealt with by two different staff members who subsequently left the agency. It was allocated to a third Case Manager. Despite the delays, a conciliation meeting was successfully convened, resulting in an agreement that satisfied both parties. A payment plan was implemented by the complainant, and the provider undertook to alter procedures to ensure the issue did not arise again.

Agency Performance - Complaints Management Report

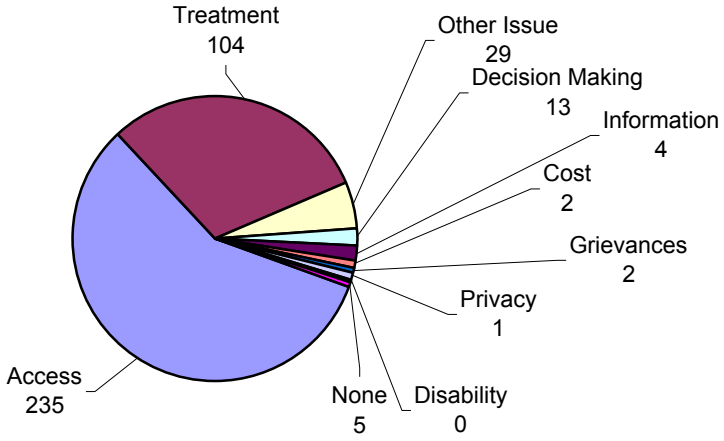
Prisoner complaints

Prisoner complaints are unique in that they are both assessed and conciliated by the Assessment Team. Prison health systems attract the second highest amount of complaints that we received, representing 21.9% of new complaints last year.

The Assessment Team have handled 380 new complaints about prison health services in the past year, and in the same period they closed 395 prisoner complaints.

The health services provided in a prison system aim to be comparable with what is provided in the public health system. The most common prisoner complaint issues are access to health services and the treatment provided itself, as detailed below.

Graph 13: Prisoner Complaints by Major Issue



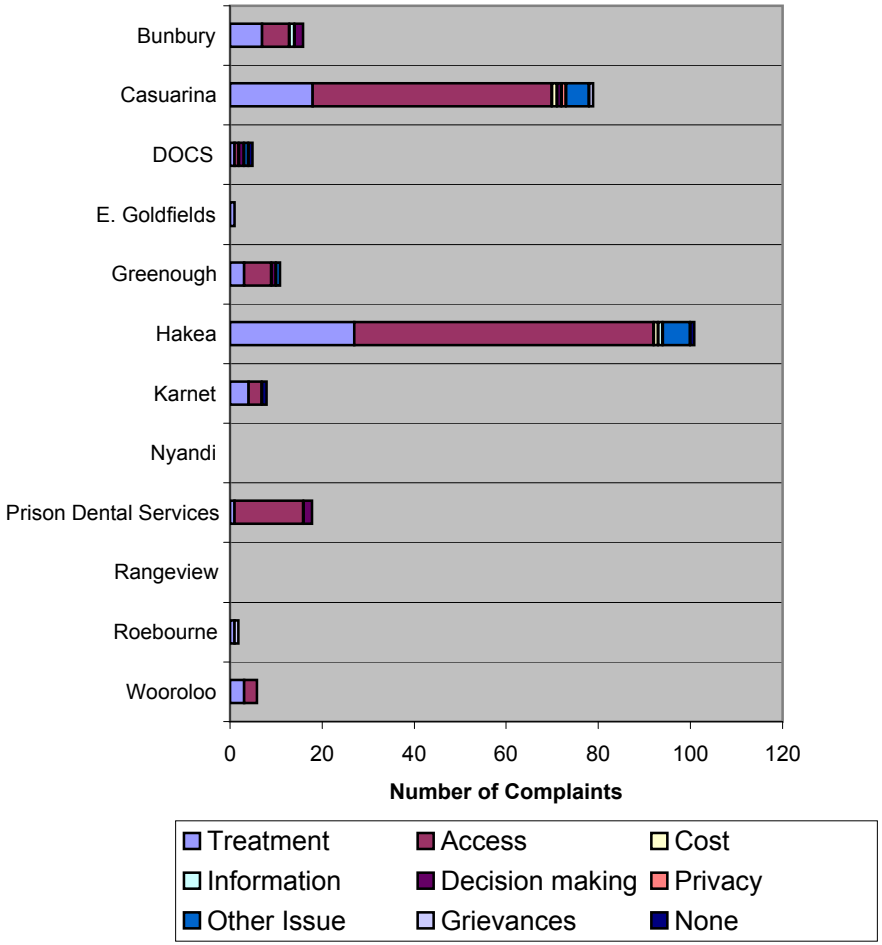
Many prisoner complaints are able to be resolved quickly with assistance from Assessment Officers, who work closely with prison staff.

As the chart (right) shows, we have received no complaints from prisoners at either the Nyandi or Rangeview prisons. This could indicate:

- they have an effective internal complaints resolution system,
- there are barriers in place that prevent prisoners from complaining,
- prisoners are not aware of OHR, or,
- another issue exists that we have not considered.

We will continue to look closely at this issue next year.

Graph 14: Major Complaint Issues in Each Prison



Agency Performance - Complaints Management Report

Change in prisoner complaint process

From November, OHR had to coordinate all of our complaints about broader prison health services through a newly created division called ACCESS (within the Department of Corrective Services). This division is responsible for the administration of complaints, compliments and suggestions within the entire Western Australian prison system.

Every complaint made to OHR must go through this body, when previously complaints were taken directly to the Clinical Nurse Managers onsite. While this has assisted the prisons to log complaints and ensure they are aware of system-wide trends, this transition could explain the development of prison complaints taking extra time to resolve.

In the past year, the Manager of Complaints Operations and the Assessment Team Leader met with the Inspector of Custodial Services to raise common issues. These issues include the problems with prison transport to medical appointments, access to medications, and delays to treatment. As a result we have agreed to further discussions to highlight areas of concern.

Together with the Inspector, we have had the opportunity to visit the Bandyup, Casuarina and Rangeview prison facilities over the last year.

We have also been developing a Memorandum of Understanding with the Department of Corrective Services around the safety and security of OHR staff. Under this agreement, we are able to obtain a picture and release date for any prisoner who we feel may pose a threat to our staff.

Case Study

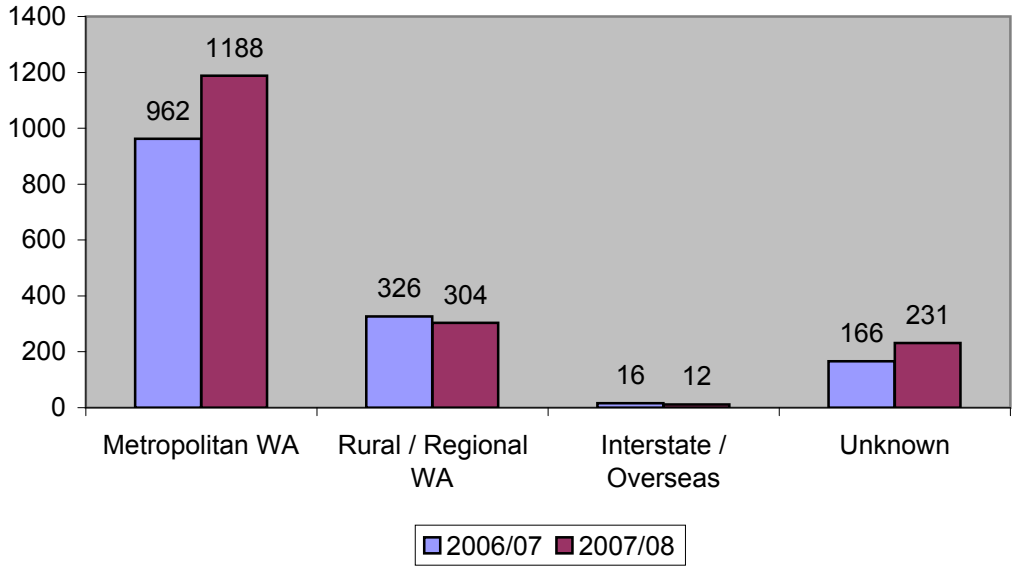
A prisoner raised the concern that he needed his denture fixed, and was told his appointments had been cancelled by the prison. Without treatment he was in a lot of pain. The Assessment Officer taking his query followed this issue up with the prison, and an appointment was made the following week.

Rural and Regional Western Australia

Rural and regional Western Australian health and disability services represented 17.5% of our new complaints last year.

While overall complaint numbers increased last year, the number of complaints from rural and regional areas in Western Australia declined by 7%. The decrease in rural complaints may be due to the hospitals' increasing ability to deal with complaints internally.

Graph 15: Number of New Complaints by Region 2006/07 and 2007/08



Despite this downward trend, there have been many outreach activities conducted in regional areas to promote awareness of OHR along with numerous conciliation meetings. These activities have taken place in Geraldton, Karratha, the South West and the Indian Ocean Territories.

