



CLINICAL
EXCELLENCE
COMMISSION

SAFE PATIENTS REWARDING WORKPLACES

ANNUAL REPORT 2007–2008





The Clinical Excellence Commission

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THE NSW CLINICAL EXCELLENCE COMMISSION (CEC) was established in 2004 to promote and support improved clinical care, safety and quality across the NSW health system.

The CEC's mission is to build confidence in health care in NSW by making it demonstrably better and safer for patients and a more rewarding workplace.

The CEC's vision is to be the publicly respected voice providing the people of NSW with assurance of improvement in the safety and quality of health care.

The key functions of the CEC are to:

- Promote and support improvement in clinical quality and safety in health services
- Monitor clinical quality and safety processes and performance of public health organisations, and to report to the Minister thereon
- Identify, develop and disseminate information about safe practices in health care on a Statewide basis, including (but not limited to):
 - Developing, providing and promoting training and education programs
 - Identifying priorities for and promoting the conduct of research about better practices in health care
- Consult broadly with health professionals and members of the community
- Provide advice to the Minister and Director-General on issues arising out of its functions.

The CEC fulfils these functions by:

- Providing advice to the Minister and Director-General of Health
- Notifying system-wide safety concerns
- Conducting quality system assessments
- Working with public health organisations to facilitate quality improvements
- Providing a source of expert advice and assistance
- Developing and promoting a Statewide approach to improving safety and quality
- Engaging clinicians and the community
- Identification and development of training and education strategies and clinical tools
- Leading the development and system-wide dissemination of evidence-based guidelines
- Focusing on system issues for improvement across NSW.



CLINICAL
EXCELLENCE
COMMISSION

The Hon John Della Bosca
Minister for Health
Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

Dear Minister

We have pleasure in submitting the Clinical Excellence Commission's 2007/08 Annual Report.

The report complies with the requirements for annual reporting under the Accounts and Audit Determination for public health organisations and the 2007/08 Directions for Health Service Annual Reporting.

Yours sincerely

Professor Bruce Barraclough AO
Chairman

Professor Clifford Hughes AO
Chief Executive Officer

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HIGHLIGHTS AND ACHIEVEMENTS

Publications

- The Collaborating Hospitals' Audit of Surgical Mortality (CHASM)
- Quality of Healthcare in NSW: A Chartbook 2007
- Incident Management in the NSW Public Health System January-June 2007
- Incident Management in the NSW Public Health System July-December 2007

Reviews

- Implantation procedures for permanent pacemakers and related devices
- Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents in NSW
- Review of Systematic Audits of Medical Records such as Quality at Royal North Shore (QaRNS)

Partnerships

- Citizens Engagement Advisory Council
- Shared quality and safety reporting function with NSW Department of Health
- Hospital Alliance for Research Collaborative (HARC)
- Centre for Health Record Linkage (CHeReL)
- Regular meetings with Greater Metropolitan Clinical Taskforce (GMCT) and Institute of Medical Education and Training (IMET)

Research

- Ian O'Rourke PhD Scholar
- Database to support Collaborating Hospitals' Audit of Surgical Mortality (CHASM)
- Hospital Alliance for Research Collaborative (HARC)

Education and training

- Clinical Leadership Program
- E-learning modular program for quality improvement
- Conference and seminar presentations

New project focus areas

- Recognition and management of the deteriorating patient – Between the Flags

Strategic planning and development

- Recruitment of Deputy Chief Executive Officer
- Recruitment of Director, Patient Safety and expansion of Patient Safety portfolio
- Reviewed Information Management services and recruited a biostatistician
- Board members visited to two rural area health services
- Submitted a paper to the Special Commission of Inquiry into Acute Healthcare Services in NSW

Assessment

- QSA second stage Development Project completed and QSA methodology and survey tools finalised
- Implementation of Medication Safety Self Assessment



CHAIRMAN'S REPORT

An active Board, generous with their time, a dedicated staff and strong leadership from our CEO, Professor Cliff Hughes, has meant that there are a large number of successful activities from which to select some highlights for comment. We are proud of these activities that allow us to fulfill our Charter and Mission. My personal choices of highlights from the past year are three in number.

1 Firstly, **Quality Systems Assessment (QSA)** – an innovative program aimed at providing assurance about the quality and safety of public system healthcare by examining compliance with standards and policy requirements of the NSW Department of Health. The roll out of QSA was completed in February this year with 97% of facilities completing the assessment. It showed a high level of awareness of quality and safety concepts, a general sense that there has been improvement in safety and quality of patient care over the past two years, but also showed significant room for improvement in the implementation of new guidelines in regard to hygiene / infection control and patient identification procedures. These same issues are now the focus for CEC attention in the coming year.

2 My second highlight is the **Chartbook**, the first in a series of annual publications of health system indicators containing 63 charts and associated text. It provides a key resource for driving change across the system that also reports on the outcomes of key safety and quality initiatives of CEC and NSW Health. Over time it will be regarded as a very useful tool for measuring and reporting publicly on the safety and quality of the NSW health system at State and at Area Health Service levels.

3 My third highlight is the **Collaborating Hospitals Audit of Surgical Mortality (CHASM)** – a systemic and peer review audit of deaths associated with surgical care. It is designed to identify improvement opportunities from system and process errors associated with death following surgery. It is supported by the Royal Australasian College of Surgeons and has been piloted successfully in two health areas this year and will be rolled out state wide including gynaecology and the private hospitals. Similar projects in Scotland and Western Australia have led to significant improvements in surgical care. State level results of this audit will be part of CEC's public reporting and individual results will be fed back to surgeons to drive practice change.

Members of the CEC Board and staff have had opportunities to provide advice to the "Garling" Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals. This has provided a welcome opportunity to push for greater resources for, and focus on, safety and quality issues. The results of this inquiry will almost certainly offer new challenges for CEC.

The people of NSW have had great service on the CEC Board from Dr Graham Beaumont and Ms Liz Rummary AM, who retired from the Board at the completion of their appointed terms. I add my grateful thanks for their commitment and their work with CEC. We have had further inspiring additions to the Board and have welcomed Prof Deb Thoms, Chief Nursing Officer of NSW, Prof Janice Reid AM, Vice Chancellor and President, University of Western Sydney and Prof Ron McCallum AO, Professor of Law, University of Sydney and Deputy Chair, Vision Australia.

I have a very positive view of what can be achieved by effectively supporting clinicians and managers to provide the very best care. The programs CEC has in place are helping to do that and will continue to increase in effectiveness.

Professor Bruce Barraclough AO
Board Chairman

CHIEF EXECUTIVE OFFICER'S REPORT

The health system, not only in NSW, but indeed all jurisdictions, has come under increasing public scrutiny, and with good cause. In NSW alone, health consumes almost 30 percent of the entire State budget. But more importantly, as the population ages, and as more of our community turn to our public health system for help in times of crises, our citizens, our families, our colleagues, our friends want to know that they are receiving safe care, and better quality care.

As you read through this report, I believe that you will see the exciting programs in which the Clinical Excellence Commission has been able to participate, the value of the networks that we have developed, and the evidence of significant improvements in health care delivery that have followed in the last three years of intense design and construction of the Clinical Excellence Commission. This report is really about networks. Networks that bring people together to meet common challenges, provide innovative solutions, to test, trial and evaluate good ideas, and to build on the learnings of ourselves and others.

The most important network is, of course, our staff. Staff numbers have continued to grow, but the work that they have produced has grown even more. The directorates have worked together on many projects to enhance each other's work, to inform each other

of lessons learned (both good and bad), and to provide a much greater efficiency than we would encounter if each project or program was acting in yet another silo! Each of our staff have contributed to the network in many, many ways, all have brought a significant level of expertise and experience to the organisation, and have put their individual stamp upon many of our programs. We do need to acknowledge the hard work that they are doing in a difficult environment, under such scrutiny, and particularly when the bad news in one line can undermine the good news of the entire report!

Perhaps one of the strongest networks has been that developing between ourselves, the clinicians, and particularly through the Greater Metropolitan Clinical Taskforce (GMCT), the Institute of Medical Education and Training (IMET), and the Rural Institute. All three groups have a common goal of improving the quality of care, and at the same time improving the quality of work and life of our clinicians and clinicians in training. A further example of the benefit to clinicians of networking has been the response and the outcomes from the Clinical Leadership Program. Having graduated numbers of nurses, doctors and managers, we have seen them immediately produce valuable work around their personal projects during the course. But they have

also begun to add value to the whole system. The second cohort is currently in training and the first group have formed alumni of their own volition to continue to share and explore joint opportunities in the future.

The clinical networks, of course, have also been involved at the coalface, particularly working around the hand hygiene project where we are revisiting our earlier work with an audit of current practices. We believe that this audit will show the need to continue to maintain networks, even when the initial ground-breaking work is complete and the evidence gathered. We look forward to working with the infection control practitioners and microbiologists in future projects.

The networks of the Clinical Excellence Commission have been greatly enhanced by closer work with the intensive care co-ordination and monitoring unit, particularly around the CLAB ICU project. This has brought together ICUs from across the State with our clinical practice improvement groups and with the NSW Department of Health Quality and Safety Branch to address a common problem. The lessons learned are already being applied, and we look forward to extending this project beyond the ICU in coming years.



“ This report describes the progress of the Clinical Excellence Commission during a pivotal year for NSW Health and the commission itself.”

Our networks have been further expanded within the Blood Watch program. A very extensive program involving co-ordinators in each area health service, key haematologists, and transfusion committees has begun to demonstrate dramatic reductions in unnecessary blood transfusions. We have been able to link with market researchers and educators to understand prescribing practices and to develop educational material that will continue to lead change. In co-operation with the area health services and other jurisdictions, in particular, South Australia, we have been able to roll out an e-learning package, which will provide a credentialing process for junior staff managing this precious resource.

Information technology and networks are often synonymous. But in health, there is a huge array of different databases doing differing functions, often collecting the same data. We have been pleased to continue our work with the Sax Institute, and with the CHeReL program to utilise data more efficiently and to inform such valuable projects as the Chartbook, Blood Watch, CLABs and the Quality Systems Assessment program. The opportunity for trapping ever so much more information in such networks (read webs!) is tantalising. There is a temptation, however, to wait until “the solution” is in place. The Clinical Excellence Commission, while

anxiously waiting and supporting the development of the electronic medical record and paperless programs, has continued to work with clinicians and the information they currently use, to drive change.

This has been particularly true in the roll-out and completion of the Quality Systems Assessment program. The entire acute care public health system has been involved in this process which involves self lodgement of data, internal correlation of that data across each level of the system and feedback to every area health service, facilities and clinical units. Each Area health service will be provided with its own database for internal analysis. All the initial work in the eight major areas has been completed and analysed, and reports are approaching finalisation for each, as well as for the State as a whole. The challenge for the next six months will be to develop an active verification process, and to target those areas of greatest concern for future Quality Systems Assessment surveys.

The data from IIMS continues to increase our knowledge of the system and the potential for error that any complex technological and biological system would encounter. In order to achieve maximum value from the data, the safety group has worked through the Root Cause (RCA) Analysis Review Committee, the Reportable Incident

Review Committee (RIRC) and the Quality and Safety Branch to provide lessons learned, safety alerts where necessary, and to develop themes for further action and implementation throughout the system. The six-monthly reports are now a matter of course, but we must be careful that they do not become just another report, but continue to be a stark reminder of the need for continued vigilance and proactive clinical practice improvement.

The Special Committees have continued to expand their networks. We were saddened to lose Dr Chris Borton as chair of the Special Committee Investigating Deaths under Anaesthesia (SCIDUA) due to ill-health, and we wish him well in his recovery. That committee is now chaired by Professor Ross Holland, who instigated that program over 40 years ago! It continues to provide invaluable feedback to anaesthetists throughout the State.

The Special Committee Investigating Deaths Associated with Surgery (SCIDAWS), has been renamed the Collaborating Hospitals' Audit of Surgical Mortality (CHASM). It has developed an intriguing network of surgeons across the State who have volunteered not only to report their own cases but to evaluate the cases of others (anonymously), and where necessary to do a file audit or second-line assessment of those cases with issues of concern. This program

CHIEF EXECUTIVE OFFICER'S REPORT (cont.)

will be one of the largest audits of surgical mortality in the world, and we have been very grateful for the ability to network with the Scottish Audit of Surgical Mortality (SASM), and the staff at the Western Australian Audit of Surgical Mortality (WAASM) to make this dream a reality. This work is chaired by Professor Michael Fearnside.

We have been delighted to see a significant increase in the work of the Clinical Council, as it has spread its network amongst clinicians of all varieties, and across all parts of the State. The work of the co-chairs, Professor Mary Chiarella and Dr Austen Curtin has been fantastic and that group has now been pro-active in addressing issues such as delirium and aggression, that are such common problems throughout our hospitals. The council has taken upon itself a very active role in spreading information regarding the Clinical Excellence Commission programs, and also in providing information to help us realign our priorities for the future.

At the same time, the Citizens Engagement Advisory Council (CEAC) has broadened its horizons, and dramatically increased its activity. Under the chairmanship of Major General Peter Dunn, we have seen an increase in the number of community representatives involved in that program, as well as the development of a very close liaison with members from the area health advisory committees. The council has focused on communication and is proposing some exciting new work for the next 12 months.

All networks require strong ties, or stakeholders and we continue to work closely with NSW Department of Health, and particularly with the Deputy Director-General, Health System Performance (Professor Katherine

McGrath, and more latterly, Dr Tony O'Connell). Of course our particular contact is with the Quality and Safety Branch, and it is pleasing to see the regular interchange of information between both groups. This capacity has also been greatly enhanced by our continued involvement with the directors of clinical governance, in each area, and with the 'CareSafe' forum, in which we are able to share ideas, ideals, and programs. We have also been very pleased to see the continued strong support for the work of the commission from the Director-General, Professor Debora Picone, from various deputy directors-general, and in particular this year, from finance. Recognition of common goals around patient safety, particularly in the Blood Watch program, is already providing great benefits in terms of effective drivers, and effective outcomes, both clinical and financial, across all area health services. These networks must reach out to all area health services and we have greatly appreciated the support of each and all of the chief executives.

Finally, we look forward to continuing the enormous networking opportunities provided by our board. We were sorry to see the departure of Professor Kathy Baker, Dr Graham Beaumont and Mrs Liz Rummery AM, and have enormous respect for their contribution to the board and to the community. We were also pleased to welcome Professor Ron McCallum, Professor Janice Reid, and Adjunct Professor Debra Thoms. They have already made their mark on the organisation and the board.

The board has also been adding to our networking and this year visited two country areas. This provided members with the opportunity to meet the clinicians at the coalface and see first-hand the very differing issues confronting our rural sector in very large geographic areas. Finally, it is important to recognise that networks are complex dynamic structures, and without good administration and support they can easily entangle even those engaged in their construction. We are grateful for the strong support provided by the Deputy Chief Executive Officer, Dr Peter Kennedy and other members of the staff that enable us to keep our eye firmly on the task ahead, build strong linkages, and ensure that people do not fall through the gaps! To all those involved in these networks, we say thank you, and look forward to even stronger ties that will inevitably be developed in the years to come.



Clifford F Hughes AO
Clinical Professor
Chief Executive Officer

PROFILE, PURPOSE AND GOALS

The Clinical Excellence Commission (CEC) was established in 2005 and forms a major component of the NSW Patient Safety and Clinical Quality Program.

CEC BOARD

The CEC is a board-governed, statutory health corporation established under the Health Services Act 1997, with the Chief Executive Officer reporting directly to the NSW Minister for Health.



Professor Bruce Barraclough AO

Professor Bruce Barraclough AO is Chair of the Board of the NSW Clinical Excellence Commission. He is President of the International Society for Quality in Health Care, e-Health Medical Director CSIRO, ICT Centre, Associate Dean (clinical strategy) of the University of Western Sydney Medical School, Chair of a WHO working party to develop a medical school curriculum in Safety and Quality and is a member of the NSW Health Care Advisory Council. He was President of the Royal Australasian College of Surgeons (1998-2001), Professor / Director of Cancer Services, Northern Sydney Health and the University of Sydney, (2000-2005) and Chair of the Australian Council for Safety & Quality in Health Care (2000-2005).

Board chair since:
1 February 2005

Appointment expires:
31 January 2010



Professor Clifford Hughes AO

Professor Clifford Hughes AO is the Chief Executive Officer of the Clinical Excellence Commission. For 25 years he was a cardiothoracic surgeon at Royal Prince Alfred Hospital in Sydney and, for the last ten years, head of that department. He was a foundation member of the Australian Council for Safety and Quality in Health Care, chairman of the Therapeutic Device Evaluation Committee and the founding chair of the NSW Special Committee Investigating Deaths Associated With Surgery (SCIDAWS). He has been a senior examiner and councillor of the Royal Australasian College of Surgeons. He has received an alumni award from the University of NSW for "services to the community" and was made an Officer in the Order of Australia "for service to medicine, in particular as a cardiac surgeon, to international relations and to the community".

Board member since:
4 January 2005

Appointment expires:
4 January 2010



Dr Alan Amodeo

Dr Alan Amodeo has over 20 years experience in private and public health care. He has experience in sales, marketing and business development at senior levels in domestic and international markets and has extensive experience liaising with health departments. Dr Amodeo has a strong commitment to the community, including many years in various positions on the board of Telstra Child Flight.

Board member since:
1 February 2005

Appointment expires:
31 January 2009



Dr Graham Beaumont

Dr Graham Beaumont retired from Qantas in 2003, where he held several management and training captain positions with the flight operations department. He was responsible for the initial development and implementation of human factors training programs for Qantas aircrew and his doctoral research concerned human factors in the management of dynamic real-time operational scenarios. He continues to work in this area as a consultant to airlines in the South Pacific and is a member of the Committee of Management of the Australian Aviation Psychology Association. He is actively involved in the establishment of a professional body for health care simulation and the uptake of simulation as a safety and quality tool by the health care sector.

Board member since:
1 February 2005

Retired from the Board:
31 January 2008



Major General Peter Dunn AO

Major General Peter Dunn AO (Retd) is a member of the global management consultancy firm Hay Group and specialises in the fields of leadership, change management and organisational design. He was the inaugural Commissioner of the ACT Emergency Services Authority that was established as a result of recommendations made following the disastrous fires in Canberra in 2003. Prior to this he held a senior appointment in the Australian Public Service. Before joining the public service he was a career military officer and held numerous senior leadership positions in the Australian Army. He was instrumental in restructuring the strategic Defence personnel organisation. He has also worked in the fields of acquisition, logistics and information systems.

Board member since:
1 February 2005

Appointment expires:
31 January 2010



Professor Phillip Harris

Professor Phillip Harris is a Clinical Director of the Cardiovascular Service in Sydney South West Area Health Service, the Chair of the Patient Care Committee at Royal Prince Alfred Hospital and former Head of the Department of Cardiology and the Division of Medicine. He is Clinical Professor of Medicine at the University of Sydney, a former Board member of the Heart Foundation and Heart Research Institute and past President of the Cardiac Society of Australia and New Zealand and the National Heart Foundation of Australia (NSW Division).

Board member since:
1 February 2005

Appointment expires:
31 January 2009



Professor Ron McCallum AO

Professor Ron McCallum AO is Professor of Law in the Faculty of Law of the University of Sydney. He was formerly Dean of Law University of Sydney from July 2002 to September 2006, and formerly Blake Dawson Waldron Professor in Industrial Law from January 1993 to September 2007. He is a Deputy-Chair of Vision Australia, and also Chair of Radio for the Print Handicapped of NSW Cooperative Ltd which operates 2RPH for vision impaired and other print handicapped listeners. Professor McCallum is the inaugural President of the Australian Labour Relations Association and also the Asian regional Vice-President of the International Society for State Governments and has assisted with the drafting of labour legislation. He has researched, written and lectured on all aspects of labour and employment law and has taught in the United States and Canada.

Board member since:
3 December 2007

Appointment expires:
31 January 2009



Associate Professor Brian McCaughan

Associate Professor Brian McCaughan is a cardiothoracic surgeon whose major clinical interest is the management of lung cancer. He is a clinical associate professor at the University of Sydney and held a number of positions with the Royal Australasian College of Surgeons, culminating in chairmanship of the NSW State Committee from 1992 to 1994. Professor McCaughan was a member of the NSW Ministerial Advisory Committee on Quality in Health Care. He was appointed to the NSW Health Council, and served as president of the NSW Medical Board from October 1999 until December 2004. He is Chair of the Sustainable Access Health Priority Taskforce and a member of the Health Care Advisory Council for NSW Health. He was recently appointed as an external member of the Cabinet sub-committee overseeing the NSW State Plan.

Board member since:
1 February 2005

Appointment expires:
31 January 2009



Noel O'Brien OAM

Noel O'Brien OAM was chair of the New England Area Health Service from 2000-2004 and chair of the NSW Association of Mining Related Councils from 1999-2004. He was a councillor of Gunnedah Shire from 1991-2004 and has served two terms as mayor. He participated in the community consultation process co-chaired by the Rt. Hon Ian Sinclair and Wendy McCarthy AO. He is on the board of directors of Westpac Rescue Helicopter Service, Hunter/New England/North West and is managing director of a mining industry training company.

Board member since:
1 February 2005

Appointment expires:
31 January 2010



Professor Janice Reid AM

Professor Janice Reid AM has been Vice-Chancellor and President of the University of Western Sydney since 1998. She has served on the Federal Higher Education Council, committees of the National Health and Medical Research Council and the Australian Vice-Chancellors' Committee, the Executive of the Academy of Social Sciences in Australia (ASSA), the Federal Council for Australia-Latin America Relations (COALAR), the Board of Integral Energy, the Board of the Queensland Museum, the Trust and Council of the Queensland Institute of Medical Research, the Greater Western Sydney Economic Development Board, the 2002 Federal Higher Education Review Reference Group and as Chair of the Australian Institute of Health and Welfare from 1995 to 2001. She is currently on the Board of UniSuper and is a Trustee of the Art Gallery of New South Wales. In 2005, she became the Australian representative on the Governing Board of the Organisation for Economic Co-operation and Development's (OECD) program on Institutional Management in Higher Education (IHME).

