

Developing partnerships
to advance patient care



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.





CLINICAL
EXCELLENCE
COMMISSION

The Hon Carmel Tebbutt
Minister for Health
Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

Dear Minister

We have pleasure in submitting the Clinical Excellence Commission's 2009–10 Annual Report.

The report complies with the requirements for annual reporting under the Annual Reports (Statutory Bodies) Regulation 2010 under the *Annual Reports (Statutory Bodies) Act 1984*.

Yours sincerely

Professor Carol Pollock
Chair

Professor Clifford Hughes AO
Chief Executive Officer

Profile, Purpose and Goals



The NSW Clinical Excellence Commission (CEC) was established as a Board governed statutory health corporation in 2004 under s 41 of the Health Services Act 1997 to promote and support improved clinical care, safety and quality across the health system. It forms a major component of the NSW Patient Safety and Clinical Quality Program – the framework for enabling the identification and prevention of adverse events in public hospitals. The CEC adds value to the NSW public health system through its role in investigating, advising, supplying expertise, facilitating improvement, encouraging clinical input, evaluation and assessment of quality programs.

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

Highlights/Achievements



Assessment

- 2009 QSA Statewide and individual Public Health Organisation (PHO) reports completed
- Verification of 2009 results underway
- 2010 QSA thematic survey under development

For more information on Assessment, see p 20

Education and training

- Clinical Leadership Program
- DETECT Supertrainers program
- Hand Hygiene Gold Assessors and Ward Auditor training under the auspices of the National Hand Hygiene Initiative
- Teaching Safety and Quality to undergraduates in medicine, nursing and allied health
- Conference and seminar presentations

For more information on Clinical Leadership Program, see p 26
DETECT Supertrainers Program, see p 18
Hand Hygiene, see p 24
Undergraduate education, see p 36
Conference and Seminar Presentation, see p 62

New project focus areas

- *Between the Flags*: Recognition and Management of the Deteriorating Patient launched
- *Between the Flags*: Recognition and Management of the Deteriorating Paediatric Patient under development
- Antibiotic Stewardship in ICUs
- Health Literacy
- Public Reporting
- Incident Information Management in the NSW Public Health System July-Dec 2008 (IIMS)
- Clinical Incident Management in the NSW Public Health System Jan-June 2009 (IIMS)
- Chartbook 2008 released
- Chartbook 2009 in preparation
- Activities of the Special Committee Investigating Deaths Under Anaesthesia – 2008
- Collaborating Hospitals Audit of Surgical Mortality (CHASM) Case Booklet: January 2008 – June 2009
- Individual Report to A Participating Surgeon January 2008 – June 2009
- Quality Systems Assessment Statewide Reports completed and awaiting release

Public Reporting

- Incident Information Management in the NSW Public Health System July-December 2008 (IIMS)
- Incident Information Management in the NSW Public Health System January-June 2009 (IIMS)
- Chartbook 2008 released
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- Activities of the Special Committee Investigating Deaths Under Anaesthesia – 2008
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- Individual Report to A Participating Surgeon January 2008 – June 2009
- Quality Systems Assessment Statewide Reports completed and awaiting release



Partnerships

- Regular meetings with Agency for Clinical Innovation (ACI), Clinical Education and Training Institute (CETI) and Bureau of Health Information (BHI) which were established following recommendations in the Garling Report
- The Boards of the Clinical Excellence Commission and the Agency for Clinical Innovation have common memberships
- Citizens Engagement Advisory Council
- Clinical 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 Australian Commission on Safety and Quality in Health Care (ACSQHC)
- Conduct research and quality and safety seminars in conjunction with ACSQHC
- Teaching quality and safety to undergraduates is done in partnership with the host university as classes are co-taught with CEC staff and host university staff
- Health System Quality, Performance and Innovation Division of NSW Department of Health

Research

- Ian O'Rourke PhD Scholar
- Database to support Collaborating Hospitals' Audit of Surgical Mortality (CHASM)
- Hospital Alliance for Research Collaborative (HARC)
- Centre for Health Record Linkage (CHeReL)
- Australian Research Council (ARC) Linkage Grant on Human Factors and Patient Safety

For more information on Research, see p 43

Strategic planning and development

- Boards of the CEC and the Agency for Clinical Innovation (ACI) held a joint planning meeting to review the Strategic Plans (2009-2010) of both organisations to identify areas of synergy and/or overlap
- Regular planning meetings held with executive of ACI
- Development of Information/Communication Technology Strategic Plan
- Recruitment of Director, Patient Based Care

For more information on Strategic Planning and Development, see p 58

Publications

Annual Report 2009

Between the Flags Implementation Toolkit
Chartbook 2008

Clinical Focus reports from Review of RCAs and/or IIMS Data:

- Recognition and Management of Sepsis
- Retrieval and Inter-hospital Transfer
- Should I resuscitate? "No CPR" orders

Eleven Area Health Service specific (IIMS) reports (NSW IIMS Data Report for xx Health Service) for July – December 2008

Incident Information Management in the NSW Public Health System July-December 2008 (IIMS)

Incident Management in the NSW Public Health System January-June 2009

Position Paper – agreed way forward. Review of Serious Clinical Incident Investigation Processes (RCA) in NSW

Medical Journal of Australia supplement on Hand Hygiene October 2009

Medication Incidents Involving Hydromophone (authored with NSW TAG)

Quality Use of Antimicrobials in Intensive Care – Fact Sheet One – Quality Use of Lincosamide Antibiotics

More information on CEC publications can be found on our website www.cec.health.nsw.gov.au

Overview of Performance against Strategic Plan 2009–2010

	Objective	Strategies
Public Reporting	Report publicly to the Minister and the community on quality and safety in NSW Health	<ul style="list-style-type: none"> ➤ Develop and deliver, in collaboration with the Department of Health, a bi-annual Public Report on adverse events ➤ Develop and deliver an annual public report on quality system improvement ➤ Engage the community in an informed discussion around the quality and safety of health care
Clinical Improvement	Assist Health Services to implement effective clinical improvement programs in partnership with clinicians	<ul style="list-style-type: none"> ➤ Assist Health Services to undertake quality improvement projects ➤ Enhance professional skills within Health Services to implement effective improvement programs and methodologies ➤ To conduct Statewide quality and safety initiatives
Quality Systems Assessment	Continue Quality System Assessment (QSA) program across NSW, including identification of assessment criteria that allow themselves to be measured, benchmarked and trended over time	<ul style="list-style-type: none"> ➤ Use QSA data to identify key themes and issues related to quality and safety in NSW ➤ Continue QSA program in all public health organisations on an annual basis ➤ The QSA methodology requires Area Health Services to develop improvement plans to address particular issues
Information Management	Build a robust and integrated information base regarding peri-operative mortality and reporting for use by decision makers	<ul style="list-style-type: none"> ➤ Continue to measure and report on safety and quality by producing the Chartbook annually ➤ Continue to expand the Collaborating Hospitals' Audit of Surgical Mortality

Key	
Completed	✓
Not Completed	✗
Ongoing	→

Outcomes	Status	Future Directions
<ul style="list-style-type: none"> ➤ Bi-annual report of Incident Information Management System (IIMS) data p 22 ➤ Collaborating Hospitals Audit of Surgical Mortality (CHASM) reports p 40 ➤ Quality Systems Assessment Statewide Reports p 20 ➤ Annual Report 2008–2009 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> ➤ Continue to focus on public reporting as a tool to inform and engage the community in discussions around quality and safety of health care
<ul style="list-style-type: none"> ➤ Clinical Practice Improvement workshops conducted for staff from all Area Health Services p 28 ➤ Clinical Leadership Program (CLP) continued with increased enrolments p 26 ➤ Statewide programs in place <ul style="list-style-type: none"> — <i>Between the Flags</i> p 18 — Hand Hygiene p 24 — Medication Safety p 30 — Transfusion Medicine p 32 — Falls Prevention p 34 ➤ e-learning package around Hand Hygiene 	<ul style="list-style-type: none"> → → → ✗ 	<ul style="list-style-type: none"> ➤ Ensure that there is equity in access to education in clinical practice improvement methods for all clinicians ➤ Continue to actively promote continuation of the clinical leadership program, building on the linkages it makes between leadership, and patient safety ➤ Provide opportunities for CLP alumni to gather to network and reinforce their commitment to patient safety ➤ Continue current programs and investigate and implement new clinical improvement initiatives ➤ Continue to develop e-learning package for Hand Hygiene
<ul style="list-style-type: none"> ➤ The 2009 QSA focused on four topics p 20 ➤ The 2010 QSA self assessment will focus on three themes p 20 ➤ Statewide report makes four key recommendations on which Area Health Service improvement plans are based p 21 	<ul style="list-style-type: none"> ✓ ✓ ✓ 	<ul style="list-style-type: none"> ➤ Continue the QSA program to provide on going contemporary insights to the health system regarding key risks to patient safety and clinical quality
<ul style="list-style-type: none"> ➤ Chartbook 2008 released p 38 ➤ Chartbook 2009 in preparation p 38 ➤ Review of Information Technology and Information Management environments ➤ Shared quality and safety reporting function with Department of Health continues ➤ Increased participation by surgeons in the Collaborating Hospitals' Audit of Surgical Mortality (CHASM) continues p 40 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> ➤ Continuing to ensure that the information contained in Chartbook is relevant for clinicians and accessible to the public ➤ Development and Implementation of ICT Strategic Plan ➤ Continue shared quality and safety reporting function with the Department of Health ➤ Continue to ensure increased participation by surgeons in the audit of surgical mortality reporting processes ➤ Setting up a bi-national on line reporting system with New Zealand ➤ Undertake research projects to examine preventable deficiency of care identified from the audit