Agency Performance - Complaints Management Report

Spotlight on Patient Assisted Transfer Service (PATS)

A common issue that arises from complaints we receive from rural and regional health service consumers relate to the PATS scheme. In this scheme, travellers are partially subsidised for the costs incurred due to travelling to receive medical services. It does not reimburse or pay for all travel costs.

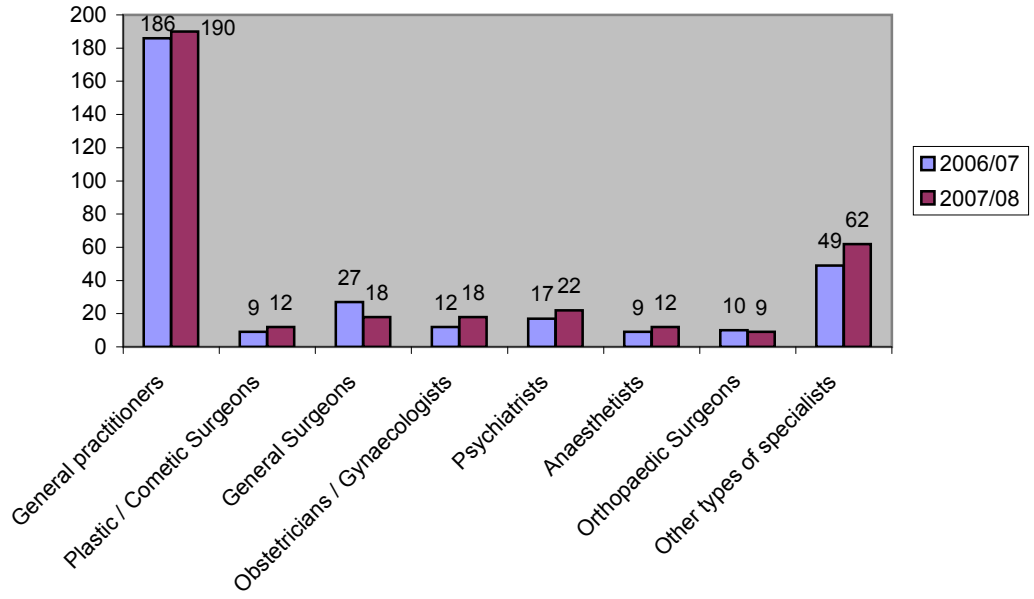
What we have found from complainants is that the amount they are given can be a small proportion of the total travel costs incurred.

Case Study

A patient was transferred by one health service to a regional hospital over a hundred kilometres away. The patient underwent surgery on the following day, and discharged the day after without a return trip having been organised.

The patient asked a friend to collect them from the hospital. The friend was subsidised $17.16 by PATS. They believed this was not reasonable as they had travelled 260 kilometres in total, and they complained to our office. We found that the payment itself was actually made outside the guidelines of PATS as payments are usually paid to the patient. In this case, they paid the patient's friend the one-way subsidy that the patient was entitled to, and as a result we could not accept the complaint.

Graph 16: Medical Practitioner Complaints by Specialty 2006/07 - 2007/08



Medical Practitioners

Medical practitioners were the third greatest service area for new complaints last year with 20.6% of total complaints. This was a 7.5% increase in complaints from last year. Within this service provider group are many different specialties. The most common complaints were regarding general practitioners, with 190 complaints. General practitioners would see more patients than any other specialty, which contributes to this proportion.

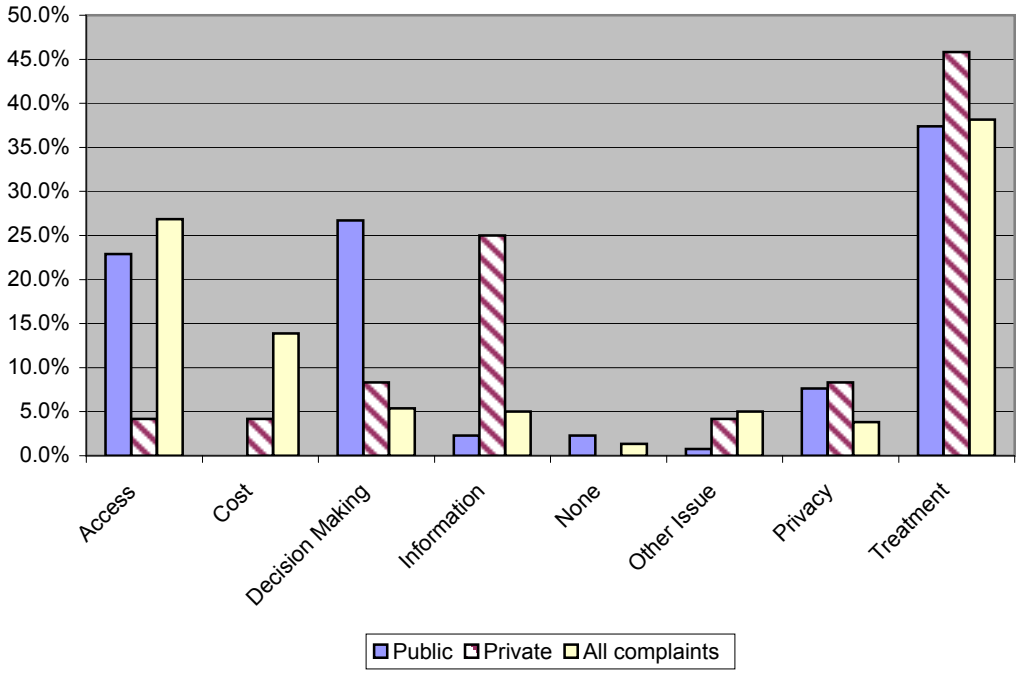
The number of complaints about general practitioners is comparable to the previous year. Other specialties demonstrated a larger increase:

- Obstetricians and gynaecologists 50%,
- Anaesthetists 30%,
- Plastic/ cosmetic surgeons 30%, and,
- Psychiatrists 29%.

Complaints declined for general surgeons by 33%, and orthopaedic surgeons by 10%.

Agency Performance - Complaints Management Report

Graph 17: Major Complaint Issues in Mental Health Services



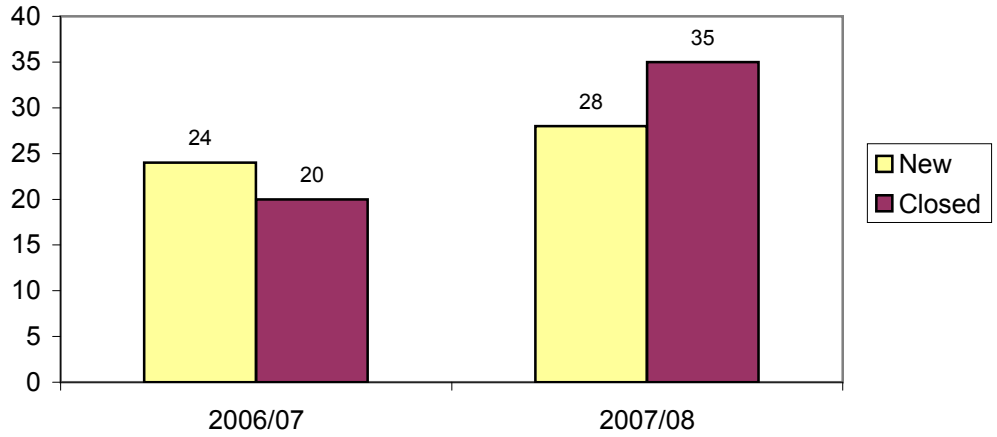
Mental Health Service Complaints

There were 179 new complaints relating to mental health services this year, 69% more than last year and representing 10.3% of our total complaints.

Treatment represented the greatest area of complaint in mental health services. Access to services and decisions made about care featured strongly in public provider complaints, while information was a bigger issue for consumers of private mental health services.

We are aware of the need to target our services more appropriately toward mental health consumers. We will review ways of providing a service that takes greater consideration of the needs of this group during the coming year.

Graph 18: Number of Disability Service Complaints 2006/07 and 2007/08



Disability Service Complaints

The Office of Health Review deals with complaints about Disability Services under Part 6 of the *Disability Services Act 1993.*

We received 28 new complaints about disability services in 2007/08, representing 1.6% of our total complaints. During the same period we closed 35 disability service complaints.

Since 2006/07 the number of new disability service complaints has increased 17%, and closure of disability service complaints has increased 75%. This reflects the efforts we have invested over the last year in reviewing old cases and encouraging a more timely resolution for providers and complainants.

Our efforts in bringing about a more timely resolution of complaints are also reflected in the number of active complaints. There were 3 active disability complaints as at 30 June 2008. These are all complaints that are being investigated.