Board member since:
3 December 2007

Appointment expires:
31 January 2009



M E (Liz) Rummery AM

M E (Liz) Rummery AM retired from legal practice after 30 years specialising in Property and Commercial Law. She was co-chair of the Rural Implementation Group and is now co-chair of the NSW Rural Taskforce, as well as being a member of the NSW Health Care Advisory Council. Her former positions include Deputy Chancellor, Southern Cross University and chair, Northern Rivers Area Health Board. Mrs Rummery currently holds directorships on the boards of HCF and Catholic Health Care Ltd. She was made a Member of the Order of Australia in 2001 for services to health and education.

Board member since:
1 February 2005

Retired from the Board:
31 January 2008



Professor Debra Thoms

Professor Debra Thoms completed her general nursing education at Prince Henry/Prince of Wales Hospitals, Sydney and her midwifery education at the Royal Darwin Hospital, NT. She holds a Bachelor of Arts in economics and Psychology and a Masters of Nursing Administration. In addition she holds a Graduate Certificate in Bioethics and an Advanced Diploma in Arts in History. Professor Thoms has worked in metropolitan, rural and remote health settings in NSW, the Northern Territory and South Australia in both acute and community health services. Prior to commencing as the Chief Nursing Officer of NSW in May 2006, Debra was the Chief Nursing Officer of South Australia. She was made an Adjunct Professor Nursing at the University of Technology, Sydney in 2003.

Board member since:
3 December 2007

Appointment expires:
31 January 2010

Board Member Meeting Attendance 2007/08

The board meets on a bi-monthly basis.

Directors	14 Aug 07	16 Oct 07	11 Dec 07	19 Feb 08	15 Apr 08	17 June 08
Prof B Barraclough	✓	✓	✓	✓	✓	✓
Dr A Amodeo		✓	✓	✓	✓	✓
Dr G Beaumont	✓		✓	Retired 31 Jan 08		
MajGen P Dunn		✓	✓	✓	✓	✓
Prof P Harris	✓	✓	✓	✓	✓	✓
Prof C Hughes	✓	✓	✓	✓	✓	✓
Prof R McCallum	Appointed 1 Feb 08			✓	✓	✓
Assoc Prof B McCaughan		✓	✓	✓	✓	✓
Mr N O'Brien	✓	✓	✓	✓	✓	✓
Prof J Reid	Appointed 1 Feb 08			✓	✓	
Mrs M E Rummery			✓	Retired 31 Jan 08		
Prof D Thoms	Appointed 1 Feb 08			✓	✓	✓

PROFILE, PURPOSE AND GOALS (cont.)

BOARD SUB-COMMITTEE: AUDIT AND RISK MANAGEMENT

Membership

- Noel O'Brien OAM (Chair)
- Major General Peter Dunn AO
- Liz Rummery AM – retired 31 January 2008
- Professor Debra Thoms – from 1 February 2008
- Professor Clifford Hughes AO

In attendance

- Deputy CEO, CEC
- Director of Internal Audit, SESIAHS
- Representatives from NSW Audit Office
- Executive Officer, CEC

The committee meets quarterly.

Objective

The committee's role is to assist the board in carrying out corporate governance responsibilities relating to the financial reporting, internal control, risk management, compliance with laws, regulations, ethics and the internal and external audit functions of the CEC.

Functions

Functions of the Audit and Risk Management Committee include assisting the board in carrying out its responsibilities as they relate to the commission's:

- Financial and other reporting
- Risk management
- Internal control
- Compliance with laws, regulations and ethics.

Activities of the Audit and Risk Management Committee include:

Internal Audit

- Review and approval of the internal audit charter
- Concurrence with the service agreement with provider for the provision of internal audit function
- Review and approval of audit plans and budgets
- Review of audit results
- Suggestions for audit topics
- Support for communication with internal auditors
- Ensure the independence of the internal auditing function from management
- Co-ordination with the external audit plan.

External Audit

- Review of the proposed audit strategy
- Review all external audit reports
- Review the financial statement preparation process
- Review external audit performance and fee
- Review management's responsiveness to the external auditor's findings.

Audit and Risk Management Committee meetings during 2007/08

18 September 2007

11 December 2007

18 March 2008

BOARD SUB-COMMITTEE: FINANCE

Membership

- Dr Alan Amodeo (Chair)
- Noel O'Brien OAM
- Dr Graham Beaumont – retired 31 January 2008
- Professor Ron McCallum – from 1 February 2008
- Professor Clifford Hughes AO

CEC staff in attendance

- Deputy CEO
- Finance Officer
- Executive Officer

The committee meets monthly, excluding January.

Objective

The primary role of the Finance Committee is to ensure that the operating funds, capital works funds and service outputs required of the commission by the NSW Department of Health are being achieved in an appropriate and efficient manner.

Functions

The Finance Committee brings to the attention of the board matters of accountability, control, audit and advice relating to:

- Forward Estimates and Plans
 - ☐ Financial planning and policy
 - ☐ Annual budget for capital, operating receipts and payments and cash flow
- Financial Management
 - ☐ Income and expenditure budgets
 - ☐ Balance sheet budgets
 - ☐ Cash flow budgets
 - ☐ Accounting standards, instructions and determinations of the board
 - ☐ Financial delegations

- Performance Reporting
 - Activity budgets, efficiency targets, benchmarks and best practice
- Other Board Committees
 - Liaise with Audit Committee with respect to accounting controls, risk management issues and insurance generally.

The board complies with the provisions of the Accounts and Audit Determination for Health Services.

Finance Committee meetings during 2007/08

10 July 2007

14 August 2007

18 September 2007

16 October 2007

13 November 2007

11 December 2007

19 February 2008

18 March 2008

15 April 2008

20 May 2008

17 June 2008

BOARD SUB-COMMITTEE: RESEARCH

Membership

- Professor Phillip Harris (Chair)
- Noel O'Brien OAM
- Dr Graham Beaumont – retired 31 January 2008
- Professor Janice Reid AM – from April 2008
- Professor Clifford Hughes AO

CEC staff in attendance

- Deputy CEO
- Executive Officer

The committee meets quarterly.

Objective

The role of the Research Committee is to advise the board on priorities and strategies for promoting the conduct of research about better practices in health care.

Functions

- Advise on the nature of, and strategic priorities for, research within the CEC, recognising priorities of the NSW Department of Health and area health services.
- Ensure the appropriate review of the quality of research undertaken or commissioned by the CEC.
- Assist with the promotion of the CEC's research work and dissemination of research results.
- Advise on the allocation of resources to research activities.
- Assist with the identification of research funding sources.
- Assist with the preparation of applications to funding bodies.
- Promote close links with appropriate research faculties and bodies, especially in conjoint research.

Research Committee meetings during 2007/08

10 July 2007

13 November 2007

15 April 2008

PROFILE, PURPOSE AND GOALS (cont.)

BOARD SUB-COMMITTEE: CITIZENS ENGAGEMENT ADVISORY COUNCIL (CEAC)

Membership

- Major General Peter Dunn AO (Chair)
- Gary Cox – resigned 16 October 2007
- Jimmy Little AO
- Julie McCrossin – resigned 22 April 2008
- David Hirsch
- Christian Damstra
- Professor Clifford Hughes AO

In attendance

- Don Palmer
- Deputy CEO, CEC
- Executive Officer, CEC

Objective

The aim of the CEAC is to have a workable model that enables the CEC, in line with its Strategic Directions, to promote key quality and safety messages within the health care community, consult broadly with members of the community in performing its functions, and to engage with the community in the development of a Statewide approach to safety and quality improvement.

Functions

The CEAC is chaired by board member, Major General Peter Dunn AO, as a sub-committee of the board. Its functions are to:

- Advise the board on strategic approaches to developing a shared understanding with the community around issues of safety and quality of health services.
- Advise the board on best practice/proven methods for facilitating a meaningful dialogue with the community around the CEC's plans, initiatives and programs.

- On behalf of the board, oversee the development and implementation of a public education campaign to inform the community about aspects impacting on the quality and safety of health care in NSW. This includes addressing the matters recommended by the General Purpose Standing Committee No. 2.
- Consult with, and where necessary co-opt the services of, those having skills and experience in areas such as safety, community engagement, adult education, media, public relations, marketing and large-scale public sector planning and consultation, to help progress the CEAC's objectives.
- Advise the board on how to shift the debate on safety and quality of health care from one which is single-issue or agenda driven, to one that is more systems focussed.
- Determine and help implement key quality and safety messages for the CEAC to promote and develop in the community on behalf of the CEC.
- Assist the board in building capacity and community development around issues that span the dimensions of quality (safety, access, effectiveness, efficiency, appropriateness, consumer participation).

The CEAC complements the Clinical Council in fostering two-way communication between the CEC and its community, and helps the CEC meet its strategic objective of consulting and engaging with health care providers and the community.



Members of the Citizens Engagement Advisory Council and CEC staff

Left to right – Peter Dunn Chair of CEAC, Jimmy Little, Don Palmer, Cliff Hughes CEC, Barbara Dundas CEC, Christian Damstra

CLINICAL COUNCIL

Membership

Those marked with an asterisk resigned from the council during the review period:

- Professor Mary Chiarella (co-chair)
- Dr Austin Curtin (co-chair)
- Patricia Bradd
- Professor Patricia Davidson
- Anthony Dombkins
- Professor Creswell Eastman AM*
- Phillip Ebbs
- A/Professor Brad Frankum*
- Julie Gawthorne
- Dr Rohan Hammett*
- Linda Justin*
- Dr Andrew Keegan*
- Dr Bill Lancashire
- Dr Michael McGlynn
- Dr Sandy Middleton
- Anne Moehead
- Dr Fenton O'Leary
- Anthony Schembri*
- Dr Gabriel Shannon
- Dr Ajeet Sidhu
- Dr Jim Telfer*
- Trent Taylor
- Penny Thornton
- Catriona Wilson

Activities are co-ordinated via the CEC's Director of Clinical Practice Improvement Projects.

Description

The Clinical Council was established in April 2005 to contribute to the development and delivery of the Commission's programs and to advise the Board on strategies to achieve comprehensive clinician participation. The Clinical Council is comprised of a group of practicing clinicians representing a variety of disciplines from across the state including nursing, medical, allied health and ambulance service who have volunteered to participate on the council. Council is chaired by two senior clinicians from the NSW Health system Professor Mary Chiarella (former chief nurse of NSW and currently a professor of Nursing at the University of Sydney) and Dr Austin Curtin (a rural specialist surgeon and chair of the Institute for Rural Clinical Services and Teaching).

Activities

The group meets monthly via videoconference and twice yearly in a face-to-face workshop and provides advice on strategies to engage doctors, nurses, allied health professionals and managers in the development of programs to improve the safety and quality of health services in New South Wales. Council also assists in the development, communication and implementation of the Commission's programs, discusses the development of strategic solutions to systemic safety and quality issues and act as advocates across the NSW health system about the importance and benefits of a Statewide approach to improving safety and quality in health care.

Key Achievements / Outcomes

- Development of formal position description for council members.
- By natural attrition over nine months in 2007, six vacancies had arisen on Clinical Council. A formal recruitment process was undertaken with an Expression of Interest (EOI) advertised through major newspapers in July 2007 seeking new members. Shortlisted candidates were interviewed by a selection panel chaired by Professor Bruce Barraclough.
- Change of format of council meetings to single meetings of full council monthly via videoconference and bi-annual workshop (rather than bi-monthly meetings of geographical areas and bi-annual face-to-face meetings of full council).
- Change of format of agenda of meetings to an issues-based agenda whereby each month two council members report on issues of significance to their area of practice or AHS which are amenable to statewide action.

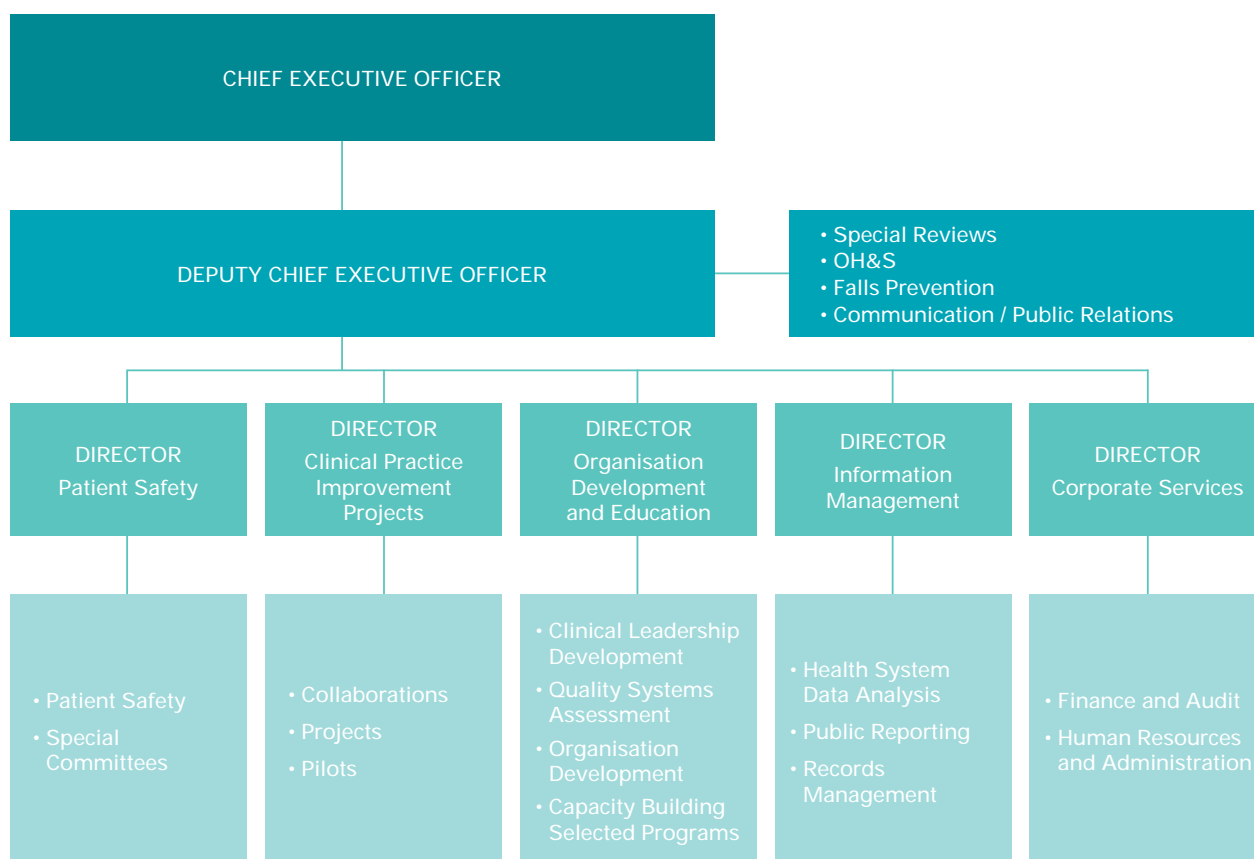
Future Directions

- Consolidate achievements of 2007/08.

PROFILE, PURPOSE AND GOALS (cont.)

ORGANISATIONAL CHART

Operational management of the CEC is overseen by a chief executive officer, and supported by directors who are responsible for discrete portfolio areas.



Principal Directors and Titles

Chief Executive Officer

Professor Clifford F Hughes AO, MBBS, FRACS, FACC, FACS, FCSANZ, FIACS

Deputy Chief Executive Officer

Dr Peter Kennedy MBBS, FRACP

Director Clinical Practice Improvement Projects

Dr Annette Pantle MBBS (Syd), Dip Obs RACOG, MPH, FRACMA

Director Corporate Services

Rhonda Topp, BAppSci (OT), BHA, MCom (on extended leave from September 2007)

André Jenkins BA (Hons) A/DCS from September 2007

Director Information Management

André Jenkins BA (Hons)

Director Organisational Development and Education

Bernie Harrison RN, RM, MPH (Hons), Grad.Cert.Med.Ed.

Director Patient Safety

Adjunct Professor Tony Burrell MBBS, FFARACS, FANZCA, FFICANZCA, FJFICM, BA (from 14 April 2008)

ALLIANCE WITH STATE HEALTH PLAN'S STRATEGIC DIRECTIONS

The CEC, as part of the NSW health system, supports and contributes towards the seven strategic directions outlined in the State Health Plan released in 2007. Key ways in which the CEC's strategic directions and core activities align with the State Health Plan are outlined below. Additional information is contained in the Performance section.

1. Make prevention everybody's business

- NSW Falls program
- Blood Watch program
- Medication Safety collaborative
- Central Line Associated Bacteraemia collaborative
- Review of incident management data
- Management of the Deteriorating Patient – *Between the Flags* project

2. Create better experiences for people using health services

- Implementation of Clinical Leadership Program across NSW
- Citizens Engagement Advisory Council (CEAC)
- Fostering of partnerships via the CEC Clinical Council
- Review of incident management data and investigations
- Participation in Statewide Incident Information Management System project

3. Strengthen primary health care and continuing care in the community

- Citizens Engagement Advisory Council (CEAC)
- Clinical Leadership program across NSW
- Partnerships with primary health care providers and managers

4. Build regional and other partnerships for health

- Citizens Engagement Advisory Council (CEAC)
- Clinical Leadership program provided across NSW
- Visits by CEC staff to health services across NSW
- Shared quality and safety reporting function with Department of Health
- Partnerships with key stakeholders within and outside health sector

5. Make smart choices about the costs and benefits of health services

- Quality Systems Assessment (QSA) program
- Partnership with Department of Health regarding quality and safety data
- Participation in Statewide Incident Information Management System project
- Release of incident management data and recommendations to the system

6. Build a sustainable health workforce

- Clinical Leadership program across NSW
- Recruitment of skilled workers to key positions within the CEC
- Inservices and training opportunities available to all CEC staff

7. Be ready for new risks and opportunities

- Review of internal risk management framework and strategy
- Participation in Statewide Incident Information Management System project
- Partnership with Department of Health regarding quality and safety data

PROFILE, PURPOSE AND GOALS (cont.)

CORPORATE GOVERNANCE STATEMENT

This statement sets out the main corporate governance practices in operation throughout the 2007/08 financial year.

The CEC Board

The board is responsible for the Clinical Excellence Commission (CEC)'s corporate governance.

The board executes its functions, responsibilities and obligations in accordance with the *Health Services Act of 1997*.

The board is committed to better practices contained in the *Guide on Corporate Governance*, issued jointly by the Health Services Association and the NSW Department of Health.

Board membership consists of a chair, ten other non-executive members and the chief executive officer. One of the co-chairs of the Clinical Council attends board meetings on an ex-officio basis.

The board has in place practices that ensure that its primary governing responsibilities are fulfilled in relation to:

- Setting strategic direction
- Ensuring compliance with statutory requirements
- Monitoring organisational performance
- Monitoring the quality of health services
- Board appraisal
- Community consultation
- Professional development.

The board identifies each board member, noting the:

- Qualifications, specific skills and experience they bring to the board
- Term of appointment of board members
- Frequency of board meetings and members' attendance at meetings.

Resources Available to the Board

The board and its members have available to them various sources of independent advice. This includes advice of the external auditor (the Auditor-General or the nominee of that office), the internal auditor, who is available to give advice direct to the board, and professional advice.

The engagement of independent professional advice subject to the approval of the board, or of a committee of the board.

Strategic Direction

The board has in place processes for the effective planning, delivery and monitoring of programs and projects to improve the safety and quality of health care in NSW. These include the setting of a strategic direction for the organisation and providing independent leadership on patient safety and quality. The CEC is currently working to Strategic Plan 2005-2008. In the second half of 2008 the Board will hold a strategic planning meeting to set the direction for the next three to five years.

Code of Ethical Behaviour

As part of the board's commitment to the highest standard of conduct, it has adopted a code of ethical behaviour to guide board members in carrying out their duties and responsibilities. The code covers such matters as responsibilities to the community, compliance with laws and regulations, and ethical responsibilities.

Risk Management

The board is responsible for supervising and monitoring the CEC's risk management, including its system of internal controls. The board has mechanisms for monitoring the operations and financial performance of the CEC.

The board receives and considers all reports of the CEC's external and internal auditors and, through the Audit and Risk Management Committee, ensures that audit recommendations are implemented.

A risk management policy and framework, incorporating a Risk Register, is in place. This is regularly reviewed, with mechanisms put in place for routine review of risk and activity, via the board's Audit and Risk Management Committee.

Committee Structure

The board meets at regular intervals and has in place mechanisms for the conduct of special meetings. They include a committee structure to enhance its corporate governance role in audit and risk management, community engagement, finance and research, with these sub-committees meeting on a regular basis throughout the year. Their terms of reference and membership are detailed in the previous section of this report.

Performance Appraisal

The board has processes in place to:

- Monitor progress of the matters contained within the performance agreement between the board and the Director-General of the NSW Department of Health.
- Regularly review the performance of the board through a process of self-appraisal.

The next Board review and planning meeting is scheduled for November 2008.