	Objective	Strategies
Capacity Building	 <p>Provide clinical leaders and the CEC with skills and tools to lead quality improvement effectively</p>	<ul style="list-style-type: none"> ➤ Continue to deliver clinical leadership development program ➤ Support rural Area Health Services by targeting rural participation in clinical practice improvement programs ➤ Develop and promote safety and quality as a core component in undergraduate health care curricula
Organisational Development	 <p>Design and build the Clinical Excellence Commission as an organisation characterised by excellence in governance</p>	<ul style="list-style-type: none"> ➤ Strengthen the CEC's governance arrangements, particularly in relation to project management, communication and budget planning ➤ Develop and implement robust risk management practices ➤ Invest in CEC's people ➤ Develop strong partnerships
Communication and Culture Change	 <p>Influence current and future decision makers, at all levels of NSW Health, to apply improvement programs and methodologies</p>	<ul style="list-style-type: none"> ➤ Develop and implement a communication strategy with Health Services that builds the profile of the CEC and inspires confidence in its work ➤ Provide the Minister, the CEC Board, the CEC Clinical Council, decision makers and the NSW Health System with key safety and quality messages and evidence based information with a practical application ➤ Work with Health Services and NSW Health in effective uptake and implementation of workplace cultural change relating to clinical improvement strategies
Primary Care	 <p>Work within the National Reform Agenda and the anticipated shift to a more robust focus on primary care</p>	<ul style="list-style-type: none"> ➤ Develop relationships with primary care services to enable expansion of CEC programs and projects into areas of primary care
Community Engagement	 <p>Engage and educate the community about safety and quality in health care</p>	<ul style="list-style-type: none"> ➤ Increase awareness in the community about issues relating to safety and quality in health care and the role of the CEC in promoting safety and quality and system wide improvement

Key	
Completed	✓
Not Completed	✗
Ongoing	→

Outcomes	Status	Future Directions
<ul style="list-style-type: none"> ➤ Enrolment figures for Clinical Leadership Program have increased every year since it began p 26 ➤ Regular internal professional development courses and workshops are held for CEC staff p 62 ➤ CEC staff support participation of rural Area Health Service staff in all capacity building programs ➤ A project to explore ways of delivering quality and safety education to New South Wales medical, nursing and allied health students commenced in January 2010 p 36 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> ➤ To meet increased demand, a second cohort of the executive program will be offered for the first time, starting in August 2010 ➤ The CEC will continue to actively promote continuation of its clinical leadership program ➤ Continue to ensure that rural Area Health Service staff are able to participate in CEC programs by conducting training programs across the state ➤ Continue to engage universities and expand the program of bringing quality and safety education to undergraduates
<ul style="list-style-type: none"> ➤ Project management processes reviewed ➤ Project management policy and procedures written and staff training carried out ➤ Risk management practices reviewed and risk register updated ➤ Regular internal professional developments courses and workshops are held for CEC staff p 62 ➤ CEC staff are encouraged to undertake external professional development activities ➤ Continued to strengthen relationships already established and developed partnerships with new stakeholders p 12 	<ul style="list-style-type: none"> ✓ ✓ ✓ ✓ ✓ ✓ 	<ul style="list-style-type: none"> ➤ Train new staff in project management processes ➤ Continually reassess and update risk register and provide regular reports to the Board ➤ Continue to provide internal education opportunities and encourage staff to participate in external education opportunities ➤ Continue to build relationships and refine synergies with the other members of the Four Agencies <ul style="list-style-type: none"> — Agency for Clinical Innovation (ACI) — Clinical Education and Training Institute (CETI) — Bureau of Health Information (BHI) ➤ Continue to strengthen relationships with other stakeholders in promoting the quality and safety agenda
<ul style="list-style-type: none"> ➤ Communications officer in place, new look website launched and regularly reviewed p 39 ➤ Continual liaison with Area Health Services through Clinical Council, Directors of Clinical Governance, Citizens Engagement Advisory Council p 55 ➤ Partnerships developed over time with various stakeholders have been instrumental in ensuring that clinical practice improvement projects are taken up and implemented p 12 	<ul style="list-style-type: none"> → → → 	<ul style="list-style-type: none"> ➤ Continually review website to ensure that information is current and meets legislative requirements ➤ Continue to work on relationships with all stakeholders to promote the quality and safety agenda ➤ Continue to provide the Minister, CEC Board and other stakeholders with reliable evidence based information to support key safety and quality messages
<ul style="list-style-type: none"> ➤ Falls Prevention Program has developed a web based directory for general practitioners to locate falls prevention programs for their patients in their local area p 34 ➤ The directory will also provide key falls prevention information ➤ Develop relationships with primary care services 	<ul style="list-style-type: none"> → → ✗ 	<ul style="list-style-type: none"> ➤ Continue to develop relationships with primary care services
<ul style="list-style-type: none"> ➤ Expansion of Citizens Engagement Advisory Council (CEAC) p 55 ➤ Rural visit by CEAC ➤ Position of Director Patient Based Care created 	<ul style="list-style-type: none"> ✓ ✓ ✓ 	<ul style="list-style-type: none"> ➤ Review membership of CEAC ➤ Further visits to rural areas planned ➤ Develop a project on health literacy



It is an honour and a privilege to have been appointed Chair of the Board of the Clinical Excellence Commission (CEC), taking over from Professor Bruce Barraclough AO in January 2010.



THE CEC CONTINUES TO PLAY A ROLE IN TRAINING CLINICAL LEADERS OF THE FUTURE THROUGH ITS HIGHLY SUCCESSFUL LEADERSHIP PROGRAM

Bruce has a long and distinguished career in quality and safety in patient care and it will be a challenge to fill his shoes. Commissioner Garling in his Special Commission of Inquiry into Acute Care Services in NSW named four 'pillars', which he saw as underpinning the delivery of excellent care to the people of NSW. The CEC was recognised as the only 'pillar' existing at the time of his report. This public recognition of the vital role played by the CEC was no doubt due to the leadership of Bruce, the commitment of the Board and the staff of the CEC under the direction of its Chief Executive, Professor Cliff Hughes AO. With the implementation of the recommendations of the Special Inquiry, under the *Caring Together* banner, the opportunity to restructure the existing Board to serve both the CEC and the newly formed Agency for Clinical Innovation (ACI) was taken. We have a dynamic and committed Board with the diversity of skills required to steer us through the challenging era of local and national health reform. The newly appointed Board recently revised and aligned the endorsed CEC strategic plan and the draft ACI strategic plan in order to position ourselves to meet these challenges.

The continued presence of Prof Hughes, and his deputy Dr Peter Kennedy has ensured that the CEC has continued to drive clinical improvements over a broad range of areas in 2010. A few successes should be highlighted. The *Between the Flags* project has been implemented across hospitals in NSW, ensuring that a uniform 'early warning' system is in place for all adult patients, hand hygiene programs have been rolled out, with audits and objective reporting showing a pleasing improvement in hand hygiene. New projects under development include a *Between the Flags* project with a focus on the paediatric patient and a sustained program designed to improve the health literacy of our community.

The Quality Systems Assessment program remains a focus of the CEC as it examines and reports on statewide compliance with policies and procedures designed to improve patient outcomes. Public reporting of accurate data is seen by the CEC as a critical element in changing behaviour to improve health outcomes. The CEC is working closely with the Bureau of Health Information and the Agency of Clinical Innovation to improve public reporting to ensure its relevance to patients, clinicians and policy makers. Reporting of Clinical Incident Management, the activities of the Special Committee Investigating Deaths Under Anaesthesia and the Collaborating Hospitals Audit of Surgical Mortality continues. As a consequence of issues raised through these processes, clinical focus reports have been generated, for example in the areas of recognition and management of sepsis, retrieval and transfer and advanced care directives.