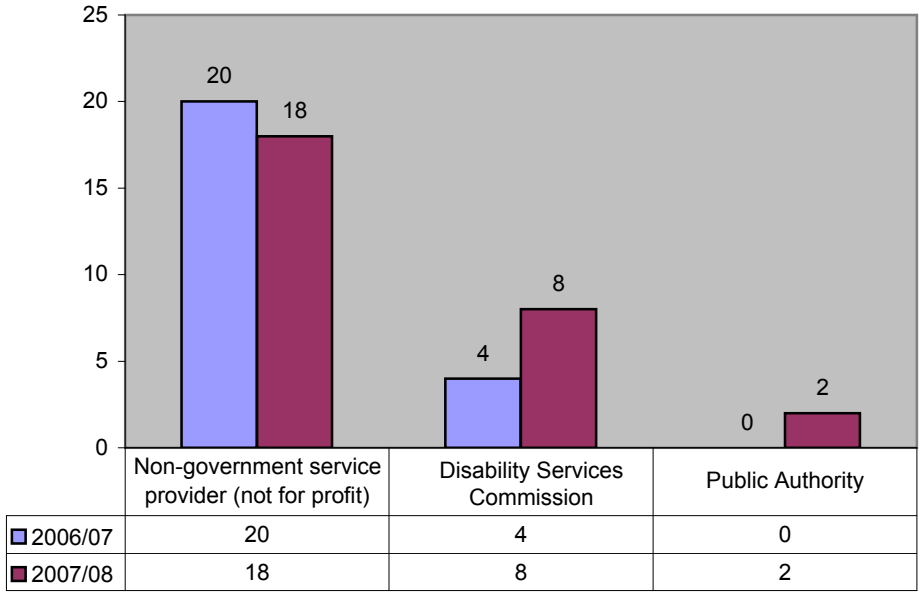
Agency Performance - Complaints Management Report

Table 3: Disability workload data 2007/08

Number of complaints carried forward from previous year	10
New complaints received	28
Total number handled	38
Number of complaints closed	35
Complaints on hand 30 June 2008	**3**

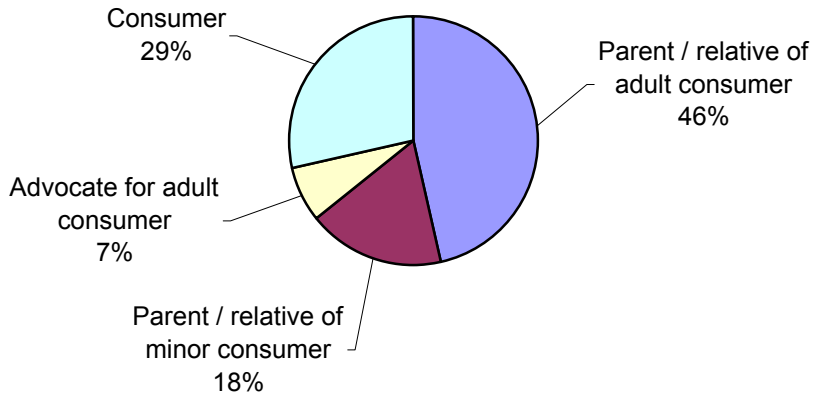
New complaints in most cases were made against non-government service providers. This reflects the structure of the disability services sector that is made up largely of not-for-profit enterprises that receive funding through the Disability Services Commission.

Graph 19: New Disability Services Complaints by Provider

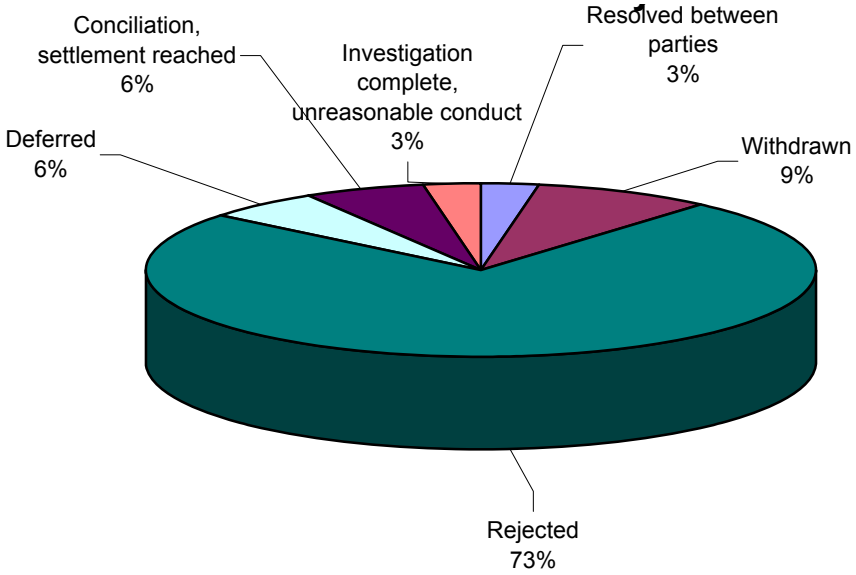


Agency Performance - Complaints Management Report

Graph 20: Who Complains About Disability Services?

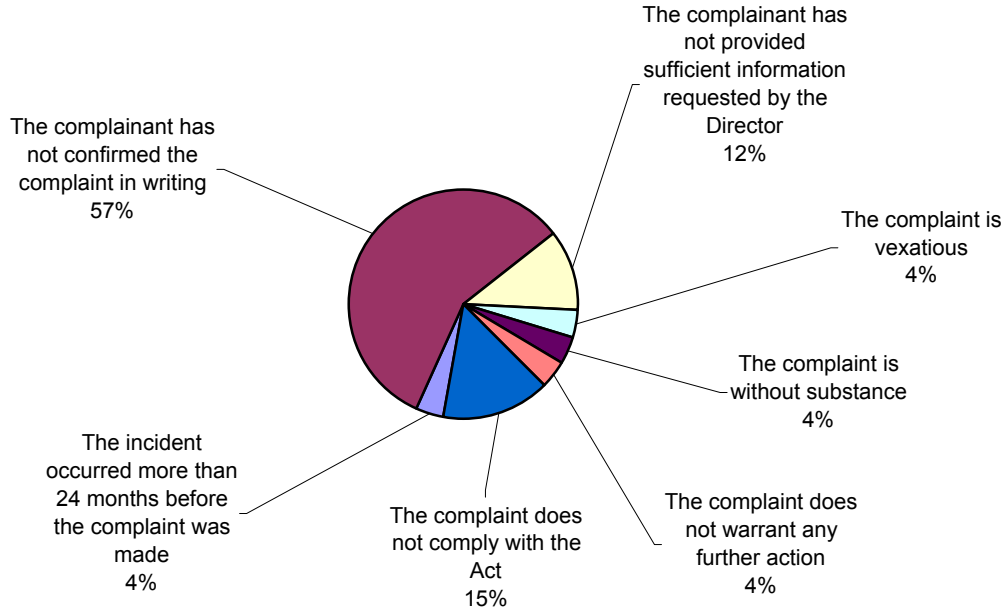


Graph 21: Outcome of Closed Disability Service Complaints



Of the 35 complaints that were closed in this period, 73% were rejected. Most rejected complaints had not been confirmed in writing. We are aware of the difficulties in place for people with disabilities and are assessing ways that we can ensure that any complaint that needs to be picked up by our office, is.

Graph 22: Reasons for Rejecting Disability Service Complaints



It is also clear from looking at who has made a complaint about a disability service over the past year that consumers themselves find it difficult to complain. In most cases, a parent or relative lodged the complaint with us.

Actual consumers of disability services lodged eight complaints, which is five more than last financial year.

Disability consumers and service providers have alerted us to the issue that many of them are not aware that the Office of Health Review can take complaints about disability services.

Agency Performance - Complaints Management Report

As reported last year, we hope awareness of OHR will be improved following our name change to the Office of Health and Disability Complaints. The name change will be enabled once proposed Amendments to the *Health Services (Conciliation and Review) Act 1995* are passed through parliament.

The most common type of complaint about disability services this year again related to the quality of the service provided. Unlike last year, funding and service eligibility became greater issues in 2007/08, with complaints about communication and withdrawn services declining.

Complaints reviewed by the State Ombudsman

Table 4: Outcome of Complaints Reviewed by the State Ombudsman 2007/08

Complaints carried over from 2006/07 year:	0
Complaints received during 2007/08 year:	0
Total complaints handled during 2007/08 year:	0
Total complaints reviewed during 2007/08 year:	0

The office of the State Ombudsman is an independent statutory authority that investigates complaints from individuals about State Government agencies. As noted in the table above, the Ombudsman's office did not receive any complaints about OHR during the year.

3.0 Significant Issues and Trends

Significant Issues and Trends

The Office encountered a number of issues that impacted on our operations and performance during the year, and 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 year, the number of complaints lodged has increased 19% from the previous year. While this means an increased workload, we have become more efficient in our handling of complaints over the past two years, and we now resolve complaints more quickly.