PERFORMANCE

STRATEGIC PLAN 2005 – 2008

KEY RESULT AREAS AND GOALS TO ACHIEVE BY 2008	STRATEGIES 2005-08	ACHIEVEMENTS DURING 2007/08
1. PUBLIC REPORTING Report publicly to the Minister and the community on quality and safety in NSW Health	1.1 Develop and deliver an annual public report on adverse events 1.2 Develop and deliver an annual public report on quality system improvements 1.3 Engage the community in an informed discussion around the quality and safety of health care	1.1 First bi-annual report of incident (IIMS) data (July-December 2007) issued in collaboration with DoH 1.2 Chartbook 2007 on safety and quality indicators released 1.3 Chartbook 2008 underway 1.4 Citizens Engagement Advisory Council further developed
2. QUALITY SYSTEMS ASSESSMENT Implement a Quality Systems Assessment (QSA) program across NSW Health, including identification of assessment criteria that allow themselves to be measured, benchmarked and trended over time	2.1 Develop the methodology for the QSA program 2.2 Conduct pilot QSA in two health services (one metro, one rural), then roll-out to all health services 2.3 Complete baseline measures based on NSW Department of Health assessment criteria across the system	2.1 QSA second stage development project completed September 2007 2.2 Staged roll-out of QSA program completed April 2008 2.3 Reporting of results and verification of data underway
3. INFORMATION MANAGEMENT Develop, in partnership with clinicians, feedback reporting systems that support clinical improvement	3.1 Develop and implement an Information Management Strategic Plan to support the work of the CEC 3.2 Work with the Department of Health to implement an incident and adverse event reporting system across NSW Health 3.3 Develop and implement effective information and reporting system for deaths associated with surgery and anaesthesia	3.1 Information Management Strategic Plan continued 3.2 Shared quality and safety reporting function with Department of Health established early 2007, continued 3.3 Surgical mortality database expanded; committees continue to meet, with secretariat services provided by the CEC
4. CLINICAL IMPROVEMENT Assist health services to implement effective clinical improvement programs in partnership with clinicians	4.1 Assist health services to undertake quality improvement projects 4.2 Enhance professional skills within health services to implement effective improvement programs and methodologies 4.3 Conduct Statewide quality and safety initiatives	4.1 Existing programs developed. New programs launched in Recognition and Management of the Deteriorating Patient – Between The Flags. CPI workshops conducted via Clinical Leadership program 4.2 Collaborative initiatives with area clinical governance units and Department of Health; Clinical Leadership program continued 4.3 Statewide programs in place in falls, medication safety, transfusion medicine, recognition and management of deteriorating patient

The CEC measures its performance against seven key result areas (KRAs) outlined in its Strategic Plan 2005-2008, and consistent with the functions outlined in the NSW Clinical Excellence Commission Directions Statement.

The KRAs, associated goals, strategies and achievements during the year are outlined in the following table, with an indication of how they align with the seven strategic directions in the State Health Plan. Profiles of more significant activities are included.

KEY RESULT AREAS AND GOALS TO ACHIEVE BY 2008	STRATEGIES 2005-08	ACHIEVEMENTS DURING 2007/08
5. CAPACITY BUILDING Provide clinical leaders and the Clinical Excellence Commission with skills and tools to effectively lead quality and safety improvement	5.1 Develop and implement clinical leadership development and education programs 5.2 Identify the specific role of the CEC in the knowledge management framework under development 5.3 Support rural health services by identifying and developing individual CEC/health service initiatives 5.4 Develop capacity within the CEC to undertake special reviews	5.1 Statewide Clinical Leadership program continued, with over 200 participants in the two modules. Second cohort started late 2007 5.2 Continued participation in Statewide knowledge management committees 5.3 Rural outreach options explored in collaboration with rural area health services during 2007-08 5.4 Special Reviews regarding ADHD in Children and Adolescents. Systematic Audits of Medical Records, QaRNS
6. ORGANISATIONAL DEVELOPMENT Design and build the Clinical Excellence Commission as an organisation characterised by excellence in governance	6.1 Strengthen the CEC's governance arrangements, particularly in relation to project management, communication and budget planning 6.2 Develop and implement robust risk management practices 6.3 Invest in the CEC's people 6.4 Develop strong partnerships	6.1 Risk management framework reviewed and incorporated into Audit and Risk Management committee schedule 6.2 Range of professional development and education programs offered throughout the year, as outlined in teaching and training section of report 6.3 CEC continues to develop partnerships with stakeholders, such as Department of Health, area health services, GMCT, IMET and the community
7. COMMUNICATION AND CULTURE CHANGE Influence current and future decision makers, at all levels of NSW Health, to apply improvement programs and methodologies	7.1 Develop and implement with health services, a communication strategy that provides the Minister, the CEC board, CEC Clinical Council, decision makers and the NSW health system with key safety and quality messages and evidence-based information 7.2 Work with area health services in effective uptake and implementation of workplace cultural change relating to clinical improvement strategies	7.1 Communications officer in place, website reviewed, Citizens Engagement Advisory Council (CEAC) further developed to assist with providing clear and effective community messages regarding health-related incidents and activities 7.2 Continued liaison with area health services by holding Board meetings in rural area health services, Clinical Council, directors of clinical governance, and via staff working on CEC projects

PERFORMANCE (cont.)

CLINICAL PROGRAMS AND PROJECTS

REDUCING CENTRAL LINE ASSOCIATED BACTERAEMIA IN INTENSIVE CARE UNITS (CLAB-ICU)

Aligns with CEC Key Result Areas:

- 4. Clinical improvement
- 7. Communication and culture change

Aligns with State Health Plan Objectives:

- 1. Make prevention everybody's business
- 2. Create better experiences for people using health services

Description

Patients in ICUs are at high-risk of health care associated infections, including central line associated blood stream infections (CLAB), many of which are considered preventable.

The Central Line Associated Bacteraemia in Intensive Care Units project (CLAB-ICU) is a Statewide initiative that began in March 2007. It aims to improve patient outcomes by reducing CLAB in ICUs.

CLAB-ICU targets insertion practice because it is thought that most CLABS are associated with non-sterile insertion technique and compliance with maximal sterile barrier precautions can result in a reduction in CLAB. The project advocates appropriate hand hygiene, skin preparation and maximal sterile barrier precautions during insertion following the quality improvement initiative in Michigan USA by Pronovost et al.¹

¹ Pronovost, P, et al 2006, An intervention to decrease catheter-related bloodstream infections in the ICU, NEJM, 355:26, 2725-2732

Key Achievements

The project uses a multi-modal approach to support this aim and to maximise uptake and sustainability. In its relatively short life-span, the project has delivered a number of outcomes in line with its objectives:

- Development of best practice guidelines informing NSW policy
- Development of an insertion checklist to monitor compliance and collect indicator data
- Development of a standard central line insertion procedure pack
- Agreement of minimum standards for training and assessment of clinicians who are new to inserting central lines in NSW
- Facilitation of a centralised data collection system and regular reporting of process and outcome measurements to participating units, NSW Health and Clinical Governance Units
- Increased awareness of CLAB and substantial improvement in compliance
- Increase in collaboration between ICU and Microbiology in diagnosis of CLAB
- Request for a Safety Alert Brief regarding guidewires, following a review of central line IIMS data
- Collaboration with Healthcare Acquired Infection (HAI) Expert Advisory Group to avoid duplication of effort and improve data consistency.

Diagram 1: % compliance and CLAB WMA

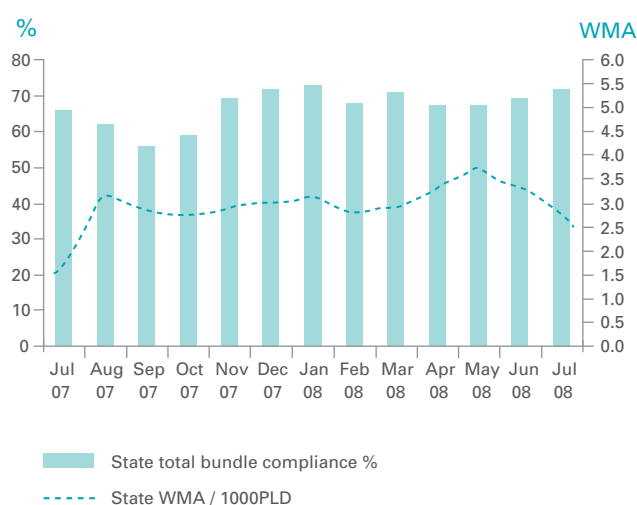
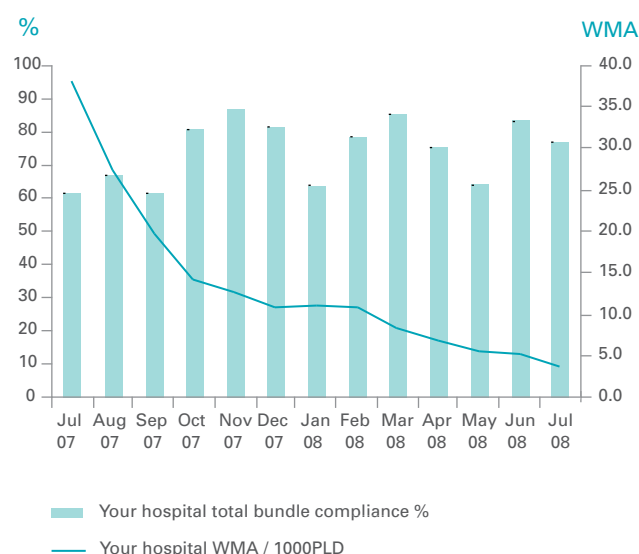


Diagram 2: Early adopter reducing CLAB



The CLAB ICU project collected data on over 7000 central line insertions in the year 1 July 2007 to 30 June 2008. As demonstrated in diagram 1, the trend in statewide CLAB does not replicate the reduction reported in the Pronovost et al study. The late adoption by major tertiary units, which has concentrated results in recent reporting periods, and incomplete capture of central line denominator data has contributed to this result. However, there is evidence that the current intervention strategies have resulted in a reduction in CLAB in early adopters as shown in diagram 2.

Embedding practice change is time-dependent and it is too soon to observe the full effect of the project on CLAB reduction. An Australian publication about the implementation of a similar multi-modal program in one hospital showed maximal CLAB reduction in its fourth year of implementation.

Future Directions

The challenge for the CLAB ICU project is to ensure that gains are sustained and developed. There is also opportunity to extend the values to related areas:

- Key performance indicators promoting compliance
- Standardisation of diagnosis and treatment of CLAB
- Evaluation of the efficacy of dedicated vascular access services
- Utilisation of continuous external auditing, reporting and disclosure to embed practice change
- Standardisation of post-insertion care.

PERFORMANCE (cont.)

FALLS PREVENTION PROGRAM

Aligns with CEC Key Result Areas:

4. Clinical improvement
7. Communication and culture change

Aligns with State Health Plan Objectives:

1. Make prevention everybody's business
2. Create better experiences for people using health services
3. Strengthen primary health care and continuing care in the community
4. Build regional and other partnerships for health

The NSW Falls Prevention Program aims to support the implementation of a range of strategies to prevent falls and fall-related injury in older people across community, hospital and residential aged care settings. The CEC Program Leader and Project Officer support each Area Health Service Falls Co-ordinator in the co-ordination and implementation of their Area Falls Plan.

There is evidence that the biggest effect for improvements in fall injury in older people and reduction in admissions to hospital will be the implementation of community-based initiatives. In NSW the implementation of best-practice falls prevention guidelines (hospital and community) is being supported.

Key Initiatives

- **April Falls Day focus:** Falls Prevention is everyone's business. **CEC April Falls Day:** Showcase of key good-practice falls initiatives in hospitals and community sector.
- **Evaluation of the NSW Falls Prevention Program** – Participation in the evaluation process which is being conducted from the Injury Risk Management Research Centre (IRMRC), UNSW. The report is due in late 2008.
- **Area Health Service Falls Prevention Forums** – Support was provided to successful forums conducted in South Eastern Sydney Illawarra Area Health Service, Hunter New England Health and Greater Southern Area Health Services.
- **Development of falls prevention trigger DVDs** – These hospital-based scenarios show specific fall-related incidents and provide best-practice interventions. They will be used to support ongoing staff education across the State.
- **Australian Commission on Safety and Quality in HealthCare** – Participation on the expert advisory group to review the falls prevention best-practice guidelines for hospitals and residential aged care. The revised versions will be completed for distribution in early 2009 and will also include community best-practice guidelines.



Opening of CEC Rural Office

The official launch of the CEC Rural Office was held at the Coffs Harbour Health campus on 30 January 2008. This facility will support regional and rural areas in undertaking safety improvement projects, and the implementation of the NSW Falls Prevention Program.

Left to right – Professor Clifford Hughes; Mary-Clare Maloney – Area Falls Prevention Coordinator, NCAHS; Chris Lee, Facilitator CLP NCAHS; Ingrid Hutchinson – Project Officer, NSW Falls Prevention Program; Lorraine Lovitt, Program Leader, NSW Falls Prevention Program

- **Supporting Area Health Service Falls Prevention** – Day by day contact to support collaboration and discussion on key issues as they arise. Each Area Health Service has established an **Area Falls Management Committee** with senior executive level representation to oversee the implementation of falls prevention initiatives. The CEC is a participating member.
- **General Practitioners** – Support to General Practice NSW in the development of a Strategic Plan to build the capacity of general practice in falls prevention.

Future Directions

Review of the NSW Management Policy to Reduce Fall Injury Among Older People – State-wide consultation for the development of policy and strategic directions for the next phase of the NSW Falls Prevention Program.



April Falls Day

This day has been identified for Area Health Services to hold activities to target hospital staff, families and carers and the general community about falls prevention.

April Falls Day 2008 at Northern Sydney Central Coast Area Health Service

Left to right – Dr Sue Kurrie, Geriatrician NSCCAH; Lorraine Lovitt, Program leaders, NSW Falls Prevention Program; Margaret Armstrong, NSCCAHS Falls Prevention Coordinator; Mathew Daly, CEO NSCCAHS; Professor Cliff Hughes, CEO, CEC

PERFORMANCE (cont.)



BETWEEN THE FLAGS

Aligns with CEC Key Result Areas:

- 4. Clinical improvement
- 7. Communication and culture change

Aligns with State Health Plan Objectives:

- 1. Make prevention everybody's business
- 2. Create better experiences for people using health services
- 6. Build a sustainable health workforce
- 7. Be ready for new risks and opportunities

Description

The lack of recognition and appropriate management of those patients whose condition deteriorates, often unexpectedly, on acute hospital wards, has been identified as a contributing factor in many adverse events and is a key patient safety issue.

A program of work on Recognition and Management of the Deteriorating Patient – called “*Between the Flags*” was launched in October 2007. The program utilises the imagery of the surf lifesaving movement, where recognition and rescue are key objectives well known to all. The project aim is to identify the safety parameters for patient wellbeing on acute hospital wards (the flags), to trial processes for improved observation and communication of that status, to understand the work process issues that impact on this issue and interfere with team dynamics (the lifesavers) and to provide recommendations for Statewide action.

Program Strategies

Combining clinical practice improvement and clinical redesign methodologies, a series of interventions were trialled and evaluated in several hospitals throughout the state in both metropolitan and rural areas.

Key Achievements

- Permission obtained from Surf Life Saving Australia to use SLSA imagery to develop a theme that resonates with clinicians about keeping patients safe.
- Worked intensively with five facilities representing tertiary, metropolitan, rural base, and rural hospitals to ensure transferability to similar NSW health facilities.
- Local clinician experts participated as clinical advisors to the project through the Expert Group, chaired by A/Prof Theresa Jacques.
- Successful implementation of ‘Productive Ward’ strategy focussing on redesigning existing work practices to reduce staff time away from patients.
- Successful trial of a colour-coded observation chart and Modified Early Warning Score as one ‘track and trigger’ system.
- Tiered models for education – targeting ward staff, home teams, and emergency response teams.
- Development of ‘dashboard indicators’ to aid easy identification of project progress for participating facilities and steering committee.
- Trial of bedside handover.

Future Directions

- A report based on the results of the evaluation is nearing completion for presentation to the Director-General of Health in September 2008.
- The Between the Flags Toolkit, that will provide a range of solutions for implementation in NSW health facilities, is under development.

MEDICATION SAFETY SELF ASSESSMENT (MSSA)

Aligns with CEC Key Result Areas:

- 3. Information management
- 4. Clinical improvement

Aligns with State Health Plan Objectives:

- 1. Make prevention everybody's business
- 2. Create better experiences for people using health services
- 4. Build regional and other partnerships for health
- 5. Make smart choices about the costs and benefits of health services

Description

- The Medication Safety Self Assessment (MSSA) and Medication Safety Self Assessment for Antithrombotic Therapy (MSSA_AT) tools were developed by the CEC together with the NSW Therapeutic Advisory Group (NSWTAG) as part of the PIMS (Performance Indicators and Medication Safety) project.
- The MSSA and MSSA_AT are diagnostic tools designed to allow self assessment of medication safety practices in hospitals and to heighten awareness of the characteristics of a safe medication system.
- The tools provide a structured framework for assessing current medication practice that can be used both for internal assessment and for benchmarking purposes. They allow hospitals systematically to identify gaps in practice and areas for improvement which can be measured over time.

Key Achievements

- The MSSA tool has been widely implemented in NSW. The MSSA_AT tool will be launched in the second half of 2008.
- Over 160 MSSA assessments have been completed by facilities in NSW, ACT, QLD, SA, VIC and WA. Interest in completing the assessment has been expressed by some New Zealand facilities.
- Data from 84 NSW public facilities which undertook the MSSA from February to November 2007 was analysed to establish trends in medication safety performance across the system and to highlight areas of concern and required action.
- The results from the MSSA development and analysis of results has been presented at various National conferences.
- The tool has the complete endorsement of the NSW Department of Health State-wide Medication Safety Committee.

Future Directions

- The MSSA will be one of the major tools for ongoing measurement and monitoring of medication management systems throughout NSW. Results will continue to be used to drive system-wide improvements.

PERFORMANCE (cont.)

BLOOD WATCH – TRANSFUSION MEDICINE IMPROVEMENT PROGRAM

Aligns with CEC Key Result Areas:

4. Clinical improvement
6. Organisational development
7. Communication and culture change

Aligns with State Health Plan Objectives:

1. Make prevention everybody's business
2. Create better experiences for people using health services
4. Build regional and other partnerships for health
5. Make smart choices about the costs and benefits of health services

Description

The Transfusion Medicine Improvement Program – Blood Watch – co-ordinates the implementation of improvements in transfusion practice across NSW-based on priority areas identified by NSW Health's Fresh Products Advisory Committee.

Key performance targets include the establishment of clinical governance structures such as Transfusion Committees, developing and implementing education strategies to inform and support changes in clinical practice, consistent quality reporting of adverse events through existing systems, such as the Incident Information Management System (IIMS), improving the appropriateness of transfusion of fresh products, and establishing a flow of information patterns between the CEC, NSW Health, clinicians, patients and other key stakeholders.

Within each Area Health Service a transfusion project officer/CNC, together with a clinical lead haematologist, drive and support local initiatives to sustain transfusion best-practice.

Key Achievements

- There is evidence of a reduction in issue of all fresh blood products reported by NSW Australian Red Cross Blood Service (ARCBS) for the year 2007-2008. Red cell supply was 6.2 per cent below the previous year and other products such as platelets and clinical fresh frozen plasma (FFP) were also significantly below plan.
- Analysis of the 2008 red cell audit data completed by each Area Health Service supports the downward trend and indicates real improvements in appropriateness and patient consent together with a decline in the number of red cell transfusions occurring.
- Published results of market research into the transfusion prescribing behaviours of senior clinicians in NSW. Results will inform a communications and direct marketing strategy in late 2008.
- Contributed a review of blood-related incidents in NSW to the Initial Australian Haemovigilance Report compiled by the National Blood Authority.
- Developed and disseminated a NSW Health and ARCBS-endorsed consumer guide to blood transfusion. The brochure has also been translated into 10 commonly spoken foreign languages.
- Introduction of standardised blood prescription and decision support tools.



BLOOD WATCH
every drop counts

Future Directions

- The development and implementation of a Statewide communications strategy aimed at senior surgeons in collaboration with the National Blood Authority.
- Statewide roll-out of e-learning program with learning management tool to assist with administration of users at a local level.
- Development and dissemination of NSW Health endorsed Consumer Guide to Blood Transfusions brochure.
- Development and implementation of Blood Watch work plan 2009-2011.
- Update the Red Cell Utilisation database for 06-07

Giving your consent

You should make sure you understand the reasons, risks and benefits when you are asked to give your consent for a transfusion. If you have any objections it is extremely important to discuss them with your doctor. In an emergency it may not be possible to obtain your consent for a transfusion, but the reasons should be explained to you when you are recovering.

When you have a blood transfusion

When you are ready to receive your blood transfusion you will be asked to confirm your identity. This is for your safety because if the wrong blood (meant for someone else) is given to you then this could cause serious medical problems. Staff will follow strict checking procedures before and during every transfusion. If you feel unwell during a transfusion, you should tell staff immediately.

What can we all do to make sure that a safe supply of blood is available?

It is important that healthy Australians donate blood. This helps ensure a safe and adequate blood supply, which saves many lives each year.

BLOOD TRANSFUSION checklist

- ☐ Do you understand why you need a blood transfusion?
Your doctor should explain why a transfusion has been recommended. You can ask about your haemoglobin level.
- ☐ Have the risks of transfusion been explained?
The risks and benefits of transfusion for your condition should be clearly explained.
- ☐ Have alternatives been discussed?
Alternatives to transfusion should always be considered and discussed with you by your doctor.
- ☐ Have all your questions been answered?

Copies of this brochure are available from:
www.transfusion.com.au
www.ccc.health.nsw.gov.au

Translated brochures available from:
www.mhcs.health.nsw.gov.au



NSW HEALTH



Disclaimer: This fact sheet is for your educational purposes only. It should not be used to guide and/or determine actual treatment choices or decisions. Any such decisions should be made in conjunction with advice from your treating practitioner. Please consult with your doctor or other health professionals to make sure this information is right for you.
Print date: May 2008 Reprint: January 2010

Blood transfusion

Answers to some common questions for you and your family.



Communicating about the risks of blood transfusion is an important part of patient education.

The Blood Watch consumer brochure on blood transfusion is available in English and ten commonly spoken languages in NSW and is available in all NSW public hospitals.