The CEC continues to play a role in training clinical leaders of the future through its highly successful Leadership Program.

Inevitably changes in service delivery will occur as part of health reform. The CEC has shown itself to be an agile and responsive arm of the health system and remains well positioned to ensure that quality and safety in the delivery of health care for every patient remains paramount.

Professor Carol Pollock
Board Chair

Chief Executive Officer's Report

2009–2010 can best be described as a year of change and partnership. The Clinical Excellence Commission (CEC) was joined by three emerging “pillars” recommended by Mr Peter Garling SC following the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals. As an already well established organisation, the CEC has enjoyed the opportunity to assist each of the others begin their journey as partners with us.



With uncertainties at both Federal and State levels regarding the structure of acute health care, the CEC continued to develop and implement our programs across the State. The second Strategic Plan built upon the first and provided a stable platform to continue to develop our priorities. Our relatively small organisation of thirty nine (39) staff has matched the performance of similar but much larger organisations around the world.

This report will provide a summary of the depth and breadth of our activities for the year and for which much more detail exists in the individual project reports and on our website at www.cec.health.nsw.gov.au

Assessment

The **Quality Systems Assessment (QSA)** represents an innovative approach to assessment of safety and quality in health care and is a world first for the NSW health system. Each year 20% of reporting health facilities have their QSA responses for the previous year checked through a verification process. The accuracy rate for the first verification process was an impressive 98.7%

Each Area Health Service has been given its own results identifying areas for improvement and exemplar programs. All Area Health Services (AHS) have developed improvement programs for the concerns identified.

Education and Training

Clinical Leadership

The Statewide **Clinical Leadership** program has begun training a third cohort of staff in each Area Health Service, 400 across NSW. A modular program for senior doctors, managers and nurses has proved so popular that this year a fourth module for forty (40) participants has been enrolled with strong support from the Department of Health

Each cohort produces a booklet of projects completed by each member working with their AHS operational staff.

Undergraduate Education

In 2009 a project was established to explore ways of delivering Quality and Safety education to New South Wales medical students. This year the project was extended to include Nursing and Allied Health Schools. The success of this important education initiative is due to the partnerships that have been developed between the CEC and the host universities.

Clinical Practice Improvement

- The **BloodWatch** project is now in its fourth year. Initial reduction in blood wastage achieved by the project has continued unabated reducing blood usage by approximately 10% and saving taxpayers in excess of \$2 million per annum
- Health care associated infections (HAI) are a significant problem in our health care system. It is well known that improving hand hygiene among health care workers is the single most effective intervention to reduce the risk of HAI. The CEC is leading the implementation of the **National Hand Hygiene Initiative** in

NSW at the request of the NSW Department of Health. Hand hygiene audits conducted in all health care facilities in NSW have demonstrated sustained improvement in hand washing just above national averages. One hundred and seventy eight facilities now participate in these quarterly audits

New Project Focus Areas

Deteriorating Patient

Failure to recognise and appropriately manage deteriorating patients is a significant issue in hospitals and health care organisations around the world. In January 2010, the *Between the Flags* program was launched by the Minister for Health at Liverpool Hospital. The program uses the analogy of Surf Life Saving Australia where Lifesavers aim to keep people safe by ensuring they are under close observation, and, should something go wrong, are rapidly rescued. Achievements in the first six months of *Between the Flags* include:

- The “Track and Trigger” Standard Adult General Observation Chart is now mandatory in all public facilities across the state and clinical staff report a high level of satisfaction with the chart
- Similar charts are under construction for mothers at risk in maternity units and paediatric patients
- An extensive awareness campaign has begun to make all 108,000 staff across NSW Health aware of this program
- A Train the Trainer course is also in place led by an emerging cohort of “super trainers” using the DETECT manual, a major text of reference material to support the program

Public Reporting

An important role for the CEC is to report publicly to the Minister and the community on quality and safety in NSW health care. The CEC is committed to engaging the community in an informed discussion on this issue.

- The CEC continues to develop bi-annual Safety Reports from the Incident Information Management System and has embarked on a program to shorten the turnaround time from notification to public reports
- The second edition of the Chartbook which provides analysis and commentary on a broad range of indicators of safety and quality has been released to the system and to the public of NSW
- A series of Clinical Focus reports has been made available to clinicians across the State highlighting priorities for safety and quality of care
- The CEC has developed strong links with the Bureau of Health Information and staff regularly exchange positions on the committees of each organisation
- The Collaborating Hospitals' Audit of Surgical Mortality has released the first annual surgeons report to participating clinicians and produced a booklet of surgical cases with significant learnings for all clinicians

Engaging with Others

We are committed to building effective partnerships with other quality and safety improvement agencies and the community. We share a common goal, promoting clinical quality and safety in health care. Partnerships include:

- The Citizens Engagement Advisory Council (CEAC) which assisted in the development of a job description, interviews and appointment of a Director, Patient Based Care
- Continued development of a body of work on health literacy across cultural groups and representatives of the Indigenous, Muslim and Asian communities among others on CEC committees
- Continued close links with the NSW Department of Health, the Quality and Safety Unit and its various committees
- Working closely with groups such as the Surgical Services Taskforce, Acute Care Taskforce and the Improving Early Pregnancy Care Project

- CEC Executive meeting regularly with the Executive of the Bureau of Health Information, the Agency for Clinical Innovation and the newly formed Clinical Education and Training Institute
- An ongoing collaboration with the Australian Commission on Safety and Quality in Health Care and the two organisations hold regular meetings
- Strong partnership with each of the Area Health Services
- Visits to rural areas. This year the Citizens Engagement Advisory Council (CEAC) visited hospitals in Dubbo and Wellington
- Clinical practice improvement programs run in all Area Health Services by CEC staff

Research

The Research Committee of the Board oversees the research activities of the CEC.

- This year saw Dr David Peiris complete and submit his PhD thesis through the CEC funded Ian O'Rourke Scholarship
- A second PhD scholarship appointment for 2010-2012 is under development
- This year the CEC collaborated on two research projects in partnerships with the Bureau of Health Information, Australian Commission on Quality and Safety in Health Care and NSW Ambulance Service
- The Research Committee also assists our staff in applying for partnership grants, for example with the School of Aviation Psychology at the University of NSW and with The Sax Institute

Financial Sustainability

The CEC achieved a Net Cost Services result of \$9.164 m against the budget approved by the Department of Health of \$9.484 m, a favourability of some \$320,000.

Expenditure for the year increased from \$8.050 m in the previous year to \$9.795 m. The increased expenditure is due to additional staff required to support projects that had previously been in the early stages of development and are now in their full delivery stage.

The liquidity position is stable with a working capital of \$4.7 m compared to 2009 of \$4.9 m. The current asset ratio decreased from 3.53 (2009) to 2.91 (2010). This amounts to a decrease of 62% due to an increase in current leave provisions.

Strategic Planning and Development

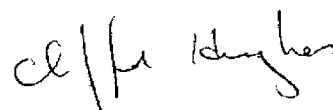
Future directions are clear. With the proposed Local Health Networks to be confirmed, each Director and the Executive has developed a strategy for taking the messages and practices of quality and safety to all parts of the acute care services in NSW. We look forward to working closely with Federal authorities on safety and quality and with each of the new agencies.

The CEC has been strengthened by our engaged and effective Board. We were sad to see the departure of some of our valuable contributors at the completion of their terms. However, the CEC has welcomed the new Board and its members who rapidly embraced the Strategic Plan and the work programs derived from it.

The work of the retiring chair, Professor Bruce Barraclough AO, cannot be overstated. He has been a source of inspiration to staff across the organisation. We are grateful for the time that our new chair, Professor Carol Pollock, is putting in to the formation of both the Agency for Clinical Innovation (ACI) and the CEC.

Challenges

The transition to Local Health Networks that will replace the current eight (8) Area Health Services will necessitate appropriate planning and assessment of issues to ensure continuity of safety and quality improvement projects. The CEC has had continued dialogue with all our stakeholders and developed strategies and programs to assist Local Governing Councils to deal with the challenges of Safety and Quality in this new environment.



Clifford F Hughes AO
Clinical Professor
Chief Executive Officer

Finance Manager's Report

The Clinical Excellence Commission for the 2009-2010 financial year was allocated a Net Cost of Services budget of \$9.484 m by the Department of Health. Audited financial statements reported Net Cost of Services of \$9.164 m, a favourable variation of \$0.320 m, or 3.4%.

The total expenditure for the year is \$9.795 m compared to the previous year of \$8.050 m. This increased expenditure is due to additional staff required to support projects that had previously been in their early stages of development and which are now in their full delivery stage.