While the increased number of complaints may be due to a variety of reasons, we look forward to helping more consumers and providers, while also trying to strategically improve the level of health and disability service delivery across our jurisdiction. One major benefit of dealing with more complaints is being able to conduct greater qualitative and quantitative analyses of data, which is something that we began in earnest during the year, and intend to undertake in greater depth during the coming year.

Part of our effort to improve levels of service includes working with providers in a pro-active way, by providing information and guidance on complaint prevention and handling. We do this by meeting and delivering presentations to relevant staff from major providers as well as registration boards and representative groups. We have found that by establishing these links we have been able to develop a climate of trust, which is beneficial for our Office and our stakeholders.

A follow-on effect from our meetings with providers that we aim to create is building their confidence in dealing with complaints. While it is understandable that people don't like dealing with complaints, we hope that by providing the right kind of information we can show how effectively dealing with complaints can result in positive outcomes for everyone involved.

From time to time we encounter some reluctance from providers in the private sector to engage in the conciliation process. This can be challenging for the Office and complainants as it gives little possibility of resolution, and we cannot force a provider to attend conciliation meetings. We hope that by engaging in the open disclosure project (see the Executive Summary for more information) we will be able to encourage more private providers to engage in dispute resolution through conciliation.

As a small agency, especially one with a large jurisdiction, one of the biggest challenges we face is effectively communicating with our target groups. While it has been easy enough to communicate with the larger providers, registration boards and professional bodies, we still face the need to communicate with the WA public as a whole. This can be difficult with limited resources, however over the next year we intend to look at a number of ways of increasing our exposure, not the least being the name change of the Office.

The Office often faces the challenge of dealing with complaints from rural and regional areas. As dispute conciliation is a process that often benefits from face-to-face communication, we have employed techniques such as video conferencing, which we have found to be a valuable tool for working with complainants and providers outside the metropolitan area. We have also had staff travel to a number of regional areas during the year to hold conciliation meetings. These regional visits have the added benefit of opportunities for community outreach activities.

The internal review of our enabling legislation conducted by our Legal Officer during the year revealed a number of areas that required our attention. One of these is Section 75 of the H*ealth Services (Conciliation and Review) Act 1995*, which states that "prescribed providers or a provider that belongs to a prescribed class of providers" should provide information to OHR on an annual basis "concerning complaints received and action taken." We are considering how we will go about prescribing providers, however this will be done in consultation with providers, and we will work with prescribed providers in establishing reporting formats.

During the coming year it is also possible that our operations will be affected by new legislation regarding the operations of the various professional health boards, and in particular the handling of dispute resolution. While we are currently unsure as to the possible outcomes, the new legislation may result in OHR working with the boards in estabishing their dispute conciliation functions.

Significant Issues and Trends

In the 2006/07 Annual Report, we included a section 'The Year Ahead,' where we listed some of our plans for the 2007/08 year. The table below compares what we planned with what we achieved:

What We Planned	What We Achieved
Developing internal guidelines and mapping for prison health services and mental health complaints	Our staff have engaged in the use of the Department of Corrective Services ACCESS program, which deals with complaints internally before progressing to an independent agency such as OHR. We have held meetings with staff from the office of the Inspector of Custodial Services to discuss our role and how we can help prisoners with health and disability service complaints. OHR has engaged with staff from the Office of the Chief Psychiatrist and from various mental health services to promote our role and to better understand the needs of consumers with mental health issues.
Developing a sound legal framework for our business, based on current legislation	The appointment of a Legal Officer in the previous financial year enabled OHR to conduct an internal review of our enabling legislation, as well as relevant sections of the Disability Services Act. Following this review, the Office drafted legislative amendments that have been presented to Parliamentary Counsel. It is anticipated that the proposed changes, if passed, will provide a more consistent legal framework for OHR's operations. Furthermore, we have continued to work collaboratively with the State Solicitor's Office to ensure appropriate interpretation and application of our legislation.
Engaging ethnic and Aboriginal communities	OHR conducted a number of regional visits during the year, at which we met with community representatives of ethnic and Aboriginal people. OHR staff members also met with the providers of health and disability services to these communities. During the year we designed and distributed posters and published advertisements that were targeted at Aboriginal people, and placed in regional publications. We advertised our services on a community radio station in three different languages, in order to reach a more diverse audience.We have also commenced discussions with the WA Country Health Service about working collaboratively to address health complaints in regional locations, with a particular focus on Aboriginal communities.
Enhancing OHR's knowledge of compensation	The Office sought and received advice from the State Solicitor's Office regarding compensation, which provided a basis for a new fact sheet targeted at providers and consumers. OHR also supported the development of a legal clinic with the Health Consumers' Council, the aim of which is to provide advice to complainants contemplating making a claim for compensation through the Courts.
Further development of service standards for dealing with complaints	Significant development of the Service Standards took place during the year. For further information, see Agency Performance, page 14.
Cultural awareness training for staff	OHR staff attended a presentation regarding Aboriginal culture and local history given by a policy officer from the Disability Services Commission. Staff were also given a presentation on Aboriginal mental health issues by an Aboriginal mental health expert from the Health Department of WA.
Conducting statistical and data analysis to ensure the usefulness of our complaints reporting	Detailed statistical and data analyses took place during the year, in an effort to determine the effectiveness of our complaints reporting. It is hoped that the implementation of our new complaints database (see below) will improve our work in this area. OHR staff members have met with representatives from other bodies such the Office of Safety and Quality to discuss optimum reporting practice. Liaison with our equivalent organisations in other states has led to consistent complaint categories that allow comparison of complaints across the nation.
Full implementation of the new complaints database	It was hoped that full implementation of the database would take place during the year. This did not occur due to a number of problems including the sourcing of appropriate staff, and the reliability of the product that was acquired. At the time of going to print, the database was operating in a simplified format. It is hoped that the new database will be fully operational toward the end of the calendar year.
Developing a knowledge base of information	During the year we regularly collated information and feedback, and incorporated it into our processes and procedures.
Enhancing the range of information we provide to consumers and providers	During the year, OHR produced a range of new information sheets, posters and brochures targeted at consumers and providers. We have also refined our existing information on an ongoing basis, incorporating feedback from stakeholders and particpants in various processes. We also advertised our services in regional newspapers and on community radio.

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 2008

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 2008, 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 "http://www.audit.wa.gov.au/pubs/Audit-Practice-Statement.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 2008

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 2008 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 2008.

GLEN CLARKE
ACTING AUDITOR GENERAL
22 September 2008

4.0 Disclosures and Legal Compliance - Certification of Financial Statements

OFFICE OF HEALTH REVIEW

FINANCIAL STATEMENTS

CERTIFICATION OF FINANCIAL STATEMENTS

The accompanying financial statements of the Office of Health Review have been prepared in compliance with the provisions of the *Financial Management Act 2006* from proper amounts and records to present fairly the financial transactions for the financial year ending 30 June 2008 and the financial position as at 30 June 2008.

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: 13 August 2008

Linley Anne Donaldson
Director
ACCOUNTABLE AUTHORITY

Date: 13 August 2008

Financial Statements

Office of Health Review

Income Statement

For the year ended 30th June 2008

	Note	2008 $	2007 $
COST OF SERVICES			
Expenses			
Employee benefits expense	6	1,355,532	1,250,415
External services	7	8,673	9,517
Depreciation expense	8	3,577	4,615
Other expenses	9	394,736	340,762
Total cost of services		**1,762,518**	**1,605,309**
INCOME			
Revenue			
Recoveries and other revenues	10	36,915	38,572
Total revenue		36,915	38,572
Total income other than income from State Government		**36,915**	**38,572**
NET COST OF SERVICES		**1,725,603**	**1,566,737**
INCOME FROM STATE GOVERNMENT			
Service appropriations	11	1,613,000	1,430,000
Resources received free of charge	12	4,643	18,035
Total income from State Government		**1,617,643**	**1,448,035**
SURPLUS/(DEFICIT) FOR THE PERIOD		**(107,960)**	**(118,702)**

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

Financial Statements

Office of Health Review

Balance Sheet

As at 30th June 2008

	Note	2008	2007
ASSETS		**$**	**$**
Current Assets			
Cash and cash equivalents	13	421,006	492,462
Total Current Assets		421,006	492,462
Non-Current Assets			
Plant and equipment	14	9,607	13,184
Total Non-Current Assets		9,607	13,184
Total Assets		**430,613**	**505,646**
LIABILITIES			
Current Liabilities			
Payables	16	74,319	27,777
Provisions	17	288,588	280,472
Total Current Liabilities		362,907	308,249
Non-Current Liabilities			
Provisions	17	23,358	45,089
Total Non-Current Liabilities		23,358	45,089
Total Liabilities		**386,265**	**353,338**
NET ASSETS		**44,348**	**152,308**
EQUITY			
Accumulated surplus/(deficiency)	18	44,348	152,308
TOTAL EQUITY		**44,348**	**152,308**

