Office of Health Review

Annual Report 2009/10














Statement of compliance

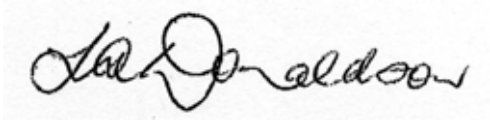
Government of **Western Australia**
Office of Health Review

HON DR KIM HAMES MLA
MINISTER FOR HEALTH

In accordance with section 61 of the *Financial Management Act 2006*, I 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 2010.

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

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 Act 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: 9 September 2010

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Overview

Over the past year the Office has been progressively putting into place processes, people and systems that support the role of the Office and its strategic objectives. Our three key strategic goals of enabling quality service, leadership and dialogue through engagement with stakeholders and research in effective complaints management have been comprehensively addressed.

The key focus of the Office is to improve the delivery of health and disability services through the complaint resolution process. The Office welcomed an increased number of enquiries this year. This resulted in a greater number of complaints being conciliated compared to the previous year.

The investigation of complaints warranting further analysis was an important priority during the year with the Office successfully completing three investigations while another seven are being progressed. Investigations have provided the opportunity to comprehensively examine a complaint and where appropriate make constructive recommendations in order to improve health and disability service delivery.

I am pleased to report that as a result of conciliations and investigations undertaken 55 service improvements were adopted by health and disability service providers. This is a very positive result as one of the main purposes of the Office is to support improvement in the delivery of health and disability services.

Whilst resolving complaints that are made to the Office is a primary function, we also work towards promoting the importance of effective complaints resolution at the service delivery level. Stakeholder and community engagement is designed to maximise awareness of the Office and capitilise on opportunities to liaise with stakeholders to build networks. During this year the focus was on increasing awareness of our services amongst some potentially vulnerable and underrepresented groups, including prisoners and people with disabilities.

In addition the Office undertook significant work in stakeholder engagement to a number of regional centres throughout WA. An important element of regional visits has been the opportunity to meet and discuss health and disability issues with representatives of regional Indigenous groups. This has provided a valuable opportunity to build local networks to gain insight into how Aboriginal community members use and view their local services. These collaborative meetings are enriching staff knowledge of regional concerns and creating a greater awareness in the management of culturally sensitive issues.

In order to increase awareness of our services amongst some potentially vulnerable and under-represented stakeholder groups the Office has worked with other Government agencies. Significant collaborative work has been undertaken with the Disability Services Commission and the Department of Corrective Services. These efforts allow us to directly engage consumer groups that can be difficult to reach, with the added benefit of staff from each agency providing their invaluable expertise. The Office looks to continue this collaboration in the future to further our engagement with communities.

Overview

This year we undertook an exciting initiative enacting regulations which prescribe a number of health service providers and the information that they will be required to submit to this Office annually. This information will enable the Office to analyse the nature of complaints and to identify trends or systemic issues to be addressed. With this information the Office intends to work collaboratively with providers to promote best practice methods of health service delivery and complaints management.

The Office is a small dynamic statutory authority and to improve operations we have consolidated the organisational structure to ensure that we operate cohesively and function well as a team. With the appointment of a Business Manager there has been a greater focus on streamlining accountability requirements in order to increase the efficiency of the Office.

A range of new complaint handling processes were introduced to the Office and these have improved the timeliness and quality of our complaints management and investigations, which has resulted in a reduction in the cost per finalised complaint.

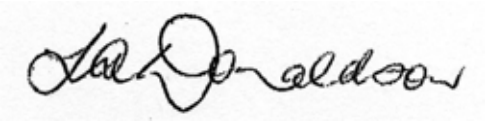
I also recognize the need for staff to be suitability qualified and to be involved in ongoing training in alternative disputes resolution practices. This has resulted in the complaints management staff acquiring National Mediation Accreditation.

By way of update subsequent to the end of the 30 June 2010 reporting period addressed in this report, it gives me great pleasure to announce that the amendments to the *Health Services (Conciliation and Review) Act 1995* and the *Disability Services Act 1993* have now been passed.

The amending Bill was passed in the Upper House of Parliament on 19 August 2010 and will allow for the streamlining of complaints to further enhance health and disability services for consumers and providers in Western Australia, once the amendments are proclaimed to commence on 30 November 2010.

The legislative amendments also enact a name change to the Health and Disability Services Complaints Office (HDSCO). With the name change imminent, the Office is preparing for a busy year ahead as this change will greatly increase our visibility as a dispute resolution agency, particularly in the area of disability services.

The staff are to be commended for their ongoing professionalism in maintaining high standards of performance in the best tradition of serving the community. I know that we all look forward to the transition to HDSCO and the positive effects the changes will have on the Western Australian community.



Anne Donaldson
Director, Office of Health Review

9 September 2010

Overview

Our Vision

Promoting leadership in the delivery of health and disability services through effective communication.

Our Mission

Supporting the improvement of health and disability services through complaints resolution.




Operational Structure

The Office of Health Review (OHR)* is an independent statutory authority, with responsibility for conciliating and investigating complaints about health and disability services in Western Australia and the Indian Ocean Territories. The Office has statutory reporting functions to the Hon Dr Kim Hames MLA, Minister for Health.

Roles and Functions

The key functions of OHR are to:

- provide an accessible and impartial service for the resolution of complaints, and
- promote improvements in health and disability services in Western Australia through complaints resolution and prevention.

A major focus throughout the year has been on the achievement of quality outcomes for both consumers and service providers.

Activities

The OHR deals with a wide range of complaints about both public and private health services. Services include those provided by individual practitioners such as doctors, dentists, nurses and physiotherapists, as well as those provided by organisations including hospitals, prison health services and ambulance services. The Office also deals with complaints about a variety of disability services including accommodation, therapy, in-home support and respite care.

Complaints are accepted from individual complainants as well as from advocates and carers. As an independent and impartial organisation, the OHR works cooperatively with both consumers and service providers, encouraging the parties to find a successful resolution to the complaint.

*The Office of Health Review is referred to as OHR, or the Office throughout this report.

The resolution of complaints may also lead to improvements in service provision. These may include the development of new policies and procedures, staff training and improved complaints management procedures. Information about specific outcomes and service improvements resulting from OHR activities are set out in the Complaints Management and Resolution Report.

When facilitating the resolution of complaints, the OHR assists consumers and providers to gain an understanding of effective dispute resolution methods. This helps both parties in dealing with similar issues they may encounter in the future.

OHR complaints resolution activities are supported by community outreach and engagement programs, and collaborative research partnerships. The Office is building effective working relationships with health and disability service providers, as well as registration boards, insurers and professional bodies.

Legislation

The primary legislation governing the operations of the OHR is the *Health Services (Conciliation and Review) Act 1995*, which sets out the role and functions of the Office. Complaints about disability services are dealt with in accordance with Part 6 of the *Disability Services Act 1993*. The Office also deals with complaints by carers about compliance with the Western Australian Carers Charter, under the *Carers Recognition Act 1994*.

Organisational Structure

The Office of Health Review has four key business areas:

- The **Operational Management Group** includes the Director, Manager Complaints Operations, Complaints Management Team Leaders and the Business Manager. This group oversees the strategic direction and operations of the Office.

- The **Assessment Team** is the first point of contact with the Office, dealing with all initial complaint enquiries. The team clarifies whether the Office can provide assistance, as well as refer to other agencies if appropriate. Recommendations are made about action on complaints and the team may resolve some straightforward matters.

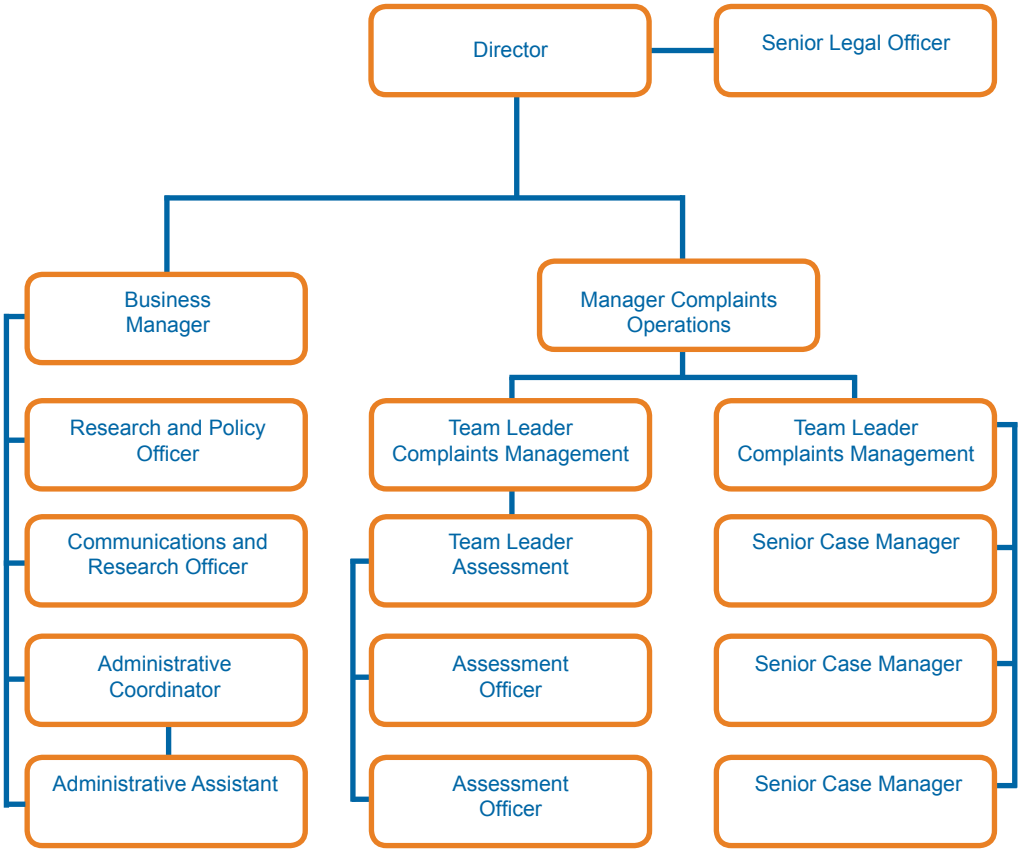
- The **Complaints Management Team** is responsible for managing and resolving more complex complaints through conciliation and investigation. The majority of complaints are conciliated, with a small proportion proceeding to investigation.

- The **Business Unit** provides corporate governance and business services to the Office. The team encompasses communications, research and corporate support and plays a leading role in strengthening the Office's capacity to effectively engage with consumers and service providers.

Support is also provided by the Health Corporate Network of the Department of Health, in the areas of human resources, procurement, finance, reporting and business systems services. An agreement with the Department of Health also provides for information and communications technology support.

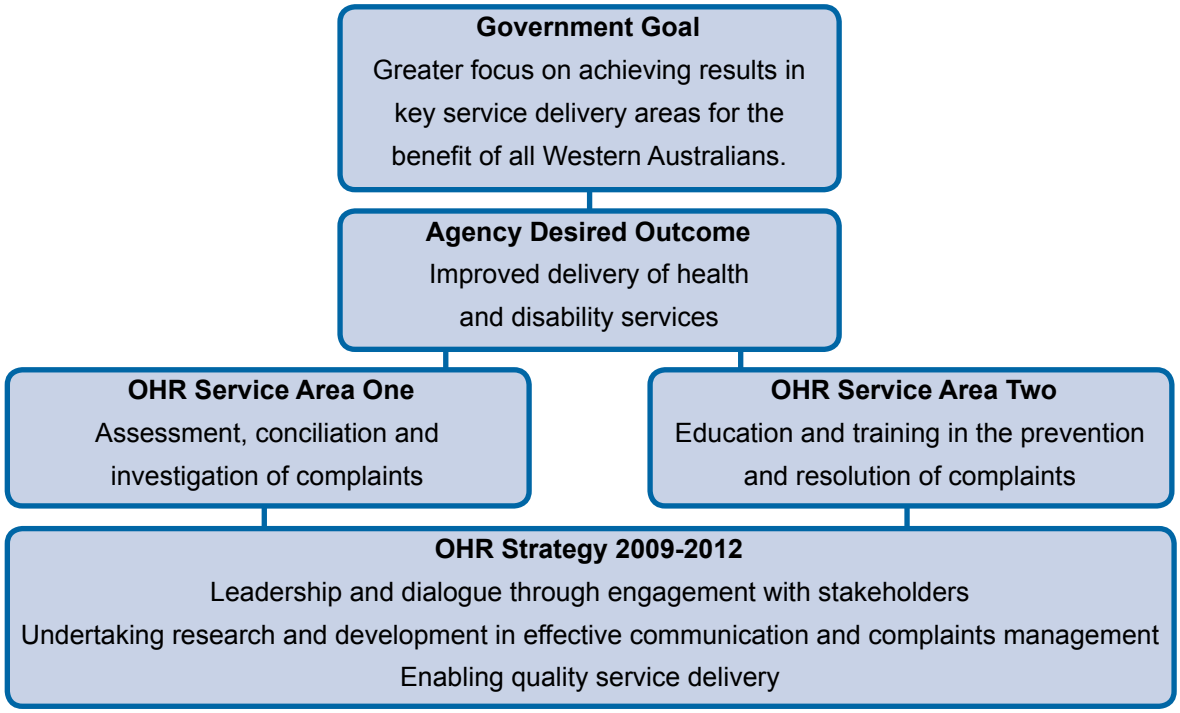
Overview

Organisational Structure



Performance Management Framework

The Office has aligned its desired strategic outcomes with a relevant whole of government goal. The Office works in partnership with both public and private health services, disability services and other key stakeholders across the State to deliver these outcomes. The information below illustrates how the government and agency goals are aligned with the agency-level services and its strategy.



Agency performance

The following areas are covered in this section:

- **Key Achievements**
- **Summary of Key Performance Indicators**
- **Complaints Management and Resolution Report**

Key achievements 2009/10

- A new complaints clinic was initiated to inform service providers about the role of the Office and good complaints management practices.
- A major project was commenced to identify barriers preventing Aboriginal people from making complaints, and ways of better engaging with Aboriginal communities.
- Data was collected from health service providers about complaints they dealt with during the year, under new regulations.
- A highly successful seminar was organised about the legal aspects of Open Disclosure, attended by a large number of clinicians, health administrators, lawyers, insurers and health consumers.
- A major campaign to inform disability services consumers and their families about OHR services was initiated in partnership with the Disability Services Commission (DSC).
- Improved communication processes were established with the Department of Corrective Services (DCS) regarding accessing information, prisoner complaint issues, and prisoner access to medical treatment.
- In a successful trial, a medical practitioner was engaged to provide medical opinion.

The Office of Health Review is committed to providing services to all Western Australians regardless of location

Regional WA

The OHR is committed to providing services to all Western Australians regardless of location. To achieve this, regional outreach activities are conducted by OHR staff each year. During these visits the OHR staff provide information about our Office, take complaints, liaise with stakeholders and educate providers and consumers about effective complaints management. In the 2009/2010 period OHR undertook a range of regional activities, as documented below.