表示同意

當醫生要求您同意輸血時，您應該確保自己瞭解輸血的原因、風險和好處。如果您有任何異議，請一定要與醫生討論，這一點極其重要。在緊急情況下，可能沒辦法在輸血前徵求您的同意，但是當您恢復時，應該向您解釋原因。

當您接受輸血時

當您準備好接受輸血時，會要求確認您的身份。這是為了您的安全起見，因為如果將不對應的血液（給別人的血液）輸送給您，就會引起嚴重的醫療問題。工作人員在每次輸血前和輸血過程中都會遵循嚴格的檢查程序。如果您在輸血過程中感覺不舒服，應該立即告訴工作人員。

我們大家可以做些什麼來確保安全的血液供應？

健康的澳大利亞人應該捐獻血液。獻血有助於確保安全和充足的血液供應，這樣每年可以挽救許多生命。

輸血 檢查清單

- ☐ 您知道您為什麼需要輸血嗎？
您的醫生應該向您解釋為什麼建議輸血。您可以詢問您的血色素水準。
- ☐ 是否向您說明輸血的風險？
應該向您清楚地說明根據您的病情進行輸血的風險和好處。
- ☐ 是否討論過替代方案？
您的醫生每次應該考慮並與您討論輸血替代方案。
- ☐ 您的問題都得到解答了嗎？

從這些地方可以獲得本手冊：
www.transfusion.com.au
www.ccc.health.nsw.gov.au
從這些地方可以獲得本手冊的翻譯版本
www.mhcs.health.nsw.gov.au



NSW HEALTH



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印製日期：2008年5月 2010年1月修訂

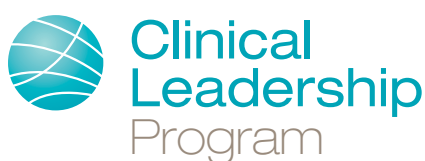
輸血

您及您家人的一些常見問題解答



Chinese

PERFORMANCE (cont.)



CLINICAL LEADERSHIP PROGRAM

Aligns with CEC Key Result Areas:

- 5. Capacity building
- 6. Organisational development

Aligns with State Health Plan Objectives:

- 2. Create better experiences for people using health services
- 5. Make smart choices about the costs and benefits of health services
- 6. Build a sustainable workforce
- 7. Be ready for new risks and opportunities

Description

The Clinical Leadership program was instigated by the CEC mid-2006 to enhance the capacity of clinicians to be agents of sustainable system improvement and patient safety. Following refinement of its content and delivery with key stakeholders, first intakes to the annual program started February 2007.

The program content aims to build a cohort of effective clinical leaders who progressively become the 'critical mass' needed for patient-centred system change. It does this by offering the program in two different modes: Statewide and Modular.

The Statewide program is multidisciplinary, delivered in five

modules by local Facilitators within an area health service. The Modular program is delivered as five intensive modules in Sydney – to senior clinician managers.

The program has secured CEC funding to February 2009.

Key Achievements

- The Modular program.
- Thirty-one senior clinician managers successfully completed the Modular program in 2007. A further thirty are expected to also successfully complete the 2008 program.
- A Clinical Service Challenge was completed by each participant as part of the program. This has served to equip them as advocates for patient safety, along with assisting them to integrate health system improvement into their everyday clinical practice.
- Planning is underway for formation of an Alumnus of previous participants.
- The Statewide program.
- The second year of operation has consolidated the program's

structure and operations more fully for facilitators and participants.

- Over 150 people successfully completed the program in 2007, and 170 are expected to successfully complete it in 2008.
- A review and planning day for facilitators was held in May 2008, highlighting program aspects that were working well and those that needed review. This resulted in four working parties (curriculum, facilitation, evaluation, innovation), which will present their recommendations to the CEC executive about potential future operations.

Future Directions

- A comprehensive evaluation of the program (Statewide and Modular) is being overseen by a CLP Evaluation steering committee. Findings from mid-term and follow-up surveys will help inform potential future programs.
- Future sources of funding to enable the program to continue to be offered to the NSW health system are being explored.



Sydney West CLP 2007 Graduating Class

Front row from left: Larissa Hoyling (CNE), Maridy Rizman (Admin), Sharen Rogers (NUM), Debbie Green (NUM), Therese Freeman (CNS) and Loretta Martin (Facilitator). Back row from left: Richard Tewson (CLP Program Manager/Facilitator), Anne-Marie Allen (NUM), Julie Mate (CNE), Julie Strukovski (CNC), Elisabeth Black (CNC), Katherine Cox (NUM) and Scott Williams (CNE).

INFORMATION MANAGEMENT INITIATIVES

Aligns with CEC Key Result Areas:

1. Public reporting
3. Information management
6. Organisational development

Aligns with State Health Plan Objectives:

4. Build regional and other partnerships for health
5. Make smart choices about the costs and benefits of health services
7. Be ready for new risks and opportunities

CHART BOOK

As part of its goal to provide assurance through credible public reporting, the CEC publishes an annual chartbook of health system indicators. The first edition – containing 63 charts and accompanying text – was released on 6 May 2008 and has been well received by the health system.

Expert analysis and advice has been provided by the placement within the CEC of a trainee biostatistician from the Health Department's biostatistical training program.

Key Achievements

The CEC Chartbook provides:

- a tool for measuring and reporting safety and quality in the NSW health system at a State and Area Health Service level
- a key resource for driving change within the NSW health system
- a simple overview of the state of knowledge of the safety and quality of healthcare services in NSW for use by the public and non-specialist audiences
- relevant information in tabular and graphical formats with interpretive text that interprets the findings, and describes the importance and implications for Area Health Services and clinical governance units, and
- reports on outcomes of key initiatives of the CEC and NSW Health that address safety and quality issues.

Future Directions

Preparation of *Chartbook 2008* is well advanced with over 50 per cent of charts drafted and authoring of draft text recently started. *Chartbook 2009* preliminary planning is also underway.

HEALTH RECORD DATA LINKAGE

The Centre for Health Record Linkage (CHeReL)

CHeReL is a collaborative venture established by NSW Health and the Cancer Institute NSW, with key partners including the CEC, ACT Health, University of Sydney, University of New South Wales, University of Newcastle and the Sax Institute.

The purpose of CHeReL is, through data linkage, to enable routinely-collected health data and information to be transformed into a powerful resource for planning, monitoring and evaluation of health services and outcomes.

CEC is eligible, through its membership of CHeReL, to a large percentage of its membership fees back in data linkage services. The CEC, through its Board Research Committee, makes these services available to the NSW health system for research projects on healthcare safety and quality that require linked data. Further details and application forms are available on CEC's website.

SUPPORTING CEC INFORMATION INITIATIVES AND REPORTING

The CEC's Information Management Team supports all CEC programs in their acquisition, use and management of information. This includes providing advice about data collections, collection methodologies, data sources, analysis, privacy and confidentiality issues.

The team is responsible for overseeing the CEC website and the final preparation of project, program and Special Review documents for external publication, as well as records management activities within the CEC.

PERFORMANCE (cont.)

PATIENT SAFETY AND INCIDENT MANAGEMENT

Aligns with CEC Key Result Areas:

1. Public reporting
3. Information management
4. Clinical improvement
5. Capacity building
6. Organisational development
7. Communication and culture change

Aligns with State Health Plan Objectives:

1. Make prevention everybody's business
2. Create better experiences for people using health services
3. Strengthen primary health care and continuing care in the community
4. Build regional and other partnerships for health
6. Build a sustainable workforce
7. Be ready for new risks and opportunities

Description

The CEC's Patient Safety Program is aligned with the NSW Patient Safety and Clinical Quality Program, which seeks to deliver a standardised, system-wide approach to ongoing improvements in the safety and quality of healthcare provided across the NSW health system. A key component is analysis of Statewide clinical incident data within the Incident Information Management System (IIMS) and feedback to clinicians and the community.

Key Achievements

The Patient Safety Program has been strengthened to enhance its analytical role within the CEC and to facilitate networking and communication back to the Area Health Services about opportunities to improve patient safety and standardise high quality clinical care.

The bi-annual shared reporting functions with NSW Health have continued, as has the provision of Statewide data on request to special interest clinical groups.

By June 2008, staff from across the NSW health system had lodged over 500,000 incidents in IIMS since its inception in 2005. Reporting rates have continued to increase steadily. IIMS is now widely accepted as a useful reporting tool which contains a wealth of data about opportunities to improve. It also provides evidence of good work done by staff in preventing adverse events. The majority of incidents reported are in fact 'near miss' events which were recognised as having the potential to cause harm.

Future Directions

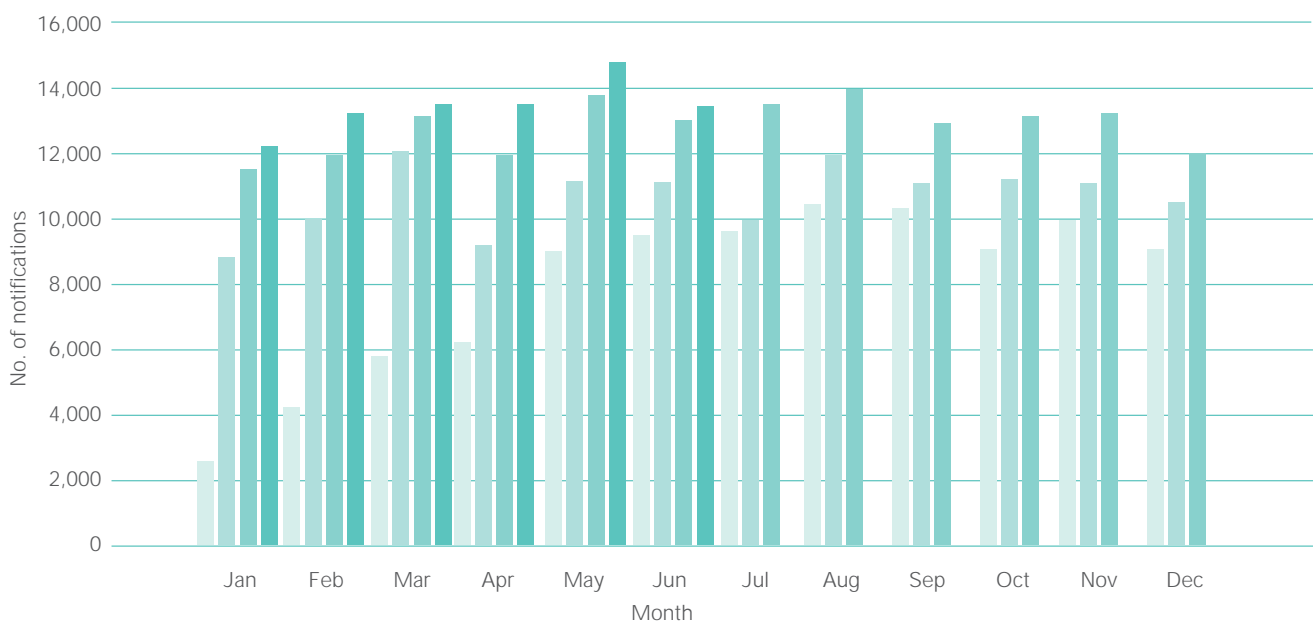
The CEC will continue to maintain strong links with Area Health Service Clinical Governance Units so that lessons learned from adverse events and successful strategies to address clinical risks can be more easily shared with all clinical staff and managers. This will include bi-annual forums for Patient Safety Managers, where skills and learnings can be shared and further developed. Other communication strategies to provide feedback of the outcome of State-level incident review processes are also being planned.

Work is also starting, in collaboration with NSW Health and universities, to improve our understanding of the contribution of human factors to health incidents, and how these can be 'engineered out' by system improvements.

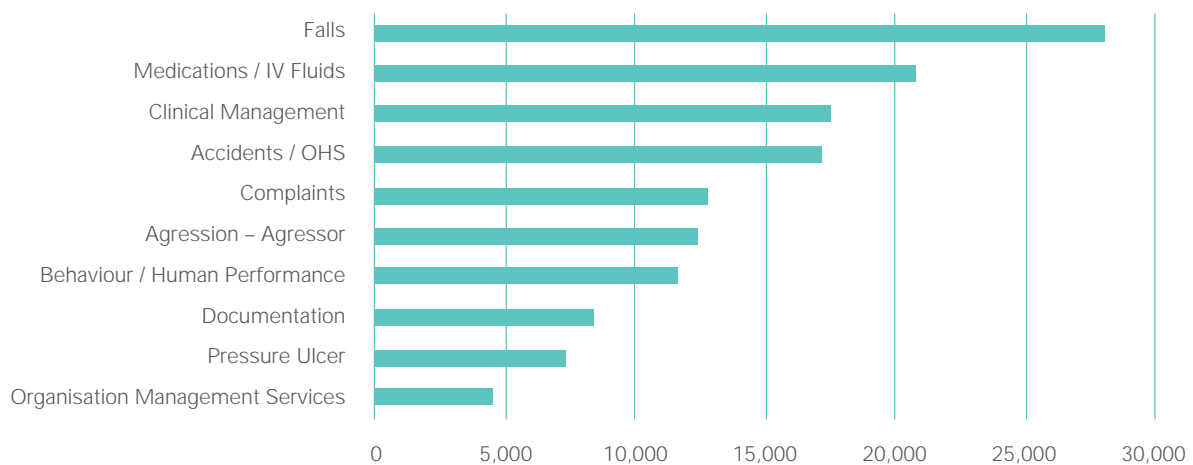
Analysis of RCA recommendations will increase so that the most effective strategies to reduce identified clinical risk can be communicated across the NSW health system.

NSW Trend IIMS Notifications 2005/06/07/08

2005 2006 2007 2008



All Incidents – Top 10 Principal Incident Types 2007-2008



PERFORMANCE (cont.)

QUALITY EDUCATION

Aligns with CEC Key Result Areas:

- 4. Clinical improvement
- 5. Capacity building
- 6. Organisational development

Aligns with State Health Plan Objectives:

- 2. Create better experiences for people using health services
- 6. Build a sustainable workforce
- 7. Be ready for new risks and opportunities

Description

The provision of education in Area Health Services about quality has varied in content and delivery. The capacity-building role of the CEC includes ensuring that staff in NSW Health have access to education in quality. The Clinical Leadership Program requires participants to undertake a clinical service challenge, which can include a quality improvement initiative.

The CEC recognises the need to provide a variety of learning modes to cater for the diverse needs of the NSW Health clinical workforce. Options need to be available for rural clinicians who face both distance and workload issues, and metropolitan clinicians whose workload may be a barrier to attendance at face-to-face delivery modes of education.

Key achievements

The CEC has partnered with NSW Health Clinical Redesign in the development of e-Learning modules in:

- clinical redesign
- project management
- clinical practice improvement methodologies.

Approximately 30 per cent of content has been drafted and reviewed by the CEC and NSW Department of Health.

Future directions

The e-Learning modules will continue to be developed by Workstar, with subject matter experts developing the content.

QUALITY SYSTEMS ASSESSMENT

Aligns with CEC Key Result Areas:

- 2. Quality Systems Assessment
- 6. Organisational development

Aligns with State Health Plan Objectives:

- 2. Create better experiences for people using health services
- 6. Build a sustainable workforce
- 7. Be ready for new risks and opportunities

Description

- The Quality Systems Assessment (QSA) Program is an innovative component of the NSW Patient Safety and Clinical Quality Program.
- The aim of the QSA is to provide assurance about the quality and safety of health care provided by public health services in NSW and examines compliance with standards and policy requirements developed by NSW Department of Health.
- The QSA encompasses all Public Health Organisations (PHO) in NSW which comprises eight Area Health Service (AHS), the NSW Ambulance Service, Justice Health and The Children's Hospital at Westmead.
- The QSA features a multi-level approach with assessment tools tailored to the different levels within each of the PHOs. This allows responses at the different levels of the organisation to be correlated to assess the effectiveness of governing and reporting structures.
- There are four components of the QSA:
 1. Completion of a self-assessment survey at the different levels of the organisation eg Areas, Network / Cluster, Facility and Department / Clinical Unit;
 2. Verification of a sample of the self assessment surveys;
 3. Feedback and reporting to respondents, the health system and the community;
 4. Development of improvement plans at each level of the organisation. These would respond to the issues identified in the self assessment process. The improvement plans will be subject to review in subsequent QSA assessments.

Key Achievements

- The second stage Development Project was completed in September 2007 with the QSA methodology and survey tools finalised.
- A staged rollout of the QSA program started with Area Health Services in November 2007 and was completed in February 2008.
- A high level of response was achieved for the first QSA, with 97 per cent of the nominated facilities and 80 per cent of the nominated Department / Clinical Units completing the assessment from all AHS in NSW.
- Justice Health and NSW Ambulance Service started the program in February 2008 and completed in April 2008.
- The response rate for all levels of assessment in both the NSW Ambulance Service and Justice Health was 100 per cent.
- Reporting of results and verification of data with feedback from the system is underway.

Future Directions

- Reports will be prepared for both the structured questions and the free text narratives.
- Reports will be provided to all levels of the system.
- Verification including on site visits will occur for a sample of respondents.
- Future QSA surveys will focus on areas requiring further policy development and identified high-risk areas which impact on the quality and safety of care for patients.

PERFORMANCE (cont.)

SPECIAL COMMITTEES

Aligns with CEC Key Result Areas

3. Information management
4. Clinical improvement
6. Organisational development
7. Communication and culture change

Aligns with State Health Plan Objectives

1. Make prevention everybody's business
2. Create better experiences for people using health services
7. Be ready for new risks and opportunities

COLLABORATING HOSPITALS' AUDIT OF SURGICAL MORTALITY (CHASM)

Description

The Collaborating Hospitals' Audit of Surgical Mortality (CHASM) is a systematic peer-review audit of deaths associated with surgical care. It originated from the former Special Committee Investigating Deaths Associated With Surgery (SCIDAWS), with expanded functions to enable the CHASM Committee to oversee more systematic and comprehensive audits of surgical deaths, including cases where no operation was performed. CHASM is designed to identify system and process errors for ongoing improvement and educational purposes. It is supported

by the NSW State Committee of the Royal Australasian College of Surgeons (RACS), the Clinical Excellence Commission (CEC) and NSW Health and is similar to audits of surgical mortality being established in other Australian States.

Key Achievements

- CEC funded eight part-time positions – one at each Area Health Service – across NSW to assist with notifying surgical deaths and supporting surgeons and the audit process over a three-year period.
- Sydney West and Hunter New England Area Health Services successfully completed the pilot phase of CHASM.
- At 30 June 2008:
 - 342 surgical deaths were reported to CHASM from four Area Health Services (Sydney West, Hunter New England, North Coast and Sydney South West)
 - 163 surgeons have agreed to participate in CHASM
- CEC has set up a Secretariat team, consisting of a Project Coordinator, a Research Analyst and two Project Officers to collect, maintain and analyse data for the audit and to provide secretarial support to the CHASM Committee and participating surgeons.
- CEC has designated a webpage on CHASM in its website to provide information about the audit, support its process and encourage surgeon participation.

- The Royal Australasian College of Surgeons (RACS) has agreed to award credit points for CHASM participation. All participating surgeons and assessors will receive one credit point per hour for time spent on the audit. The points contribute to RACS Recertification (Category 3: Clinical Governance and Evaluation of Patient Care).

Future Directions

- CHASM will expand to include gynaecology and private hospitals.
- The CHASM office will provide 12-month individual reports to participating surgeons.

SPECIAL COMMITTEE INVESTIGATING DEATHS UNDER ANAESTHESIA (SCIDUA)

Description

SCIDUA was originally convened in 1961 to provide expert clinical assessment of the cause of deaths occurring during, or shortly after, the administration of anaesthesia. After a short break in the early 1980s, the Special Committee was re-established under the *Health Administration Act 1982*, and has special privilege provided under section 23 of the same Act. SCIDUA reports to the Minister for Health through the CEC.

Key Achievements

- The CEC is pleased to report that the SCIDUA conducted its investigations efficiently in 2007/08. In addition to investigating 270 deaths reported in 2007/08, the SCIDUA Triage Committee also cleared a total of 2,198 cases backlogged from 2003 – 2006.

- The Special Committee's report on its activities undertaken in 2007 was approved by the Minister for Health and forwarded to NSW Health for information and distribution. The report recommends that NSW Health consider an amendment to the *Coroners Act 1980* to include procedures under "sedation" administered by non-anaesthetists, for notification of deaths to the Coroner.
- In 2007/08, the Special Committee consisted of 17 members drawn from:
 - Australian and New Zealand College of Anaesthetists
 - Australian Society of Anaesthetists
 - Departments of Anaesthesia at the University of Newcastle and University of Sydney
 - Departments of Surgery at the University of Sydney and University of NSW
 - The Special Committee Investigating Deaths Associated with Surgery
 - Royal College of Pathologists of Australasia

Future directions

- Professor Ross Holland has been recommended for the position of Chairman for a 12-months period to facilitate succession planning for a new Chairman, with a nomination to be submitted to the Minister for Health for approval by the end of 2008.

SPECIAL REVIEWS

Aligns with CEC Key Result Areas:

1. Public reporting
3. Information management
4. Clinical improvement

Aligns with State Health Plan Objectives:

1. Make prevention everybody's business
2. Create better experiences for people using health services
7. Be ready for new risks and opportunities

Description

The Director-General may, from time to time, require the CEC to conduct reviews in relation to the quality and safety of healthcare on his or her behalf, with the specific nature of such a review determined by the Director-General. The purpose of these reviews is to bring about improvements in clinical quality and patient safety within NSW. The CEC does not investigate matters of individual performance, nor does it deal with individual patient incidents or complaints. The following Special Reviews were undertaken by the CEC during the year:

REVIEW OF ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD) IN CHILDREN AND ADOLESCENTS

The main aim of this review was to inquire into the public health issues arising from the assessment and treatment of ADHD and the prescription of drugs associated with treating the disorder.

THE REVIEW OF SYSTEMATIC AUDITS OF MEDICAL RECORDS

The Review of Systematic Audits of Medical Records such as Quality at Royal North Shore (Q@RNS) started in March 2008 and is scheduled for completion in September 2008.

The main aim of this review is to examine the Q@RNS audit program at Royal North Shore Hospital and make recommendations about the value of the Q@RNS methodology to be incorporated in the NSW Health Patient Safety and Clinical Quality Program.

OUR PEOPLE

STAFF PROFILE

The CEC is committed to having a skilled and valued workforce, to enable it to meet key objectives in its Strategic Directions and Strategic Plan 2005-2008.

From its establishment in 2004, the CEC has recruited key executive and support positions in the strategic portfolio areas of:

- Clinical Practice Improvement
- Patient Safety
- Information Management
- Organisation Development and Education, incorporating Quality Systems Assessment
- Corporate Services

Dr Peter Kennedy commenced in August 2008 as the Deputy Chief Executive Officer.

Adjunct Professor Tony Burrell joined in April 2008 as Director, Patient Safety (.5 FTE).