The CEC's liquidity position is stable with a working capital of \$4.7 m compared to 2009 of \$4.9 m. This improved result reflects the maturing of fixed term cash investments. The value of investments at year end was \$6.547 m compared to \$5.169 m for the previous year. This represents an improvement of 26.66% with reinvestments of principal and interest on fixed term deposits.

The current asset ratio decreased from 3.53 (2009) to 2.91 (2010). This amounts to a decrease of 62% due to the increase in current leave provisions.

The CEC generated a cash flow from operations of \$6.827 m which is an improvement on \$5.647 m for 2009. This can be attributed to the effective cash management of the surplus within the operational bank account, thus resulting in the investment of fixed term deposits. Further rollover of fixed term deposits and interest have also increased our cash position for 2010.

Total current assets are \$7.249 m compared to \$6.855 m in 2009. The increase is due to our favourable cash position and prompt collection of debtors.

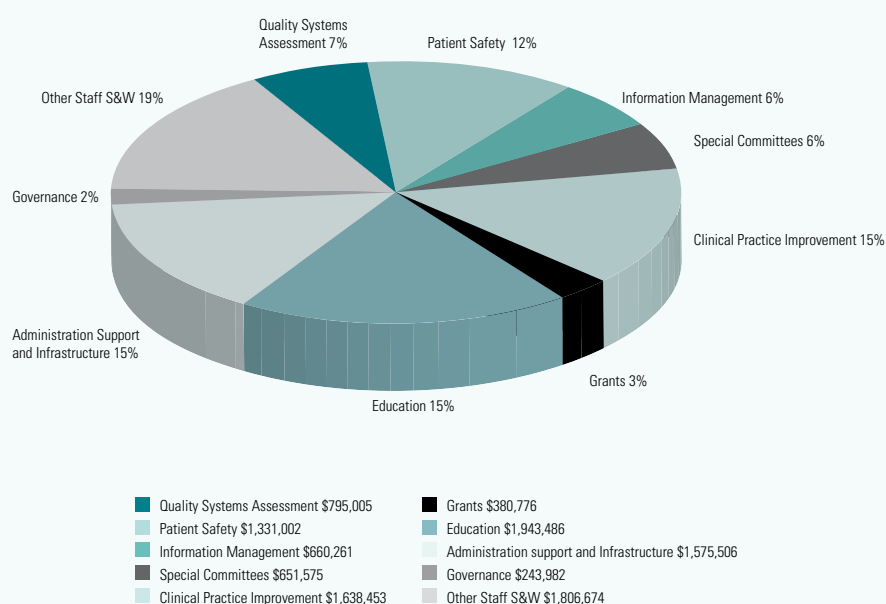
Total liabilities are \$2.570 m compared to \$2.015 m in 2009. The increase in liabilities is mainly due to the leave provisions which are currently being addressed by management.

Nick Didnal
Finance Manager

Financial Summary

Financials (\$000)	2009-10	2008-09	2007-08	2006-07	2005-06
Expenses	9,795	8,050	7,595	6,421	6,175
Revenue	633	564	254	565	176
Gain/(Loss) on Disposal	(2)	5	(9)	0	0
Government Contributions	8,511	7,837	10,187	7,925	7,492
Net Result for the Year	(653)	356	2855	2069	1493
Total Assets	8,637	8,735	7,268	4,561	2,182
Total Liabilities	2,570	2,015	904	1,034	724
Equity	6,067	6,720	6,364	3,527	1,458

Clinical Excellence Commission Expenditure 2009-10



Alliance with *Caring Together*: The Health Action Plan for NSW and the State Health Plan's strategic directions

The CEC, as part of the NSW health system, supports *Caring Together*: The Health Action Plan for NSW which is the NSW Government's response to the recommendations made by Mr Peter Garling SC following his Inquiry into Acute Care Services in NSW Public Hospitals.

The CEC's Strategic Plan and Key Result Areas align with the Final Report of the Special Commission of Inquiry – Acute Care Services in NSW Public Hospitals/*Caring Together* as well as the seven strategic directions outlined in the State Plan and State Health Plan. 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
- Management of the Deteriorating Patient – *Between the Flags* project
- Hand Hygiene
- Medication Safety
- Central Line Associated Bacteraemia collaborative
- Blood Watch Program
- Undergraduate Education in Quality and Safety
- Special Reviews
- Special Committees
- Review of incident management data

2 Create better experiences for people using health services

- Implementation of Clinical Leadership Program across NSW
- Recognition and Management of the Deteriorating Patient – *Between the Flags*
- Blood Watch
- Hand Hygiene
- Central Line Associated Bacteraemia collaborative
- NSW Falls Program
- Medication Safety
- 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

- NSW Falls Program
- Citizens Engagement Advisory Council (CEAC)
- Clinical Leadership program across NSW
- Partnerships with primary health care providers and managers
- Review of incident management data and investigations

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
- Blood Watch program
- Medication Safety

6 Build a sustainable health workforce

- Clinical Leadership program across NSW
- Recognition and Management of the Deteriorating Patient – *Between the Flags*
- Quality systems Assessment (QSA) program
- 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
- Special Reviews
- Undergraduate education in quality and safety
- Quality Systems Assessment program

PERFORMANCE

Clinical Programs and Projects



In collaboration with the Department of Health and clinicians across the State the CEC has developed a series of programs and projects to improve quality and safety in health care.

The following section outlines the performance of our improvement programs and projects during 2009–2010.



Between the Flags	18
Quality Systems Assessment (QSA)	20
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Between the Flags

ALIGNS WITH CEC KEY RESULT AREAS:

- 2 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



Failure to recognise and appropriately manage deteriorating patients is a significant issue in hospitals and health care organisations around the world. The Garling Inquiry into Public Hospitals further highlighted this issue in NSW.

The Clinical Excellence Commission has worked closely with expert clinicians, the Agency for Clinical Innovation and the NSW Department of Health to develop and implement the *Between the Flags* Program.

The program uses the analogy of Surf Life Saving Australia where Lifeguards and Lifesavers aim to keep people safe by ensuring they are under close observation, and, should something go wrong, are rapidly rescued.

The “Five Element Strategy”

The essential components of a sustainable *Between the Flags* Program are:

1. Governance structures to oversee implementation in all of the State's acute hospitals
2. Standard observation charts used for early recognition of the deteriorating patient (clinical observation and ‘track and trigger’ system)
3. Clinical Emergency Response Systems (CERS) incorporating documented clinical review and rapid response procedures in all acute facilities
4. Evaluation, including key performance indicators to be collected, collated and used to inform the users of the system and those managing the implementation and continuation of the strategies
5. Tiered education packages aimed at ensuring skills for the recognition and management of the deteriorating patient, awareness of the track and trigger and rapid response systems and essential skills and knowledge necessary to operate in the Rapid Response System.



Key Achievements

- The *Between the Flags* program was launched on 13 January 2010 at Liverpool Hospital by the Minister for Health, the Hon. Carmel Tebbutt MP
- All Area Health Services have established governance structures including an Executive sponsor
- The Standard Adult General Observation (SAGO) Chart has been implemented in all NSW Acute Facilities, except two research sites. Clinical staff report a high level of satisfaction with the chart
- Refinement by all facilities of their existing escalation procedures to meet the requirements for the Clinical Emergency Response System that link to the Red and Yellow zones on the Standard Observation Chart
- Establishment of the *Between the Flags* Paediatric Steering Committee to oversee the development and Statewide implementation of a Program for paediatrics
- Development of a curriculum for all three education tiers of the *Between the Flags* Program
- Development of an awareness program video to support implementation of *Between the Flags*
- Development of e-learning materials for all clinical staff who are first line responders, to enhance their understanding and management of clinical deterioration called: Detecting Deterioration Evaluation Treatment Escalation and Communication in Teams (DETECT)
- Publication of the DETECT manual of reference material to support the program
- Delivery of DETECT super-trainer workshops to equip staff from all Area Health Services to train further trainers and co-ordinate DETECT face to face workshops
- Key Performance Indicators developed in collaboration with clinical experts, and leaders in the field
- Engagement of key stakeholder groups from metropolitan and rural facilities, medical, nursing and allied health professional backgrounds
- Support and advice to the Department of Health for the development of the policy document "Recognition and Management of a Patient who is Clinically Deteriorating" (PD2010_026)

- Partnerships between NSW Ambulance and Area Health Services to develop the CERS (clinical emergency response system) assist program to support rural and regional facilities
- Development of five (5) age appropriate draft observation charts for paediatric patients
- Development of a draft observation chart for maternity patients
- Deteriorating patient conference in Sydney co-sponsored with the Australian Commission on Safety and Quality in Health Care (ACSQHC)
- Presentation at the Australian Association for Quality in Health Care (AAQHC) conference in Sydney