Regional Access and Awareness Program (RAAP)

The RAAP is designed to ensure that key government complaints agencies have an ongoing presence in regional areas. This year RAAP regional visits included staff from our Office, the Office of the Information Commissioner, the Commonwealth Ombudsman, State Ombudsman and the Office of Public Sector Standards Commissioner. Broome, Geraldton, Mandurah and Pinjarra were visited as part of the program.

This year, along with consumer complaints clinics and visits with public service providers, the OHR also introduced a clinic for providers. Local health and disability service providers were invited to these sessions to learn about the Office and good complaints management practice. During the Broome visit the OHR participated in the Kimberley Health Issues Group as well as the North West Expo, an event that was attended by over 6000 people. Immediately following the RAAP visit, an OHR senior case manager also delivered a presentation on “Overcoming communication barriers for Aboriginal health consumers” at the 4th Annual Rural Health Conference.

Kalgoorlie Workshop

The OHR worked collaboratively with the Health Consumers Council (HCC) to facilitate a two-day workshop in Kalgoorlie. This workshop was aimed at providing information and assistance to Aboriginal health service providers on complaints handling processes and procedures. This event gave the OHR and the HCC the opportunity to engage with Aboriginal health service providers and clients, promote services and encourage active participation in the complaint handling process. Staff also met with representatives from Kalgoorlie Regional Hospital to discuss OHR's role and complaint handling methodology.

Bunbury Community Meeting

In May 2010, Office staff attended a joint community meeting with the HCC and Commonwealth Government representatives in Bunbury. This meeting was held in response to community concerns about the way that health services were being provided to the Aboriginal population in the South West. Following the meeting OHR case managers also met individually with a number of members of the community to discuss their specific complaints and provide information about our services.

Community Engagement

OHR community engagement is designed to maximise awareness of the Office and capitalise on opportunities to liaise with stakeholders to improve our services. This year the OHR has focused on increasing awareness of our services amongst some potentially vulnerable and under-represented stakeholder groups.

Indigenous Communities Engagement

The OHR embarked on a significant project to identify barriers preventing Aboriginal people from making complaints to our service, as well as how to better engage with Aboriginal communities. This project involved members of the OHR engaging with relevant stakeholders including Aboriginal communities, Aboriginal health and disability service providers, and advocate agencies. A key focus of the project was to assist in identifying ways to encourage consumers to contact the Office and for providers to recognise and implement effective complaints management systems. This project is an ongoing priority for the Office and effective implementation methods will be identified in the coming year.

Disability Services Commission

This year the OHR commenced a major campaign focusing on the provision of information to disability service consumers and their families, in conjunction with the DSC. This has resulted in an agreement that all Local Area Coordinators (LACs) will provide their new DSC clients and families with an information pack about the OHR and the services provided.

The DSC has also featured the OHR in a number of internal and external newsletters. The OHR's commitment to connecting with disability service consumers will be further enhanced in the coming year with a review and planned improvements in methods of communication.

Open Disclosure

In 2009/10, the Office continued to promote Open Disclosure in WA health services. Open Disclosure refers to the open discussion between the health team and patient following an adverse event in healthcare.

Both the consumer and the service provider can benefit from a well structured and open dialogue. OHR experience shows that people often make complaints seeking information that could have been provided through the practice of Open Disclosure. However, a common concern voiced by healthcare professionals has been uncertainty about the legal implications of being open with patients about a clinical incident that has resulted in harm.

To address this uncertainty, the OHR organised a seminar 'Open Disclosure in Practice, The Legal Aspects', at St John of God Health Care, Subiaco. Professor David Studdert, a leading academic in law and public health, presented research about legal issues in Open Disclosure that was commissioned by the Australian Commission on Safety and Quality in Health Care. The presentation was followed by a panel discussion featuring leaders from the health, legal and insurance industries as well as consumer groups. The seminar was highly successful and attended by a large number of clinicians, health administrators, lawyers, insurers and health consumers. With the support of the WA Country Health Service, the event was also video-conferenced to rural and regional areas.

During the reporting period, OHR staff have also been actively involved in providing input to a research project on Open Disclosure. The 100 Patient Stories Project, led by Professor Rick Iedema, was commissioned by the Australian Commission on Safety and Quality in Health Care. Staff members contributed to a State forum working to develop patient-centred indicators of effective Open Disclosure.

Anne Donaldson speaking at an open disclosure forum in Perth

Memoranda of Understanding with other State and Commonwealth Agencies

During the year, the OHR has been working with a range of other agencies to promote the coordination of government services and avoid unnecessary duplication. To facilitate effective service provision, information-sharing and timely outcomes, the OHR has been developing Memoranda of Understanding with the following organisations:

- Australian Health Practitioner Regulation Agency (AHPRA) at a national level,
- AHPRA's Western Australian Office,
- Australian Competition and Consumer Commission, and
- WA Department of Commerce.

National Meeting of Health Complaints Commissioners

The bi-annual Australian Health Complaints Commissioners Conference was held in Perth in April 2010. This event was attended by the OHR's counterparts in other States, Territories and New Zealand, and allowed an opportunity for the agencies to discuss common issues and challenges. The April conference featured a series of presentations from representatives of the Australian Bureau of Statistics, the Australian Competition and Consumer Commission and APHRA.

A number of key decisions were made regarding future collaboration and cooperation between the bodies, including formal liaison with the Australian Competition and Consumer Commission and the Federal Department of Health. The conference was a successful event and provided a solid foundation for the Commissions' continued participation.

Attendees at the Australian Health Complaints Commissioners Conference in Perth, April 2010

Provision of Complaints Details by External Agencies

The enactment of new regulations this year has enabled the Office to collect information about complaints received and action taken on those complaints in the preceding year from a significant group of public and private health service providers.

This information will be reviewed and analysed to better understand emerging trends from complaints about health care service delivery. It is anticipated this will lead to improvements in complaints management as well as the provision of health care in W.A.

Department of Corrective Services

During the year, the OHR and DCS have initiated quarterly meetings to discuss issues stemming from prisoners' complaints, access to DCS information and appropriate ways to effectively deal with and improve prisoners' access to medical treatment.

Following feedback that many prisoners were unclear about the role of the Office and when to contact us, the OHR collaborated with the DCS to design and distribute material that aims to provide clear, instructive information about OHR services.

A significant investigation into prisoner access to external medical treatment was undertaken by the Office which has facilitated effective communication with the DCS. All preliminary recommendations resulting from the investigation have been accepted by the DCS. This Office will continue to work closely with the DCS to improve their complaints management system and services for consumers within the WA prison system.

Medical Practitioner

A large proportion of the complaints made to the Office concern the adequacy of clinical care patients receive. OHR staff often seek informal and formal opinions about medical care from doctors and nurses external to the agency. Until this year the OHR has not had access to internal medical advice. In 2009/10 a trial of a part-time Medical Practitioner was conducted. The Medical Practitioner's role is to provide advice and guidance to OHR staff about the complex medical issues that can surround complaints and also to assist with improving internal complaints management procedures.

The trial was very successful, with staff reporting that having fast and easy access to a medical opinion enhanced decision making and improved the timeliness of complaints resolution. Following the successful trial of the Medical Practitioner role a further tender was advertised in June 2010 and it is hoped that a practitioner will be engaged early in the next year.

Report on Key Performance Indicators

OHR's key effectiveness and efficiency indicators are intended to reflect and evaluate the agency's desired outcomes and services. These indicators are also reported in this year's audited performance indicators (see the Disclosures and Legal Compliance section for detailed key performance indicator information).

The key focus of the Office is to improve the delivery of health and disability services through the complaint resolution process. This year the OHR identified an increased number of service improvements in the form of recommendations that were identified through the conciliation and investigation process. As a result of recommendations made by our office, 55 service improvements were adopted by health and disability providers as opposed to 26 in the 2008/09 reporting period. In addition a range of new complaint handling processes have also improved the timeliness and quality of our conciliations and investigations and has resulted in a reduction in the average cost per finalised complaint from $725.53 in 2008/09 to $595.22 in 2009/10. These results support our goal to provide a range of services in a cost effective manner.

This year due to the implementation of a new database the Office reported on the percentage of complaints finalised within target timeframes. The results were positive and the Office will continue to strive to maintain these timeframes.

Complaint Management and Resolution Report

A primary function of the OHR is to provide an accessible and impartial service for the resolution of health and disability services complaints. In this section, information is provided on the number and type of enquiries and complaints received, and how complaints are resolved.*

OHR complaints resolution processes include providing information and assistance to consumers and providers, facilitating conciliations and conducting investigations. The report focuses on outcomes achieved for individual consumers as well as system improvements arising from OHR complaints resolution. Case studies, which have been de-identified to protect the privacy of all parties concerned, are used to demonstrate the range of outcomes achieved.

Information is also provided about complaints in key service sectors. These include public and private hospitals, prison health services, medical practitioners, dental services and disability service providers.

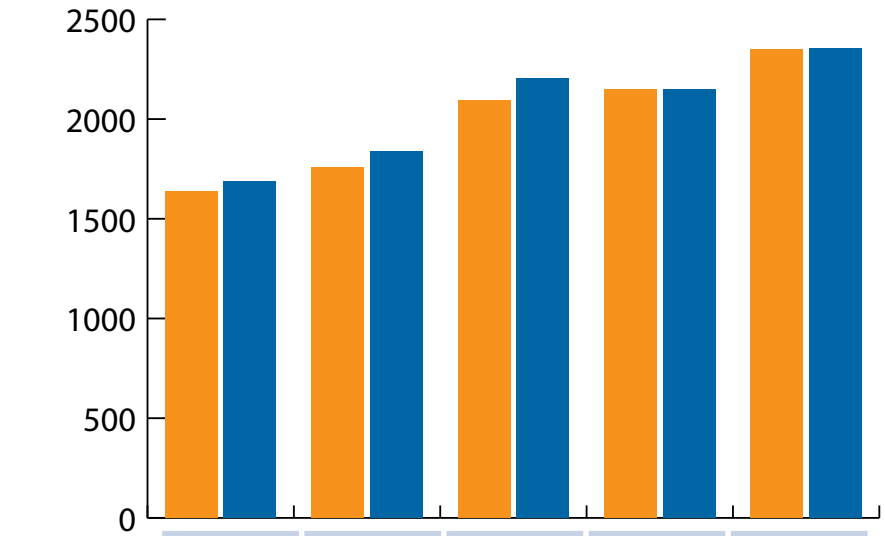
Highlights 2009/10

- The number of complaints and enquiries dealt with by the OHR was up by 9% on the previous year, continuing the trend over the past five years.
- The OHR conciliated 145 complaints about health and disability services: 65% more than in the previous year.
- There was a significant increase in the number of complaints successfully resolved at conciliation; agreement between parties was reached in 57% of cases.
- Costs were partially refunded or waived in over 50% of conciliated complaints involving dental services.
- 55 service improvements were implemented across the health and disability services sector as a result of OHR complaints resolution activities.

Complaints and Enquiries Received in 2009/10

During 2009/10 the Office received 2349 complaints and enquires from people seeking assistance; a 9% increase from the previous year. This is a continuation of the trend of increasing complaint numbers over the past five years.

Graph 1: New and closed complaints, 2005/06 - 2009/10



	2005/06	2006/07	2007/08	2008/09	2009/10
New complaints	1635	1759	2092	2151	2349
Closed Complaints	1687	1837	2202	2150	2356

Note: Closed complaints include some complaints carried over from the previous year.

*Please note that throughout this report figures have been rounded to the nearest percent. Consequently, in some cases totals may not add to 100%.

The increase in the number of complaints is partly due to the significant stakeholder engagement and regional outreach programs that the OHR has implemented over the past few years. In 2009/10, this included information presentations to consumers and providers about OHR services, engaging with DSC local area coordinators, and updating and simplifying information pamphlets and brochures.

In the coming year, OHR outreach programs will continue to focus on sectors of the community that are under-represented in complaints statistics. The OHR will also progress a wider stakeholder engagement plan to enhance the Western Australian community's awareness of the Office and its role.

It is anticipated that there will be a significant increase in enquiries and complaints following the passage of the Health and Disability Services Legislation Amendment Bill 2009. The change of name to the Health and Disability Services Complaints Office will more clearly reflect the role of the Office in resolving complaints about health and disability services.

Enquires and Complaints Received in 2009/10

Immediate Referrals

Of the complaints and enquires made to the Office in 2009/10, 568 were referred immediately to another, more appropriate agency. The high number of immediate referrals reflects the Office's policy of attempting to support consumers accessing the most appropriate source of assistance at the earliest possible stage. Table 1 below shows the agencies that people were most commonly referred to for assistance with their concerns:

Table 1: Immediate referrals: 2009/10		
Ombudsman	55	10%
Local shire	49	8%
Dept of Health	46	8%
Dept Health and Ageing	21	4%
Privacy Commissioner	18	3%
Minister for Health (State)	18	3%
Department of Commerce	15	3%
Medicare	13	2%
Private Health Insurance Ombudsman	9	2%
Minister for Health (Federal)	9	2%
Other	315	54%
Total immediate referrals	**568**	

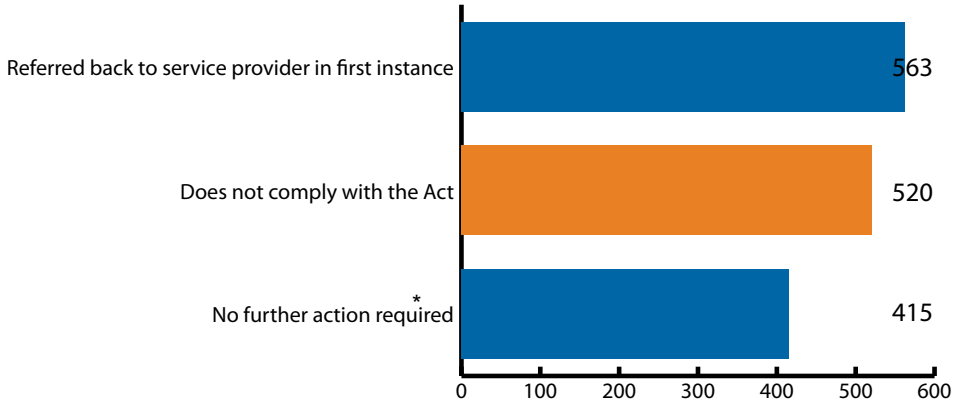
Case Study

Mr H telephoned the OHR after he had visited his mother in her aged care facility. He was concerned that she was not being fed properly. As the aged care facility is funded by the Australian Government, the OHR could not deal with Mr H's concerns. OHR staff provided Mr H with relevant information and referred him to the Department of Health and Ageing.

Matters Dealt with on Initial Enquiry and Assessment

In addition to immediate referrals outlined above, a number of other enquiries involve the provision of information or referral advice, or do not require further action. A significant proportion of the people who contacted the Office were provided with information, assistance and support to resolve the complaint directly with the service provider.

Graph 2: Matters dealt with on initial assessment.



*Includes matters where the complaint was resolved through enquiries and assistance provided by the Office.

The Office managed 563 complaints by assisting the complainant to go back to the person or organisation that initially provided the service. This is an important step in the complaints management process, as often service providers are keen to know about people's concerns and will make considerable efforts to resolve them once they are aware of the problem.

People who are referred back to the original service provider are given information on how best to go about this and advised of advocacy agencies that may be able to assist them with their complaint.