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

Financial Statements

Office of Health Review

Statement of Changes in Equity

For the year ended 30th June 2008

	Note	2008 $	2007 $
Balance of equity at start of period		152,308	287,622
ACCUMULATED SURPLUS	18		
Balance at start of period		152,308	287,622
Change in accounting policy		-	(16,612)
Restated balance at start of period		152,308	271,010
Surplus/(deficit) for the period		(107,960)	(118,702)
Balance at end of period		**44,348**	**152,308**
Balance of equity at end of period		**44,348**	**152,308**
Total income and expense for the period (a)		(107,960)	(118,702)

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

Financial Statements

Office of Health Review

Cash Flow Statement

For the year ended 30th June 2008

	Note	2008 $ Inflows (Outflows)	2007 $ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		1,613,000	1,430,000
Net cash provided by State Government		1,613,000	1,430,000
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Supplies and services		(374,786)	(335,090)
Employee benefits		(1,346,585)	(1,112,213)
Receipts			
Other receipts		36,915	38,572
Net cash (used in) / provided by operating activities	19(b)	(1,684,456)	(1,408,731)
Net increase / (decrease) in cash and cash equivalents		(71,456)	21,269
Cash and cash equivalents at the beginning of period		492,462	471,193
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	19(a)	421,006	492,462

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

Office of Health Review

Notes to the Financial Statements

For the year ended 30th June 2008

Note 1 Australian equivalents to International Financial Reporting Standards

General

The Authority's financial statements for the year ended 30 June 2008 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 2008.

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 11 '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 and some revaluations 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.

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

Computer equipment	4 to 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 of plant and equipment, where the Authority has substantially all of the risks and rewards of ownership, are classified as finance leases.

Finance lease rights and obligations are initially recognised, at the commencement of the lease term, as assets and liabilities equal in amount to the fair value of the leased item or, if lower, the present value of the minimum lease payments, determined at the inception of the lease. The assets are depreciated over the period during which the Authority is expected to benefit from their use. Minimum lease payments are apportioned between the finance charge and the reduction of the outstanding lease liability, according to the interest rate implicit in the lease.

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 (cash and cash equivalents, 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 (refer note 16) 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' and note 15 'Receivables')

(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 16 '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 17 ‘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)

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 9 'Other expenses' and note 17 'Provisions'.)

(n) Superannuation Expense

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

(a) Defined benefit plans - Change in the unfunded employer's liability (i.e. current service cost and, actuarial gains and losses) assumed by the Treasurer in respect of current employees who are members of the Pension Scheme and current employees who accrued a benefit on transfer from that Scheme to the Gold State Superannuation Scheme (GSS); and

(b) 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 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 benefits provision

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 the past 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 2007 that impacted on the Authority:

1) AASB 7 'Financial Instruments: Disclosures' (including consequential amendments in AASB 2005-10 'Amendments to Australian Accounting Standards [AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023 & AASB 1038]'). This Standard requires new disclosures in relation to financial instruments and while there is no financial impact, the changes have resulted in increased disclosures, both quantitative and qualitative, of the Authority's exposure to risks, including enhanced disclosure regarding components of the Authority's financial position and performance, and changes to the way of presenting certain items in the notes to the financial statements.

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:

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

AASB Standards and Interpretations	
101	'Presentation of Financial Statements' (relating to the changes made to the Standard issued in October 2006)
2005-10	'Amendments to Australian Accounting Standards (AASB 132, AASB 101, AASB 114, AASB 117, AASB 133, AASB 139, AASB 1, AASB 4, AASB 1023, & AASB 1038)'
2007-1	'Amendments to Australian Accounting Standards arising from AASB Interpretation 11 [AASB 2]'
2007-4	'Amendments to Australian Accounting Standards arising from ED 151 and Other Amendments (AASB 1, 2, 3, 4, 5, 6, 7, 102, 107, 108, 110, 112, 114, 116, 117, 118, 119, 120, 121, 127, 128, 129, 130, 131, 132, 133, 134, 136, 137, 138, 139, 141, 1023 & 1038)'. The amendments arise as a result of the AASB decision to make available all options that currently exist under IFRSs and that certain additional Australian disclosures should be eliminated. The Treasurer's instructions have been amended to maintain the existing practice when the Standard was first applied and as a consequence there is no financial impact.
2007-5	'Amendments to Australian Accounting Standard – Inventories Held for Distribution by Not-for-Profit Entities [AASB 102]'
2007-7	'Amendments to Australian Accounting Standards [AASB 1, AASB 2, AASB 4, AASB 5, AASB 107 & AASB 128]'
ERR	Erratum 'Proportionate Consolidation [AASB 101, AASB 107, AASB 121, AASB 127, Interpretation 113]'
Interpretation 10	'Interim Financial Reporting and Impairment'
Interpretation 11	'AASB 2 – Group and Treasury Share Transactions'
Interpretation 1003	'Australian Petroleum Resource Rent Tax'

Voluntary changes in accounting policy

Effective from 1 July 2007, the Authority has increased its asset capitalisation threshold from $1,000 to $5,000 for plant and equipment.

Retrospective application of the change in accounting policy has resulted in assets below the $5,000 threshold amounting to $16,612 being expended against the opening balance of accumulated surplus/(deficiency) as at 1 July 2006. The amounts of adjustments for each of the financial periods prior to 2006-07 have not been disclosed, as it is impracticable to trace back acquisitions, disposals and depreciation of these assets.

The comparatives for plant and equipment, depreciation expense, and repairs, maintenance and consumable equipment expense have been restated to disclose the effect of the policy change (See note 20 'Voluntary changes in accounting policy').

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
Review of AAS 27 'Financial Reporting by Local Governments', 29 'Financial Reporting by Government Departments' and 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' (December 2007).	1 July 2008
AASB 1050 'Administered Items' (December 2007).	1 July 2008
AASB 1051 'Land Under Roads' (December 2007).	1 July 2008
AASB 1052 'Disaggregated Disclosures' (December 2007).	1 July 2008

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

Title	Operative for reporting periods beginning on/after
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] (December 2007).	1 July 2008
Interpretation 1038 'Contributions by Owners Made to Wholly-Owned Public Sector Entities (revised) (December 2007).	1 July 2008
The existing requirements in AAS 27, AAS 29 and AAS 31 have been transferred to the above new and existing topic-based Standards and Interpretation. These requirements remain substantively unchanged. AASB 1050, AASB 1051 and AASB 1052 only apply to government departments. The other Standards and Interpretation make some modifications to disclosures and provide additional guidance (for example, Australian Guidance to AASB 116 'plant and equipment' in relation to heritage and cultural assets has been introduced), otherwise, there will be no financial impact.	

AASB 3 'Business Combinations' (March 2008)	1 July 2009
AASB 8 'Operating Segments'	1 January 2009
AASB 123 'Borrowing Costs' (June 2007). This Standard has been revised to mandate the capitalisation of all borrowing costs attributable to the acquisition, construction or production of qualifying assets. The Authority already capitalises borrowing costs directly attributable to buildings under construction, therefore, this will be no impact on the financial statements when the Standard is first applied.	1 January 2009
AASB 127 'Consolidated and Separate Financial Statements' (March 2008)	1 July 2009
AASB 1049 'Whole of Government and General Government Sector Financial Reporting'	1 July 2008
AASB 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 to 8	1 January 2008
AASB 2007-3 'Amendments to Australian Accounting Standards arising from AASB 8 [AASB 5, AASB 6, AASB 102, AASB 107, AASB 119, AASB 127, AASB 134, AASB 136, AASB 1023 & AASB 1038]'	1 January 2009
AASB 2007-6 'Amendments to Australian Accounting Standards arising from AASB 123 [AASB 1, AASB 101, AASB 107, AASB 111, AASB 116 & AASB 138 and Interpretations 1 & 12]'	1 January 2009
AASB 2007-8 'Amendments to Australian Accounting Standards arising from AASB 101'	1 January 2009
AASB 2008-1 'Amendments to Australian Accounting Standard - Share-based Payments: Vesting Conditions and Cancellations'	1 January 2009
AASB 2008-2 'Amendments to Australian Accounting Standards – Puttable Financial Instruments and Obligations arising on Liquidation [AASB 7, AASB 101, AASB 132, AASB 139 & Interpretation 2]'	1 January 2009
AASB 2008-3 'Amendments to Australian Accounting Standards arising from AASB 3 and AASB 127 [AASBs 1, 2, 4, 5, 7, 101, 107, 112, 114, 116, 121, 128, 131, 132, 133, 134, 136, 137, 138, 139 and Interpretations 9 & 107]'	1 July 2009
Interpretation 4 'Determining whether an Arrangement contains a Lease' (February 2007)	1 January 2008
Interpretation 12 'Service Concession Arrangements'	1 January 2008
Interpretation 13 'Customer Loyalty Programmes'	1 July 2008
Interpretation 14 'AASB 119 – The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction'	1 January 2008
Interpretation 129 'Service Concession Arrangements: Disclosures'	1 January 2008

Note 6 Employee benefits expense	2008 $	2007 $
Salaries and wages (a)	1,025,456	932,996
Superannuation - defined contribution plans (b)	113,144	98,841
Annual leave and time off in lieu leave (c)	109,757	97,228
Long service leave (c)	107,175	121,350
	1,355,532	1,250,415

(a) Includes the value of the fringe benefit to the employees. The fringe benefits tax component is included at note 9 '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 9 'Other expenses'. The employment on-costs liability is included at note 17 'Provisions'.