Partnerships

- Area Health Services
 - Chief Executives
 - Directors of Clinical Governance
 - *Between the Flags* Project Managers
 - Educators
 - Clinicians
- Clinical Safety Quality and Governance Unit NSW Department of Health
- Statewide Services
- Nursing and Midwifery office (NaMO)
- Primary Health and Community Partnerships
- Perinatal Services Network
- Agency for Clinical Innovation
- NSW Ambulance Service
- Expert advisors on the *Between the Flags* steering and advisory committees

Future Directions

- Implementation of the paediatric observation charts in all facilities caring for paediatric patients
- Implementation of the maternity observation chart
- Review of the Standard Adult General Observation Chart
- Development and implementation of a BTF chart for use in Emergency departments not currently using electronic medical record (eMR), and to develop principles for enhancement of eMR to enable Emergency departments to implement *Between the Flags*
- Implementation of the Clinical Emergency Response System (CERS) Assist Program
- Development of a Statewide database for recording of rapid response call data
- Evaluation of the *Between the Flags* Program

Publications

- *Between the Flags*: Implementation Toolkit

Challenges

- Release and backfilling of 65,000 staff to attend DETECT training
- Transition to *Between the Flags* Program for facilities with research site status
- Maintaining dialogue, listening and learning, working with clinical and administrative colleagues to make sure that the above challenges do not become barriers to implementation
- Ensuring that the electronic medical record (eMR) provides clinicians with the same capacity to track patient observations and trigger an appropriate response that the paper-based standard observation charts provide

Quality Systems Assessment (QSA)

Some of the QSA Assessor trainees 2010



ALIGNS WITH CEC KEY RESULT AREAS:

- 3 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

Some of the QSA Assessor trainees 2010

L to R Alan Morrison, Dr Brett Courtenay, Dr Patricia Saccasan-Whelan, Bradley Williams, A/Prof Stephen Della-Fiorentina, Dr Marcel Leroi, Prof Michael Fulham, Trish Alexander, Lee Silk, Deborah Elliget, Dr K Suresh Badami, Dr Antonella Ventura, Allan Hall, Dr Tracey Tay, Wendy Jamieson, Marianne Lackner, Chris Lemmer, Dr Lyn Currie

- The QSA focuses on systems, not on individual performance
- Onsite verification provides a valuable opportunity to engage with service providers about their performance in relation to the themes assessed through the QSA

Key Achievements

Self assessment

- The 2009 QSA was completed in November 2009 and focused on four topics:
 - Medication safety
 - Clinical handover
 - Communication in clinical environment
 - Deteriorating patient
- These areas were chosen based on their current importance within the NSW public health system, the findings from the 2007 QSA and review of data from the Incident Information Management System (IIMS)
- The 2009 QSA self assessment involved over 1080 clinical departments, 96 facilities, 36 networks and achieved an overall 90% response rate
- Analysis of results demonstrates areas where performance is strong, such as the implementation of programs for the deteriorating patient and use of standardised methods for clinical communication, and further identifies areas for improvement, for example,

the lack of standardised processes for clinical handover and lack of policies in relation to high risk medication

- Almost all clinical units (96%) agreed or strongly agreed there was a positive culture of safety and quality with 88% of respondents agreeing or strongly agreeing that there had been an improvement in safety and quality of patient care in their unit over the past two years. As well a high proportion of departments/units are using patient experience to drive improvements in safety and quality
- These responses are encouraging and suggest that the NSW Patient Safety and Clinical Quality Program has had a positive impact in addressing system wide safety and quality issues within NSW
- The 2010 QSA self assessment will focus on three themes:
 - Healthcare Associated Infection (HAI)
 - Open disclosure
 - Teamwork

Onsite verification program

- In July 2009 the CEC commenced the QSA on-site verification program for all PHOs
- Each year twenty per cent of the AHS facilities will be subject to an onsite visit. This will see all facilities in NSW having participated in the QSA verification program over a five year cycle

The QSA program is made up of four elements (Figure 1):

Figure 1: The QSA model

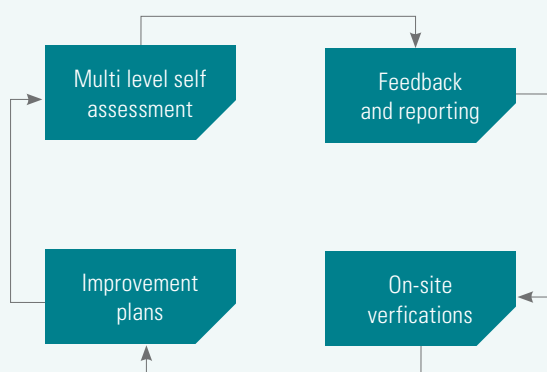
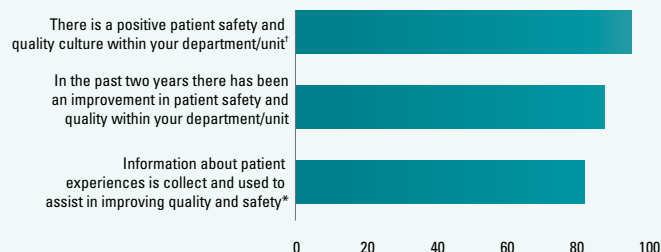


Figure 2: Department/unit responses



† percentage of department/unit level respondents who agreed or strongly agreed

* percentage of department/unit level respondents who answered 'yes'

➤ The aim of the program is to:

- verify self assessment ratings from the previous year
- review evidence such as policies and guidelines cited in self assessment responses
- determine areas for improvement
- review use of QSA data/results from previous self assessment
- review improvement plan progress
- share best practice by encouraging staff to share information on any innovations they have successfully designed and adopted
- The CEC invites expressions of interest from each public health organisation for staff to volunteer to become assessors
- Over 50 staff including doctors, nurses, and allied health professionals have undertaken training in a competency based program

Results

- The results from the 2007–2008 QSA verification program demonstrated an overall accuracy rate of 98.7% for the 2,795 responses reviewed
- AHS staff feedback indicated that the majority of AHS staff found the on-site verification process beneficial, effective and undertaken professionally
- The assessors indicated that it was a valuable exercise for them and that they were well trained to undertake the verification process
- While there were areas for each AHS to improve upon, the CEC also identified ways to refine and improve the verification process for 2010

Reporting

- The data collected from the 2009 QSA was analysed and a suite of reports have been developed
- Statewide report which presents select results around the four themes
- Supplementary report which has in-depth information about the program, 2009 self assessment results, and verification program
- Executive summary
- Individual PHO reports
- The Statewide report makes four key recommendations with each PHO expected to develop an improvement plan that will address the recommendations as well as specific issues raised in the self assessments that relate to their service

Improvement plans

- The improvement plan provides an integrated approach between the self assessment and recommendations
- Following the analysis and reporting of data, all NSW PHOs are expected to develop an improvement plan that:
 - a. Addresses policy areas where performance is less than the State average
 - b. Addresses the organisation specific risks identified in the self assessment and
 - c. Addresses the statewide report's recommendations
- Formal yearly review and onsite verification visit gives accountability to AHSs to ensure processes are implemented and outcomes are measured

Partnerships

- Clinical staff in all public health organisations across NSW
- Directors of Clinical Governance in all public health organisation across NSW
- NSW Department of Health

Future Directions

- As the QSA self-assessment occurs annually, it has the capacity to continually provide the health system with contemporary insights regarding its key risks to patient safety and clinical quality
- The onsite verification program adds further depth to information provided in the self assessment, allows for areas of exemplary practice and innovation to be identified and provides a means to collect information from front line clinical staff that can be utilised to inform subsequent assessments

Challenges

- To make the QSA of increasing practical value to departments, facilities and Area Health Services
- To avoid duplication of effort around quality and safety activities



Patient safety and incident management

ALIGNS WITH CEC KEY RESULT AREAS:

- 1 Public reporting
- 2 Clinical improvement
- 4 Information management
- 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



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 with safety and quality of health care provided across the NSW health system.

The patient safety team continues to utilise Incident Information Management System (IIMS) and Root Cause Analysis (RCA) reports, along with discussions with key clinical groups and directors of clinical governance, to identify opportunities for improvements in the safety and quality of clinical care. The team also has responsibility for education and support of incident investigation processes and associated skills.