Anyone who is referred back to the provider is sent a survey form and a reply paid envelope. The survey form asks them to let the Office know whether their attempts at resolving the matter directly with the provider were successful. People are encouraged to come back to the OHR for further assistance if they are not successful at resolving the matter directly with the provider.

Case Study

Mr P was unhappy about treatment of his head injury at the emergency department of a public hospital. He felt that the nurses did not clean his wound properly and were rude to him. He was also concerned that he was not given any information about how to care for the wound when he was discharged.

Mr P contacted the hospital and made a complaint. He received a written response, but he was still not happy. When staff from the OHR discussed the matter with the hospital, they agreed that the response did not fully address Mr P's concerns and offered to meet with him. Although he had already tried once to resolve his complaint directly with the hospital, Mr P was pleased to be offered a meeting, and happy to talk to the hospital without the process being further facilitated by the OHR.

In 2009/10 there were 520 complaint enquiries that for different reasons did not comply with the OHR's legislative requirements. This may have been because the complaint was outside the prescribed time limits or because people did not provide the essential information needed to progress the matter. If a complaint is out of time, the Office will always try to assist a person to find an alternative pathway to resolution.

In these circumstances callers were provided with information about the role of the Office and the information required to progress a complaint. A number of people decided at this stage that they did not wish to formally progress their complaint. These complaints may be dealt with in the future should the complainant decide to proceed. Many people indicated that they were satisfied to know that the Office had officially recorded their concerns and could use them to identify systemic issues and trends.

The OHR Assessment Team provides general information to people who have queries and concerns about the health and disability services they have received. In some cases, after making a number of inquiries and providing information to the complainant, it is ascertained that no further action is required by the Office.

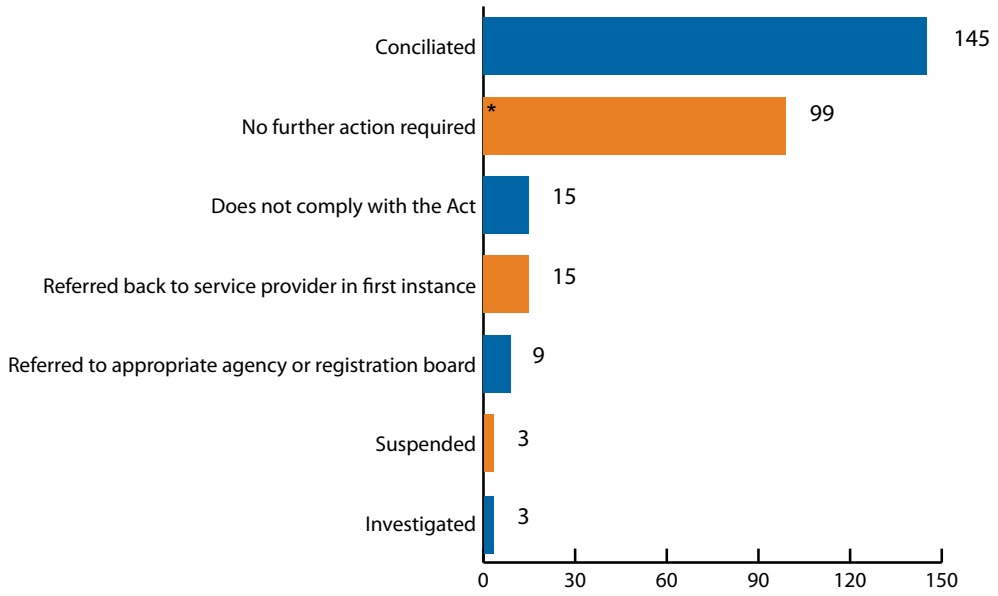
In 2009/10, 415 complaints were dealt with in this way. In some cases the matter was resolved as a result of OHR inquiries, or by providing information about other relevant services available to assist with their immediate issues.

Written Complaints

In addition to dealing with incoming enquiries, making immediate referrals and providing assistance and information to complainants about resolving their concerns, the OHR deals with formal complaints about health and disability services.

In 2009/10, there were 289 formal written complaints. Graph 3 below shows the way that formal complaints were dealt with over the year.

Graph 3: Written Complaints 2009/10.



*Includes matters where the complaint was resolved through enquires and assistance provided by the Office.

An important aspect of OHR work is referring complaints to appropriate bodies, including registration boards. The Office will refer a matter to a registration board immediately if it clearly raises issues of potential significant misconduct by a registered practitioner.

During 2009/10, some formal written complaints were withdrawn or resolved between the consumer and the provider. The Office encourages parties to a complaint to work together, whether through conciliation, or outside of conciliation to reach a satisfactory resolution. For example, when a complainant is seeking a refund, it may be offered outside the formal conciliation process. In these and other circumstances, no further action is required by the Office.

Case Study

Mrs J came to the OHR with a complaint about the quality of subsidised dentures made for her by a dental clinic. She had gone back to the clinic on two occasions with sore spots caused by the dentures, which could not be adjusted to her satisfaction and she stopped using them. When Mrs J later went to another dental clinic, she was encouraged to bring her complaint to the OHR. Mrs J was particularly unhappy because she would have to wait some years until she was again eligible for subsidised dentures. In the meantime she could not use the ones she had. Mrs J's complaint was outside the 12 months time limit, however, with Mrs J's consent, her complaint was referred to the Australian Dental Association for consideration under their dispute resolution scheme.

Conciliation

In 2009/10 the OHR conciliated 145 complaints about health and disability services, an increase of 65% from the previous year. Over 50% of all formal written complaints were conciliated.

Table 2: Written and conciliated complaints, 2008/09 - 2009/10

	2008/09	2009/10	Increase
Total written complaints received	265	289	9%
Total written complaints conciliated	88	145	65%

Conciliation encourages settlement of a health or disability service complaint by case managers arranging informal, confidential discussions between the parties. Issues discussed or information exchanged cannot be used in any court or tribunal process. This allows for open and frank disclosure, and discussion between the parties.

Conciliation is entirely voluntary and either party can withdraw from the process at any stage. In 2009/10, the OHR operated two different, flexible methods of conciliation. The first method is face-to-face meetings attended by both parties and facilitated by a conciliator. The second is an exchange of correspondence between the parties through the conciliator. Experience has shown that face-to-face meetings generally result in a more positive outcome for both parties, however, it is accepted that this method will not suit all complaints.

Of the 145 conciliated complaints, the OHR achieved agreement between the parties in 57% of all cases. This demonstrates a significant increase in the number of matters resolved at conciliation compared to 2008/09. This increase can be partly attributed to an increase in the number of complaints received and successfully resolved for WA prisoners.

Outcomes of Conciliation

The following table outlines the outcomes that were achieved for all conciliations held in the reporting period. This shows that the two most common outcomes were that the complainant's concerns were registered formally with the provider and that an explanation was provided about the issues of concern, for example, the treatment provided.

Table 3: Outcomes achieved in conciliated complaints: 2009/10		
Concern registered	45	31%
Explanation given	40	28%
Apology given	21	14%
Service obtained	19	13%
Change in procedure/practice agreed	13	9%
Costs refunded/waived	12	8%
Other	25	17%
Total outcomes	**175**	
Total cases	**145**	

Note: More than one outcome can be achieved for one complaint as depicted in the above table.

A key subject for discussion during many conciliations is communication between the consumer and provider. This indicates there is potential for improvement in the way that information is provided about services, and the way complaints are initially managed by providers. The OHR has recognised this systemic concern, and is developing effective tools for use by health and disability service providers to improve communication and complaints processes.

Case Study

Mr H complained that the gastric band surgery he had undergone did not produce the required results and he had put weight on rather than losing it. He was concerned about the lack of information about the potential failure of the band and the information provided after the surgery which suggested that the band was not placed correctly. He felt belittled by the hospital treatment team and had lost faith in their ability to help him.

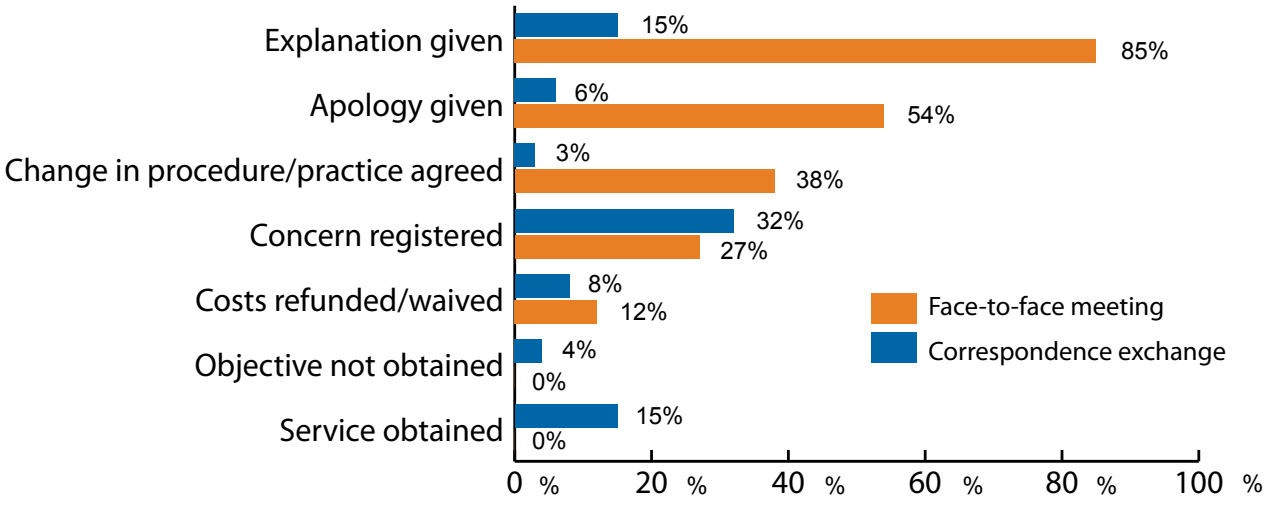
Mr H wanted to meet with the hospital, for an explanation of why the gastric band was not working and to discuss the information that had been provided. He also wanted an apology from the surgeon about his treatment by the hospital staff and help with on-going costs associated with having the gastric band corrected by another surgeon.

A face-to-face meeting was held between the complainant, a support person and representatives from the hospital. The hospital provided Mr H with an explanation as to why the gastric band might have failed, an undertaking to assist with the correction of the placement of the band, ongoing support for weight loss and an apology for the manner of the treatment team.

As a result of this complaint, the hospital revised their verbal and written communication to patients undergoing gastric banding, including the development of pre and post operative fact sheets.

Graph 4 below shows that in the majority of face-to-face conciliations an explanation and apology is achieved, with a significant percentage of complaints also resulting in a change to the service provider's practices or procedures. For conciliations that are conducted by an exchange of correspondence, the most common outcome is to have the concern registered with the provider, and in some cases a service which had been sought is obtained. While a higher number of conciliations were conducted by an exchange of correspondence, in general, better outcomes were achieved via face-to-face conciliations.

Graph 4: Conciliation method and outcomes, 2009/10.



The Office has found that there is a general reluctance by many health and disability service providers to engage in face-to-face conciliation meetings. This has a direct impact on the number of conciliations conducted via an exchange of correspondence. In the coming year, the OHR will be working with provider groups to explain the objectives and benefits of face-to-face conciliations. This will assist service providers to gain a greater understanding of the Office's role and to review their own complaints management processes.

Case Study

Ms T believed that a general practitioner had misdiagnosed her illness and had sent her for unnecessary testing. She was upset that the doctor had not responded to her written complaint and when she called into the surgery she was dismissed by the doctor and not given an explanation or apology.

Ms T wanted to discuss her complaint directly with the doctor; however, the doctor did not wish to engage in a face-to-face meeting. On advice from the doctor's insurance company a letter was provided to Ms T explaining why the doctor had determined additional tests were required and what action had been taken.

Ms T was satisfied with the explanation given as to why the tests were requested, but she was not happy about the doctor's reluctance to discuss the matter in person. She remained unhappy that the doctor had not apologised for failing to respond to her complaint initially, or acknowledged her distress at having believed she was ill.

Investigation

The OHR has the ability to investigate complaints about health and disability service providers. A complaint about a disability service provider cannot be investigated unless an attempt has been made to conciliate the issues. If conciliation is unsuccessful then the complaint must be investigated. For health complaints, conciliation will generally be conducted prior to considering whether a matter is suitable for investigation. This allows for the issues to be discussed and hopefully resolved by the parties.

At the end of an investigation, the Director may make recommendations to the service provider for remedial action. The provider must respond to these recommendations and advise the Office of the action taken. The OHR also has the ability to review and identify causes of complaints and to conduct enquiries into significant systemic issues.

Case Study

Mrs S complained about the quality of early intervention services that had been provided to her young child by a publicly funded disability service. She was concerned about the lack of service provision and the ability of the therapists to provide a meaningful service.

A conciliation meeting between the family and service provider representative did not result in agreement. The complaint was then investigated.

During the investigation, information from the provider was reviewed, relevant standards and legislation were considered, and an independent opinion was sought from an interstate expert. The outcome was that the provider was found to have acted unreasonably in three areas:

- failing to provide suitably experienced staff to provide services to the child,
- allocating a disproportionate amount of time to planning rather than service delivery, and
- failing to comply with the organisation's complaints management process.

Recommendations for remedial action were made to the provider who submitted a response showing how these issues were being addressed. The response was also discussed with Mrs S and her family. The investigation identified possible systemic issues in the provision of services for people with disabilities. The Office is currently working with a number of agencies to address the identified issues.

The OHR completed three investigations in the reporting period and had a further seven investigations in progress. At 30 June 2010, two of the in-progress investigations were at the preliminary report stage with all suggested recommendations being accepted by the service providers.

Complaint Outcomes

Working collaboratively with service providers to resolve complaints has resulted in a number of system improvements and changes to processes and procedures. During the year, the OHR developed and implemented a new procedure to more effectively monitor service improvements resulting from conciliation and investigation.

In 2009/10, 55 service improvements were implemented in the health and disability services sector as a result of OHR complaints resolution activities. Examples are outlined in the following section on health and disability service providers.