The number of full-time equivalent staff at 30 June 2008 was 29.63, comprising 26.37 appointed staff.

(3.5 of these medical), 3.00 FTE agency staff and 1.00 FTE contractor.

Full-Time Equivalent Staff at 30 June:

2007-2008	29.87
2006-2007	29.63
2005-2006	23.76
2004-2005	13.70

EXECUTIVE REPORTS

Name: Professor Clifford F Hughes AO

Health Service: Clinical Excellence Commission

Period in Position: 18 January 2005 to 30 June 2008

STRATEGIC INITIATIVES

- Continued development of additional strategies in key portfolios of Quality Systems Assessment, Clinical Practice Improvement Projects, Information Management and Organisation Development and Education.
- Provide Statewide leadership, support and guidance for clinical practice improvement projects, including falls; medication safety; transfusion medicine; CLAB-ICU, recognition and management of the deteriorating patient – *Between the Flags*.
- Continuation of Statewide Clinical Leadership Program.
- Publication of first six monthly report (January – June 2007) of IIMS Statewide data in January 2008.
- Preparation of the second six monthly report (July – December 2007) of IIMS Statewide data for publication.
- The first annual CEC Chartbook – 2007 containing NSW safety and quality indicators released and *Chartbook 2008* under development.
- Completion of the first phase of Blood Watch Transfusion Medicine Improvement Program and next phase underway.
- Completion of the second stage of QSA Development Project and finalisation of QSA methodology and survey tools.
- Continued development of the Citizens Engagement Advisory Council to progress community engagement around the quality and safety of healthcare with a communication project under development.
- Rollout of the Collaborating Hospitals Audit of Surgical Mortality (CHASM) has been completed in all Area Health Services.
- Developed strong partnerships which include regular meetings with the Quality and Safety Branch of the Health Department, the Greater Metropolitan Clinical Taskforce (GMCT) and the Institute of Medical Education and Training (IMET).
- The Cardiothoracic Network partnership with the Greater Metropolitan Clinical Taskforce has been implemented in most hospitals and data managers have been appointed in most areas.
- Reviews completed into the management of ADHD in Children and Adolescents in NSW, and the Management of Pacemaker Insertion in NSW.
- The inaugural Ian O'Rourke Scholar, Dr David Peiris, is mid way through his three year doctoral research program and is progressing well.
- The Board of the CEC visited two rural Area Health Services and it is intended to continue such visits to country health facilities.

MANAGEMENT ACCOUNTABILITIES

- Appointment of a Deputy Chief Executive Officer.
- Appointment of a Director Patient Safety and expansion of the Patient Safety portfolio.
- The first CEC rural campus was opened in Coffs Harbour with the relocation of the Program Leader, NSW Falls Program.
- Ongoing management of CEC projects in collaboration with executive staff.
- All statutory and financial reporting requirements completed.
- Continued review and development of corporate risk register.
- Appointment of Occupational Health and Safety (OH&S) representative and implementation of recommendations following OH&S risk assessment.
- Establishment of CEC Employee Assistance program.

EQUAL EMPLOYMENT OPPORTUNITY

The CEC has a service level agreement with South Eastern Sydney and Illawarra Area Health Service (SESAHS) for human resources and other corporate services. The CEC applies SESAHS's EEO strategies regarding recruitment, and has developed a targeted professional development program to ensure that the skills and experience of its staff are enhanced during their periods of employment.

ETHNIC AFFAIRS PRIORITY STATEMENT

In undertaking its core duties and in developing and implementing projects and strategies, the CEC is committed to supporting and endorsing the principles of multiculturalism contained within the *Community Relations Commission and Principles of Multiculturalism Act 2000* and the white paper, *Cultural harmony: The next decade 2002 – 2012*.

Specifically and in accordance with the Act, the CEC undertakes, via its Ethnic Affairs Priority Statement, to:

- Respect and make provision for the expression of culture, language and religion by staff and constituents
- Provide full opportunity for staff and constituents to utilise and participate in relevant CEC activities and programs
- Recognise the linguistic and cultural assets in the population of New South Wales as a valuable resource, and promote this resource where possible

- Consider in its service planning and development activities, strategies to incorporate and draw on the experience and wisdom of its diverse and multicultural population
- Not limit or withhold provision of its services to any individuals or organisation on the basis of linguistic, religious, racial or ethnic background.

For the reporting period, the CEC has upheld the Ethnic Affairs Priority Statement by:

- Funding and appointing a successful candidate to a three-year PhD scholarship in indigenous health, via the Ian O'Rourke Scholarship
- Offering its services and knowledge to all people of NSW, irrespective of linguistic, religious, racial or ethnic background
- Broadening its multicultural staff base via merit-based recruitment
- Development of a Citizens Engagement Advisory Council, which links in with multicultural and indigenous agency, and identifies strategies to enable the CEC to engage effectively with its diverse community.

OUR PEOPLE (cont.)

THE CEC TEAM WORKING TOGETHER FOR THE COMMUNITY – WRAPS WITH LOVE

In a demonstration of its commitment to teamwork and involvement with the wider community, the staff of the CEC took part in the annual 'knit-in' for Wraps With Love Inc. CEC needle-twiddlers, knit-pickers and stitchers came together in June to take part in the annual charity event. Cubicle walls were soon adorned with coloured woollen squares, as hidden talents emerged in the form of creative patterns and office chatter soon turned to woolly matters. The multi-coloured rugs, each made up of 28 squares are a perfect symbol of the diversity of the healthcare workforce and illustrate the importance of teamwork in achieving quality and safety in healthcare.

OCCUPATIONAL HEALTH AND SAFETY

At 30 June 2008, the CEC had not received any workers compensation claims.

There were three reported incidents and corrective action was taken in each instance to remove the hazard.



Some of the members of the 'Clinical Knitting Commission' show their handiwork

Left to right – Lesley Harvey, Bernie Harrison, Teresa Pudo, Kay Wright, Barbara Dundas, Cliff Hughes



One clever knitter even managed to include a message from the CEC

CONFERENCE PRESENTATIONS

The following outlines conference presentations by CEC staff during the review year. It does not include professional in-services, seminars or lectures which staff also delivered.

Professor Clifford Hughes AO Chief Executive Officer

- Patient Safety Improvement Think Tank, Patient Safety Centre, Royal Brisbane & Women's Hospital, Brisbane, 13 July 2007
- Australian Lawyers Alliance Medical Law Conference 2007, Darling Harbour, Sydney, 20 July 2007
- Oral Anticoagulant Management Meeting, Hua Hin, Thailand, 23-24 July 2007
- 5th Australasian Conference on Safety and Quality in Health Care, Brisbane Convention & Exhibition Centre, 6-8 August 2007
- 55th Annual Scientific Meeting of the Cardiac Society of Australia and New Zealand, Christchurch, New Zealand, 10-11 August 2007
- HIQA International Patient Safety Conference, Dublin, Ireland, 6-7 September 2007
- Hunter New England Health RMIA Risk Management Conference – Is Managing Risk an Art or a Science? Royal Newcastle Centre, 15-16 November 2007
- Annual Scientific Meeting of the John Loewenthal Society, the University of Sydney, 21 November 2007
- IQPC Patient Safety & Quality Improvement Conference – Embedding a Culture of Safety in our Hospitals & Health Organisations, Darling Harbour, Sydney, 4-5 December 2007
- Thai Medical Excellence Centres – New Frontiers of Better Clinical Management: Is the Clinical Excellence Management... The answer? Bangkok, Thailand, 7 December 2007
- 17th Two Days in Cardiology Meeting, Phuket, Thailand, 10 December 2007
- Informa The National Prostheses Congress: Industry Growth, Challenges & Reform, Sydney, 12 December 2007
- Grand Rounds, Coffs Harbour, presentation "Sailing North! – A Passion for Excellence", 31 January 2008
- Royal Australasian College of Surgeons NSW State Committee, presentation "Keeping Patients Safe: Recognition and Management of the Deteriorating Patient", 12 February 2008
- CT CON 2008, 54th Annual Conference of the Indian Association of Cardiovascular Thoracic Surgeons, presentation "The Impact of Warfarin in the Health Care System: The Unnecessary Burdens" Pune, India, 21-24 February 2008
- Royal Prince Alfred Hospital, lecture, "The Minefield of Medical Devices – Where is it now", 4 March 2008
- Scientific Meeting of the NSW Medicolegal Society, Lyceum Theatre, Wesley Conference Centre, Presentation "Open Disclosure, Morally Right", 5 March 2008
- Performance Improvement Series – Lessons from the UK – Leadership for Transformation, The Grace Hotel, participated, 11 March 2008
- Special Commission of Inquiry, Sydney, presentation with Professor Katherine McGrath, "Major Reform in Health Service Delivery", 13 March 2008
- OBHC 2008 – Culture and Climate: Cracking the Code – Debate "No one can change culture", Presentations "Cultural and Associated Enablers of, and Barriers to, Adverse Incident Reporting", and "Derailed? The Climate and Culture of Rail and Health Care", Citigate Central Sydney Hotel, Sydney, 26-28 March 2008
- Informa Addressing the Healthcare Skills Crisis, Crowne Plaza Darling Harbour, 27-28 March 2008
- HARC Symposium – Professor Kieran Walshe, Carillon Room, Newtown, 1 April 2008
- Patient Safety Lecture – UNSW Undergraduate Students, Central Lecture Block, UNSW, "Patient Journeys, Patient Safety and Quality of Care", 22 April 2008
- ACTION on VTE Summit, Heritage Ballroom, Westin Hotel, Sydney, Professor Hughes closed the morning session at 12.40pm, 2 May 2008
- ARCBS Transfusion Update 08, Crown Conference Centre, Melbourne, 5 May 2008
- RACS Conjoint Annual Scientific Congress 2008, Hong Kong, presentations – "Open Disclosure – Is saying sorry enough?" and verbal presentation – "Bjork Shiley Convexo/Concave (BSCC) Heart Valve Crisis – 30 years later!" 10-16 May 2008
- ACSQHC Conference of Chairs and Heads of Peak Australian Safety & Quality Organisations, "Overview of the Clinical Excellence Commission", 20 May 2008
- CRE in Patient Safety Conference, Monash University – Melbourne, 23 May 2008

OUR PEOPLE (cont.)

- Council of International Hospitals Australasia Meeting, Westin Hotel, Sydney, 26 May 2008
- "Finding True North" Advisory Board – CLP Modular, Citigate Hotel, Sydney, 27 May 2008
- Patient Safety Education Project 'PSEP Safety Trainer' Conference, Pennsylvania, USA, 30 May – 1 June 2008
- Queensland Health Patient Safety Symposium, Brisbane Convention Centre, 18 June 2008
- IIR 8th Annual Adverse Event Management Conference, Melbourne, giving address and participating as a panel member, 23-24 June 2008
- AFR Conference, Melbourne, 24 June 2008

Dr Annette Pantle

Director Clinical Practice Improvement Projects

Hand Hygiene – The Challenge, The Simple Strategy, The Improvement, Royal Australian College of Nursing, Annual Conference, Sydney – 19 July 2007

RACMA CEP Group, Sydney – 2 August 2007

CPI Methodology and the Eye Emergency Manual, GMCT SOS Project, Sydney – 13 September 2007

Sorry Mate! Open Disclosure in Australia (on behalf of Prof Cliff Hughes), ISQua conference, Boston USA – 2 October 2007

Strategies for Implementing Safety and Quality Projects: An Overview, UTS Masters students presentation – 9 November 2007

CLAB-ICU, Institute for Medical Education and Training Forum – 2 May 2008

Ms Bernie Harrison

Continuous Improvement: a reality for health systems or an unachievable aspiration?, Children's Hospital Nursing and Allied Health Conference, Sydney – 29 August 2007

Quality Systems Assessment: A new initiative of the Clinical Excellence Commission for the New South Wales health system, 24th ISQua Conference, Boston – 3 October 2007

Blood Watch Program, Queensland Blood Management Program, Brisbane – 12 June 2008

Clinical Practice Improvement Workshop, IIR Adverse Events conference, Melbourne – 25-26 June 2008

OFFICIAL OVERSEAS TRAVEL BY CEC STAFF

Professor Clifford Hughes AO

Chief Executive Officer

- Patient Safety Education Program, Pittsburgh, USA 30 May – 1 June 2008

Dr Peter Kennedy

Deputy Chief Executive Officer

- Quality and Safety in Health Care, European Forum, Paris, 22-25 April 2008*
- Patient Safety Conference, London, 22-23 May 2008*
- Patient Safety Education Program, Pittsburgh, USA 29 May – 31 May 2008*

Dr Annette Pantle

Director Clinical Practice Improvement

- 24th International Conference of the International Society for Quality in Health Care, Boston, 30 September – 3 October 2007*
- World Health Organisation, World Alliance for Patient Safety, Global Patient Safety Challenge "Safe Surgery Saves Lives", Geneva 10-11 January 2008*

Ms Bernie Harrison

- AAQHC Conference, Brisbane, 6-8 August 2007
 - Quality and Safety in Health Care, European Forum, Paris, 23-25 April 2008
 - Patient Safety Education Program (PSEP), Pittsburgh, USA, 29-31 May 2008
- * Visits marked with an asterisk were funded from staff specialist TESL entitlement.

RESEARCH

In addition to having a research committee, the CEC is involved in research-related activities via its Clinical Practice Improvement (CPI) programs, information management initiatives and partnerships. Specific research-related activities in which the CEC has been involved during the reporting period are highlighted below.

Ian O'Rourke Scholarship in Patient Safety

Dr David Peiris, who was awarded the inaugural Ian O'Rourke Scholarship in Patient Safety, is midway through his three year PhD research program at the University of Sydney through the George Institute for International Health. Dr Peiris' doctoral study is entitled Improving health outcomes for Indigenous Australians at high cardiovascular risk through strategies to reduce systems barriers to quality care. His program is progressing well, with collection of data completed and preparation of manuscripts for publication underway. Achievements so far by the Ian O'Rourke Scholar include receiving the Public Health Association of Australia Early-in-Career Award at the 2008 Coalition for Research to Improve Aboriginal Health Conference and Dr Peiris has been appointed to the Royal Australian College of General Practitioners National Standing Committee for Aboriginal Health.



Mr Ivan Wellington, Board member of the Tharawal Aboriginal Corporation in Sydney and Dr David Peiris, the Ian O'Rourke Scholar.

This photograph was taken at the Budbutt Heart Clinic in Sydney and is used with the permission of The George Institute for International Health.

CHeReL

CEC is eligible, through its membership of CHeReL, to access a large percentage of its membership fees in data linkage services. The CEC, through the Board Research Committee, is making these services available to the NSW health system for research projects on healthcare safety and quality that require linked data.

Membership of Advisory Board

The CEC is a member of the International Advisory Board. CEC staff attended the 2008 annual meeting for hospital executives forum in Sydney on 27 May 2008, where the topic was 'Dispelling Leadership Myths – Targeting Engagement and Accountability of Staff and Clinicians'. Advisory Board staff also delivered a workshop for the Clinical Leadership Program (modular), entitled 'Finding True North'.

TEACHING AND TRAINING INITIATIVES

The CEC is committed to professional development of its staff. Sharing knowledge on safety and quality initiatives from around the world is fundamental to the work of the CEC. In response to this need, a development program provides regular professional development opportunities and a forum for sharing information and knowledge.

Internal professional development courses and workshops have been held in the CEC – including presentations / workshops by CEC staff, journal club and external consultants. Topic areas have included:

- CIAP training
- Advisory Board Company international meeting
- Quality and Safety Risk management
- Aviation Safety
- Productive ward NHS
- Simulation training in patient safety
- CHASM
- Clinical services redesign program

Staff also benefited from attendance at a range of local, national and international conferences relating to quality and safety. Topic areas have included:

- Aboriginal Health & Research conference
- National Red Cell Utilisation data
- ACHSE National Conference
- Emotional Intelligence workshop
- Adverse Events conference
- Helen Bevan workshops – Leadership for transformation; The Productive Leader; Productive Ward
- Developing a valid questionnaire for health

International

- International Forum on Quality and Safety in Health Care – Paris (Prof Cliff Hughes, Dr Peter Kennedy, Bernie Harrison)
- Patient Safety Education Program – Pittsburgh (Prof Cliff Hughes, Dr Peter Kennedy, Bernie Harrison)

OUR COMMUNITY

CITIZENS ENGAGEMENT ADVISORY COUNCIL

The role of the Citizens Engagement Advisory Council is outlined in more detail in an earlier section of this report. In summary, it is designed to:

- Engage the community in a meaningful dialogue about safety and quality
- Ensure that the views of the community about the safety and quality of health services are heard by the CEC
- Ensure that the views of the community usefully inform the work of the CEC and any changes or redesign of the system that flow from it.

The model complements existing links the CEC has with the Statewide Health Care Advisory Council, which is attended by the chairman of the CEC board and which provides a valuable link between the CEC and Area Health Care Advisory Councils.

SPONSORSHIP

The CEC provided sponsorship and hosted an information stand at the 8th International Aviation Psychology Association Symposium Human Factors in Health Care held in Sydney on 11 April 2008.

FREEDOM OF INFORMATION (FOI) REPORT

During the 2007-08 financial year the Clinical Excellence Commission received four requests for information under the *Freedom of Information Act 1989* (FOI), compared with nil for the 2006-2007 financial year.

The CEC completed three FOI applications during 2007-08 financial year, with one carried forward to the next reporting period.

Three applications required consultation with parties outside the CEC. No Ministerial certificates were issued within the reporting period.

FOI fees received in the 2007-2008 financial year amounted to \$120.00.

FINANCIAL REPORTS

Financial Overview

For the year ended 30 June 2008

The audited financial statements presented for the Clinical Excellence Commission for the 2007-2008 financial year provide for a Net Cost of Services budget of \$10,831 million, against which the audited actual of \$7,350 million represents a variation of \$3,481 million, or 32%.

Activity has increased during this financial year and has resulted in higher expenditure than in previous years. However, the actual result was better than budget expectations due to lower than expected projected costs throughout the year. This was mainly due to several projects that were budgeted for the full year but which did not begin until the latter part of the financial year. These projects will continue into the next financial year. The result also reflects a higher than expected actual revenue which has contributed to a lower Net Cost of Services result.

In achieving the above result, the Clinical Excellence Commission is satisfied that it has operated within the level of government cash payments and managed its operating costs to the budget available. It has also ensured that no general creditors exist at the end of the month in excess of levels agreed with the NSW Department of Health.

Comparisons of actual performance with the preceding twelve months is provided in the following table:

	2006-2007 \$000	2007-2008 \$000	Comparison \$000	Movement %
EXPENSES EXCLUDING LOSSES				
Employee Related	3,917	3,735	(182)	5
Other Operating Expenses	2,257	3,104	847	38
Depreciation and Amortisation	90	671	581	100+
Grants and Subsidies	157	85	(72)	46
Total Expenses	6,421	7,595	1,174	18
Sale of Goods and Services	36	151	115	100+
Investment Income	34	48	14	41
Grants and Contributions	495	55	(440)	89
Total Revenue	565	254	(311)	55
Gain/(Loss) on Disposal	0	(9)	(9)	100
Net Cost of Services	5,856	7,350	1,494	26

Certification of Financial Statement Parent/Consolidated

For the year ended 30 June 2008

Certification of Parent/Consolidated Financial Statements For the Period Ended 30 June 2008

The attached financial statements of the Clinical Excellence Commission for the year ended 30 June 2008:

- i) Have been prepared in accordance with the requirements of applicable Australian Accounting Standards which include Australian equivalents to International Financial Reporting Standards (AEIFRS), the requirements of the *Public Finance and Audit Act 1983* and its regulations, the *Health Services Act 1997* and its regulations, the *Accounts and Audit Determination* and the *Accounting Manual for Area Health Services and Public Hospitals*;
- ii) Present fairly the financial position and transactions of the Clinical Excellence Commission;
- iii) Have no circumstances which would render any particulars in the financial statements to be misleading or inaccurate;

Professor Bruce Barracough, AO
Chairman

14 October 2008

Professor Clifford Hughes, AO
Chief Executive Officer

14 October 2008

Mr Andre Jenkins
A/Director, Corporate Services

14 October 2008

Independent Audit Report

For the year ended 30 June 2008



GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

CLINICAL EXCELLENCE COMMISSION AND ITS CONTROLLED ENTITY

To Members of the New South Wales Parliament

I have audited the accompanying financial report of the Clinical Excellence Commission (the Commission) and the Commission and its controlled entity (the consolidated entity), which comprises the balance sheet as at 30 June 2008, and the operating statement, statement of recognised income and expense, cash flow statement, and a summary of significant accounting policies and other explanatory notes. The consolidated entity comprises the Commission and the entities it controlled at the year's end or from time to time during the financial year.

Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Commission and the consolidated entity as at 30 June 2008, and of their financial performance and their cash flows for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2005

The Chief Executive's Responsibility for the Financial Report

The Chief Executive is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the PF&A Act. This responsibility includes establishing and maintaining internal control relevant to the preparation and fair presentation of the financial report that is free from material misstatement whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on my audit. I conducted my audit in accordance with Australian Auditing Standards. These Auditing Standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Chief Executive, as well as evaluating the overall presentation of the financial report.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

My opinion does not provide assurance:

- about the future viability of the Commission or consolidated entity,
- that they have carried out their activities effectively, efficiently and economically,
- about the effectiveness of their internal controls, or
- on the assumptions used in formulating the budget figures disclosed in the financial report.

Independence

In conducting this audit, the Audit Office of New South Wales has complied with the independence requirements of the Australian Auditing Standards and other relevant ethical requirements. The PF&A Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General, and
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their role by the possibility of losing clients or income.