Note 7 External Services

Fuel, light and power	3,811	3,094
Food supplies	1,039	2,598
Purchase of other external services	3,823	3,825
	8,673	9,517

Note 8 Depreciation expense

Depreciation		
Computer equipment	2,031	2,063
Other plant and equipment	1,546	2,552
Total depreciation and amortisation	3,577	4,615

Note 9 Other expenses

Communications	43,114	23,421
Computer services	6,227	2,357
Employment on-costs (a)	27,707	17,209
Insurance	-	2,195
Legal expenses	4,643	18,035
Motor vehicle expenses	2,015	-
Operating lease expenses	143,907	102,694
Printing and stationery	17,297	16,759
Repairs, maintenance and consumable equipment expense	43,651	41,859
Purchase of external services	63,964	34,638
Audit fees - external	16,500	16,100
Bureau costs	-	13,000
External consulting fees	7,123	46,982
Other	18,588	5,513
	394,736	340,762

(a) Includes workers' compensation insurance and other employment on-costs. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 17 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Note 10 Other revenues

Recoveries	36,726	38,509
Other	189	63
	36,915	38,572

Note 11 Service appropriations

Appropriation revenue received during the year:

Service appropriations	1,613,000	1,430,000

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 12 Resources received free of charge

	2008 $	2007 $
Resources received free of charge has been determined on the basis of the following estimates provided by agencies.		
State Solicitor's Office	4,643	18,035
	4,643	18,035

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 determined and which would have been purchased if not donated, and those fair values shall be recognised as assets or expenses, as applicable. The exception occurs where the contribution of assets or services are in the nature of contributions by owners, in which case the Authority makes the adjustment direct to equity.

Note 13 Cash and cash equivalents

Cash on hand	400	400
Cash at bank	420,606	492,062
	421,006	492,462

Note 14 Plant and equipment

Computer equipment		
At cost	19,989	19,989
Accumulated depreciation	(17,024)	(14,993)
	2,965	4,996
Other plant and equipment		
At cost	25,766	25,766
Accumulated depreciation	(19,124)	(17,578)
	6,642	8,188
Total of plant and equipment	9,607	13,184

Reconciliations

Reconciliations of the carrying amounts of 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	4,996	7,059
Depreciation	(2,031)	(2,063)
Carrying amount at end of year	2,965	4,996
Other plant and equipment		
Carrying amount at start of year	8,188	10,740
Depreciation	(1,546)	(2,552)
Carrying amount at end of year	6,642	8,188
Total plant and equipment		
Carrying amount at start of year	13,184	17,799
Depreciation	(3,577)	(4,615)
Carrying amount at end of year	9,607	13,184

(a) Impairment loss recognised in the Income Statement.

Note 15 Impairment of Assets

There were no indications of impairment to plant and equipment at 30 June 2008.

The Authority held no goodwill or intangible assets with an indefinite useful life during the reporting period and at balance sheet date there were no intangible assets not yet available for use.

All surplus assets at 30 June 2008 have either been classified as assets held for sale or written off.

Note 16 Payables

	2008 $	2007 $
Current		
Trade creditors	41,086	6,705
Accrued expenses	4,478	14,879
Accrued salaries	28,755	6,193
	74,319	27,777

(See also note 2(l) 'Payables' and note 27 'Financial instruments')

Note 17 Provisions

Current		
Employee benefits provision		
Annual leave (a)	108,733	109,101
Long service leave (b)	179,855	171,371
	288,588	280,472
Non-current		
Employee benefits provision		
Long service leave (b)	23,358	45,089
	23,358	45,089
Total Provisions	311,946	325,561

(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	108,733	109,101
More than 12 months after balance sheet date	-	-
	108,733	109,101

(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	93,141	87,133
More than 12 months after balance sheet date	110,072	129,327
	203,213	216,460

Note 18 Accumulated surplus/(deficit)

Balance at start of year	152,308	287,622
Result for the period	(107,960)	(118,702)
Change in accounting policy	-	(16,612)
Balance at end of year	44,348	152,308

Note 19 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 13)	421,006	492,462
	421,006	492,462

Note 19 Notes to the Cash Flow Statement (continued)	**2008 $**	**2007 $**

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

Net cash used in operating activities (Cash Flow Statement)	(1,684,456)	(1,408,731)
Decrease/(increase) in liabilities:		
Payables	(46,542)	(1,318)
Current provisions	(8,116)	(107,939)
Non-current provisions	21,731	(26,099)
Non-cash items:		
Depreciation and amortisation expense (note 8)	(3,577)	(4,615)
Resources received free of charge (note 12)	(4,643)	(18,035)
Net cost of services (Income Statement)	(1,725,603)	(1,566,737)

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

Note 20 Voluntary changes in accounting policy

Effective from 1 July 2007, the Authority has increased its asset capitalisation threshold from $1,000 to $5,000 for plant and equipment and intangible assets (See note 5 'Voluntary changes in accounting policy'). The adjustments relating to the 2006-07 financial year are as follows:

Reconciliation of equity at the end of the last reporting period under previous asset capitalisation policy : 30 June 2007

	Before policy change 30th June 2007	Adjustment	After policy change 30th June 2007
	$	$	$
Assets			
Current Assets	492,462	-	492,462
Non-Current Assets (a)	34,455	(21,271)	13,184
Total Assets	526,917	(21,271)	505,646
Liabilities			
Current Liabilities	308,249	-	308,249
Non-Current Liabilities	45,089	-	45,089
Total Liabilities	353,338	-	353,338
Total Equity (b)	173,579	(21,271)	152,308
Accumulated surplus/(deficiency)			
Opening balance	*287,622*	*(16,612)*	271,010
Surplus/(Deficit) for the period	*(114,043)*	*(4,659)*	(118,702)
Closing balance	*173,579*	*(21,271)*	*152,308*
(a) Plant and equipment	*34,455*	*(21,271)*	*13,184*
(b) Accumulated surplus/(deficiency)	*173,579*	*(21,271)*	*152,308*

Reconciliation of income statement for the year ended 30 June 2007

	Before policy change 30th June 2007	Adjustment	After policy change 31st June 2007
	$	$	$
Expenses (a)	1,600,650	4,659	1,605,309
Total income other than income from State Government	38,572	-	38,572
Net cost of services	1,562,078	4,659	1,566,737
Income from State Government	1,448,035	-	1,448,035
Surplus/(Deficit) for the period	(114,043)	(4,659)	(118,702)
(a) Depreciation expense	*9,383*	*(4,768)*	*4,615*
Repairs, maintenance and consumable equipment	*32,432*	*9,427*	*41,859*
	41,815	*4,659*	*46,474*

Office of Health Review

Notes to the Financial Statements

For the year ended 30th June 2008

Note 20 Voluntary changes in accounting policy (continued)

Reconciliation of cash flow statement for the year ended 30 June 2007

	Before policy change 30th June 2007	Adjustment	After policy change 31st June 2007
	$	$	$
Cash flows from State Government	1,430,000	-	1,430,000
Utilised as follows:			
Net cash (used in) / provided by -			
Operating activities (a)	(1,399,304)	(9,427)	(1,408,731)
Investing activities (b)	(9,427)	9,427	(0)
Net increase / (decrease) in cash and cash equivalents	21,269	-	21,269
Cash and cash equivalents at the beginning of period	471,193	-	471,193
Cash and cash equivalents at the end of period	492,462	-	492,462
(a) Payments for supplies and services	(325,663)	(9,427)	(335,090)
(b) Payments for purchase of non-current physical assets	(9,427)	9,427	(0)

Note 21 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, non-monetary benefits and other benefits for the financial year, fall within the following bands are:

	2008	**2007**
$190,001 - $200,000	1	1
Total	1	1
	$	**$**
The total remuneration of senior officers is:	193,930	199,149

The total remuneration includes the superannuation expense incurred by the Authority in respect of senior officers other than senior officers reported as members of the Accountable Authority.

The senior officer presently employed is not a member of the Pension Scheme.

Note 22 Remuneration of auditor

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

Auditing the accounts, financial statements and performance indicators	17,000	16,500

Note 23 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	152,260	-
Later than 1 year, and not later than 5 years	456,780	-
Later than 5 years	-	-
	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 2008.