Health and Disability Service Providers Report

This section of the report details complaints made to OHR about the following service sectors:

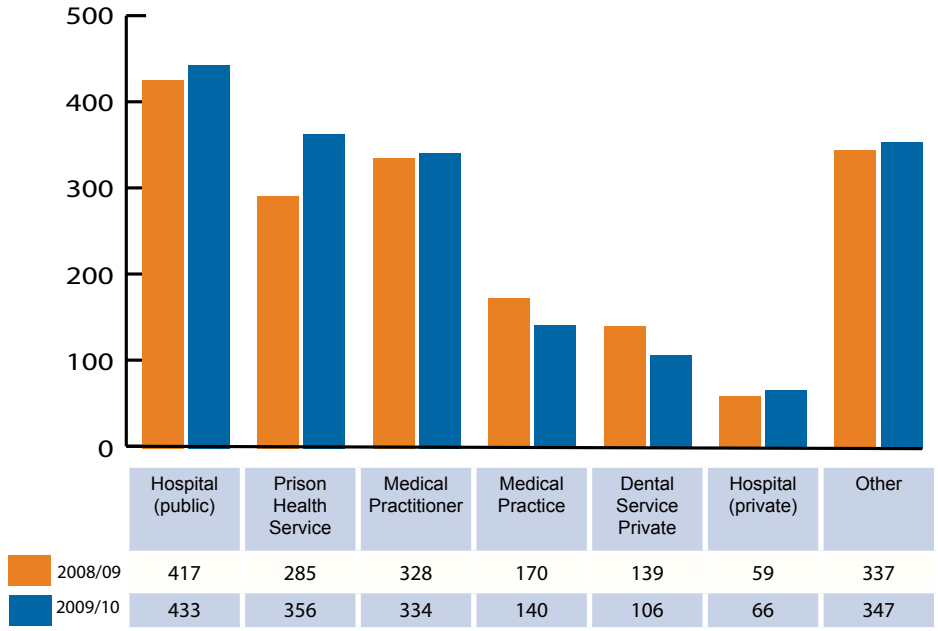
- Public and Private Hospitals,
- Prison Health Services,
- Medical Practitioners and Practices,
- Dental Services, and
- Disability Services.

Services in these areas account for the majority of enquiries and complaints received by the OHR. They also cover the largest percentage of health and disability services provided in the community.

The report shows the main concerns raised in complaints and enquiries. It also outlines the outcomes for individual complainants, and improvements in service provision arising from OHR complaints resolution processes.

Graph 5 below shows the number of complaints about different types of health service providers that the OHR received during the past two years.

Graph 5: Complaints about various health service providers, 2008/09 & 2009/10.



	Hospital (public)	Prison Health Service	Medical Practitioner	Medical Practice	Dental Service Private	Hospital (private)	Other
2008/09	417	285	328	170	139	59	337
2009/10	433	356	334	140	106	66	347

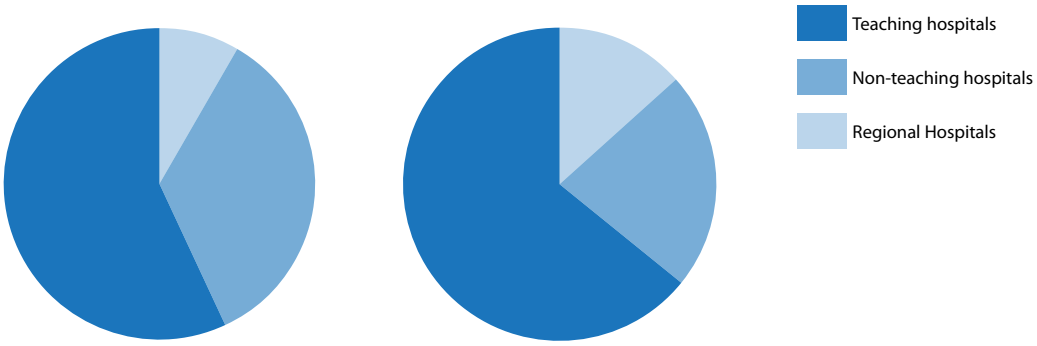
The most common complaint enquiries concerned:

- public hospitals (25%),
- prison health services (20%), and
- medical practitioners (19%).

Together these three groups accounted for over 63% of the 1781 enquiries and complaints received in 2009/10.

Public Hospitals

The number of enquiries and complaints made about public hospitals remained relatively constant, with 433 received in 2009/10, compared to 417 in the previous year.



Graph 6: 2008/09
public hospital complaints

Graph 7: 2009/10
public hospital complaints

As shown by the graphs above, the number of complaints received about public non-teaching hospitals has reduced while the number of complaints about regional hospitals has increased. The increase in complaints about regional hospitals may relate to the OHR's increased presence in regional and rural Western Australia.

Table 4: Most common issues raised in complaints about public hospitals	
Inadequate treatment	94
Unexpected treatment outcome/complications	94
Attitude/manner	58
Wrong/inappropriate treatment	39
Refusal to admit or treat	33
Delay in treatment	25
Waiting lists	22
Excessive treatment	20
Inadequate consultation	20
Inadequate discharge	19
Total complaint enquiries	**433**

Note: More than one issue may be raised in a complaint, therefore totals may not always reflect other data.

The most common complaints made about public hospitals involved inadequate treatment (22%) and unexpected treatment outcome or complications (22%). This is similar to data recorded in previous years and is in line with the experiences of other State health complaints bodies.

Outcomes for Consumers

Participants reached full or partial agreement in 70% of the public hospital complaints conciliated by the OHR. Common outcomes for individual complainants were an apology and explanation relating to the issues of concern, and agreement to change policy or procedure. In some cases there was a refund of some charges or a service provided.

Case study

Mrs E, an elderly in-patient at a metropolitan public hospital, had a family member appointed as her official guardian. Her guardian lived in a WA country town and visited Mrs E when possible, as well as phoning and emailing the hospital to check on her condition.

Mrs E's guardian became concerned about the care and treatment that Mrs E was receiving; in particular that Mrs E was being given morphine based medications, to which she had previously had a bad reaction. Her guardian was also unhappy about the level and nature of the communication by the hospital.

Following separate meetings with the hospital and the guardian, a conciliation meeting was held with the guardian, family members, the patient's specialist and the hospital's nurse manager. During the meeting, hospital staff apologised for the communication problems the family had experienced, and information was provided about the family's concerns, including the decision to give Mrs E morphine based medications.

The guardian reported that she was happy for Mrs E to continue to receive morphine based medications and that she had greater trust in the hospital. Staff from the hospital reported that they had a better understanding of the basis for the guardian's concerns, and how to communicate successfully with the family.

Service Improvements

A range of service improvements were identified and adopted by public hospitals as a result of involvement in OHR complaints resolution processes. These included:

- Introduction of improved verbal and written communication procedures for patients about pre and post operative procedures,
- Development of information packs to be given to families when a family member dies in hospital,
- Use of a number of complaints as staff teaching aids/case studies, and
- Installation of a new electronic system at a rural hospital to enable doctors on call to access patient's notes from different locations.

Private Hospitals

Complaints about private hospitals represent a relatively small proportion of overall complaints and enquiries. However, there was a 12% increase in complaints over the previous year. The increase has been across a broad range of services with the highest increase in complaints about administrative practices. Billing practices and financial consent rated in the top four issues most commonly complained about.

Table 5: Most common private hospital concerns raised	
Billing practices	19
Inadequate treatment	16
Unexpected treatment outcome/complications	15
Financial consent	7
Inadequate discharge	7
Inadequate information provided	5
Cost of treatment	4
Attitude/manner	3
Inappropriate disclosure of information	3
Access to/transfer of records	2
Diagnosis	2
Incorrect/misleading information provided	2
Refusal to admit or treat	2
Total complaint enquiries	**66**

Note: More than one issue may be raised in a complaint, therefore totals may not always reflect other data.

Outcomes for Consumers

Agreement was reached in 82% of complaints conciliated involving private hospitals. Common outcomes for individuals included an explanation and apology, and having the hospital register and acknowledge the concerns that were raised.

Case Study

Mrs C, who attended a private hospital for a surgical procedure complained that she found fresh and old blood in her room. She was also concerned that nobody advised her daughter why the operation was taking longer than planned. She was still heavily medicated when discharged and had not been given a post-operative wash. Mrs C was diagnosed with an MRSA infection at the wound site, and believed that she contracted the infection during her hospital stay.

A positive outcome was achieved through two conciliation meetings held with hospital representatives and Mrs C. At the first meeting, the participants discussed her concerns relating to hospital hygiene, clinical care, communication and administration. Several procedural changes were implemented as a result of the complaint and the hospital manager apologised.

At the second conciliation meeting, the participants discussed the MRSA infection. Information and explanation was provided by the hospital and it was agreed that de-identified details of the situation would be used for training purposes.

Service Improvements

A number of service improvements were identified and adopted by private hospitals as a result of involvement in OHR complaints resolution processes. These included:

- New procedures were introduced to remind staff of the importance of obtaining full financial consent from a patient or carer,
- Information from complaints was used to develop training tools for staff, and
- Improved procedures for communication between private consultants and hospital staff were introduced.

Prisoner Health Complaints – Department of Corrective Services

There are over 5000 prisoners in metropolitan and regional prisons operated by the Department of Corrective Services (DCS). Health services are provided to prisoners by DCS staff, public hospitals and external specialists. Prisoners are able to contact the Office on a direct dial line to discuss concerns about health or disability services.

Complaints from prisoners make up 20% of all health and disability service enquiries and complaints. In 2009/10, the Office received 362 new enquiries and complaints from prisoners, an increase of 22% on the previous year.

Table 6: Prisoner complaints by prison, 2008/09 - 2009/10

Prisoner Complaints	2008/09	2009/10
Acacia Prison	39	53
Albany Regional Prison	15	31
Bandyup Prison	16	16
Banksia Hill	-	1
Boronia Prison	6	3
Broome Regional Prison	4	3
Bunbury Regional Prison	31	38
Casuarina Prison	82	68
Eastern Goldfields Prison	1	3
Greenough Prison	4	8
Hakea Prison	86	122
Karnet Prison Farm	6	9
Pardelup	-	1
Rangeview	1	0
Roebourne Prison	2	1
Wooroloo Prison Farm	3	5
Total	**296**	**362**

The most common complaints made by prisoners concerned allegations of inadequate treatment and allegations of refusal to admit or to treat medical conditions. As shown in the table below, a large number of concerns also related to the prescription, supply and administration of medications. Another common factor was concern about waiting lists and delays in receiving treatment.

Table 7: Most common prison health concerns raised		
Inadequate treatment	155	43%
Refusal to admit or treat	51	14%
Delay in treatment	28	8%
Prescribing medication	23	6%
Service availability	21	6%
Administering medication	18	5%
Waiting lists	13	4%
Diagnosis	12	3%
Attitude/manner	11	3%
Supply/security/storage of medication	9	2%
Total enquiries and complaints	362	

Note: More than one issue may be raised in a complaint, therefore totals may not always reflect other data.

Outcomes for Prisoners

There was a significant increase in the number of prison health complaints conciliated in 2009/10. Of the 66 complaints formally conciliated, full or partial agreement was reached in 65% of cases. In addition to obtaining an explanation about issues of concern, a common outcome for prisoners was to obtain access to a health service.

Case Study

Mr G began to suffer severe headaches when he was in prison. He was advised by the prison GP that the headaches may be stress-related. Mr G noted that he did not feel stressed in prison, and thought there was something more seriously wrong with him. He made a complaint to the OHR because he wanted the prison to take his concerns seriously and arrange additional tests. The complaint was conciliated and the prison medical services agreed to send Mr G for a CT scan. Following the scan Mr G was satisfied that he had received relevant tests and he and the doctor discussed appropriate medications.

Service Improvements

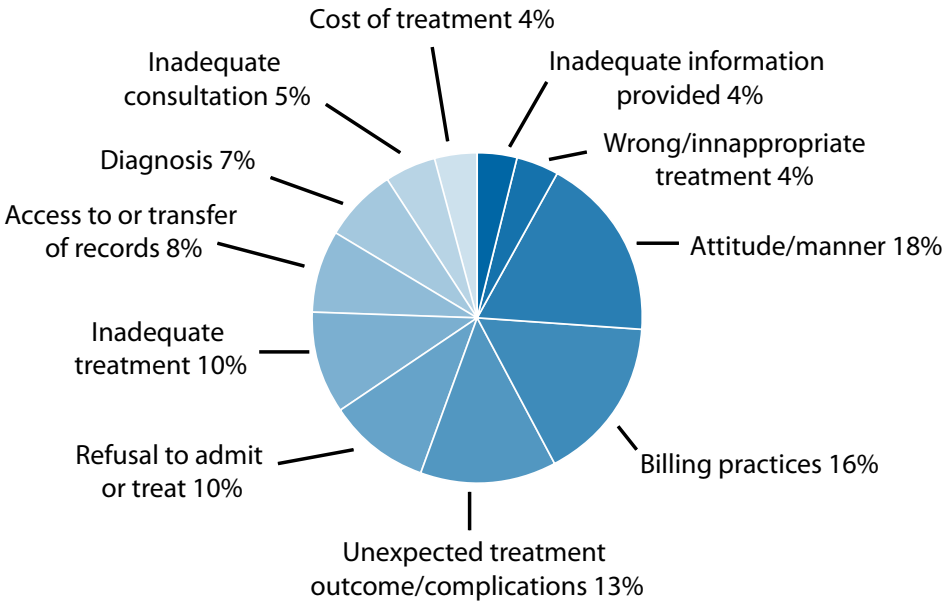
The OHR has held regular meetings with DCS representatives during the reporting period to improve communication and build an effective working relationship. The OHR has also had an increased presence within the prison system, engaging with both prisoners and DCS staff. During the year, OHR staff have visited prisons with the Office of the Inspector of Custodial Services.Outcomes of OHR complaints resolution and engagement activities include:

- A specifically designed pamphlet was made available to all prisons to advise of the OHR's role and contact details,
- An investigation into a complaint about DCS resulted in acceptance of recommendations to improve access to external medical treatment, and
- Improved processes were implemented between DCS and a large public hospital to ensure treatment details are correct for prisoners with ongoing medical needs.

Medical Practitioner and Medical Practices

The Office received 334 new enquiries and complaints about medical practitioners and 140 about medical practices. The majority of complaints received were in relation to general practitioners, reflecting the high percentage of medical services that are provided by this group.The most common complaints about medical practitioners and practices relate to the attitude or manner of the practitioner or practice staff. Billing practices and treatment outcomes were also areas of concern.

Graph 8: Complaint categories regarding medical practitioners and practices, 2009/10



Outcomes for Consumers

The OHR only conciliated a small number (15) of complaints against medical practitioners or practices this year. Agreement or partial agreement was reached in 36% of cases. Of the matters conciliated, outcomes included identifying areas for improvement and providing the complainant with an explanation, apology and/or partial refund of costs.

Case Study

Mr G attended a specialist for treatment of a hernia. The condition was treated effectively and he was entirely satisfied with the level of service received. The account for services included costs that were not covered in the initial quotation. When Mr G queried the account, the practice manager denied there was a problem. Mr G asked to speak to the specialist but was unable to do so.

After nine months, Mr G reported his complaint to the OHR and a review was conducted. The case manager spoke to the practice staff and the specialist at length. It was recognised that Mr G had been overcharged and he was refunded.

Mr G met with the specialist who acknowledged his complaint. Both parties were fully satisfied with the outcome of the complaint.

Service Improvements

Outcomes of OHR complaints resolution and engagement activities include:

- Improved quotations introduced by a medical practice to more clearly identify fees, charges, and gap payments, and,
- Information materials for general practitioners about patient feedback and complaints are being developed through collaboration between state health complaints bodies and the Royal Australian College of General Practitioners.

Dental Services

In 2009/10, the OHR received 106 enquiries and complaints in relation to private dental services. This is a significant decrease from the 139 complaints received in 2008-09. The decrease in complaints may be attributed to the work that was undertaken by the Australian Dental Association to highlight the importance of informed financial consent for dental patients.