Key Achievements

➤ Clinical focus reports

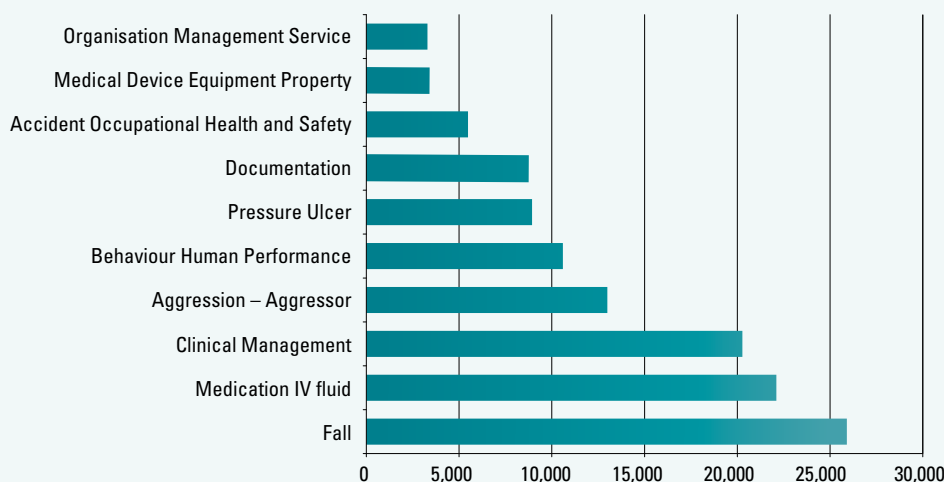
Three reports were finalised and distributed

Use of Midazolam	July 2009
Recognition and Management of Sepsis	December 2009
Retrieval and Inter-hospital Transfer	June 2010

Other activities undertaken

- Human factors training (in partnership with the University of NSW) was held in March 2010, with a follow up session planned for July 2010. A resource was developed for use by RCA team leaders and patient safety managers following the training. It will be uploaded to the CEC website. Many of this training group and other patient safety managers will attend a seminar with Professor René Amalberti, the Clinical Excellence Commission's Visiting Professor in August 2010 to further enhance their learning and application of human factors approaches to incident investigations and safety solutions

The most frequently reported incident types in IIMS 2009-2010



- RCA training – the original Safety Improvement program (SIP) training for the core RCA methodology has been updated and was run in Greater Southern Area Health Service in June 2010. Learnings from the human factors training and open disclosure have been incorporated into the training. Further training is planned with other Area Health Services in the coming months
- Specialist medical consultations survey was undertaken in February 2010, to understand the issues involved in ensuring timely and appropriate specialist reviews of hospital patients. The initial results were provided to health service staff and further publication of results will occur
- A rapid incident response project has been initiated with one metropolitan and one rural area health service. This is based on the approach used at the University of Illinois Chicago, which applies a rapid coordinated response to clinical incidents, ensuring that there is clear support for all involved and a much shorter incident investigation time lag than the current RCA process
- Support structures to increase the engagement of consumers in RCA review processes are being developed, so that consumers can have greater input into the CEC-based RCA review committees (clinical management, mental health drug and alcohol and maternity/perinatal)

- Public reporting continues to be a focus of the patient safety team. Routine reporting processes include:
 - Six-monthly public reports on incident management
 - Annual reports on IIMS data to each health service
 - Clinical focus reports referred to above

Partnerships

The patient safety team worked closely with

- University of NSW aviation for both the human factors training and the ongoing work of the Australian Research Council (ARC) linkage grant related to analysis of human factors in health care incidents
- NSW Department of Health in relationship to incident management and reporting functions, as well as RCA review committees with the Mental Health Drug and Alcohol Office (MHDAO) and Primary Health Community Partnerships
- Directors of Clinical Governance, patient safety staff
- Human factors and patient safety leaders within Australia and internationally

Future Directions

The team will focus on core existing programs over the next year, ensuring they are implemented in a sustainable way before starting other work. A small increase in capacity will facilitate a coordinated approach to early recognition and management of sepsis, initiated in response to the clinical focus report cited earlier.

Challenges

- Achieving consistently good practice across devolved processes associated with incident management, including open disclosure and engagement of the patient, family and staff affected by clinical incidents
- The expanded activity in partnership with seventeen Local Hospital Networks and regional clusters will be a challenge for our staff and resources

Hand Hygiene

ALIGNS WITH CEC KEY RESULT AREAS:

- 1 Public reporting
- 2 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
- 5 Make smart choices about the costs and benefits of health services
- 6 Build a sustainable health workforce
- 7 Be ready for new risks and opportunities



Health care associated infections (HAI) are a significant problem in our healthcare system. It is well known that improving hand hygiene among health care workers (HCW) is the single most effective intervention to reduce the risk of HAI.^{1,2}

The Clinical Excellence Commission is leading the implementation of the National Hand Hygiene Initiative in NSW at the request of the NSW Department of Health. The Initiative is based on the "5 Moments for Hand Hygiene" promoted by the World Health Organisation (WHO) – World Alliance for Patient Safety program – "Clean Care is Safer Care". The 5 moments are:

1. Before touching a patient
2. Before a procedure
3. After a procedure
4. After touching a patient
5. After leaving the patient's environment

Key Achievements

- Progressive implementation of Gold Standard Assessor (GSA) and Ward Auditor training in each Area Health Service (AHS), with over 700 GSAs and ward auditors trained to conduct hand hygiene audits across NSW
- Hand Hygiene Compliance Audits conducted in 158 facilities across all Area Health Services
- NSW Hand Hygiene Improvement Training Workshop conducted in March 2010, attended by teams from each Area Health Service to build capacity for change management initiatives in infection control at an AHS level (capacity building)
- Publication of Medical Journal of Australia (MJA) supplement on Hand Hygiene in October 2009, with editorial comment provided by Prof. Didier Pittet, World Health Organisation
- Inclusion of the 5 Moments for Hand Hygiene in the latest version of the Australian Council of Health Care Standards (ACHS) national accreditation program – EQulPv5
- Celebration of World Hand Hygiene day in May 2010 with a marquee in Martin Place, Sydney and interview on Channel 7 Sunrise program regarding the importance of hand hygiene and alcohol based hand rub



CEC Hand Hygiene staff join Mister Germ, the Germinator and members of the NCAHS Primary School Hygiene and Nutrition Program in Martin Place Sydney on World Hand Hygiene Day, 5 May 2010.

Partnerships

The Hand Hygiene program has successfully partnered with health-based, community and other public services, including:

- Hand Hygiene Australia
- Area Health Services
- NSW Department of Health
- North Coast Area Health Service 'Mister Germ' Primary School Hygiene and Nutrition Program
- Development of hand hygiene education video with Northside Baptist Community Pre-school
- Contributed to procurement process for Alcohol Based Hand Rub products in the development of tender specifications

Future directions

The Hand Hygiene Program will seek:

- To improve processes for managing and reporting Staph aureus bacteraemia (SAB) through a standardised investigation and review process by development and testing of a data linkage process (linking pathology laboratory data with Health Information Exchange data) to improve reliability of capture of SAB data
- To develop and implement strategies to improve medical leadership in hand hygiene compliance

Challenges

- Developing effective links between clinicians in Local Hospital Networks, the CEC, the NSW Department of Health and the Australian Commission on Safety and Quality in Health Care
- Improving hand hygiene compliance beyond current levels

¹ Allegranzi B, Pittet D. Role of hand hygiene in healthcare-associated infection prevention. *Journal of Hospital Infection*. 2009 Dec;73(4):305-15.

² Boyce JM, Pittet D. Guideline for Hand Hygiene in Health-Care Settings: recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *Infect Control Hosp Epidemiol*. 2002 Dec;23(12 Suppl):S3-40.

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

The CEC Clinical Leadership Program has a focus on improving patient safety and clinical quality by supporting and developing clinical leaders in the workplace. It has been running for three years and is delivered over a calendar year.

The program is offered in two modalities: foundational (Statewide CLP) and executive (Modular CLP). The foundational CLP is a multidisciplinary program, delivered by local Area Facilitators within an Area Health Service. The executive program is delivered as six intensive modules in Sydney, to senior clinician managers. Both are delivered over a calendar year.

Interest has remained strong, with enrolment figures increasing over the past three years. For 2010, over two hundred (200) participants are enrolled in the foundational (Statewide) program and forty (40) in the executive (Modular). To meet increased demand, a second cohort of the executive program will be offered for the first time, starting in August 2010.

The value of investing in clinical leadership programs is recognised at statewide, national and international levels. The CEC's CLP is

consistent with directions outlined in the NSW Health Strategic Plan and the NSW *Caring Together* report, by linking leadership with patient safety and governance and ensuring interests of patients and staff remain at the heart of healthcare delivery.