Jack Kheir BEc, FCPA
Director, Financial Audit Services

15 October 2008
SYDNEY

Operating Statement

For the year ended 30 June 2008

		PARENT			CONSOLIDATION		
		Actual 2008 \$000	Budget 2008 \$000		Actual 2008 \$000	Actual 2008 \$000	Actual 2007 \$000
Notes							
EXPENSES EXCLUDING LOSSES							
Operating Expenses							
Employee Related	3	0	4,663	0	3,735	4,663	3,917
Personnel Services	4	3,735	0	3,917	0	0	0
Other Operating Expenses	5	3,104	5,315	2,257	3,104	5,315	2,257
Depreciation and Amortisation	2(h), 6	671	803	90	671	803	90
Grants and Subsidies	7	85	50	157	85	50	157
Total Expenses excluding losses		7,595	10,831	6,421	7,595	10,831	6,421
REVENUE							
Sale of Goods and Services	8	151	0	36	151	0	36
Investment Revenue	9	48	0	34	48	0	34
Grants and Contributions	10	55	0	550	55	0	495
Total Revenue		254	0	620	254	0	565
Gain/(Loss) on Disposal	11	(9)	0	0	(9)	0	0
Net Cost of Services	21	7,350	10,831	5,801	7,350	10,831	5,856
GOVERNMENT CONTRIBUTIONS							
NSW Health Department Recurrent Allocations	2(d)	10,131	10,131	7,870	10,131	10,131	7,870
Acceptance by the Crown Entity of employee benefits	2(a)(ii)	56	57	0	56	57	55
Total Government Contributions		10,187	10,188	7,870	10,187	10,188	7,925
Result for the year		2,837	(643)	2,069	2,837	(643)	2,069

The accompanying notes form part of these Financial Statements.

Statement of Recognised Income and Expense

For the year ended 30 June 2008

		PARENT		Actual 2007 \$000	CONSOLIDATION		Actual 2007 \$000
		Actual 2008 \$000	Budget 2008 \$000		Actual 2008 \$000	Actual 2008 \$000	
Notes							
TOTAL INCOME AND EXPENSE RECOGNISED DIRECTLY IN EQUITY		0	0	0	0	0	0
Result for the Year	18	2,837	(643)	2,069	2,837	(643)	2,069
TOTAL INCOME AND EXPENSE RECOGNISED FOR THE YEAR		2,837	(643)	2,069	2,837	(643)	2,069

The accompanying notes form part of these Financial Statements.

Balance Sheet

As at 30 June 2008

		PARENT		Actual 2007 \$000	CONSOLIDATION		Actual 2007 \$000
		Actual 2008 \$000	Budget 2008 \$000		Actual 2008 \$000	Actual 2008 \$000	
Notes							
ASSETS							
Current Assets							
Cash and Cash Equivalents	12	4,498	438	438	4,498	438	438
Receivables	13	419	1,102	1,101	419	1,102	1,101
Total Current Assets		4,917	1,540	1,539	4,917	1,540	1,539
Non-Current Assets							
Plant and Equipment	14	604	698	699	604	698	699
Intangible Assets	15	1,747	1,680	2,323	1,747	1,680	2,323
Total Non-Current Assets		2,351	2,378	3,022	2,351	2,378	3,022
Total Assets		7,268	3,918	4,561	7,268	3,918	4,561
LIABILITIES							
Current Liabilities							
Payables	16	97	372	371	97	372	371
Provisions	17	755	596	597	755	596	597
Total Current Liabilities		852	968	968	852	968	968
Non-Current Liabilities							
Provisions	17	52	66	66	52	66	66
Total Non-Current Liabilities		52	66	66	52	66	66
Total Liabilities		904	1,034	1,034	904	1,034	1,034
Net Assets		6,364	2,884	3,527	6,364	2,884	3,527
EQUITY							
Accumulated Funds	18	6,364	2,884	3,527	6,364	2,884	3,527
Total Equity		6,364	2,884	3,527	6,364	2,884	3,527

The accompanying notes form part of these Financial Statements.

Cash Flow Statement

For the year ended 30 June 2008

	Notes	PARENT		CONSOLIDATION			
		Actual	Budget	Actual	Actual	Actual	Actual
		2008	2008	2007	2008	2008	2007
		\$000	\$000	\$000	\$000	\$000	\$000
CASH FLOWS FROM OPERATING ACTIVITIES							
Payments							
Employee Related		0	(4,606)	0	(3,535)	(4,606)	(3,873)
Other Operating Expenses		(6,873)	(5,315)	(5,849)	(3,338)	(5,315)	(1,976)
Grants and Subsidies		(85)	(50)	(157)	(85)	(50)	(157)
Total Payments		(6,958)	(9,971)	(6,006)	(6,958)	(9,971)	(6,006)
Receipts							
Sale of Goods and Services		793	0	(360)	793	0	(360)
Interest Received		48	0	34	48	0	34
Grants and Contributions		55	0	495	55	0	495
Total Receipts		896	0	169	896	0	169
Cash Flows From Government							
NSW Health Department Recurrent Allocations		10,131	10,131	7,870	10,131	10,131	7,870
Net Cash Flows from Government		10,131	10,131	7,870	10,131	10,131	7,870
Net Cash Flows from Operating Activities	21	4,069	160	2,033	4,069	160	2,033
CASH FLOWS FROM INVESTING ACTIVITIES							
Purchases of Land and Buildings, Plant and Equipment, Infrastructure Systems and Intangible Assets		(9)	0	(1,728)	(9)	0	(1,728)
Net Cash Flows from Investing Activities		(9)	0	(1,728)	(9)	0	(1,728)
CASH FLOWS FROM FINANCING ACTIVITIES							
Proceeds from Borrowings and Advances		0	0	0	0	0	0
Net Cash Flows from Financing Activities		0	0	0	0	0	0
Net increase/(decrease) in cash		4,060	160	305	4,060	160	305
Opening Cash and Cash Equivalents		438	438	133	438	438	133
CLOSING CASH AND CASH EQUIVALENTS	12	4,498	598	438	4,498	598	438

Notes to and forming part of the Financial Statements

For the year ended 30 June 2008

1. THE CLINICAL EXCELLENCE COMMISSION

The Institute for Clinical Excellence (ICE) was established on 5 December 2001 by the Health Services Amendment (Institute for Clinical Excellence) Order 2001. The Order established the Institute for Clinical Excellence as a statutory health corporation under Schedule 2 of the Health Services Act 1997. The Institute for Clinical Excellence's name change to Clinical Excellence Commission (CEC) was effected on 20th August 2004, in accordance with Amendment No. 154 to the Health Services Act 1997.

The mission of the Clinical Excellence Commission is to build confidence in healthcare in NSW by making it demonstrably better and safer for patients and a more rewarding workplace. The CEC will be the publicly respected voice providing the people of NSW with assurance of improvement in the safety and quality of health care.

With effect from 17 March 2006 fundamental changes to the employment arrangements of the Clinical Excellence Commission were made through amendment to the Public Sector Employment and Management Act 2002 and other Acts including the Health Services Act 1997.

The status of the previous employees of the Clinical Excellence Commission changed from that date. They are now employees of the Government of New South Wales in the service of the Crown rather than employees of the Clinical Excellence Commission. Employees of the Government are employed in Divisions of the Government Service.

In accordance with Accounting Standards these Divisions are regarded as special purpose entities that must be consolidated with the financial report of the Clinical Excellence Commission. This is because the Division was established to provide personnel services to enable the Clinical Excellence Commission to exercise its functions.

As a consequence the values in the annual financial statements presented herein consist of the Clinical Excellence Commission (as the parent entity), the financial report of the special purpose entity Division and the consolidated financial report for the economic entity. Notes have been extended to capture both the Parent and Consolidated values with Notes 3, 4, 10, 17 and 22 being especially relevant.

In the process of preparing the consolidated financial statements for the economic entity consisting of the controlling and controlled entities, all inter-entity transactions and balances have been eliminated.

The Clinical Excellence Commission is consolidated as part of the NSW Total State Sector Accounts. The Clinical Excellence Commission is a not-for-profit entity as profit is not its principal objective.

These financial statements have been authorised for issue by the Chief Executive Officer on 14 October 2008.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The Clinical Excellence Commission's Financial Statements are a general purpose financial report which has been prepared in accordance with applicable Australian Accounting Standards, (which include Australian equivalents to International Financial Reporting Standards (AIFRS)), the requirements of the Health Services Act 1997 and its regulations including observation of the Accounts and Audit Determination for Area Health Services and Public Hospitals.

Property, plant and equipment, investment property and assets held for trading and available for sale are measured at fair value. Other financial statement items are prepared in accordance with the historical cost convention.

All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

Judgements, key assumptions and estimations made by management are disclosed in the relevant notes to the financial report.

Comparative figures are, where appropriate, reclassified to give a meaningful comparison with the current year.

No new or revised accounting standards or interpretations are adopted earlier than their prescribed date of application. Set out below are changes to be effected, their date of application and the possible impact on the financial report of the Clinical Excellence Commission.

Standards/Interpretation	Operative Date	Comment
AASB3, AASB127 & AASB2008-3, Business Combinations	1 July 2009	The changes address business combinations and the Australian Accounting Standards Board has indicated that it is yet to consider its suitability for combinations among not-for-profit entities.
AASB8 & AASB2007-3, Operating Segments	1 July 2009	The changes do not apply to not-for-profit entities and have no application within NSW Health.
AASB101 & AASB2007-8, Presentation of Financial Statements	1 July 2009	Health agencies are currently required to present a statement of recognised income and expense and no variation is expected.
AASB123 & AASB2007-6, Borrowing Costs	1 July 2009	Borrowing costs that are directly attributable to the acquisition, construction or production of a qualifying asset form part of the cost of that asset. As Health Service borrowings are restricted to the Sustainable Energy Development Authority negligible impact is expected.
AASB1004, Contributions	1 July 2008	The requirements on contributions from AASB27, 29 and 31 have been relocated, substantially unamended in AASB4.
AASB1049, Whole of Government and General Government Sector Financial Reporting	1 July 2008	The standard aims to provide the harmonisation of Government Finance Statistics and Generally Accepted Accounting Principles (GAAP) reporting. The impact of changes will be considered in conjunction with the reporting requirements of the Financial Reporting Code for Budget Dependent General Government Sector Agencies.
AASB1050 regarding administered items	1 July 2008	The requirements of AAS29 have been relocated, substantially unamended and are not expected to have material effect on Health entities.
AASB1051 regarding land under roads	1 July 2008	The standard will require the disclosure of 'accounting policy for land under roads'. It is expected that all such assets will need to be recognised 'at fair value'. The standard will have negligible impact on Health entities.
AASB1052 regarding disaggregated disclosures	1 July 2008	The standard requires disclosure of financial information about Service costs and achievements. Like other standards not yet effective the requirements have been relocated from AAS29 largely unamended.
AASB2007-9 regarding amendments arising from the review of AAS27, AAS29 and AAS31	1 July 2008	The changes made are aimed at removing the uncertainties that previously existed over cross references to other Australian Accounting Standards and the override provisions in AAS29.
AAS2008-1, Share Based Payments	1 July 2008	The standard will not have application to health entities under the control of the NSW Department of Health.
AASB2008-2 regarding puttable financial instruments	1 July 2008	The standard introduces an exception to the definition of financial liability to classify as equity instruments certain puttable financial instruments and certain instruments that impose on an entity an obligation to deliver to another party a pro-rata share of the net assets of the entity only on liquidation. Nil impact is anticipated.

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

Other significant accounting policies used in the preparation of these financial statements are as follows:

a) Employee Benefits and Other Provisions

i) Salaries & Wages, Annual Leave, Sick Leave and On Costs

At the consolidated level of reporting liabilities for salaries and wages (including non monetary benefits), annual leave and paid sick leave that fall wholly within 12 months of the reporting date are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

All Annual Leave employee benefits are reported as 'Current' as there is an unconditional right to payment. Current liabilities are then further classified as 'Short Term' or 'Long Term' based on past trends and known resignations and retirements. Anticipated payments to be made in the next twelve months are reported as 'Short Term'. On costs of 17% are applied to the value of leave payable at 30 June 2008, such on costs being consistent with actuarial assessment (Comparable on costs for 30 June 2007 were 21.7% which in addition to the 17% increase also included the impact of awards immediately payable at 30 June 2007).

Unused non-vesting sick leave does not give rise to a liability as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued in the future.

The outstanding amounts of workers' compensation insurance premiums and fringe benefits which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

ii) Long Service Leave and Superannuation

At the consolidated level of reporting Long Service Leave employee leave entitlements are dissected as 'Current' if there is an unconditional right to payment and 'Non Current' if the entitlements are conditional. Current entitlements are further dissected between 'Short Term' and 'Long Term' on the basis of anticipated payments for the next twelve months. This in turn is based on past trends and known resignations and retirements.

Long Service Leave provisions are measured on a short hand basis at an escalated rate of 8.1% (also 8.1% at 30 June 2007) for all employees with five or more years of service. Actuarial assessment has found that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

The Clinical Excellence Commission's liability for the closed superannuation pool schemes (State Authorities Superannuation Scheme and State Superannuation Scheme) is assumed by the Crown Entity. The Clinical Excellence Commission accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as 'Acceptance by the Crown Entity of Employee Benefits'. Any liability attached to Superannuation Guarantee Charge cover is reported in Note 16 'Payables'.

The superannuation expense for the financial year is determined by using the formulae specified by the NSW Department of Health. The expense for certain superannuation schemes (ie Basic Benefit and First State Super) is calculated as a percentage of the employees' salary. For other superannuation schemes (ie State Superannuation Scheme and State Authorities Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

iii) Other Provisions

Other provisions exist when: the Clinical Excellence Commission has a present legal or constructive obligation as a result of a past event; it is probable that an outflow of resources will be required to settle the obligation; and a reliable estimate can be made of the amount of the obligation.

These provisions are recognised when it is probable that a future sacrifice of economic benefits will be required and the amount can be measured reliably.

b) Insurance

The Clinical Excellence Commission's insurance activities are conducted through the NSW Treasury Managed Fund Scheme of self insurance for Government Agencies. The expense (premium) is determined by the Fund Manager based on past experience.

c) Finance Costs

Finance costs are recognised as expenses in the period in which they are incurred.

d) Income Recognition

Income is measured at the fair value of the consideration or contribution received or receivable. Additional comments regarding the accounting policies for the recognition of revenue are discussed below.

Sale of Goods and Services

Revenue from the sale of goods and services comprises revenue from the provision of products or services, ie user charges. User charges are recognised as revenue when the service is provided or by reference to the stage of completion.

Investment Revenue

Interest revenue is recognised using the effective interest method as set out in AASB139, 'Financial Instruments: Recognition and measurement'. Rental revenue is recognised in accordance with AASB117 'Leases' on a straight line basis over the lease term. Dividend revenue is recognised in accordance with AASB118 'Revenue' when the Health Service's right to receive payment is established.

Debt Forgiveness

Debts are accounted for as extinguished when and only when settlement occurs through repayment or replacement by another liability.

Grants and Contributions

Grants and Contributions are generally recognised as revenues when the Health Service obtains control over the assets comprising the contributions. Control over contributions is normally obtained upon the receipt of cash.

NSW Department of Health Allocations

Payments are made by the NSW Department of Health on the basis of the allocation for the Clinical Excellence Commission as adjusted for approved supplementations mostly for salary agreements, patient flows between Health Services and approved enhancement projects. This allocation is included in the Operating Statement before arriving at the 'Result for the Year' on the basis that the allocation is earned in return for the health services provided on behalf of the Department. Allocations are normally recognised upon the receipt of Cash.

e) Accounting for the Goods & Services Tax (GST)

Revenues, expenses, assets and liabilities are recognised net of the amount of GST. The Clinical Excellence Commission is registered as part of the South Eastern Sydney and Illawarra Area Health Service Group for GST purposes.

f) Acquisition of Assets

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by the Clinical Excellence Commission. Cost is the amount of cash or cash equivalents paid or the fair value of the other consideration given to acquire the asset at the time of its acquisition or construction or, where applicable, the amount attributed to that asset when initially recognised in accordance with the specific requirements of other Australian Accounting Standards.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition except for assets transferred as a result of an administrative restructure. (Note 2(z) refers)

Fair value means the amount for which an asset could be exchanged between knowledgeable, willing parties in an arm's length transaction.

Where settlement of any part of cash consideration is deferred beyond normal credit terms, its cost is the cash price equivalent, i.e. the deferred payment amount is effectively discounted at an asset-specific rate.

Land and Buildings which are owned by the Health Administration Corporation or the State and administered by the Health Service are deemed to be controlled by the Health Service and are reflected as such in the financial statements.

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

g) Plant & Equipment and Infrastructure Systems

Individual items of property, plant & equipment are capitalised where their cost is \$10,000 or above.

'Infrastructure Systems' means assets that comprise public facilities and which provide essential services and enhance the productive capacity of the economy including roads, bridges, water infrastructure and distribution works, sewerage treatment plants, seawalls and water reticulation systems.

h) Depreciation

Depreciation is provided for on a straight line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life to the Clinical Excellence Commission. Land is not a depreciable asset.

Details of depreciation rates initially applied for major asset categories are as follows:

Buildings	2.5%
Electro Medical Equipment	
– Costing less than \$200,000	10.0%
– Costing more than or equal to \$200,000	12.5%
Computer equipment	20.0%
Infrastructure Systems	2.5%
Motor Vehicle Sedans	12.5%
Motor Vehicles, Trucks & Vans	20.0%
Office Equipment	10.0%
Plant and Machinery	10.0%
Line	25.0%
Furniture, Fittings and Furnishings	5.0%

Depreciation rates are subsequently varied where changes occur in the assessment of the remaining useful life of the assets reported.

i) Revaluation of Non Current Assets

Non-specialised assets with short useful lives are measured at depreciated historical cost, as a surrogate for fair value.

j) Impairment of Property, Plant and Equipment

As a not-for-profit entity with no cash generating units, the Clinical Excellence Commission is effectively exempt from AASB 136 "Impairment of Assets" and impairment testing. This is because AASB136 modifies the recoverable amount test to the higher of fair value less costs to sell and depreciated replacement cost. This means that, for an asset already measured at fair value, impairment can only arise if selling costs are regarded as material. Selling costs are regarded as immaterial.

k) Intangible Assets

The Clinical Excellence Commission recognises intangible assets only if it is probable that future economic benefits will flow to the Health Service and the cost of the asset can be measured reliably. Intangible assets are measured initially at cost. Where an asset is acquired at no or nominal cost, the cost is its fair value as at the date of acquisition. All research costs are expensed. Development costs are capitalised only when certain criteria are met.

The useful lives of intangible assets are assessed to be finite. Intangible assets are subsequently measured at fair value only if there is an active market. As there is no active market for the Clinical Excellence Commission's intangible assets, the assets are carried at cost less any accumulated amortisation. The Clinical Excellence Commission's intangible assets are amortised using the straight line method over a period of 7 years. In general, intangible assets are tested for impairment where an indicator of impairment exists. However, as a not-for-profit entity the Clinical Excellence Commission is effectively exempted from impairment testing (see Note 2[j]).

l) Maintenance

The costs of maintenance are charged as expenses as incurred, except where they relate to the replacement of a component of an asset in which case the costs are capitalised and depreciated.

m) Leased Assets

A distinction is made between finance leases which effectively transfer from the lessor to the lessee substantially all the risks and benefits incidental to ownership of the leased assets, and operating leases under which the lessor effectively retains all such risks and benefits.

Where a non-current asset is acquired by means of a finance lease, the asset is recognised at its fair value at the commencement of the lease term. The corresponding liability is established at the same amount. Lease payments are allocated between the principal component and the interest expense.

Operating lease payments are charged to the Operating Statement in the periods in which they are incurred.

n) Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the operating statement when impaired, derecognised or through the amortisation process.

Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

o) Impairment of financial assets

All financial assets, except those measured at fair value through profit and loss, are subject to an annual review for impairment. An allowance for impairment is established when there is objective evidence that the entity will not be able to collect all amounts due.

For financial assets carried at amortised cost, the amount of the allowance is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. The amount of the impairment loss is recognised in the operating statement.

When an available for sale financial asset is impaired, the amount of the cumulative loss is removed from equity and recognised in the operating statement, based on the difference between the acquisition cost (net of any principal repayment and amortisation) and current fair value, less any impairment loss previously recognised in the operating statement.

Any reversals of impairment losses are reversed through the operating statement, where there is objective evidence, except reversals of impairment losses on an investment in an equity instrument classified as 'available for sale' must be made through the reserve. Reversals of impairment losses of financial assets carried at amortised cost cannot result in a carrying amount that exceeds what the carrying amount would have been had there not been an impairment loss.

p) De-recognition of financial assets and financial liabilities

A financial asset is derecognised when the contractual rights to the cash flows from the financial assets expire; or if the agency transfers the financial asset:

- where substantially all the risks and rewards have been transferred; or
- where the Health Service has not transferred substantially all the risks and rewards, if the entity has not retained control.

Where the Health Service has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Health Service's continuing involvement in the asset.

A financial liability is derecognised when the obligation specified in the contract is discharged or cancelled or expires.

q) Payables

These amounts represent liabilities for goods and services provided to the Clinical Excellence Commission and other amounts. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short-term payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

Payables are recognised for amounts to be paid in the future for goods and services received, whether or not billed to the Clinical Excellence Commission.

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

t) Budgeted Amounts

The budgeted amounts are drawn from the budgets agreed with the NSW Health Department at the beginning of the financial reporting period and with any adjustments for the effects of additional supplementation provided.

u) Program Statement

The Clinical Excellence Commission only operates under one program, that program being 6.1 Teaching & Research (see below). A separate program statement is, therefore, not required.

Program 6.1 Teaching & Research

To develop the skills and knowledge of the health workforce to support patient care and population health. To extend knowledge through scientific enquiry and applied research aimed at improving the health and well being of people of New South Wales.

r) Borrowings

Loans are not held for trading or designated at fair value through profit or loss and are recognised at amortised cost using the effective interest rate method. Gains or losses are recognised in the operating statement on derecognition.

The finance lease liability is determined in accordance with AASB 117 Leases.

s) Equity Transfers

The transfer of net assets between agencies as a result of an administrative restructure, transfers of programs/functions and parts thereof between NSW public sector agencies is designated as a contribution by owners and is recognised as an adjustment to 'Accumulated Funds'.

Transfers arising from an administrative restructure between Health Services/Government Departments are recognised at the amount at which the asset was recognised by the transferor Health Service/Government Department immediately prior to the restructure. In most instances this will approximate fair value. All other equity transfers are recognised at fair value.