Note 24 Contingent liabilities and contingent assets

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

Note 25 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 26 Explanatory Statement

(A) Significant variances between actual results for 2007 and 2008

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	2008 Actual $	2007 Actual $	Variance $
Expenses				
Employee benefits expense	(a)	1,355,532	1,250,415	105,117
External services		8,673	9,517	(844)
Depreciation expense	(b)	3,577	4,615	(1,038)
Other expenses	(c)	394,736	340,762	53,974
Income				
Recoveries and other revenues		36,915	38,572	(1,657)
Service appropriations	(d)	1,613,000	1,430,000	183,000
Resources received free of charge	(e)	4,643	18,035	(13,392)

(a) Employee benefits expense
The variance has predominately resulted from the increase in staff numbers and the payments of leave liabilities to other government agencies for three staff members who were terminated in prior years.

(b) Depreciation expense
Reduced number of plant and equipment assets being depreciated, as a result of the change in asset capitalisation threshold from $1,000 to $5,000.

(c) Other expenses
Increased expenditure associated with the rental of office accommodation and communication.

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

(e) Resources received free of charge
Reduced number of legal advices received from the State Solicitor's Office.

(B) Significant variations between estimates and actual results for 2008

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

	Note	2008 Actual $	2008 Estimates $	Variance $
Operating expenses				
Employee benefits expense	(a)	1,355,532	1,139,000	216,532
Other goods and services	(b)	406,986	328,000	78,986
Total expenses		1,762,518	1,467,000	295,518
Less: Revenues	(c)	(36,915)	-	(36,915)
Net cost of services		1,725,603	1,467,000	258,603

(a) Employee benefits expense
The recruitment of additional staff resulted in an increase in salaries and related superannuation costs for the year. The increase also includes the payment of leave liabilities for three staff members terminated in prior years.

(b) Other goods and services
The additional expenditure related to the fitouts of new offices at Level 8 St Martins Tower, and increased rental charges.

(c) Revenues
The Authority recovered salary costs for staff seconded to other government agencies during the year.

Office of Health Review

Notes to the Financial Statements

For the year ended 30th June 2008

Note 27 Financial instruments

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

Financial instruments held by the Authority are cash and cash equivalents, receivables 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 Authority measures credit risk on a fair value basis and monitors risk on a regular basis.

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

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 (for example, equity securities or commodity prices changes).

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

b) **Categories of financial instruments**

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

	2008 $	2007 $
Financial Assets		
Cash and cash equivalents	421,006	492,462
Financial Liabilities		
Financial liabilities measured at amortised cost	74,319	27,777

Office of Health Review

Notes to the Financial Statements

For the year ended 30th June 2008

Note 27 Financial instruments (continued)

c) **Financial instrument disclosures**

Credit risk, liquidity risk and interest rate risk exposure

The following table details the exposure to liquidity risk and interest rate risk as at the balance sheet date. The Authority's maximum exposure to credit risk at the balance sheet date is the carrying amount of the financial assets as shown on the following table. The table is based on information provided to senior management of the Authority. The contractual maturity amounts in the table are representative of the undiscounted amounts at the balance sheet date. An adjustment for discounting has been made where material.

	Weighted average effective interest rate	Variable interest rate	Non-interest bearing	Contractual maturity dates: Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years	Total
As at 30th June 2008	**%**	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**
Financial Assets										
Cash and cash equivalents			421,006							421,006
		-	421,006	-	-	-	-	-	-	421,006
Financial Liabilities										
Payables			74,319							74,319
		-	74,319	-	-	-	-	-	-	74,319

	Weighted average effective interest rate	Variable interest rate	Non-interest bearing	Contractual maturity dates: Within 1 year	1-2 years	2-3 years	3-4 years	4-5 years	More than 5 years	Total
As at 30th June 2007	**%**	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**	**$**
Financial Assets										
Cash and cash equivalents			492,462							492,462
		-	492,462	-	-	-	-	-	-	492,462
Financial Liabilities										
Payables			27,777							27,777
		-	27,777	-	-	-	-	-	-	27,777

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

Estimates of Expenditure

Estimates of expenditure for 2008-09

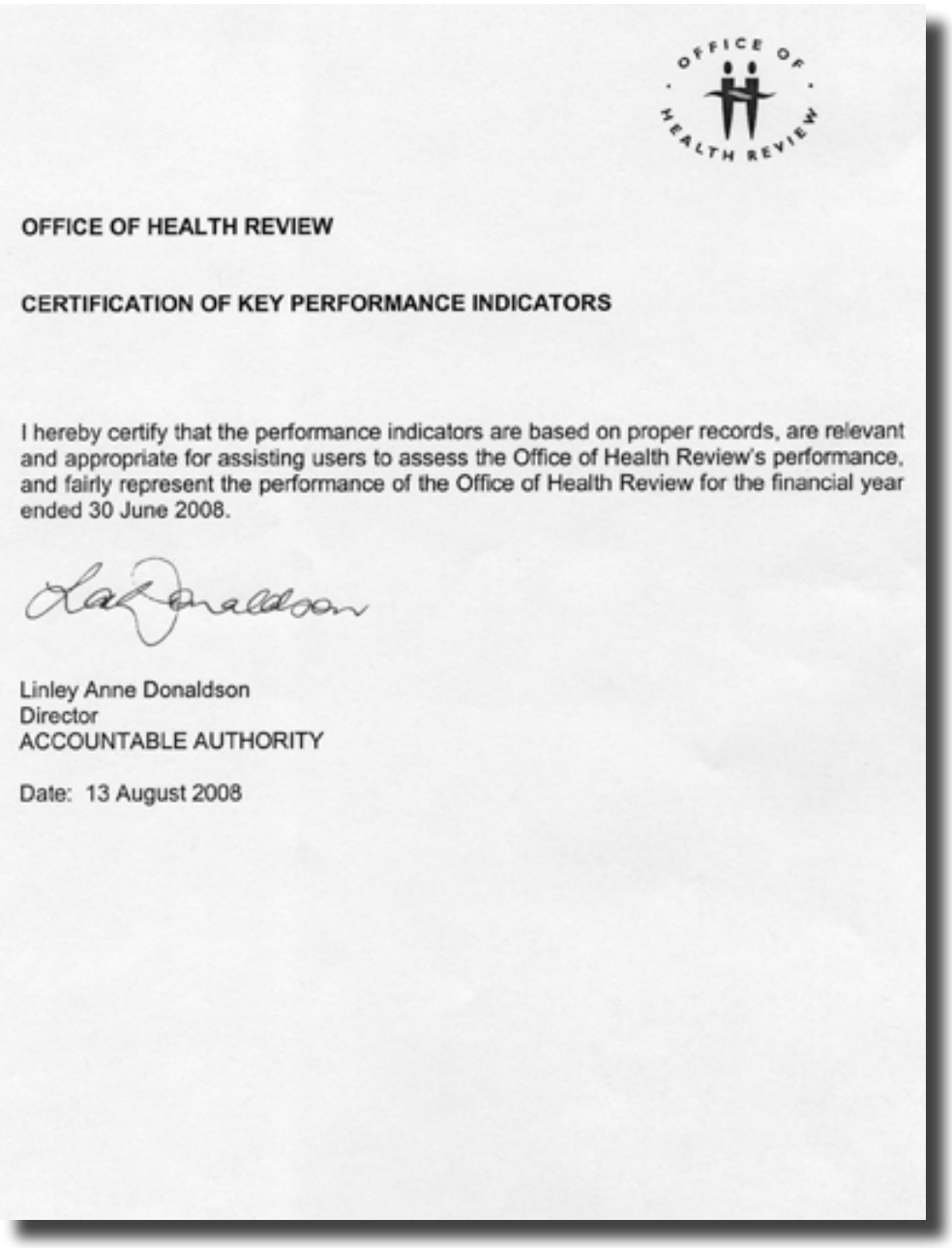
The following estimates of expenditure for the year 2008-09 are prepared on an accrual accounting basis.

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 2008-09 do not form part of the preceding audited financial statements.

Revenue	**2008-09**
Revenues from Government	$1,642,000

4.2 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 2008.

Linley Anne Donaldson
Director
ACCOUNTABLE AUTHORITY

Date: 13 August 2008

Performance Indicators

The Office of Health Review has produced Key Effectiveness and Efficiency indicators for 2007-2008. 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.