Table 8: Dental service provider complaints 2008/09 - 2009/10

Dental Service Provider	2008/09	2009/10
Dentist	100	81
Dental prosthetist	12	15
Dental practice	10	3
Oral and maxillofacial surgeon	1	2
Prosthodontist	2	2
Endodontist	1	1
Orthodontist	7	1
Periodontist	2	1
Dental technician	4	0
Total	**139**	**106**

The most common complaint about private dental services was unexpected treatment outcomes and complications. This accounted for 28% of all complaints. The next most common complaint was concern about billing practices.

Outcomes for Consumers

In 55% of the complaints that progressed to conciliation, costs were refunded or waived, resulting in a successful outcome being achieved.

Case study

Four months after having dental work, Ms D had a toothache and went to another dentist where cavities were found on three teeth. The teeth with the cavities had been examined and treated by the dentist she had initially consulted, and she was unhappy that the problem had not been picked up or properly treated on the previous occasion.

Ms D contacted the clinic seeking a full refund for her treatment; however they were only prepared to offer a partial refund for the actual work undertaken on the teeth that she had cavities in, and not the full cost which included fees for the consultation and x-rays.

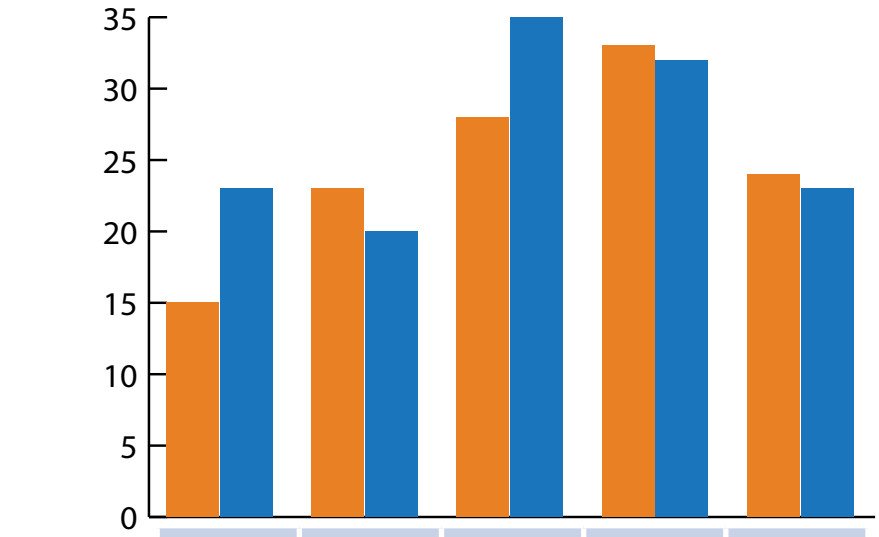
When Ms D came to the OHR, she sought a full refund for the initial treatment undertaken to resolve the complaint. A paper-based conciliation process began, but after discussions with both parties the dental clinic agreed to provide a full refund as a gesture of good faith. Ms D was satisfied with this outcome.

Disability Complaints

The Office can take complaints about any service provided specifically to people with disabilities and their carers. As it can be difficult to complain about services that people regularly rely on, the Office has been working with the DSC to increase awareness of the benefits of the complaints resolution process. The Office continues to promote its role and encourage people with disabilities to access OHR services.

This increase in outreach, and the proposed name change for the Office to include specific reference to disability services, is anticipated to lead to an increase in the use of OHR services in the future.

Graph 9: New and closed disability service complaints, 2005/06 - 2009/10



	2005/06	2006/07	2007/08	2008/09	2009/10
New complaints	15	23	28	33	24
Closed complaints	23	20	35	32	23

Note: Complaints from people with disabilities in relation to health services are dealt with in the health services section of this report.

The majority of disability services complaints dealt with in 2009/10 related to non-government service providers (61%) followed by the DSC (35%). The concerns raised in complaints are shown in the table below.

Table 9: Most common disability service complaints issues	
Staff conduct	7
Service quality	5
Complaints handling	4
No/inadequate service	3
Grant of funds refused	3
Communication	3
Treatment	2
Service withdrawn	2
Service eligibility	2
Inclusion of carer in service planning and delivery	2
Considering the views and needs of carers	2
Other	6
Total enquries and complaints	**24**

Note: More than one issue may be raised in a complaint, therefore totals may not always reflect other data.

Outcomes for Consumers

Outcomes for individuals included registering their concerns with the agency, receiving explanations relating to their concerns, apology and changes to procedures.

Case Study

Mr M complained that a not-for-profit disability provider had withdrawn services and he was unable to access appropriate care. Through discussions facilitated by the Office, an agreement was reached between the provider and Mr M whereby he was able to access alternative funding arrangements. The agency apologised to Mr M for the distress caused by the temporary lapse in services.

Mr M was satisfied with the outcome and the services provided by the Office. The Office also provided information to the service provider about improving communication techniques for dealing with clients.

As a result of investigations carried out by the OHR a significant number of service improvements were implemented by disability service providers. These included:

- Agreement on additional standards for staff who design therapy programs for children,
- Inclusion of an appeals process when a decision is made to discontinue services,
- Development of policies and procedures to ensure decision making processes include people with disabilities and their carers, and
- Adoption of clear and open communication policies.

Health Services Complaints Data

A quality improvement approach to complaints handling means managing complaints as part of risk management, enabling reporting, assessment and follow up as well as learning from complaints, consumer feedback and facilitating improvements to systems of care.

An important aspect of the OHR's work is to identify the causes of complaints and work with health service providers to try to resolve them. The resolution of a complaint should not and does not mean that it is limited to the individual complaint, but rather to consider whether or not that one complaint is part of a pattern or trend of related complaints. The role of the Office in this broader agenda is reflected in the intent of section 75 of the *Health Services (Conciliation and Review) Act 1995*. Section 75 of the Act requires the collection of complaints management information from organisations which provide health services.

To enable this information gathering process the OHR has enacted regulations that prescribe certain health service providers and the information that they must give the Director. In preparation for this the Office engaged in preliminary consultation in August and September 2009 and then developed an implementation plan. Since March we have met with representatives from all providers who are required to provide this data.

A working party of OHR staff and representatives from health service providers along with a data analyst will develop a model of collaborative analysis. All health service providers who have provided information will be invited to participate in the analysis. The collaborative analysis process will enable us to consider the information with a better understanding of the factors that affect the delivery of health services as well as complaints management. The analysis will occur towards the end of 2010.

Participants

The providers that have been prescribed under the section 75 regulations are:

- Health Directorate, Department of Corrective Services
- St John Ambulance Australia (Western Australia) Inc.
- Ramsay Health Care Limited
- Healthscope Limited
- Mercy Hospital Mount Lawley
- Bethesda Hospital
- Health Solutions (WA) Pty Ltd
- St John of God Health Care
- Child and Adolescent Health Service, Department of Health
- Dental Health Services, Department of Health
- North Metropolitan Area Health Service, Department of Health
- South Metropolitan Area Health Service, Department of Health
- Western Australian Country Health Service, Department of Health.

The OHR wishes to thank these providers for their support and cooperation throughout the process so far. The collaborative manner in which our public and private sector partners have worked with is is impressive.

Data Quality

The data that was collected this year came from databases already held by the prescribed providers. Historically, not all providers gathered the same data. Although there were similarities between the prescribed data and that which already existed, it was not a perfect match. This meant that some providers could not provide some parts of the required data. The OHR intends to work with the relevant health service providers to improve and refine the data quality on a number

of fronts over time. In doing this, the following principles which were developed by the Audit Commission for local authorities and the National Health Service in England (October 2007) are relevant:

1. Accuracy: Data should be sufficiently accurate for the intended use and should be captured only once although it may have multiple uses. Data should be captured at the point of activity.
2. Validity: Data should be recorded and used in compliance with relevant requirements, including the correct application of any rules or definitions.
3. Reliability: Data should reflect stable and consistent data collection processes across collection points and over time. Progress towards performance targets should reflect real changes rather than variations in data collection approaches or methods.
4. Timeliness: Data should be captured as quickly as possible after the event or activity and must be available for the intended use within a reasonable time period. Data must be available quickly and frequently enough to support information needs and to influence service or management decisions.
5. Relevance: Data captured should be relevant to the purposes for which it is to be used. This will require a periodic review of requirements to reflect changing needs.
6. Completeness: Data requirements should be clearly specified based on the information needs of the organisation and data collection processes matched to these requirements.

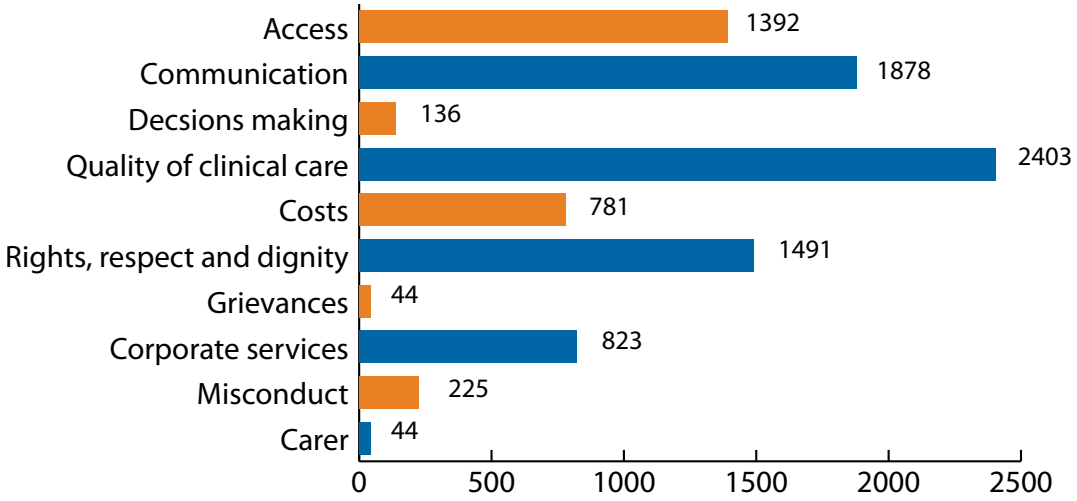
Issues and Outcomes

The prescribed health services received more complaints about the quality of clinical care than any other type of complaint. Complaints in this area were mostly about perceptions of inadequate treatment / therapy, medication, inadequate assessment, and discharge or transfer arrangements.

The next largest group of complaints relate to communication. These types of complaints were to do with claims of inappropriate verbal or non verbal communication, misinformation or failure in communication and failure to listen to the patient, client, carer or family.

Concerns about a person's rights, respect and dignity was another major source of complaints. User perceptions in this area were largely about inconsiderate services, lack of courtesy, absence of caring and patients' rights.

Graph 10: Health service complaint issues

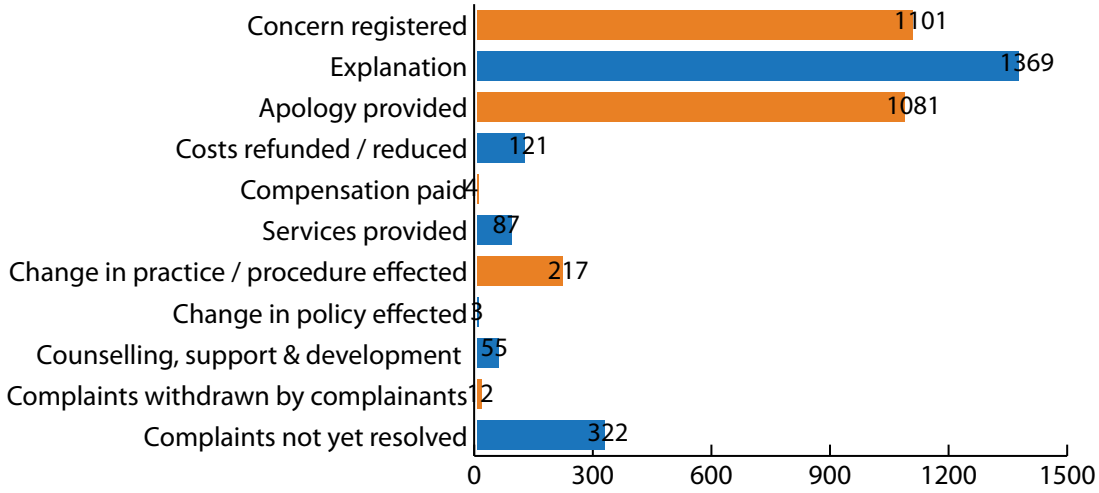


Complaint Outcomes

From the data collected it seems that health service providers in WA are able to effectively resolve and address patient complaints with only a comparative small number of complaints reported as yet-to-be resolved.

These issues are being addressed by service providers by registering the complaint, providing an explanation to the user of the situation from the perspective of the service provider, and when required, providing an appropriate apology. In some instances complaints have lead to costs being refunded and changes in the policies and practices of health service providers.

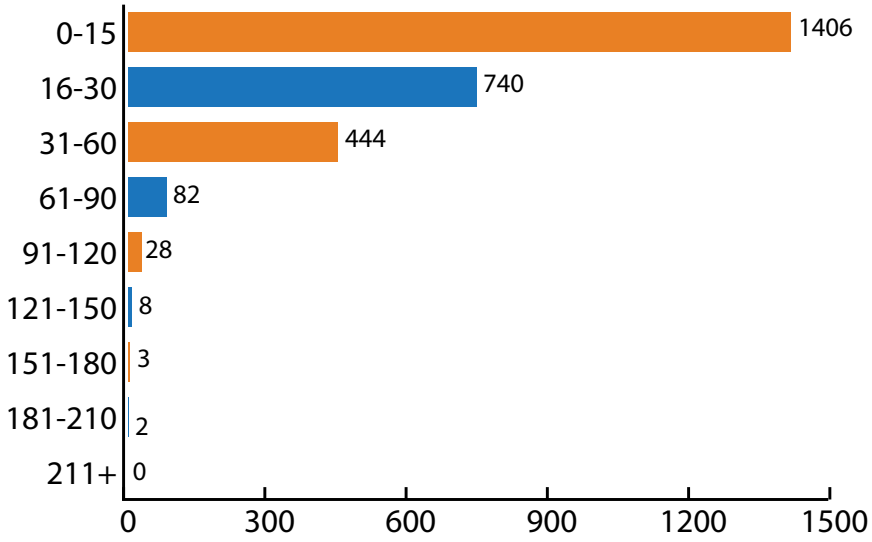
Graph 11: Complaint numbers and outcomes



Time Taken to Resolve Complaints

Health service providers reported being able to resolve the majority of complaints within 0-15 days. Only a comparatively small number of complaints were reported as extending beyond 30 days to resolve.

Graph 12: Time taken to resolve complaints



Significant issues

Legislative Amendments

It was reported in the 2008/09 annual report that the Office's empowering legislation was being amended to improve the capacity of the Office to resolve health and disability complaints by (among other things):

- changing the name of the Office to the Health and Disability Services Complaints Office to better reflect the functions of the Office, thereby making it more accessible to consumers;
- including negotiated settlement as a further dispute resolution alternative to litigation;
- removing statutory inconsistencies between the respective health and disability complaints legislation;
- increasing the time period for making a health complaint from one to two years; and
- authorising a person to be recognized as a health user's representative in the complaints process if the user has died.