Key Achievements

- A major benefit in 2009 was the provision of substantial program funding by the NSW Department of Health, to allow the program to continue on an annual basis. This facilitated the employment of local program facilitators and early planning for the 2010 program roll out
- Over two hundred (200) participants completed the program in 2009, with all participants undertaking an individual or team clinical improvement initiative designed to improve patient safety and clinical quality



**LEFT Greater Southern Area Health Service (GSAHS)
Clinical Leadership Statewide Program 2009
Cohort Graduation**

From left to right: Jacinta Elphick, Kathy Grady, Conie Bostock (facilitator), Ken Hampson (Central Sector A/ GM), Jodie Bloomfield, Alison Kincaid, Mid Battye, Cheryl Duncan, Amanda Baker (facilitator), Catherine Walker

Absent graduates: Brigid Horne, Fiona Renshaw, Jenny Bateman, Sarah Roach, Mark Gibbs

ABOVE 2009 Modular Clinical Leadership Program – Final Presentation day 23 April 2010

Left to right standing: Gillian Bishop (SSWAHS), Claire Harris (SSWAHS), Simone Locke (Ambulance), Craig Boutlis (SESAHS), Rob Davies (NCAHS), Dion Forstner (SSWAHS), Jens Kilian (SSWAHS), Michael Parr (SSWAHS), Andrew Bailey (NCAHS), James Cameron (HNEAHS), Deborah Zador (Justice Health), Allan Kerrigan (GWAHS), Amanda Hugman (NSCCAHS), Graeme Malone (Ambulance), Cameron Dart (HNEAHS), David Smith (NCAHS), Sergio Diez Alvarez (HNEAHS), Stephen Nolan (NSCCAHS), Fiona Mackie (SESAHS), **Seated left to right:** Kay Wright (CEC), Trevor Chan (SESAHS), Joanne Rogerson (Ambulance), Marcia Fogarty (SWAHS), Cliff Hughes (CEC), Bernie Harrison (CEC), Ralph Stanford (SESAHS), Karen Waters (CHW), Susan Piper (NSCCAHS)

Absent: Maura McCambridge (HNEAHS), Carmelo Aquilina (SWAHS), Paul Middleton (Ambulance), Daniel Challis (SESAHS), David Winlaw (CHW), Terry O'Shea (NCAHS), Andrew Bisitis (HNEAHS), David Greenberg (Justice Health), David Furrows (NCAHS), Antonella Ventura (Justice Health), Nicholas Wilcken (SWAHS)

- The executive (Modular) CLP closing ceremony in April 2010 was attended by the NSW Minister for Health, the Hon Carmel Tebbutt MP, and a number of senior health executives. The session included feedback by participants on how the program had benefited patient safety and clinical quality. Similar graduations and project-sharing were held at the local level for participants completing the Statewide CLP. A summary of all projects undertaken through the program is compiled by the CEC on an annual basis and made available in hard and electronic copy
- Participants completing the 2009 program were surveyed on how well the program met their expectations and key program deliverables. Results reinforced external evaluation of the program in 2008, indicating that the CEC CLP has a strong and appropriate concept and that the content is well aligned to participants' needs. In many cases, the expectations of participants and other stakeholders were exceeded as indicated by testimonial responses
- Strong interest and enrolment figures indicate the program is providing a much-needed and welcome resource in the NSW health service

Partnerships

- The CLP is a collaborative enterprise between the CEC, NSW Department of Health, Area Health Services and external business partners. In addition to delivering specific program content, it links with associated programs at area and statewide levels to help build capacity and improve quality and patient safety at local levels
- The CEC also assists other jurisdictions seeking to develop clinical leadership programs. During 2009-2010, the NSW Institute of Research and Clinical Services Training implemented a Clinical Team Leadership Program which linked with the CEC Statewide CLP. The CEC's Professor Clifford Hughes and CLP Program Manager, Colleen Leathley participated in a clinical leadership forum hosted by the Victorian Quality Council

Future Directions

- The CEC will continue to actively promote continuation of its clinical leadership program, building on the linkages it makes between leadership, patient safety and governance within the NSW Health system
- Opportunities for CLP alumni to gather to network and reinforce their commitment to patient safety are also being explored

Challenges

Significant gains have been made throughout the program's first four years. The challenge is to build on and sustain the momentum gained to date, while responding to broader challenges of funding and reform uncertainties.

Clinical Practice Improvement

ALIGNS WITH CEC KEY RESULT AREAS:

- 2 Clinical improvement
- 5 Capacity building
- 6 Organisational development

ALIGNS WITH STATE HEALTH PLAN OBJECTIVES:

- 1 Make prevention everybody's business
- 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



The Clinical Excellence Commission provides clinical practice improvement (CPI) training to participants of the Clinical Leadership Program and to front line clinicians in NSW health facilities.

The CEC also works closely with Area Health Services, the Children's Hospital Westmead, Justice Health and Ambulance Service Quality Managers, to build the capacity and capability for them to support health care improvement projects and teams within public health organisations (PHOs).

The CPI methodology provides a framework whereby clinicians can undertake a comprehensive diagnostic of the causes of process failures which lead to inefficiencies and/or patient harm and design solutions to continuously improve care for patients.

The basic principles of Clinical Practice Improvement include the following:

- Health care is a process which can be analysed
- Both the process and the outcomes of clinical work can be measured
- Profound knowledge of the processes of care exist within individuals who work in the system, in particular 'microsystems'
- Multi disciplinary teamwork and the design of novel solutions are essential in effecting improvements in the health process
- There is the will and leadership to implement change

Phases of CPI

As an adjunct to face to face training, the CEC, in collaboration with NSW Department of Health's, Health Service Performance Improvement Branch (HSPIB), has developed e-learning modules in health care improvement methods including CPI methodology.

CPI Program Objectives

The program aims to improve the safety and quality of care to patients through:

- Enhancing the knowledge of clinicians about quality improvement theory
- Improving the ability of clinicians to identify causes of process failures within their clinical teams
- Enhancing clinicians' personal and professional leadership skills (teamwork)
- Equipping health care facilities with personnel who can apply improvement methodology to effect change; implement evidence based practice and address problems arising out of root cause analyses
- Designing effective solutions using plan, do, study, act (PDSA) tests of change
- Awareness of microsystem re-engineering, human factors and reliable design principles
- Foundation in measuring for quality using statistical process control charts
- Spreading and sustaining change and improvement

Key Achievements

In 2009 – 2010 the CEC conducted a total of 24 CPI workshops which included:

- CEC Clinical Leadership Program and NSW Rural Institute Clinical Team Leadership Program; 250 nursing, medical and allied health clinicians have undergone CPI training. All participants completed an improvement project
- Two day CPI workshops were offered to AHS Clinical Governance Units with 175 participants attending local workshops and undertaking local improvement projects
- A CPI facilitator network was formed during the second half of 2009 to focus on building capacity for CPI training and support of improvement projects
- CPI e-learning modules were completed in November 2009 and a 'CPI course', which includes shared clinical redesign e-learning modules, is now available on the NSW GEM platform for all NSW public health employees

Partnerships

Proposed initiatives to consolidate Health Care Improvement training include:

- Developing web based information outlining health care improvement courses in NSW, including staff, problems and issues they would suit, through partnership between CEC, NSW HSPIB and Nursing and Midwifery Office

- Creating a forum for collaboration around improvement training through partnerships between, CEC, NSW Health and Clinical Education and Training Institute (CETI)
- Reviewing alignment of health care improvement initiatives with NSW Health key performance indicators through partnership with NSW HSPIB
- Progressing more standardised care processes across the system, including more reliable work setting design and training front line staff in improvement methods and human factors through partnership with the Agency for Clinical Innovation (ACI)
- Improving the measurement capability in the system e.g. Electronic Medical Record to enhance data linkage and feedback loops, through partnership with the Bureau for Health Information (BHI)
- Continue to build on the successful international partnership with Dr Brent James at Intermountain Health Care's Institute for Health Care Delivery research in the USA, who is a key advisor for the CEC's CPI Program
- Continue to build on the successful collaboration with the Institute for Healthcare Improvement in Boston and to continue to contribute to international best practice in quality and safety education for front line staff