The Statement of Recognised Income and Expense does not reflect the Net Assets or change in equity in accordance with AASB 101 Clause 97.

	PARENT		CONSOLIDATION	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
3. EMPLOYEE RELATED				
Employee related expenses comprise the following:				
Salaries and Wages	0	0	2,790	3,234
Superannuation [see note 2(a)] – defined benefit plans	0	0	56	55
Superannuation [see note 2(a)] – defined contributions	0	0	190	187
Long Service Leave [see note 2(a)]	0	0	192	90
Annual Leave [see note 2(a)]	0	0	344	281
Sick Leave and Other Leave	0	0	133	58
Workers Compensation Insurance	0	0	14	12
Fringe Benefits Tax	0	0	16	0
	0	0	3,735	3,917
4. PERSONNEL SERVICES				
Personnel Services comprise the purchase of the following:				
Salaries and Wages	2,790	3,234	0	0
Awards	0	0	0	0
Superannuation [see note 2(a)] – defined benefit plans	56	55	0	0
Superannuation [see note 2(a)] – defined contributions	190	187	0	0
Long Service Leave [see note 2(a)]	192	90	0	0
Annual Leave [see note 2(a)]	344	281	0	0
Sick Leave and Other Leave	133	58	0	0
Nursing Agency Payments	0	0	0	0
Other Agency Payments	0	0	0	0
Redundancies	0	0	0	0
Workers Compensation Insurance	14	12	0	0
Fringe Benefits Tax	16	0	0	0
	3,735	3,917	0	0

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

	PARENT		CONSOLIDATION	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
5. OTHER OPERATING EXPENSES				
Domestic Supplies and Services	9	5	9	5
Food Supplies	12	17	12	17
Fuel, Light and Power	7	1	7	1
General Expenses (See (a) below)	1,960	1,009	1,960	1,009
Information Management Expenses	236	147	236	147
Insurance	0	1	0	1
Maintenance Contracts	5	4	5	4
New/Replacement Equipment under \$10,000	9	64	9	64
Repairs	1	2	1	2
Maintenance/Non Contract	0	0	0	0
Other	0	1	0	1
Postal and Telephone Costs	56	36	56	36
Printing and Stationery	147	178	147	178
Rates and Charges	1	1	1	1
Rental	296	244	296	244
Special Service Departments	21	18	21	18
Staff Related Costs	90	201	90	201
Travel Related Costs	254	328	254	328
	3,104	2,257	3,104	2,257

	PARENT		CONSOLIDATION	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
(a) General Expenses include:				
Advertising	13	11	13	11
Audio, Visual	31	2	31	2
Books, Magazines and Journals	4	16	4	16
Consultancies	813	298	813	298
Courier and Freight	2	1	2	1
Sitting Allowance Committee Membership Fees	4	0	4	0
Auditor's Remuneration – Audit of financial reports	15	18	15	18
Auditor's Remuneration – Other Services	42	0	42	0
Legal Services	57	107	57	107
Membership/Professional Fees	150	127	150	127
Other Operating Lease Expense – minimum lease payments	0	1	0	1
Translator Services	0	1	0	1
Project Payments:				
Transfusion Medicine Improvement Program	53	2	53	2
Clinical Council	0	2	0	2
CEC Administration and Program Development	0	21	0	21
Clinical Practice Improvement Projects	0	7	0	7
Information Management	12	22	12	22
Quality System Assessment	9	154	9	154
Safety Improvement Program	20	1	20	1
Short Term Projects	0	84	0	84
Clinical Leadership Program	683	117	683	117
Other	52	17	52	17
	1,960	1,009	1,960	1,009
(b) Maintenance				
Reconciliation Total Maintenance				
Maintenance (non employee Maintenance expense – contracted labour and other related), included in Note 5	15	71	15	71
Total maintenance expenses included in Notes 3, 4 and 5	15	71	15	71

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

	PARENT		CONSOLIDATION	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
6. DEPRECIATION AND AMORTISATION				
Depreciation – Plant and Equipment	95	23	95	23
Amortisation – Intangible Assets	576	67	576	67
	671	90	671	90
7. GRANTS AND SUBSIDIES				
Research Organisations	50	0	50	0
Safer System Saving Lives Program	0	140	0	140
Ian O'Rourke Scholarship Fund (University of Sydney)	35	17	35	17
	85	157	85	157
8. SALE OF GOODS AND SERVICES				
Rendering of Services comprise the following:				
Commercial Activities	(4)	32	(4)	32
Other	155	4	155	4
	151	36	151	36
9. INVESTMENT REVENUE				
Interest	48	34	48	34
	48	34	48	34
10. GRANTS AND CONTRIBUTIONS				
NSW Government grants	55	495	55	495
Personnel Services – Superannuation Defined Benefits	0	55	0	0
	55	550	55	495

	PARENT		CONSOLIDATION	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
11. GAIN/(LOSS) ON DISPOSAL				
Property Plant and Equipment	34	0	34	0
Less Accumulated Depreciation	0	0	0	0
Written Down Value	34	0	34	0
Less Proceeds from Disposal	25	0	25	0
Gain/(Loss) on Disposal of Property Plant and Equipment	(9)	0	(9)	0
Total Gain/(Loss) on Disposal	(9)	0	(9)	0
12. CASH & CASH EQUIVALENT ASSETS				
Cash at bank and on hand	4,498	438	4,498	438
	4,498	438	4,498	438
Cash & cash equivalent assets recognised in the Balance Sheet are reconciled to cash at the end of the financial year as shown in the Cash Flow Statement as follows:				
Cash and cash equivalents (per Balance Sheet)	4,498	438	4,498	438
Closing Cash and Cash Equivalents (per Cash Flow Statement)	4,498	438	4,498	438
13. RECEIVABLES				
Current				
(a) Sale of Goods and Services:				
NSW Health Department	37	0	37	0
Debtors Intra Health	373	1,040	373	1,040
Other Debtors	3	15	3	15
Sub Total	413	1,055	413	1,055
Prepayments	6	46	6	46
Total	419	1,101	419	1,101

Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired are disclosed in Note 24.

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

	PARENT		CONSOLIDATION	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
14. PLANT AND EQUIPMENT				
Plant and Equipment				
At Fair Value	722	754	722	754
Less Accumulated depreciation and impairment	(118)	(55)	(118)	(55)
Net Carrying Amount	604	699	604	699
Total Plant and Equipment At Net Carrying Amount	604	699	604	699

	PLANT AND EQUIPMENT	TOTAL
	\$000	\$000
PARENT AND CONSOLIDATION		
Plant and Equipment – Reconciliations		
2008		
Carrying amount at start of year	699	699
Additions	34	34
Disposals	(34)	(34)
Depreciation expense	(95)	(95)
Carrying amount at end of year	604	604
2007		
Carrying amount at start of year	676	676
Additions	46	46
Depreciation expense	(23)	(23)
Carrying amount at end of year	699	699

Above categories and transaction type should be deleted if not applicable.

	PARENT		CONSOLIDATION	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
15. INTANGIBLE ASSETS				
Software				
Cost (Gross Carrying Amount)	2,390	2,390	2,390	2,390
Less Accumulated Amortisation and Impairment	(643)	(67)	(643)	(67)
Net Carrying Amount	1,747	2,323	1,747	2,323
Total Intangible Assets At Net Carrying Amount	1,747	2,323	1,747	2,323

PARENT AND CONSOLIDATION	SOFTWARE	TOTAL
	\$000	\$000
Intangibles – Reconciliations		
2008		
Carrying amount at start of year	2,323	2,323
Additions (from internal development or acquired separately)	0	0
Amortisation (recognised in depreciation and amortisation)	(576)	(576)
Net Carrying amount at end of year	1,747	1,747
2007		
Net Carrying amount at start of year	708	708
Additions (from internal development or acquired separately)	1,682	1,682
Amortisation (recognised in depreciation and amortisation)	(67)	(67)
Net Carrying amount at end of year	2,323	2,323

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

	PARENT		CONSOLIDATION	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
16. PAYABLES				
Current				
Accrued Salaries and Wages	0	0	5	40
Accrued Liability – Purchase of Personnel Services	5	40	0	0
Trade Creditors	92	326	92	326
Other Creditors	0	5	0	5
	97	371	97	371

Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired are disclosed in Note 24.

17. PROVISIONS

Current Employee benefits and related on-costs

Employee Annual Leave – Short Term Benefit	0	0	212	85
Employee Annual Leave – Long Term Benefit	0	0	157	71
Employee Long Service Leave – Short Term Benefit	0	0	92	95
Employee Long Service Leave – Long Term Benefit	0	0	294	346
Provision for Personnel Services Liability	755	597	0	0
Total Current Provisions	755	597	755	597

Non-Current Employee benefits and related on-costs

Employee Long Service Leave – Conditional	0	0	52	66
Provision for Personnel Services Liability	52	66	0	0
Total Non Current Provisions	52	66	52	66

Aggregate Employee Benefits and Related On-costs

Provisions – current	755	597	755	597
Provisions – non-current	52	66	52	66
Accrued Salaries and Wages and on costs	5	40	5	40
Total Aggregate Employee Benefits	812	703	812	703

	ACCUMULATED FUNDS		TOTAL EQUITY	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
18. PARENT AND CONSOLIDATION – EQUITY				
Balance at the beginning of the financial reporting period	3,527	1,458	3,527	1,458
Restated Opening Balance	3,527	1,458	3,527	1,458
Changes in equity other than transactions with owners as owners				
Result for the year	2,837	2,069	2,837	2,069
Balance at the end of the financial reporting period	6,364	3,527	6,364	3,527

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

	PARENT		CONSOLIDATION	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
19. COMMITMENTS FOR EXPENDITURE				
(a) Other Expenditure Commitments				
Aggregate other expenditure contracted for at balance date but not provided for in the accounts:				
Not later than one year	110	93	110	93
Later than one year and not later than five years	457	387	457	387
Later than five years	114	43	114	43
Total Other Expenditure Commitments (Including GST)	681	523	681	523
Other expenditure commitments reflect service level agreements with SESIAHS.				
(b) Operating Lease Commitments				
Commitments in relation to non-cancellable operating leases are payable as follows:				
Not later than one year	280	206	280	206
Later than one year and not later than five years	290	411	290	411
Later than five years	0	0	0	0
Total Operating Lease Commitments (Including GST)	570	617	570	617

The operating lease commitments above are for rental payments as per lease agreement.

(c) Contingent Asset related to Commitments for Expenditure

The total of 'Commitments for Expenditure' \$1.251 million as at 30 June 2008 includes input tax credits of \$111,000 that are expected to be recoverable from the Australian Taxation Office.

20. CONTINGENT LIABILITIES

There are no contingent liabilities.

	PARENT		CONSOLIDATION	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
21. RECONCILIATION OF NET CASH FLOWS FROM OPERATING ACTIVITIES TO NET COST OF SERVICES				
Net Cash Flows from Operating Activities	4,069	2,033	4,069	2,033
Depreciation	(671)	(90)	(671)	(90)
Acceptance by the Crown Entity of Employee Superannuation Benefits	(56)	0	(56)	(55)
(Increase)/Decrease in Employee Entitlements	(144)	(69)	(144)	(29)
(Increase)/Decrease in Other Debtors (Intra Hlth)	(642)	396	(642)	396
Increase/(Decrease) in Prepayments	(40)	40	(40)	40
(Increase)/Decrease in Creditors	274	(241)	274	(281)
Net Gain/(Loss) on Sale of Property, Plant and Equipment	(9)	0	(9)	0
(NSW Health Department Recurrent Allocations)	(10,131)	(7,870)	(10,131)	(7,870)
Net Cost of Services	(7,350)	(5,801)	(7,350)	(5,856)

22. UNCLAIMED MONEYS – PARENT AND CONSOLIDATION

Unclaimed salaries and wages are paid to the credit of the Department of Industrial Relations and Employment in accordance with the provisions of the Industrial Arbitration Act, 1940, as amended.

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

23. BUDGET REVIEW – PARENT AND CONSOLIDATED

Net Cost of Services

The actual Net Cost of Services was lower than budget by \$3.48m. This was primarily due to some major projects still in their service delivery stage, which continues to reflect the timing differences between budgeted allocation and actual projected expenditure. Greater than budgeted actual revenue of \$254K represents mainly additional project funding from NSW Health for short term projects. The remainder represents commercial activity revenue from health campaign resource development and dissemination on behalf of NSW Health.

Result for the Year

The result for the year was higher than budget by \$3.48m due to the favourable Net Cost of Services position.

Assets and Liabilities

Current Assets

Current Assets were greater than budget by \$3.38m. This was primarily due to higher than budgeted cash comprising of the rollover allocated to the Clinical Excellence Commission for 07/08 from the NSW Department of Health. The Clinical Excellence Commission has been in a position to negotiate its cash allocation based on its expenditure requirements.

Non-Current Assets

Non-current assets were less than budget by only \$27k reflecting the IIMS increase in depreciation to reflect its true value.

Current Liabilities

The current creditors are less than budget due to the Clinical Excellence Commission's prompt payments cycle.

Current leave provisions are greater than budget due to an increase in staffing levels.

Non-Current Liabilities

Non- Current Liabilities were less than budget due to a decrease in leave provisions and other reflecting long service leave payments.

Cash Flows

Operating Activities

The better than expected actual result is largely attributable to lower actual expenditure, however this continues to reflect timing differences between budget allocation and service delivery.

Investing Activities

Actual capital expenditure has no significant variance compared to budget.

Financing Activities

Financing activities continues to reflect intra-health debtors.

Movements in the level of the NSW Health Department Recurrent Allocation that have occurred since the time of the initial allocation on 30th July 2007 are as follows:

	2008 \$000	2007 \$000
Initial Allocation, 30th July 2007	11,418	7,414
Budget Reduction Effected By Treasury	0	(1)
Clinical Audit Managers	(262)	0
Central Line Associated Bloodstream Infection	311	0
Statewide Clinical Leadership Program	(1,495)	0
Falls Prevention Program	125	270
Super Guarantee Charge	34	187
Balance as per Operating Statement	10,131	7,870

24. FINANCIAL INSTRUMENTS

The Clinical Excellence Commission's principal financial instruments are outlined below. These financial instruments arise directly from the Clinical Excellence Commission's operations or are required to finance its operations. The Clinical Excellence Commission does not enter into or trade financial instruments, including derivative financial instruments, for speculative purposes.

The Clinical Excellence Commission's main risks arising from financial instruments are outlined below, together with the Health Service's objectives, policies and processes for measuring and managing risk. Further quantitative and qualitative disclosures are included throughout this financial report.

The Chief Executive has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. Risk management policies are established to identify and analyse the risk faced by the Clinical Excellence Commission, to set risk limits and controls and monitor risks. Compliance with policies is reviewed by the Audit Committee/Internal auditors on a continuous basis.

	PARENT*		CONSOLIDATION*	
	2008 \$000	2007 \$000	2008 \$000	2007 \$000
a) Financial Instrument Categories				
Financial Assets				
Class: Category				
Cash and Cash Equivalents (note 19)	4,498	438	4,498	438
Receivables at Amortised Cost (note 13) ¹	413	1,055	413	1,055
Total Financial Assets	4,911	1,493	4,911	1,493
Financial Liabilities				
Payables (Note 16) ²	97	371	97	371
Total Financial Liabilities	97	371	97	371

Notes

* Total carrying amounts as per the Balance Sheet

1 Excludes statutory receivables and prepayments (ie not within scope of AASB 7)

2 Excludes unearned revenue (ie not within scope of AASB 7)

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

b) Credit Risk

Credit risk arises when there is the possibility of the Entity's debtors defaulting on their contractual obligations, resulting in a financial loss to the Entity. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from financial assets of the Entity i.e receivables. No collateral is held by the Entity nor has it granted any financial guarantees.

Credit risk associated with the Clinical Excellence Commission's financial assets, other than receivables, is managed through the selection of counterparties and establishment of minimum credit rating standards. Authority deposits held with NSW Tcorp are guaranteed by the State.

Cash

Cash comprises cash on hand and bank balance deposited in accordance with Public Authorities (Financial Arrangements) Act approvals. Interest is earned on daily bank balances at rates of approximately 6.71% in 2007/08 compared to 5.04% in the previous year.

Receivables – trade debtors

All trade debtors are recognised as amounts receivable at balance date. Collectibility of trade debtors is reviewed on an ongoing basis. Procedures as established in the NSW Department of Health Accounting Manual and Fee Procedures Manual are followed to recover outstanding amounts, including letters of demand. Debts which are known to be uncollectable are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect the amounts due. The evidence includes past experience and current and expected changes in economic conditions and debtor credit ratings. No interest is earned on trade debtors.

The Clinical Excellence Commission is not materially exposed to concentrations of credit risk to a single trade debtor or group of debtors. Based on past experience, debtors that are not past due (2008:\$0.371m; 2007: \$1.048m) and not more than [3] months past due (2008: \$0; 2007:\$6k) are not considered impaired and together these represent 90% of the total trade debtors.

The only financial assets that are past due or impaired are 'sales of goods and services' in the 'receivables' category of the balance sheet.

	2008			2007		
	Total \$000	Past due but not impaired \$000	Considered impaired \$000	Total \$000	Past due but not impaired \$000	Considered impaired \$000
< 3 months overdue	371	0	0	1048	0	0
3 months – 6 months overdue	0	0	0	0	0	0
4 months – 6 months overdue	42	42	0	7	7	0
	413	42	0	1055	7	0

The ageing analysis excludes statutory receivables, as these are not within the scope of AASB 7.

(c) Liquidity risk

Liquidity risk is the risk that the Clinical Excellence Commission will be unable to meet its payment obligations when they fall due. The Clinical Excellence Commission continuously manages risk through monitoring future cash flows and maturities planning to ensure adequate holding of high quality liquid assets. The objective is to maintain a balance between continuity of funding and flexibility through effective management of cash, investments and liquid assets and liabilities.

The Clinical Excellence Commission has negotiated no loan outside of arrangements with the NSW Department of Health or the Sustainable Energy Development Authority.

During the current and prior year, there were no defaults or breaches on any loans payable. No assets have been pledged as collateral. The Clinical Excellence Commission exposure to liquidity risk is deemed insignificant based on prior periods' data and current assessment of risk.

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set by the NSW Department of Health. If trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or a statement is received.

The table below summarises the maturity profile of the Health Service's financial liabilities together with the interest rate exposure.

	INTEREST RATE EXPOSURE					MATURITY DATES			Weighted Average Effective int rate %
	Fixed Interest Rate %	Variable Interest Rate %	Nominal Amount ¹ \$	Actual Variable Interest Rate \$000	Non- Interest Bearing \$000	< 1 Yr \$000	1-5 Yr \$000	> 5Yr \$000	
2008									
Payables:									
Accrued salaries			5						
Creditors			92						
			97						
2007									
Payables:									
Accrued salaries			40						
Creditors			331						
[Specify other major categories]			371						

Notes

¹ The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities, therefore the amounts disclosed above will not reconcile to the balance sheet in respect of non interest bearing loans negotiated with the NSW Department of Health.

Notes to and forming part of the Financial Statements (cont.)

For the year ended 30 June 2008

(d) Market risk

Market risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in market prices. The Clinical Excellence Commission exposures to market risk are primarily through interest rate risk on the Clinical Excellence Commission's borrowings and other price risks associated with the movement in the unit price of the Hour Glass Investment facilities. The Clinical Excellence Commission has no exposure to foreign currency risk and does not enter into commodity contracts.

The effect on profit and equity due to a reasonably possible change in risk variable is outlined in the information below, for interest rate risk and other price risk. A reasonably possible change in risk variable has been determined after taking into account the economic environment in which the Clinical Excellence Commission operates and the time frame for the assessment (i.e. until the end of the next annual reporting period). The sensitivity analysis is based on risk exposures in existence at the balance sheet date. The analysis is performed on the same basis for 2007. The analysis assumes that all other variables remain constant.

Interest rate risk

Exposure to interest rate risk arises primarily through the Health Service's interest bearing liabilities.

However, the Clinical Excellence Commission are not permitted to borrow external to the NSW Department of Health (Sustainable Energy Development Authority loans which are negotiated through Treasury excepted). Both SEDA and NSW Department of Health loans are set at fixed rates and therefore are generally not affected by fluctuations in market rates. For financial instruments a reasonably possible change of +/-1% is consistent with trends in interest. The Clinical Excellence Commission exposure to interest rate risk is set out below.

	Carrying Amount \$000	-1% Profit	Equity	+1% Profit	Equity
2008					
Financial Assets					
Cash and cash equivalents	4,498	-45	-45	45	45
Receivables	413	-4	-4	4	4
Financial assets at fair value					
Other financial assets					
Financial Liabilities					
Payables	92	-1	-1	1	1
2007					
Financial Assets					
Cash and cash equivalents	438	-4	-4	4	4
Receivables	1,055	-11	-11	11	11
Financial assets at fair value					
Other financial assets					
Financial Liabilities					
Payables	331	-3	-3	3	3

25. Post Balance Date Events

Since the reporting date, there are no events that have come to light that require the financial report to be amended.

Certification of Financial Statement Special Purpose Service Entity

For the year ended 30 June 2008

Certification of Special Purpose Service Entity Financial Statements for the Period Ended 30 June 2007

The attached financial statements of the Clinical Excellence Commission Special Purpose Service Entity for the year ended 30 June 2008:

- i) Have been prepared in accordance with the requirements of applicable Australian Accounting Standards which include Australian equivalents to International Financial Reporting Standards (AEIFRS), the requirements of the *Public Finance and Audit Act 1983* and its regulations, the *Health Services Act 1997* and its regulations, the *Accounts and Audit Determination* and the *Accounting Manual for Area Health Services and Public Hospitals*;
- ii) Present fairly the financial position and transactions of the Clinical Excellence Commission Special Purpose Service Entity; and
- iii) Have no circumstances which would render any particulars in the financial statements to be misleading or inaccurate.