	2006/07	2007/08
Proportion of recommendations resulting in improvements to practices and agreed actions for implementation by agencies and providers (1)	100% (32)	100% (30)

Key Efficiency Indicators

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

Service 1: Assessment, conciliation and investigation of complaints

	2006/07	2007/08
(1) Average cost per finalised complaint (2)	$864.70	$816.50
(2) Average length of time to finalise a complaint (3)	130.8 days	87.8 days

Below is a further breakdown of the time taken to finalise a written complaint in 2007/08:

Table 5: Time taken to resolve written complaints 2007/08

Time taken	Number of Complaints
0 to 3 months	448
3 to 6 months	64
6 to 9 months	24
9 to 12 months	18
12 to 18 months	19
18 to 24 months	6
24 months and over	7
Total:	**586**

Key Performance Indicators

There were 1,258 complaints managed through the assessment phase that did not eventuate in a written complaint, and often resulted in the consumer seeking to resolve the complaint directly with the provider.

A total of 586 written complaints were closed this year. The following breakdown shows the case stage at closure.

Table 6: Complaint stage at closure.

Health complaints		**Disability Complaints**	
Enquiry	275	Enquiry	11
Assessment	98	Assessment	4
Conciliation	192	Conciliation	4
Investigation	1	Investigation	1
Total:	**566**	**Total:**	**20**

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

The education/training and consultation sessions for 2007-08 can be broken down into the following two groups:

Group 1 (cost for the development, production and distribution of information: {$78,097})

- pamphlets (a total of 4,786 leaflets were sent out throughout the year);
- newsletters were developed and sent to more than 200 organisations;
- a total of 3,688 survey data collection forms were sent to consumers and providers;
- three Information/Facts Sheets were developed, including Compensation, Dealing with Complaints, and a summary brochure.

Group 2 (Presentations and Consultations): ($141,954)

- presentations to stakeholders (including 39 presentations);
- stakeholder consultations (20); and
- regional visits (2).

	2006/07	**2007/08**
(1) Average cost per education/training and consultation (see Group 2 listed above) (4)	$4,115.40	$2,406.00

The Office of Health Review will define and further break down the items in Group 1 and Group 2 in the next financial year using the relevant government policies and guidelines.

This is the second year that OHR has reported on education/training. As the OHR is a central agency covering the whole of WA, it is important to use a range of processes to reach a wide group of stakeholders, thus the development of written information, presentations and consultations. The presentations/consultations were to a wide range of consumers, providers and stakeholders in the health and disability sectors.

A total of 39 presentations and 20 consultations were delivered/held with consumers, providers and stakeholders during 2007/2008.

Table 7: Proportion of stakeholder engagements

Presentations (39) Health groups (31) Disability groups (4) Prisons groups (4)	**66.1%**
Consultations (20)	**33.9%**

These presentations were attended by a variety of groups including:

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

Notes:

1. There were 30 complaints identified for the year with recommendations to providers for procedures/policy changes. All of these records have been reviewed to show that as at 30 June 2008, there was evidence that all recommendations have been implemented by the providers as part of the continuous improvement process.

2. Based on the accrual costs for the 2007/2008 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. Based on staff time and overheads to provide education, training, consultation and information sessions, divided by the number of presentations.

4.3 Ministerial Directives

4.3 Ministerial Directives
The Office did not receive any Ministerial directives during the year.

4.4 Other Financial Disclosures

4.4.1 Pricing Policies of Services Provided
The Office does not charge for any of the services we provide.

4.4.2 Capital Works
The Office did not undertake any capital works during the year.

4.4.3 Employment and Industrial Relations
As at 30 June 2008, OHR employed 18 people, 5 of whom were part-time employees. This includes contract staff. All employees are public servants.

Table 8: Employees by category

Employee Category	Number of staff as at 30 June	
	2006/07	2007/08
Full-time permanent	11	12
Full-time contract	1	1
Part-time permanent	2	4
Part-time contract	1	1
Total	15	18

Staffing Policies
During the year OHR redeveloped a range of policies encompassing human resource management. These policies will be reviewed on an ongoing basis. The polcies relate to a number of areas including confidentiality, grievance resolution, conflict of interest and performance development.

Industrial Relations
OHR staff are employed under the Public Service General Agreement 2006. No industrial disputes were recorded during the year.

Occupational Safety and Health
OHR staff have been trained in emergency procedures including building evacuation and managing adverse security events. First aid kits are available and a number of staff are trained in first aid procedures.

The Office encourages staff to achieve a work-life balance and offers confidential assistance counselling services to employees and their immediate families should they require it.

No claims for compensation were processed during the year.

4.5 Governance Disclosures
(i) Shares in Statutory Authority
While we are a statutory authority, the Office does not have any shares.

(ii) Shares in Subsidiary Bodies
The Office does not have any subsidiary bodies.

(iii) Interests in Contracts by Senior Officers
There have been no declarations of an interest in any existing or proposed contracts by senior officers in 2007-08.

(iv) Benefits to Senior Officers through Contracts
This is not applicable as no senior officers have received any benefits through any contract with suppliers.

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

4.6 Other Legal Requirements

Advertising (Electoral Act 1907 S175ZE)

The Office is required to report on expenditure incurred during the financial year in relation to advertising agencies, market research organisations, polling organisations, direct mail organisations and media advertising organisations.

During the financial year, OHR engaged in print and radio advertising to promote the Office and the services we offer to the public. Details are as follows:

Table 9: Advertising expenditure

Market Research	
Polling	
Advertising (non Salary Vacancies)	1212.29
Direct mail organisations	
Media advertising organisations	

Disability Access and Inclusion Plan Outcomes

As an agency that deals with disability service complaints, OHR is keenly aware of the requirements of people with disabilities and the need to make our services available to those people.

The Office is contactable through telephone, TTY machine, fax, email and SMS. Our publications, which the Office aims to write in plain English, are available in a number of formats and other languages on request. The OHR web site, which is W3C compliant, features a wide range of information, including all of our current electronic and hard copy publications.

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

Complaints made to the Office regarding disability services are given special consideration. For example, the relevant legislation does not compel complainants to first try to resolve the issue with their service provider. Disability service complainants are also given two years 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 outcome of the conciliation process. Being a small organisation, the Office does not often hold events where accessibility by people with disabilities might be an issue. However, at any event held by the Office accessibility is a key consideration.

Compliance with Public Sector Standards and Ethical Codes

During the year, OHR adopted a new Code of Conduct, which is based on the Code developed by the Office of the Public Sector Standards Commissioner. The new Code was discussed in general meetings, hard copies were circulated amongst staff and an electronic version is available on the OHR intranet. Staff were also requested to sign a letter stating that they had received and read the Code

In 2007/08 OHR was not faced with any compliance issues regarding public sector standards, the WA Code of Ethics or our own Code of Conduct.

Recordkeeping Plans

During the year, OHR's adminstrative record-keeping system was evaluated by Corporate Services staff members. It was found that the archiving of older files, the development of a detailed thesaurus and the establishment of new file creation procedures had resulted in a more efficient system for file location, tracking and retrieval.

A comprehensive training session for use of the record-keeping system was provided to all staff following its introduction. New staff members are made aware of their responsibilities and roles regarding the system as part of their induction procedures. Ongoing training is also conducted for all staff.

The efficiency and effectiveness of OHR's recordkeeping training will be evaluated in the next financial year.

Other Legal Requirements

Corruption Prevention

The Office has a strong culture of confidentiality, transparency and accountability. This is reflected in the way we work and all of our dealings with stakeholders.

OHR's corporate and business planning, which is reviewed annually, aims to identify any risks to good corporate governance and to prevent any form of corruption or misconduct from occurring. The Office has also incorporated risk management associated with corruption and perceived conflict of interest into strategic planning activities.

Senior OHR staff members have attended educational seminars held by the Corruption and Crime Commission. The information obtained at the seminars was shared amongst staff at meetings and kept on record for future reference.

In addition to being required to abide by the Office's Code of Conduct, all of our staff are required to 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.

4.7 Government Policy Requirements

Occupational Safety and Health

OHR is committed to maintaining a safe workplace for staff and managing any injuries that occur within the workplace.

Due to the small size of the Office and established informal communication channels, staff can raise any Occupational Safety and Health issues within the workplace directly with Corporate Services staff or with the Director. OSH issues can also be raised within the more formal structure of monthly staff meetings.

In accordance with the injury management requirements of the *Worker's Compensation and Injury Management Act 1981*, the Office has developed and endorsed an Injury Management System. This policy has been introduced to staff and has been placed on the Office's intranet. A Return to Work program has also been developed in accordance with the Act.

Table 10: OSH targets 2007/08

Indicator	Target 2007/08
Number of fatalities	Zero (0)
Lost time injury/diseases (LTI/D) incidence rate	Zero (0)
Lost time injury severity rate	Zero (0)

Appendices

Registration Boards

Chiropractor's 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*.
Podiatrist's Registration Board under the *Podiatrists Registration Act 1984*.
Psychologists Board of Western Australia under the *Psychologists Registration Act 1976*.

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.

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

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

Office of Health Review
PO Box B61 PERTH WA 6838
Ph: 9323 0600
Fax: 9221 3675
Freecall: 1800 813 583
email: mail@healthreview.wa.gov.au
Web: www.healthreview.wa.gov.au