The Acts Amendment (Health and Disability Services) Bill 2008 was introduced in the Legislative Assembly on 19 August 2009. Several further amendments were incorporated into the Bill during the reporting period as a result of ongoing liaison with stakeholders and Members of Parliament. The Bill was debated and passed in the Legislative Assembly on 23 June 2010. The Bill was strongly supported by the Opposition and independent Members of Parliament. This is illustrated in the following comments of Roger Cook MLA, Shadow Minister for Health, as lead speaker for the Opposition, who stated in Parliament that:

"I am sure that every member in the chamber is very pleased to see this legislation come forward…
This is an unusual piece of legislation because everyone is sitting around, as they say, in furious agreement."

The Bill, now called the Health and Disability Services Legislation Amendment Bill 2009, is expected to be debated in the Legislative Council in August 2010. The Director and stakeholders alike await the amendments being passed in both Houses of Parliament to enable the speedy implementation of the Office's reform agenda.

Upon the amendments coming into effect, the Office will revise its complaints management policies and procedures to reflect the new legislative framework. The Office will also work closely with stakeholders once the Bill is passed to assist their understanding of the amendments.

National Registration of Health Practitioners

Australia is adopting a new national scheme for the registration and accreditation of health professionals through the adoption of a national law in each State and Territory. The Health Practitioner Regulation National Law (WA) Bill 2010 was passed in the Legislative Assembly on 19 May 2010 and is expected to come before the Legislative Council early in the next reporting period.

National registration will ensure consistency of standards, which is important with the increasing mobility of health professionals. Once the national registration legislation is passed in WA, there will be a number of consequential amendments made to the OHR's principal legislation.

A new statutory relationship will be established between the OHR and the national registration agency, the Australian Health Practitioner Regulation Agency (AHPRA). Regular consultations will be held to determine which body should deal with a complaint about a registered practitioner, and to advise on the outcome of complaints received.

Effective consultation will ensure that complaints are dealt with by the most appropriate body in the most effective and timely manner. The OHR is working collaboratively with other state health complaints bodies and AHPRA to establish a national Memorandum of Understanding between the parties. During 2009/10, the OHR also commenced discussions with AHPRA's WA staff to promote an effective process for complaints management and the exchange of information.

Significant issues

Unregistered Practitioners

Media reports during the year highlighted community concerns regarding the services provided by some unregistered health practitioners.

At a national meeting of Health Ministers in February 2010, it was noted that government reports and inquiries in some states highlighted serious concerns about the lack of public protection in this area. In particular, concerns centred on the conduct of some practitioners who, if they had been registered, may have lost the right to practice.

The Ministers agreed that this issue should be examined with a view to achieving a nationally consistent approach. Following a national consultation process a report will be made to the Australian Health Workforce Ministerial Council. As part of the national consultation, the OHR provided a submission regarding unregistered health practitioner complaints received over the past 10 years.

Regulation and consistency in this area is an emerging significant issue which is likely to have an impact on the work of the Office, as well as substantial benefits for the Western Australian community. The Office will continue to work with other states' health complaints bodies and health departments on this matter.

Alternatives to the Legal Pathway

The OHR offers a dispute resolution service to consumers and service providers that is free, confidential and enables complaint issues to be resolved with a skilled case manager assisting the parties to work towards a mutually agreed outcome.

To be effective, conciliation requires the full participation and cooperation of all parties involved to a complaint. Conciliation can provide a quick resolution to issues that may not have been pursued through legal avenues due to concerns about costs, time delays, and the adversarial nature of the legal process.

In the coming year, the Office is planning to establish a consultative process to develop a model for resolving matters where financial settlement may be an element. This ties in to the OHR's work to facilitate Open Disclosure, and work being done across Australia towards implementation of the National Open Disclosure Standard in all health care facilities.

Open Disclosure

Open Disclosure became a mandatory operational directive for all public hospitals and health services in Western Australia from May 2008. Much of the private sector in Western Australia is responding by implementing similar initiatives, having seen the benefits of open discussions with patients following an adverse incident. It is anticipated that in 2010/11 a greater number of open disclosures will take place in the WA than ever before.

To support the successful development and adoption of Open Disclosure principles across WA, the OHR initiated a collaborative partnership of health, insurance and legal industries in Western Australia in 2008. This partnership has provided a forum to explore how Open Disclosure can be successfully implemented in the State, and the issues to be considered from different industry perspectives.

Since initiating the industry partners group, the OHR has worked collaboratively to implement a program of events to further the Open Disclosure agenda and discuss shared concerns. These include public forums and promoting research papers, including the work of Dr Tom Gallagher. These programs have received an overwhelming positive response.

The OHR acknowledges the support of the following industry partners in the Open Disclosure collaboration, and looks forward to their continued involvement in the collaboration in 2010/11: Department of Health WA, Ramsay Health Care, St John of God Health Care, RiskCover, MDA National, Health Consumers' Council, Australian Medical Association WA, Edith Cowan University, the Commission for Safety and Quality in Health Care, the Val Lishman Health Research Foundation and other leaders of the national Open Disclosure movement.

Significant issues

In the coming year, OHR will take an active interest in how well Open Disclosure is being implemented by health-care providers, and will continue to work with industry partners to pinpoint any barriers. The OHR will also continue to promote the movement towards Open Disclosure gaining momentum nationally.

National Accreditation of Conciliation Staff

The OHR aims to provide a professional and effective conciliation service for the resolution of disputes between health and disability service providers and the community. Professional development of staff to ensure best practice in alternative dispute resolution techniques is a priority. During the year, the Office has been working on a project to gain National Accreditation of conciliation staff. This will be progressed in the coming year and will ensure the development and maintenance of high level staff skills, and implementation of nationally recognised professional stand-ards.

Access for Regional and Rural WA

As the OHR is a small organisation, a major challenge is to provide services across a geographically large State with a widely dispersed population. In the coming year the Office will examine available technological options to improve regional and rural access to the OHR's services.

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 2010

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

The financial statements comprise the Statement of Financial Position as at 30 June 2010, and the Statement of Comprehensive Income, Statement of Changes in Equity and Statement of Cash Flows 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 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. This document is available on the OAG website under "How We Audit".

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 2010

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 2010 and its financial performance and cash flows for the year ended on that date. They are in accordance with Australian Accounting Standards 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 2010.

COLIN MURPHY
AUDITOR GENERAL
9 September 2010

Certification of Financial Statements

Government of **Western Australia**
Office of Health Review

OFFICE OF HEALTH REVIEW

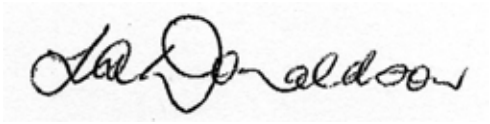
CERTIFICATION OF FINANCIAL STATEMENTS

The accompanying financial statements of the Office of Health Review have been prepared in accordance 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 2010 and financial position as at 30 June 2010.

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: 1 September 2010



Linley Anne Donaldson
DIRECTOR
ACCOUNTABLE AUTHORITY

Date: 1 September 2010

Office of Health Review

Statement of Comprehensive Income

For the year ended 30th June 2010

	Note	2010 $	2009 $
COST OF SERVICES			
Expenses			
Employee benefits expense	6	1,320,051	1,408,712
External services	7	8,248	8,650
Depreciation expense	8	1,989	3,085
Repairs, maintenance and consumable equipment	9	4,974	26,683
Other expenses	10	353,471	392,324
Total cost of services		**1,688,733**	**1,839,454**
INCOME			
Revenue			
Recoveries		-	21,915
Total revenue		-	21,915
Total income other than income from State Government		**-**	**21,915**
NET COST OF SERVICES		**1,688,733**	**1,817,539**
INCOME FROM STATE GOVERNMENT			
Service appropriations	11	1,933,000	1,715,946
Resources received free of charge	12	11,686	17,067
Total income from State Government		**1,944,686**	**1,733,013**
SURPLUS/(DEFICIT) FOR THE PERIOD		**255,953**	**(84,526)**
TOTAL COMPREHENSIVE INCOME FOR THE PERIOD		**255,953**	**(84,526)**

The Statement of Comprehensive Income should be read in conjunction with the accompanying notes.

Office of Health Review

Statement of Financial Position

As at 30th June 2010

	Note	2010	2009
		$	$
ASSETS			
Current Assets			
Cash and cash equivalents		578,518	318,095
Receivables	13	25,672	-
Other current assets	14	49	100
Total Current Assets		604,239	318,195
Non-Current Assets			
Plant and equipment	15	4,533	6,522
Total Non-Current Assets		4,533	6,522
Total Assets		**608,772**	**324,717**
LIABILITIES			
Current Liabilities			
Payables	17	95,624	80,134
Provisions	18	257,226	264,005
Total Current Liabilities		352,850	344,139
Non-Current Liabilities			
Provisions	18	40,147	20,756
Total Non-Current Liabilities		40,147	20,756
Total Liabilities		**392,997**	**364,895**
NET ASSETS		**215,775**	**(40,178)**
EQUITY			
Accumulated surplus/(deficiency)	19	215,775	(40,178)
TOTAL EQUITY		**215,775**	**(40,178)**

The Statement of Financial Position should be read in conjunction with the accompanying notes.

Office of Health Review

Statement of Changes in Equity

For the year ended 30th June 2010

	Note	2010 $	2009 $
Balance of equity at start of period		(40,178)	44,348
ACCUMULATED SURPLUS/(DEFICIT)	19		
Balance at start of period		(40,178)	44,348
Surplus/(deficit) for the period		255,953	(84,526)
Balance at end of period		215,775	(40,178)
Balance of equity at end of period		215,775	(40,178)

The Statement of Changes in Equity should be read in conjunction with the accompanying notes.

Statement of Cash Flows

For the year ended 30th June 2010

	Note	2010 $ Inflows (Outflows)	2009 $ Inflows (Outflows)
CASH FLOWS FROM STATE GOVERNMENT			
Service appropriations		1,933,000	1,715,946
Net cash provided by State Government		1,933,000	1,715,946
Utilised as follows:			
CASH FLOWS FROM OPERATING ACTIVITIES			
Payments			
Employee benefits		(1,272,128)	(1,439,762)
Supplies and services		(374,777)	(401,010)
Other payments	13	(25,672)	-
Receipts			
Recoveries and other receipts		-	21,915
Net cash (used in) / provided by operating activities	20b	(1,672,577)	(1,818,857)
Net increase / (decrease) in cash and cash equivalents		260,423	(102,911)
Cash and cash equivalents at the beginning of period		318,095	421,006
CASH AND CASH EQUIVALENTS AT THE END OF PERIOD	20a	578,518	318,095

The Statement of Cash Flows should be read in conjunction with the accompanying notes.

Notes to the Financial Statements
For the year ended 30th June 2010

Note 1 Australian Accounting Standards

General

The Authority's financial statements for the year ended 30 June 2010 have been prepared in accordance with Australian Accounting Standards. The term 'Australian Accounting Standards' refers to Standards and Interpretations issued by the Australian Accounting Standard Board (AASB).

The Authority has adopted any applicable, new and revised Australian Accounting Standards from their operative dates.

Early adoption of standards

The Authority cannot early adopt an Australian Accounting Standard unless specifically permitted by Treasurer's Instruction 1101 *'Application of Australian Accounting Standards and Other Pronouncements'*. No Australian Accounting Standards that have been issued or amended but not operative have been early adopted by the Authority for the annual reporting period ended 30 June 2010.

Note 2 Summary of significant accounting policies

(a) General Statement

The financial statements constitute general purpose financial statements that have been prepared in accordance with 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 Australian Accounting Standards, the Framework, Statements of Accounting Concepts and other authoritative pronouncements of the Australian Accounting Standards Board.

Where modification is required and has had 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 end of the reporting period 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.

Refer to note 11 'Income from State Government' for further information.

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.

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.

Notes to the Financial Statements
For the year ended 30th June 2010

(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 Statement of Comprehensive Income (other than where they form part of a group of similar items which are significant in total).

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

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

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

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

In order to apply this policy, the diminishing value with a straight line switch method is utilised for plant and equipment. Under this depreciation method, the cost amounts of the assets are allocated on average on a diminishing value basis over the first half of their useful lives and a straight line basis for the second half of their useful lives.

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

Computer equipment	5 years
Other plant and equipment	10 years

(e) Impairment of Assets

Plant and equipment are tested for any indication of impairment at the end of each reporting period. 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 the end of each reporting period.
Refer to note 16 'Impairment of assets' for the outcome of impairment reviews and testing.
Refer also to note 2(j) 'Receivables' for impairment of receivables.

(f) Leases

Leases in which the lessor retains significantly all of the risks and rewards of ownership are classified as operating leases. Operating lease payments are expensed on a straight line basis over the lease term as this represents the pattern of benefits derived from the leased items.

(g) Financial Instruments

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

These have been disaggregated into the following classes:

- Financial Assets
* Cash and cash equivalents
* Receivables

- 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.

Notes to the Financial Statements
For the year ended 30th June 2010

(h) Cash and Cash Equivalents

For the purpose of the Statement of Cash Flows, 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.

(i) Accrued Salaries

Accrued salaries (see note 17 'Payables') represent the amount due to employees but unpaid at the end of the financial year, as the pay date for the last pay period for that financial year does not coincide with the end of the financial year. Accrued salaries are settled within a fortnight of the financial year end. The Authority considers the carrying amount of accrued salaries to be equivalent to its net fair value.

(j) 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 against the allowance account. 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.

Refer to note 2(g) 'Financial Instruments' and note 13 'Receivables'.

Goods and Services Tax

Rights to collect amounts receivable from the Australian Taxation Office and responsibilities to make payment for GST have been assigned to the 'Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals' (Metropolitan Health Services). This was a result of application of the grouping provisions of "A New Tax System (Goods and Service Tax) Act 1999" whereby the Minister for Health in his Capacity as the Deemed Board of the Metropolitan Public Hospitals became the representative member for Health entities as part of governments' shared services initiative.

(k) 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.

Refer to note 2(g) 'Financial instruments' and note 17 'Payables'.

(l) 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 the end of each reporting period.

Refer to note 18 'Provisions'.

Annual Leave and Long Service Leave

The liability for annual and long service leave expected to be settled within 12 months after the reporting period 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 reporting period 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 end of the reporting period.

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 end of the reporting period 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 end of the reporting period.

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 Statement of Comprehensive Income for this leave as it is taken.

Notes to the Financial Statements
For the year ended 30th June 2010

(l) Provisions (continued)

Superannuation

The Government Employees Superannuation Board (GESB) in accordance with legislative requirements administers public sector superannuation arrangements in Western Australia.

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 has no liabilities under the Pension or the GSS Schemes. The liabilities for the unfunded Pension Scheme and the unfunded GSS Scheme transfer benefits due to members who transferred from the Pension Scheme, are assumed by the Treasurer. All other GSS Scheme obligations are funded by concurrent contributions made by the Authority to the GESB. The concurrently funded part of the GSS Scheme is a defined contribution scheme as these contributions extinguish all liabilities in respect of the concurrently funded GSS Scheme obligations.

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.

Refer to note 2(m) 'Superannuation Expense'.

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'.
Refer to note 10 'Other expenses' and note 18 'Provisions'.