Professor Bruce Barraclough, AO
Chairman

14 October 2008



Professor Clifford Hughes, AO
Chief Executive Officer

14 October 2008



Mr Andre Jenkins
A/Director, Corporate Services

14 October 2008

Independent Audit Report Special Purpose Service Entity

For the year ended 30 June 2008



GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

CLINICAL EXCELLENCE COMMISSION SPECIAL PURPOSE SERVICE ENTITY

To Members of the New South Wales Parliament

I have audited the accompanying financial report of the Clinical Excellence Commission Special Purpose Service Entity (the Entity), which comprises the balance sheet as at 30 June 2008, and the income statement, statement of recognised income and expense and cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes.

Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Entity as at 30 June 2008, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2005.

Chief Executive's Responsibility for the Financial Report

The Chief Executive is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the PF&A Act. This responsibility includes establishing and maintaining internal controls relevant to the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

My responsibility is to express an opinion on the financial report based on my audit. I conducted my audit in accordance with Australian Auditing Standards. These Auditing Standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal controls relevant to the entity's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal controls. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Chief Executive, as well as evaluating the overall presentation of the financial report.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independent Audit Report (cont.) Special Purpose Service Entity

For the year ended 30 June 2008

My opinion does not provide assurance:

- about the future viability of the Entity,
- that it has carried out its activities effectively, efficiently and economically, or
- about the effectiveness of its internal controls.

Independence

In conducting this audit, the Audit Office of New South Wales has complied with the independence requirements of the Australian Auditing Standards and other relevant ethical requirements. The PF&A Act further promotes independence by:

- providing that only Parliament, and not the executive government, can remove an Auditor-General, and
- mandating the Auditor-General as auditor of public sector agencies but precluding the provision of non-audit services, thus ensuring the Auditor-General and the Audit Office of New South Wales are not compromised in their role by the possibility of losing clients or income.



Jack Kheir BEC, FCPA
Director, Financial Audit Services

15 October 2008
SYDNEY

Income Statement of Clinical Excellence Commission

Special Purpose Service Entity for the year ended 30 June 2008

	2008 \$000	2007 \$000
INCOME		
Personnel Services	3,735	3,917
Acceptance by the Crown Entity of Employee Benefits	56	55
Total Income	3,791	3,972
EXPENSES		
Salaries and Wages	2,790	3,234
Defined Benefit Superannuation	56	55
Defined Contribution Superannuation	190	187
Long Service Leave	192	90
Annual Leave	344	281
Sick Leave and Other Leave	133	58
Redundancies	0	0
Workers Compensation Insurance	14	12
Fringe Benefits Tax	16	0
Grants & Subsidies	56	55
Total Expenses	3,791	3,972
Result For The Year	0	0

The accompanying notes form part of these Financial Statements.

Balance Sheet of Clinical Excellence Commission

Special Purpose Service Entity as at 30 June 2008

	Notes	2008 \$000	2007 \$000
ASSETS			
Current Assets			
Receivables	2	760	637
Total Current Assets		760	637
Non-Current Assets			
Receivables	2	52	66
Total Non-Current Assets		52	66
Total Assets		812	703
LIABILITIES			
Current Liabilities			
Payables	3	5	40
Provisions	4	755	597
Total Current Liabilities		760	637
Non-Current Liabilities			
Provisions	4	52	66
Total Non-Current Liabilities		52	66
Total Liabilities		812	703
Net Assets		0	0
EQUITY			
Accumulated funds		0	0
Total Equity		0	0

The accompanying notes form part of these Financial Statements.

Statement of Recognised Income and Expense of Clinical Excellence Commission

Special Purpose Service Entity for the year ended 30 June 2008

	2008 \$000	2007 \$000
Total Income and Expense Recognised Directly in Equity	0	0
Result for the Year	0	0
Total Income and Expense Recognised for the year	0	0

The accompanying notes form part of these Financial Statements.

Cash Flow Statement of Clinical Excellence Commission

Special Purpose Service Entity for the year ended 30 June 2008

	2008 \$000	2007 \$000
Net Cash Flows from Operating Activities	0	0
Net Cash Flows from Investing Activities	0	0
Net Cash Flows from Financing Activities	0	0
Net Increase/(Decrease) in Cash	0	0
Closing Cash and Cash Equivalents	0	0

The Clinical Excellence Commission Special Purpose Service Entity does not hold any cash or cash equivalent assets and therefore there are no cash flows.

The accompanying notes form part of these Financial Statements.

Notes to and forming part of the Financial Statements

Special Purpose Service Entity for the year ended 30 June 2008

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

a) The Clinical Excellence Commission Special Purpose Service Entity

The Clinical Excellence Commission Special Purpose Service Entity 'the Entity', is a Division of the Government Service, established pursuant to Part 2 of Schedule 1 to the Public Sector Employment and Management Act 2002 and amendment of the Health Services Act 1997. It is a not-for-profit entity as profit is not its principal objective. It is consolidated as part of the NSW Total State Sector Accounts. It is domiciled in Australia and its principal office is at Wollongong, New South Wales.

The Entity's objective is to provide personnel services to the Clinical Excellence Commission.

The Entity commenced operations on 17 March 2006 when it assumed responsibility for the employees and employee-related liabilities of the Clinical Excellence Commission. The assumed liabilities were recognised on 17 March 2006 with an offsetting receivable representing the related funding due from the former employer.

The financial report was authorised for issue by the Chief Executive Officer on 14 October 2008. The report will not be amended and reissued as it has been audited.

b) Basis of Preparation

This is a general purpose financial report prepared in accordance with the requirements of Australian Accounting Standards, the requirements of the Health Services Act 1997 and its regulations including observation of the Accounts and Audit Determination for Area Health Services and Public Hospitals.

Generally, the historical cost basis of accounting has been adopted and the financial report does not take into account changing money values or current valuations. However certain provisions are measured at fair value. See note (j).

The accrual basis of accounting has been adopted in the preparation of the financial report, except for cash flow information.

Management's judgements, key assumptions and estimates are disclosed in the relevant notes to the financial report.

All amounts are rounded to the nearest one thousand dollars and are expressed in Australian currency.

c) Comparative Information

The financial statements and notes comply with Australian Accounting Standards which include AEIFRS. Comparative figures are, where appropriate, reclassified to give meaningful comparison with the current year.

d) New Australian Accounting Standards Issued But Not Effective

No new or revised accounting standards or interpretations are adopted earlier than their prescribed date of application. Set out below are changes to be effected, their date of application and the possible impact on the financial report of the Clinical Excellence Commission Special Purpose Service Entity.

Standards/Interpretation	Operative Date	Comment
AASB3, AASB127 & AASB2008-3, Business Combinations	1 July 2009	The changes address business combinations and the Australian Accounting Standards Board has indicated that it is yet to consider its suitability for combinations among not-for-profit entities.
AASB8 & AASB2007-3, Operating Segments	1 July 2009	The changes do not apply to not-for-profit entities and have no application within NSW Health.
AASB101 & AASB2007-8, Presentation of Financial Statements	1 July 2009	Health agencies are currently required to present a statement of recognised income and expense and no variation is expected.
AASB123 & AASB2007-6, Borrowing Costs	1 July 2009	Borrowing costs that are directly attributable to the acquisition, construction or production of a qualifying asset form part of the cost of that asset. As Health Service borrowings are restricted to the Sustainable Energy Development Authority negligible impact is expected.
AASB1004, Contributions	1 July 2008	The requirements on contributions from AASB27, 29 and 31 have been relocated, substantially unamended in AASB4.
AASB1049, Whole of Government and General Government Sector Financial Reporting	1 July 2008	The standard aims to provide the harmonisation of Government Finance Statistics and Generally Accepted Accounting Principles (GAAP) reporting. The impact of changes will be considered in conjunction with the reporting requirements of the Financial Reporting Code for Budget Dependent General Government Sector Agencies.
AASB1050 regarding administered items	1 July 2008	The requirements of AAS29 have been relocated, substantially unamended and are not expected to have material effect on Health entities.
AASB1051 regarding land under roads	1 July 2008	The standard will require the disclosure of 'accounting policy for land under roads'. It is expected that all such assets will need to be recognised 'at fair value'. The standard will have negligible impact on Health entities.
AASB1052 regarding disaggregated disclosures	1 July 2008	The standard requires disclosure of financial information about Service costs and achievements. Like other standards not yet effective the requirements have been relocated from AAS29 largely unamended.
AASB2007-9 regarding amendments arising from the review of AAS27, AAS29 and AAS31	1 July 2008	The changes made are aimed at removing the uncertainties that previously existed over cross references to other Australian Accounting Standards and the override provisions in AAS29.
AAS2008-1, Share Based Payments	1 July 2008	The standard will not have application to health entities under the control of the NSW Department of Health.

Notes to and forming part of the Financial Statements (cont.)

Special Purpose Service Entity for the year ended 30 June 2008

e) Income

Income is measured at the fair value of the consideration received or receivable. Revenue from the rendering of personnel services is recognised when the service is provided and only to the extent that the associated recoverable expenses are recognised.

f) Receivables

A receivable is recognised when it is probable that the future cash inflows associated with it will be realised and it has a value that can be measured reliably. It is derecognised when the contractual or other rights to future cash flows from it expire or are transferred.

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the operating statement when impaired, derecognised or through the amortisation process.

Short term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

If there is objective evidence at year end that a receivable may not be collectable, its carrying amount is reduced by means of an allowance for impairment and the resulting loss is recognised in the income statement. Receivables are monitored during the year and bad debts are written off against the allowance when they are determined to be irrecoverable. Any other loss or gain arising when a receivable is derecognised is also recognised in the income statement.

g) Impairment of Financial Assets

As both receivables and payables are measured at fair value through profit and loss there is no need for annual reviews for impairment.

h) De-recognition of Financial Assets and Financial Liabilities

A financial asset is derecognised when the contractual rights to the cash flows from the financial assets expire, or if the agency transfers the financial asset:

- where substantially all the risks and rewards have been transferred; or
- where the Entity has not transferred substantially all the risks and rewards,
- if the Entity has not retained control.

Where the Entity has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Entity's continuing involvement in the asset.

A financial liability is derecognised when the obligation specified in the contract is discharged or cancelled or expires.

i) Payables

Payables include accrued wages, salaries, and related on costs (such as payroll deduction liability, payroll tax, fringe benefits tax and workers' compensation insurance) where there is certainty as to the amount and timing of settlement.

A payable is recognised when a present obligation arises under a contract or otherwise. It is derecognised when the obligation expires or is discharged, cancelled or substituted.

Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short term payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial. Payables are recognised for amounts to be paid in the future for goods and services received, whether or not billed to the Entity.

j) Employee benefit provisions and expenses

i) Salaries and Wages, current Annual Leave, Sick Leave and On-Costs

Liabilities for salaries and wages (including non-monetary benefits), annual leave and paid sick leave that fall wholly within 12 months of the reporting date are recognised and measured in respect of employees' services up to the reporting date at undiscounted amounts based on the amounts expected to be paid when the liabilities are settled.

All Annual Leave employee benefits are reported as 'Current' as there is an unconditional right to payment. Current liabilities are then further classified as 'Short Term' and 'Long Term' based on past trends and known resignations and retirements. Anticipated payments to be made in the next 12 months are reported as 'Short Term'. On costs of 17% are applied to the value of leave payable at 30 June 2008, such on costs being consistent with actuarial assessment. (comparable costs for 30 June 2007 were 21.7% which, in addition to the 17% increase, also included the impact of awards immediately payable at 30 June 2007).

Unused non-vesting sick leave does not give rise to a liability, as it is not considered probable that sick leave taken in the future will be greater than the benefits accrued in the future.

The outstanding amounts of payroll tax, workers' compensation insurance premiums and fringe benefits tax, which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

ii) Long Service Leave and Superannuation Benefits

Long Service Leave employee leave entitlements are dissected as 'Current' if there is an unconditional right to payment and 'Non-Current' if the entitlements are conditional. Current entitlements are further dissected between 'Short Term' and 'Long Term' on the basis of anticipated payments for the next 12 months. This in turn is based on past trends and known resignations and retirements.

Long Service Leave provisions are measured on a short hand basis at an escalated rate of 8.1% above the salary rates immediately payable at 30 June 2008 (also 8.1% at 30 June 2007) for all employees with five or more years of service. Actuarial assessment has found that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

The Entity's liability for the closed superannuation pool schemes (State Authorities Superannuation Scheme and State Superannuation Scheme) is assumed by the Crown Entity. The Entity accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as 'Acceptance by the Crown Entity of Employee benefits'. Any liability attached to Superannuation Guarantee Charge cover is reported in Note 3, 'Payables'.

The superannuation expense for the financial year is determined by using the formulae specified in the NSW Health Department Directions. The expense for certain superannuation schemes (i.e. Basic Benefit and Superannuation Guarantee Charge) is calculated as a percentage of the employees' salary. For other superannuation schemes (i.e. State Superannuation Scheme and State Authorities Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

Notes to and forming part of the Financial Statements (cont.)

Special Purpose Service Entity for the year ended 30 June 2008

	2008 \$000	2007 \$000
2. RECEIVABLES		
Current		
Accrued Income – Personnel Services Provided	760	637
Non-Current		
Accrued Income – Personnel Services Provided	52	66
Total Receivables	812	703
3. PAYABLES		
Current		
Accrued Salaries and Wages and On Costs	5	40
Total Payables	5	40
Details regarding credit risks, liquidity risk and market risk, including financial assets that are either part due or impaired are disclosed in Note 5		
4. PROVISIONS		
Current Employee benefits and related on-costs		
Annual Leave – Short Term Benefit	212	85
Annual Leave – Long Term Benefit	157	71
Long Service Leave – Short Term Benefit	92	95
Long Service Leave – Long Term Benefit	294	346
Total Current Provisions	755	597
Non-Current Employee Benefits and Related On Costs		
Long Service Leave - Conditional	52	66
Total Non-Current Provisions	52	66
Aggregate Benefits and Related On Costs		
Accrued Salary & Wages & on-costs	5	40
Provision – Current	755	597
Provision – Non-Current	52	66
Total	812	703

5. FINANCIAL INSTRUMENTS

The Clinical Excellence Commission Special Purpose Service Entity's financial instruments are outlined below. These financial instruments arise directly from the Entity's operations or are required to finance its operations. The Entity does not enter into or trade financial instruments, including derivative financial instruments for speculative purposes.

The Chief Executive has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. The Entity carries minimal risks within its operation as it carries only the value of employee provisions and accrued salaries and wages offset in full by accounts receivable from the Parent Entity. Risk management policies are established by the Parent Entity to identify and analyse the risk faced by the Entity, to set risk limits and controls and monitor risks. Compliance with policies is reviewed by the Audit Committee/Internal auditors of the Parent Entity on a continuous basis.

	2008 \$000	2007 \$000
a) Financial Instrument Categories		
Financial Assets		
Receivables at Amortised Cost ¹ (note 2)	812	703
Total Financial Assets	812	703
Financial Liabilities		
Class:		
Payables (Note 3) ¹	5	40
Total Financial Liabilities	5	40

¹ Excludes statutory receivables and prepayments, i.e. not within the scope of AASB 7.

Notes to and forming part of the Financial Statements (cont.)

Special Purpose Service Entity for the year ended 30 June 2008

b) Credit Risk

Credit risk arises when there is the possibility of the Entity's debtors defaulting on their contractual obligations, resulting in a financial loss to the Entity. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from financial assets of the Entity i.e receivables. No collateral is held by the Entity nor has it granted any financial guarantees.

Receivables – trade debtors

Receivables are restricted to accrued income for personnel services provided and employee leave provisions and are recognised as amounts receivable at balance date. The parent entity of the Clinical Excellence Commission Special Purpose Service Entity is the sole debtor of the Entity and it is assessed that there is no risk of default. No accounts receivables are classified as 'Past Due but not Impaired' or 'Considered Impaired'.

c) Liquidity Risk

Liquidity risk is the risk that the Entity will be unable to meet its payment obligations when they fall due. No such risk exists with the Entity not having any cash flows. All movements that occur in Payables are fully offset by an increase in Receivables from the Clinical Excellence Commission parent entity.

d) Market Risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. The Entity's exposures to market risk are considered to be minimal and the Entity has no exposure to foreign currency risk and does not enter into commodity contracts.

Interest rate risk

Exposure to interest rate risk arises primarily through interest bearing liabilities.

However the Entity has no such liabilities and the interest rate is assessed as Nil. Similarly it is considered that the Entity is not exposed to other price risks.

e) Fair Value

Financial instruments are generally recognised at cost.

The amortised cost of financial instruments recognised in the balance sheet approximates fair value because of the short term nature of the financial instruments.

6. RELATED PARTIES

The Clinical Excellence Commission is deemed to control the Clinical Excellence Commission Special Purpose Service Entity in accordance with Australian Accounting Standards. The controlling entity is incorporated under the Health Services Act 1997.

Transactions and balances in this financial report relate only to the Entity's function as provider of personnel services to the controlling entity. The Entity's total income is sourced from the Clinical Excellence Commission.

Cash receipts and payments are effected by the Clinical Excellence Commission on the Entity's behalf.

7. POST BALANCE DATE EVENTS

No post balance date events have occurred which warrant inclusion in this report.

Abbreviations

ACHS	The Australian Council of Healthcare Standards	QSB	Quality and Safety Branch, NSW Department of Health
ARCHI	Australian Resource Centre for Healthcare Innovations	RCA	Root Cause Analysis
CEAC	Citizens Engagement and Advisory Council	SAC	Severity Assessment Code
CEC	Clinical Excellence Commission	SCIDAWS	Special Committee Investigating Deaths Associated With Surgery
CEO	Chief Executive Officer	SCIDUA	Special Committee Investigating Deaths Under Anaesthesia
CGU	Clinical Governance Unit	SESAHS	South Eastern Sydney & Illawarra Area Health Service
CFCC	Communicating for Clinical Care project	SSSL	Safer Systems, Saving Lives
CHASM	Collaborating Hospitals' Audit of Surgical Mortality	TAG	Therapeutic Advisory Group
CheReL	Centre for Health Record Linkage	TASC	Towards a Safer Culture
CIAP	Clinical Information Access Project (online information resource)	TESL	Training, Education and Study Leave for salaried medical practitioners
CLAB	Central Line Associated Bacteraemia		
CLP	Clinical Leadership Program		
CNC	Clinical Nurse Consultant		
CPI	Clinical Practice Improvement		
DOH	Department of Health		
EEO	Equal Employment Opportunity		
FOI	Freedom of Information		
GMCT	Greater Metropolitan Clinical Taskforce		
HARC	Hospital Alliance for Research Collaboration		
ICU	Intensive Care Unit		
IIMS	Incident Information Management System		
ISMP	Institute for Safe Medicine Practices (Canada)		
MRO	Multi-resistant organisms		
MSSA	Medication Safety Self Assessment		
NICS	National Institute of Clinical Studies		
NSW	New South Wales		
OH&S	Occupational Health and Safety		
QSA	Quality Systems Assessment		

Glossary

Adverse Event

Un-intended patient injury or complication from treatment that results in disability, death or prolonged hospital stay and is caused by health care management.

Area health service (AHS)

Area health services provide the operational framework for the provision of public health services in particular geographic areas in New South Wales.

Clinical Excellence Commission (CEC)

Statutory corporation, established in 2004, under the *Health Services Act 1997* to improve patient safety and clinical quality in the NSW health system.

Clinical Information Access Program (CIAP)

Provides access to clinical information and resources to support evidence-based practice at the point of care. This resource is available to all nurses, midwives, doctors, allied health, community health, ancillary and library staff working in the NSW public health system.

Clinical Practice Improvement (CPI)

An established process for improving a clinical service, using a 'plan, do, study act' model.

Clinician

A health practitioner or health service provider.

Director-General

The Director-General for NSW Health, appointed by the Minister for Health.

IIMS

The NSW Health Incident Information Management System. This electronic system records notifications of clinical and corporate incidents occurring in the health care setting under four incident categories: clinical; staff-visitor-contractor; property-security-hazard; and complaints.

Incident

An event or circumstance which could have, or did, lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage.

Incident Management

A systematic process for identifying, notifying, prioritising, investigating and managing the outcomes of an incident within the NSW health system.

Minister

NSW Minister for Health, responsible for the administration of health legislation within NSW.

Near-Miss

An event that could have had adverse consequences but did not, and which is indistinguishable from an actual incident in all but outcome.

NSW Department of Health (the Department)

NSW Department of Health and its staff. The department monitors the performance of the NSW public health system and supports the statutory role of the NSW Minister for Health.

Open Disclosure

The open discussion of incidents that result in harm to a patient while receiving health care.

Public Health Organisation (PHO)

An area health service, statutory health corporation or affiliated health organisation as defined in the *Health Services Act 1997*. They plan, deliver and co-ordinate local health services and provide services such as public and community health, hospitals, emergency transport, acute care, rehabilitation, counselling, and community support programs.

Quality Systems Assessment (QSA)

Assesses the patient safety and clinical quality frameworks of a service.

Reportable Incident Brief (RIB)

The method for reporting defined health care incidents to the NSW Department of Health.

Root Cause Analysis (RCA)

A method used to investigate and analyse an 'extreme risk' (SAC 1) incident to identify the root causes and factors that contributed to the incident and to recommend actions to prevent future occurrence.

Severity Assessment Code (SAC)

A numerical score (1-4) that categorises adverse events, based on the type of event, its likelihood of recurrence and its consequence. A matrix is used to stratify the actual and/or potential risk associated with an incident. SAC 1 incidents are those with extreme risk, that have a serious outcome, and require a root cause analysis.

Statutory (Health) Corporation

Corporation established by Act of Parliament, whose services and support extend across the State.

A

Adverse Events 22, 28, 30, 34

Audit 2, 4, 5, 8, 14, 15, 20, 21, 30
38, 40, 49, 50, 74, 79, 80

B

Best Practice 15, 16, 24, 26, 30

Blood Watch 7, 8, 19, 30, 31, 40, 44

Board 4, 5, 8, 10, 11, 12, 13, 14, 15
16, 17, 20, 21, 23, 28, 33, 40, 44, 45, 46

C

CLAB project	6, 24, 25, 40, 44
Chairman's Report	5
Chief Executive's Report	6
Citizens Engagement	
Advisory Council.....	4, 8, 16, 19 22, 23, 40, 41, 46
Clinical Council.....	7, 16, 17, 19, 20, 23
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