(m) Superannuation Expense

The superannuation expense in the Statement of Comprehensive Income comprises employer contributions paid to the GSS (concurrent contributions), the West State Superannuation Scheme (WSS), and the GESB Super Scheme (GESBS).

The GSS Scheme is a defined benefit scheme for the purposes of employees and whole of government reporting. However, 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.

(n) 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.

Where assets or services are received from another State Government agency, these are separately disclosed under Income from State Government in the Statement of Comprehensive Income.

(o) 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 provisions

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

Note 4 Key sources of estimation uncertainty

The key estimates and assumptions made concerning the future and other key sources of estimation uncertainty at the reporting 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 10.8%. This assumption was based on an analysis of the turnover rates exhibited by employees over a five year period. 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.

Notes to the Financial Statements
For the year ended 30th June 2010

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 effective for annual reporting periods beginning on or after 1 July 2009 that impacted on the Authority:

AASB 101	*Presentation of Financial Statements* (September 2007) This Standard has been revised and introduces a number of terminology changes as well as changes to the structure of the Statement of Changes in Equity and the Statement of Comprehensive Income. It is now a requirement that owner changes in equity be presented separately from non-owner changes in equity. There is no financial impact resulting from the application of this revised Standard.
AASB 2007-10	*Further Amendments to Australian Accounting Standards arising from AASB101* This Standard changes the term 'general purpose financial report' to 'general purpose financial statements', where appropriate in Australian Accounting Standards and the Framework to better align with IFRS terminology. There is no financial impact resulting from the application of this Standard.
AASB 2008-13	*Amendments to Australian Accounting Standards arising from AASB Interpretation 17 – Distributions of Non-cash Assets to Owners [AASB 5 & AASB 110].* This Standard amends AASB 5 '*Non-current Assets Held for Sale and Discontinued Operations*' in respect of the classification, presentation and measurement of non-current assets held for distribution to owners in their capacity as owners. This may impact on the presentation and classification of Crown land held by the Authority where the Crown land is to be sold by the Department of Regional Development and Lands (formerly Department for Planning and Infrastructure). The Authority does not expect any financial impact when the Standard is first applied prospectively.
AASB 2009 - 2	*Amendments to Australian Accounting Standards – Improving Disclosures about Financial Instruments AASB 4, AASB 7, AASB 1023 & AASB 1038.* This Standard amends AASB 7 and will require enhanced disclosures about fair value measurements and liquidity risk with respect to financial instruments. There is no financial impact resulting from the application of this Standard.

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

AASB 1	*First-time Adoption of Australian Accounting Standards*
AASB 3	*Business Combinations*
AASB 8	*Operating Segments*
AASB 123	*Borrowing Costs* This Standard has been revised to mandate the capitalisation of all borrowing costs attributable to the acquisition, construction or production of qualifying assets. However, AASB 2009-1 '*Amendments to Australian Accounting Standards – Borrowing Costs of Not-for-Profit Public Sector Entities [AASB 1, AASB 111 & AASB 123]*' issued in April 2009 and applicable to annual reporting periods beginning on or after 1 January 2009, amends revised AASB 123, which will allow not-for-profit public sector entities to continue to choose whether to expense or capitalise borrowing costs relating to qualifying assets.
AASB 127	*Consolidated and Separate Financial Statements*
AASB 1039	*Concise Financial Reports*
AASB 1049	*Whole of Government and General Government Sector Financial Reporting* (revised – October 2007)
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]*
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]*
AASB 2007-8	*Amendments to Australian Accounting Standards arising from AASB 101*
AASB 2008-1	*Amendments to Australian Accounting Standard - Share-based Payments: Vesting Conditions and Cancellations [AASB 2]*
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]*
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]*
AASB 2008-5	*Amendments to Australian Accounting Standards arising from the Annual Improvements Project [AASB 5, 7, 101, 102, 107, 108, 110, 116, 118, 119, 120, 123, 127, 128, 129, 131, 132, 134, 136, 138, 139, 140, 141, 1023 &1038]*

Notes to the Financial Statements
For the year ended 30th June 2010

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

AASB 2008-6	*Further Amendments to Australian Accounting Standards arising from the Annual Improvements Project [AASB 1 & AASB 5]*
AASB 2008-7	*Amendments to Australian Accounting Standards – Cost of an Investment in a Subsidiary, Jointly Controlled Entity or Associate [AASB 1, AASB 118, AASB 121, AASB 127 & AASB 136]*
AASB 2008-8	*Amendments to Australian Accounting Standards – Eligible Hedged Items [AASB 139]*
AASB 2008-9	*Amendments to AASB 1049 for Consistency with AASB 101*
AASB 2008-11	*Amendments to Australian Accounting Standard – Business Combinations Among Not-for-Profit Entities [AASB 3]*
AASB 2009-1	*Amendments to Australian Accounting Standards – Borrowing Costs of Not-for-Profit Public Sector Entities [AASB 1, AASB 111 & AASB 123]*
AASB 2009-4	*Amendments to Australian Accounting Standards arising from the Annual Improvements Project [AASB 2 and AASB 138 and AASB Interpretations 9 & 16]*
AASB 2009-6	*Amendments to Australian Accounting Standards*
AASB 2009-7	*Amendments to Australian Accounting Standards [AASB 5, 7, 107, 112, 136 & 139 and Interpretation 17]*
Interpretation 13	*Customer Loyalty Programmes*
Interpretation 15	*Agreements for the Construction of Real Estate*
Interpretation 16	*Hedges of a Net Investment in a Foreign Operation*
Interpretation 17	*Distributions of Non-cash Assets to Owners*
Interpretation 18	*Transfers of Assets from Customers*

Future impact of Australian Accounting Standards not yet operative

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

Title		Operative for reporting periods beginning on/after
AASB 2009-11	*Amendments to Australian Accounting Standards arising from AASB 9 [AASB 1, 3, 4, 5, 7, 101, 102, 108, 112, 118, 121, 127, 128, 131, 132, 136, 139, 1023 & 1038 and Interpretations 10 & 12].* The amendment to AASB 7 requires modification to the disclosure of categories of financial assets. The Authority does not expect any financial impact when the Standard is first applied. The disclosure of categories of financial assets in the notes will change.	1 January 2013
AASB 1053	*Application of Tiers of Australian Accounting Standards* This Standard establishes a differential financial reporting framework consisting of two tiers of reporting requirements for preparing general purpose financial statements. The Standard does not have any financial impact on the Authority. However it may affect disclosures in the financial statements of the Authority if the reduced disclosure requirements apply. The Department of Treasury and Finance has not yet determined the application or the potential impact of the new Standard for agencies.	1 July 2013
AASB 2010-2	*Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements* This Standard makes amendments to many Australian Accounting Standards, including Interpretations, to introduce reduced disclosure requirements into these pronouncements for application by certain types of entities. The Standard is not expected to have any financial impact on the Authority. However this Standard may reduce some note disclosures in financial statements of the Authority. The Department of Treasury and Finance has not yet determined the application or the potential impact of the amendments to these Standards for agencies.	1 July 2013

Notes to the Financial Statements
For the year ended 30th June 2010

Note 6 Employee benefits expense

	2010 $	2009 $
Salaries and wages (a)	1,104,207	1,148,373
Superannuation - defined contribution plans (b)	120,453	111,590
Annual leave and time off in lieu leave (c)	90,737	96,538
Long service leave (c)	4,654	52,211
	1,320,051	1,408,712

(a) Includes the value of the fringe benefit to the employees. The Authority did not pay any fringe benefits tax during the reporting period.

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

(c) Includes a superannuation contribution component.

Employment on-costs expense is included at note 10 'Other expenses'. The employment on-costs liability is included at note 18 'Provisions'.

Note 7 External services

Fuel, light and power	4,503	3,519
Food supplies	641	633
Purchase of external services	3,104	4,498
	8,248	8,650

Note 8 Depreciation expense

Computer equipment	934	2,031
Other plant and equipment	1,055	1,054
	1,989	3,085

Note 9 Repairs, maintenance and consumable equipment

Repairs and maintenance	2,275	6,914
Consumable equipment	2,699	19,769
	4,974	26,683

Note 10 Other expenses

Communications	34,146	37,734
Computer services	796	8,817
Employment on-costs (a)	24,788	43,451
Insurance	7,501	574
Legal expenses	8,021	17,067
Motor vehicle expenses	3,243	2,903
Operating lease expenses	197,412	179,617
Printing and stationery	12,216	11,303
Purchase of external services	36,224	57,192
Audit fees	18,500	17,000
Other	10,624	16,666
	353,471	392,324

(a) Includes staff development costs and transport costs. The on-costs liability associated with the recognition of annual and long service leave liability is included at note 18 'Provisions'. Superannuation contributions accrued as part of the provision for leave are employee benefits and are not included in employment on-costs.

Note 11 Service appropriations

Appropriation revenue received during the year:		
Service appropriations	1,933,000	1,715,946

See note 2(c) 'Income'.

Notes to the Financial Statements
For the year ended 30th June 2010

	2010 $	2009 $
Note 12 Resources received free of charge		
Resources received free of charge have been determined on the basis of the following estimates provided by agencies.		
State Solicitor's Office - legal service	8,021	17,067
Department of Treasury and Finance - accommodation management fees	3,665	-
	11,686	17,067

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

Note 13 Receivables

Current		
Debtors	25,672	-

$25,672 was an incorrect payment made to the Health Corporate Network in May 2010 due a processing error.

The Authority does not hold any collateral as security or other credit enhancements relating to receivables.

See also note 2(j) 'Receivables' and note 29 'Financial instruments'.

Note 14 Other current assets

Prepayments	49	100

Note 15 Plant and equipment

Computer equipment		
At cost	19,989	19,989
Accumulated depreciation	(19,989)	(19,055)
	-	934
Other plant and equipment		
At cost	25,766	25,766
Accumulated depreciation	(21,233)	(20,178)
	4,533	5,588
Total plant and equipment	4,533	6,522

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	934	2,965
Depreciation	(934)	(2,031)
Carrying amount at end of year	-	934
Other plant and equipment		
Carrying amount at start of year	5,588	6,642
Depreciation	(1,055)	(1,054)
Carrying amount at end of year	4,533	5,588
Total plant and equipment		
Carrying amount at start of year	6,522	9,607
Depreciation	(1,989)	(3,085)
Carrying amount at end of year	4,533	6,522

Notes to the Financial Statements
For the year ended 30th June 2010

Note 16 Impairment of Assets

There were no indications of impairment to plant and equipment at 30 June 2010.

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

Note 17 Payables	2010 $	2009 $
Current		
Trade creditors	50,945	15,112
Accrued expenses	10,150	40,132
Accrued salaries	34,529	24,890
	95,624	80,134

See also note 2(k) 'Payables' and note 29 'Financial instruments'.

Note 18 Provisions

Current		
Employee benefits provision		
Annual leave (a)	99,750	82,203
Time off in lieu leave (a)	-	135
Long service leave (b)	157,476	181,667
	257,226	264,005
Non-current		
Employee benefits provision		
Long service leave (b)	40,147	20,756
Total provisions	297,373	284,761

(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 the reporting date. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of the reporting date	70,321	58,345
More than 12 months after the reporting date	29,429	23,993
	99,750	82,338

(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 the reporting period. Assessments indicate that actual settlement of the liabilities will occur as follows:

Within 12 months of the reporting period	39,537	46,337
More than 12 months after the reporting period	158,086	156,086
	197,623	202,423

Note 19 Accumulated surplus/(deficit)

Balance at start of year	(40,178)	44,348
Result for the period	255,953	(84,526)
Balance at end of year	215,775	(40,178)

Note 20 Notes to the Statement of Cash Flows

a) **Reconciliation of cash**

Cash assets at the end of the financial year as shown in the Statement of Cash Flows is reconciled to the related items in the Statement of Financial Position as follows:

Cash and cash equivalents	578,518	318,095

Notes to the Financial Statements
For the year ended 30th June 2010

	2010	2009
Note 20 Notes to the Statement of Cash Flows (Continued)	$	$
b) Reconciliation of net cost of services to net cash flows used in operating activities		
Net cash used in operating activities (Statement of Cash Flows)	(1,672,577)	(1,818,857)
Increase/(decrease) in assets:		
Current receivables	25,672	-
Prepayments	(51)	100
Decrease/(increase) in liabilities:		
Payables	(15,490)	(5,815)
Current provisions	6,779	24,583
Non-current provisions	(19,391)	2,602
Non-cash items:		
Depreciation expense (note 8)	(1,989)	(3,085)
Resources received free of charge (note 12)	(11,686)	(17,067)
Net cost of services (Statement of Comprehensive Income)	(1,688,733)	(1,817,539)

At the end of the reporting period, the Authority had fully drawn on all financing facilities, details of which are disclosed in the financial statements.

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 and other benefits for the financial year fall within the following bands are:

$220,000 - $230,000	1	1
Total	1	1
	$	$
The total remuneration of members of the Accountable Authority is:	228,883	224,746

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

Note 22 Remuneration of auditor

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

Auditing the accounts, financial statements and performance indicators	19,300	18,500

Note 23 Commitments

a) **Operating lease commitments:**

Commitments in relation to non-cancellable leases contracted for at the end of the reporting period but not recognised in the financial statements, are payable as follows:

Within 1 year	248,560	157,263
Later than 1 year, and not later than 5 years	277,366	314,526
	525,926	471,789

The operating lease commitments are all inclusive of GST.

b) **Other expenditure commitments:**

There were no other expenditure commitments as at 30th June 2010.

Note 24 Contingent liabilities and contingent assets

At the reporting date, the Authority was not aware of any contingent liabilities or contingent assets.

Note 25 Events occurring after the reporting period

There were no events occurring after the reporting period which had significant financial effects on these financial statements.

Notes to the Financial Statements
For the year ended 30th June 2010

Note 26 Related bodies

A related body is a body which receives more than half its funding and resources from the Authority and is subject to operational control by the Authority.

The Authority had no related bodies during the financial year.

Note 27 Affiliated bodies

An affiliated body is a body which receives more than half its funding and resources from the Authority and is not subject to operational control by the Authority.

The Authority had no affiliated bodies during the financial year.

Note 28 Explanatory Statement

(A) Significant variances between actual and prior year actual results

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	2010 Actual $	2009 Actual $	Variance $
Expenses				
Employee benefits expense	(a)	1,320,051	1,408,712	(88,661)
External services		8,248	8,650	(402)
Depreciation expense	(b)	1,989	3,085	(1,096)
Repairs, maintenance and consumable equipment	(c)	4,974	26,683	(21,709)
Other expenses	(d)	353,471	392,324	(38,853)
Income				
Recoveries	(e)	-	21,915	(21,915)
Service appropriations	(f)	1,933,000	1,715,946	217,054
Resources received free of charge	(g)	11,686	17,067	(5,381)

(a) Employee benefits expense
Decrease reflects employee shortage and retention issues experienced for significant periods throughout the financial year.

(b) Depreciation expense
One item of computer equipment was fully depreciated during the financial year.

(c) Repairs, maintenance and consumable equipment
Decrease reflects reduction of expenditure in office fit-out. In 2008/2009, the Authority underwent refurbishment of office space.

(d) Other expenses
Decrease reflects the following:
- the completion and development of complaints database in 2008/2009;
- the Authority received additional funding in 2009/2010 for the placement of a medical practitioner; however a practitioner was appointed for a three month period only; and
- the Authority's legislation did not pass through the Parliament, therefore the significant costs associated with the name change were not disbursed.

(e) Recoveries
The Authority did not recover funds from Attorney General's Department as travel to the Indian Ocean Territories was not planned for this financial year.

(f) Service appropriations
The Authority received additional recurrent funding in this financial year to rectify the shortfall in the budget and out-years for approved staff level, funding for new initiatives including the placement of a medical practitioner, communication, education and training funds and to address the cost pressures relating to rent increases.

(g) Resources received free of charge
Decrease reflects less consultation with the State Solicitor's Office with the appointment of an experienced senior legal officer by the Authority.

Notes to the Financial Statements
For the year ended 30th June 2010

Note 28 Explanatory Statement (continued)

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

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

	Note	2010 Actual $	2010 Estimates $	Variance $
Operating expenses				
Employee benefits expense		1,320,051	1,419,000	(98,949)
Other goods and services	(a)	368,682	257,000	111,682
Total expenses		1,688,733	1,676,000	12,733
Less: Revenues	(b)	-	-	-
Net cost of services		1,688,733	1,676,000	12,733

(a) Other goods and services

Variance mainly reflects the rent review conducted in July 2009 on office accommodation and the significant increase in the insurance renewal contribution.

(b) Revenues

The Authority had not planned to travel to the Indian Ocean Territories in this financial year.

Note 29 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 maximum exposure to credit risk at the end of the reporting period in relation to each class of recognised financial assets is the gross carrying amount of those assets inclusive of any provisions for impairment as shown in the table at Note 29(c) 'Financial Instrument disclosures'.

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

Liquidity risk

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

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

Market risk is the risk that changes in market prices such as foreign exchange rates and interest rates will affect the Authority's income or the value of its holdings of financial instrument. The Authority does not trade in foreign currency and is not materially exposed to other price risks.

b) **Categories of Financial Instruments**

In addition to cash, the carrying amounts of each of the following categories of financial assets and financial liabilities at the end of the reporting period are as follows :

	2010 $	2009 $
Financial Assets		
Cash and cash equivalents	578,518	318,095
Loans and receivables	25,672	-
Financial Liabilities		
Financial liabilities measured at amortised cost	95,624	80,134

c) **Financial Instrument disclosures**

Credit Risk and Interest Rate Risk Exposures

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

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

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

Interest rate exposures and ageing analysis of financial assets

			Interest rate exposure	
	Weighted average effective interest rate %	Carrying amount $	Variable interest rate $	Non-interest bearing $
Financial Assets				
2010				
Cash and cash equivalents	0.0%	578,518	-	578,518
Receivables		25,672	-	25,672
		604,190	-	604,190
2009				
Cash and cash equivalents	0.0%	318,095		318,095
Receivables		-	-	-
		318,095	-	318,095

The Authority did not have any receivables that were past due as at the end of the reporting period but not impaired.

Liquidity Risk

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

Interest rate exposures and maturity analysis of financial liabilities

			Interest rate exposure		Maturity dates
	Weighted average effective interest rate %	Carrying amount $	Variable interest rate $	Non-interest bearing $	Up to 3 months $
Financial Liabilities					
2010					
Payables		95,624	-	95,624	95,624
		95,624	-	95,624	95,624
2009					
Payables		80,134	-	80,134	80,134
		80,134	-	80,134	80,134

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

Disclosures and legal compliance

Estimates of Expenditure

The following estimates of expenditure for the year 2010/11 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 2010/11 year do not form part of the preceding audited financial statements.

Revenue	2010-11
Revenues from Government	$1,964,000

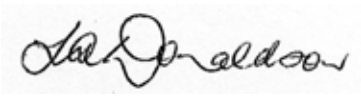
Key Performance Indicators

Government of **Western Australia**
Office of Health Review

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 (OHR) performance and fairly represent the performance of the OHR for the financial year ending 30 June 2010.



LINLEY ANNE DONALDSON
DIRECTOR
ACCOUNTABLE AUTHORITY

Date: 1 September 2010

Desired Outcome: Improved delivery of health and disability services.

The Office of Health Review has produced Key Effectiveness and Efficiency Indicators for 2009-2010. 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.

KEY EFFECTIVENESS INDICATOR

The Key Effectiveness Indicator relates to improvements in the provision of health and disability services. A number of service improvements were identified by the OHR through the complaint resolution process and were adopted by service providers.

Examples of service improvements include:

- New procedures were introduced to remind staff of the importance of obtaining full financial consent from a patient or carer;
- Information from complaints was used to develop training tools for staff;
- Improved procedures for communication between private consultants and hospital staff were introduced;
- Improved verbal and written communication procedures for patients about pre and post operative procedures;
- Development of information packs to be given to families when a family member dies in hospital; and
- Installation of a new electronic system at a rural hospital to enable doctors on call to access patient's notes from different locations.

During the 2009/10 reporting period outcomes from complaints conciliated by the OHR resulted in 44 recommendations for service improvement being made to providers. Forty-two of these recommendations have been implemented by the relevant providers and two remain outstanding, which will be followed up in 2010/11.

In 2008/09 18 recommendations were outstanding as at 30 June 2009, and were carried forward to 2009/10 for implementation. Thirteen of these have now been implemented. The remaining five have not been implemented by providers.

In total the OHR dealt with 62 recommendations in 2009/10 and out of this total, 55 recommendations were agreed to and implemented by providers. The proportion of OHR recommendations, resulting in improvements in practises and agreed actions for implementation by agencies and providers, is set out in the table below:

	2009/2010	2008/2009
Proportion of recommendations resulting in implementation by providers	55/62	26/45

KEY EFFICIENCY INDICATORS

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

Service 1: Assessment, conciliation and investigation of complaints.

A primary function of the OHR is to provide an accessible and impartial service for the resolution of health and disability services complaints. During 2009/10 the Office closed 2,356 complaints which is a 9.6% increase in the number of complaints closed from the previous year. The number of complaints and enquiries dealt with by the Office also increased by 9% from 2008/09 and this demonstrates a continuation of the trend of increasing complaint numbers over the past five years.

(1) Average cost per finalised complaint:

2009/2010	2008/2009
$595.22	$725.53

(2) Percentage of complaints finalised within target timeframes:

Legislative requirement	Legislative timeframe	2009/10 Actual	Target Set
Preliminary assessment by Director s.34 (1)	28 Days	83%	85%
Preliminary assessment by Director s.34 (1) (c)	56 days	74%	80%
Notice to provider and others s.35	14 days	80%	85%

Due to the implementation of an improved complaints database, from this year forward it is possible for the OHR to report on the percentage of complaints finalised within target timeframes. These are set out within the *Health Services (Conciliation and Review) Act 1995* and the *Disability Services Act 1993*.

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

The education/training and consultation sessions for 2009/2010 can be broken down into the following two groups:
Group 1 - Cost for the development, production and distribution of information: $92,237

- A total of 3,538 pamphlets were sent out throughout the year;
- The OHR website has been reviewed and is under development;
- Four quarterly newsletters were produced and sent to more than 300 organisations and individuals; and
- Information packages, brochures and guides were developed on compensation, complaint handling for disability service providers, conciliation information packages for both for health service consumers and complaint guides for prisoners.

Group 2 - Cost of presentations, consultations and networking sessions: $185,468

OHR stakeholder and community engagement is designed to maximise awareness of the Office and capitilise on opportunities to liaise with stakeholders to improve our services. During this financial year the focus was on increasing awareness of our services amongst some potentially vulnerable and underrepresented stakeholder groups, including prisoners and disability groups.

The OHR delivered 13 presentations which were tailored to the requirements of specific community groups in order to raise awareness of the Office and the services that are provided both to consumers and providers. In order to undertake these presentations the OHR staff engaged in 128 consultations and 39 networking sessions with various stakeholders.

(1). Average cost per education/training session:

2009/2010	2008/2009
$1, 591.04	$1, 564.63

The calculation of this efficiency indicator is based on staff time and overheads to provide education, training, consultation and information sessions divided by the number of presentations, consultations and networking sessions.

Disclosures and legal compliance

Ministerial Directives

The OHR did not receive any directives from the Minister for Health during the reporting period.

Other Financial Disclosures

Pricing Policies of Services Provided

The OHR does not charge for any of the services provided to clients.

Capital Works

The OHR did not undertake any capital works during the reporting period.

Employment, Industrial Relations and Worker's Compensation

As at 30 June 2010, the OHR employed 17 people, 5 of whom were part-time employees. With the exception of the Director, all OHR employees were public servants.

Table 10: Employees and categories

Employee Category	Numbers of staff as at 30 June	
	2008/09	2009/10
Full-time permanent	9	8
Full-time contract	3	4
Part-time permanent	5	5
Part-time contract	1	
Total	**18**	**17**

Governance Disclosures

(i) Shares in a Statutory Authority

No senior officer holds shares in a statutory authority.

(ii) Shares in Subsidiary Bodies

The OHR does not have any subsidiary bodies.

(iii) Interests in Contracts by Senior Officers

The OHR's Code of Conduct specifically addresses conflict of interest and employees are required to place their public duties before private interests. Conflict of interest covers both the employee and when family members or friends stand to benefit from a decision or action of which they are a part.

The following policies are relevant to the management of interest by all staff, including senior Officers, are subject to annual review and periodic awareness-raising throughout the OHR:

- OHR Code of Conduct;
- Western Australian Public Sector Code of Ethics and OPSSC Conduct Guide;
- Gifts, Benefits and Awards Policy; and
- Procurement Policy and relevant guidelines.

(iv) Benefits to Senior Officers through Contracts

This is not applicable as no senior Officers have received any benefits in the 2009/10 financial year.

(v) Insurance Premiums to Indemnify Directors

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

Other Legal Requirements

Advertising

The OHR has not engaged any advertising, market research, polling, direct mail or media advertising companies or organisations that require disclosure under s.175(z)(e) of the *Electoral Act 1907*. Table 11 below provides a breakdown of costs relating to advertising.

Table 11: Advertising costs

Market research	0
Pollling	0
Advertising (non-salary vacancies)	0
Direct mail organisations	0
Media advertising organsiations	0
Total	**0**

Complaints made to us regarding disability services are given special consideration

Disability Access and Inclusion Plan

As the OHR deals with disability service complaints, we are aware of the need to make our services accessible to people with a range of disabilities. We are easily contactable through a number of ways including telephone, TTY machine, fax and email. We write our publications in plain English, and provide them in a number of formats and other languages on request. Our web site features all of our current publications in electronic format for viewing and downloading. Our accommodation features a shared reception area that is spacious and wheelchair accessible. Our building also has an elevator designed for wheelchair use and the ground floor is at street level for easy access.

Currently, complaints made to us regarding disability services are given special consideration. For example, our legislation does not compel complainants to resolve their complaint with their service provider in the first instance. Disability service complainants are also given 24 months to make a complaint regarding a service, rather than the 12 months currently given for health service complainants, until the legislative amendments come into effect. Disability service complaints are also automatically investigated by a senior member of staff should no agreement be reached in conciliation.

At any Office event, accessibility for people with disabilities is a key consideration. We chose venues for events such as meetings and focus groups on the basis of ease of access, proximity to convenient parking and public transport.

The proposed amendments to our primary legislation support access and inclusion for people with disabilities. Our proposed name change to 'Health and Disability Services Complaints Office' should greatly enhance our visibility in the context of disability service complaints. The proposed amendments will also remove some inconsistencies to ensure equal access for all of our complainants.

During the year we began work on a project to implement a Disability Access and Inclusion Plan (DAIP). While we have always been sensitive to the needs of people with disabilities and their families, we believe that implementing the DAIP will help to improve access to all of our services.

Disclosures and legal compliance

Public Sector Standards and Ethical Codes

The OHR has a Code of Conduct that all staff members are required to observe in the course of their work. The Code of Conduct is discussed regularly in meetings and hard copies have been circulated amongst staff and an electronic version is available on our intranet.

The following is an overview of the OHR's activities with respect to compliance with public sector standards and ethical codes:

- The continual development of a comprehensive range of human resource policies;
- Communicating to staff the Western Australian Public Sector Code of Ethics and the Conduct Guide developed by OPSSC;
- Training provided to all staff on accountable and ethical decision making in the public sector; and
- Discussion of the Western Australian Public Sector Code of Ethics and Conduct Guide at meetings.

The OHR was not faced with any compliance issues regarding public sector standards, the WA Code of Ethics or the OHR Code of Conduct during the year, nor did the OHR receive any breach of standard claims.

Recordkeeping Plan

The OHR is committed to continuously improving record keeping practices consistent with the *State Records Act 2000* and aims for best practice record keeping practices.

The OHR's Retention and Disposal Schedule was approved in 2008. All OHR's records are stored in a secure repository and archived files are kept in off-site secure storage. During 2009/10 the OHR's record keeping processes continued to undergo review to demonstrate compliance with the framework and a commitment to efficient recordkeeping practices.

This year the focus has been on reviewing and evaluating the OHR Record Keeping Plan which was approved by the State Records Office in late 2007.

The evaluation consisted of a series of meetings and a staff survey that was held to determine the usefulness of the plan and in particular the naming and structure of our electronic records. The survey promoted staff awareness of the naming convention and file structure. The naming and structure issues were resolved by using the results from the staff survey in order to make the naming and file structure used in the recordkeeping plan more accessible and transparent.

Following the amendments to the recordkeeping plan, staff members were given a presentation about the changes. The presentation was a key part of our recordkeeping training program, which appears to be an efficient and effective way of keeping staff informed of their obligations.

As part of the induction process, the coordinator of records management conducts individual training sessions with new staff members, with follow-up training and help desk assistance provided as required. An electronic document records management system (EDRMS) called TRIM (Tower Records Information Management) will be implemented in 2010-2011.

Occupational Safety, Health and Injury Management

OHR is committed to the management of workplace injuries and maintaining a healthy workplace for employees, contractors and visitors. Our policies about occupational safety and health (OSH) and injury management were developed in consultation with staff members and are available for viewing on our intranet.

We aim to maintain a 'zero harm' workplace free of injury and occupational hazards. We encourage any risk to be identified, reported and rectified as soon as possible. Employees are able to raise any OSH matter directly with the Director or the Business Coordinator. OSH matters can also be raised and discussed through more formal means such as staff meetings.

In accordance with the injury management requirements of the *Worker's Compensation and Injury Management Act 1981*, we have an injury management plan designed to handle worker's compensation claims efficiently and with due care, and to ensure that injured workers can stay at work or return at the earliest appropriate time. This policy is available for our staff to view on our intranet.

A return to work program has also been developed in accordance with the above legislation. A self evaluation of our occupational safety and health management systems was carried out during the year, which included a summary of findings.

Table 12 below below indicates our performance in relation to occupational safety, health and injury management during the year.

Table 12: OSH and Injury Management Performance.

Indicator	2009/10
Number of fatalities	0
Lost time injury/disease incidence rate	0
Lost time injury severity rate	0
Percentage of injured workers returned to work within 28 weeks	n/a
Percentage of managers trained in occupational safety, health and injury management responsibilities	16%

The Office of Health Review is an independent statutory authority established to deal with complaints about health and disability services.

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