Future Directions

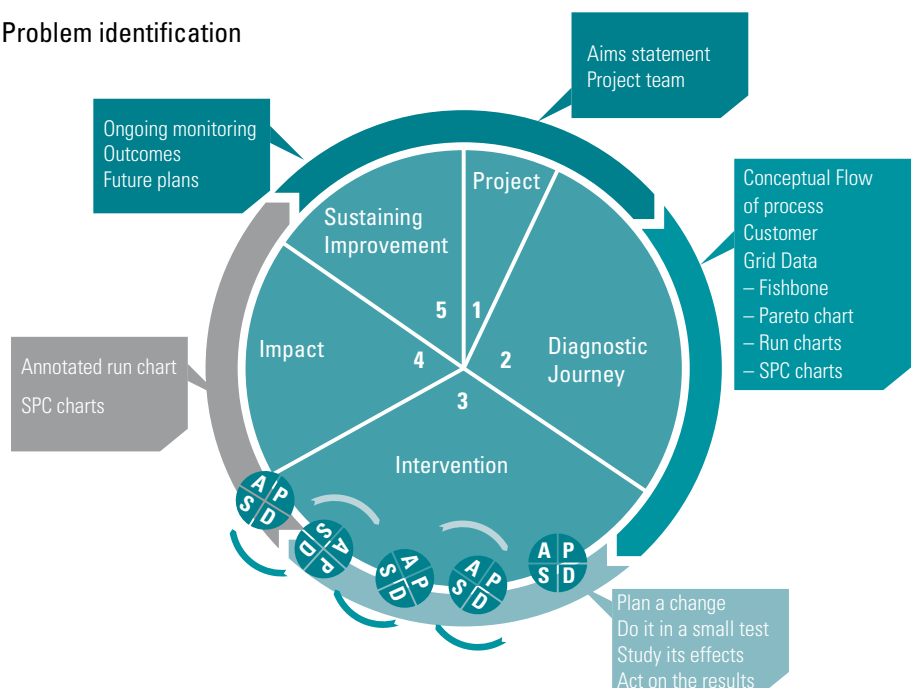
Following consultation with key stakeholders in relation to health care improvement training needs in NSW a planning day was held in collaboration with NSW Health Department's Health Service Performance Improvement Branch and the NSW Institute for Medical Education and Training (IMET) in April 2010. The objective was to ensure that there is equity in educational delivery in improvement methods for all clinicians; that the education is easily accessible and that care for patients is improved.

Challenges

- Improving the health system's understanding of health care improvement training and the variety of methods that can be used to implement it
- Engaging effectively with emerging Local Health Networks executive so that clinical practice improvement initiatives are supported and resourced in local facilities
- Maintain close cooperation with other quality improvement programs, eg co-design and clinical network activities

Phases of CPI

Problem identification



Medication Safety

ALIGNS WITH CEC KEY RESULT AREAS:

- 2 Clinical improvement
- 4 Information management

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



The Clinical Excellence Commission is actively involved in improving the quality and safety of medicines use. The medication safety/quality use of medicines program of the CEC has focussed around the provision of tools and resources which enable hospitals to analyse and improve their systems.

The major tools developed have been the:

- Medication Safety Self Assessment for Australian Hospitals (MSSA)
- Medication Safety Self Assessment for Antithrombotic Therapy in Australian Hospitals (MSSA-AT) and
- Indicators for Quality Use of Medicines in Australian Hospitals

These tools provide hospitals with a method of assessing their medication management systems for inherent risks. They also provide a mechanism for measuring performance improvement over time.

In addition to providing these tools, the CEC has actively supported facilities in completing them, and in responding to the results obtained.

The Quality Use of Antimicrobials in Intensive Care project started during this reporting period and will examine ways to optimise the use of antibiotics and other agents used to treat infections in the Intensive Care Unit (ICU). In optimising the use of these medicines, it is anticipated that patient outcomes will be improved and the development of resistant organisms will be reduced.

Key Achievements

- The MSSA continues to be widely used throughout Australia. Two hundred and twenty one (221) facilities, including 158 in NSW, have completed the tool
- Twenty one (21) facilities have repeated the MSSA, showing an average improvement of almost 10% on their baseline score. This demonstrates that the MSSA is being used to drive improvement activities related to medication safety

Partnerships

The Clinical Excellence Commission continues its role as an advocate for medication safety and provides input to the work of a number of NSW Health committees, advisory groups and working parties focussing on issues related to medicines use.

The NSW Therapeutic Advisory Group and the CEC continue to work together in a number of key areas. Ongoing work related to the MSSA program is a key collaboration of the two organisations. The two organisations have also co-authored a number of reports prepared for the information of drug and therapeutics committees, highlighting risks associated with certain medications.

The CEC is working with academics from the Faculty of Pharmacy, University of Sydney and the Centre for Innovation in Practice School of Pharmacy and Pharmaceutical Sciences, University of Manchester to analyse the safety culture climate within hospital pharmacy departments.



The CEC is an active partner of the Australian Commission on Safety and Quality in Health Care (ACSQHC) and continues to contribute to a number of their medication safety programs including the development of national safety and quality health care standards, development of tools and resources to support the continuity of care and development of a national standard for the application of Tall Man lettering.

Future Directions

- The CEC has subscribed to an international project developing a chemotherapy safety self assessment. This project will deliver a tool for piloting in 2010-2011 and for ongoing use by Australian hospitals soon after
- The CEC will continue to investigate ways to optimise the use of antimicrobials in the ICU

Challenges

- Encouraging facilities to repeat the MSSA and determine what actions they still need to take in order to improve their medication management systems
- Facilitating the transition from measuring the safety of medicines management systems to active systems improvement
- Ensuring that medication safety is appropriately resourced

Blood Watch – Transfusion Medicine Improvement Program

ALIGNS WITH CEC KEY RESULT AREAS:

- 2 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



The CEC Blood Watch Program, now in its fourth year, coordinates the implementation of improvements in transfusion practice across NSW based on priority areas identified by the NSW Department of Health Blood Clinical and Scientific Advisory Committee.

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

Within each Area Health Service local transfusion improvement teams made up of nursing, scientist and medical clinicians with expertise in transfusion, drive and support local initiatives to sustain transfusion best practice.

Key Achievements

- The Red Cell Utilisation results for 2007–2008 showed an average 10% reduction in red cell usage for all inpatient activity in NSW hospitals despite an increase in hospital activity. This reduction has been sustained over two years and equates to a direct product cost of approximately \$2,383,855 savings (based on \$A260 per unit). This figure is inclusive of the Commonwealth Government's 63% contribution to the State's blood budget. Local red cell audits continue to support this downward trend
- The BloodSafe e-learning program, endorsed by the CEC, has been supported and implemented across most NSW public hospitals. Over 11,000 NSW registrants have successfully completed the modules on blood administration and safety
- In 2008 the CEC conducted a successful communications campaign directed at senior orthopaedic and cardiothoracic surgeons with the aim of influencing their prescribing behaviours. In 2009 the CEC undertook a second campaign. The targeted audience in 2009 included the next biggest group of red cell prescribers (in the haemodynamically stable adult population): gastroenterologists, obstetricians, gynaecologists and anaesthetists. The multi-channel approach included direct email marketing to the target group, advertising in key publications and an on-line debate at www.thetransfusionquestion.com.au which was again supported by an international "virtual faculty". Over 3000 visitors entered the site during the second campaign. Visitors from over 80 countries entered the site despite the campaign being directed at NSW clinicians only. Numerous comments were posted on the debate pages relating to the new topics.



The campaign won two Public Relations Institute of Australia awards in the Health category.

Partnerships

- Continuous collaboration with the National Blood Authority in the areas of haemovigilance and the e-learning program
- Continuous partnerships with all Area Health Services in the implementation of Blood Watch initiatives
- Close partnerships with key stakeholders such as the Australian Blood Service and NSW Department of Health through the Blood Clinical and Scientific Advisory Committee
- Sharing of information and methodologies with other jurisdictions, for example data linkage work with the South Australian Department of Health

Future Directions

- Develop a five year business plan and secure funding for the continuation of the Blood Watch Program
- Implementation of Blood Watch work plan 2010–2011 with particular emphasis on the recognition and treatment of iron deficiency anaemia as a way of reducing inappropriate red cell transfusion
- Continue work within NSW to establish a haemovigilance reporting system
- Dissemination and implementation of the new National Health and Medical Research Council (NHMRC)/Australasian Society of Blood Transfusion (ASBT) Blood Management Guidelines

Challenges

- Continuous improvement of transfusion practice and sustaining those improvements

Falls Prevention Program

ALIGNS WITH CEC KEY RESULT AREAS:

- 2 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
- 2 Strengthen primary health care and continuing care in the community
- 3 Build regional and other partnerships for health



The NSW Falls Prevention Program is focused on older people to reduce the incidence and severity of falls and to reduce the social, psychological and economic impact of falls among older people, families and carers.

The prevention and reduction of falls and falls injury is a priority for NSW Health. The *NSW State Health Plan 2006-2010* supports projects to reduce fall injuries by promoting healthy ageing and enabling increased levels of physical activity and early identification and management strategies for those at risk. The NSW Falls Prevention Program extends Statewide across a health continuum of care: hospitals, community and residential aged care. It is supported by the CEC Program Leader and Project Officer who work closely with the eight Area Falls Co-ordinators and Project Officer for the NSW Falls Prevention Network. Each Area Health Service (AHS) has governance structures supporting the implementation of area falls plans across all eight AHSs.

Key Achievements

In partnership with the NSW Falls Prevention Network

Rural Falls Forum (with 3 x 2hr videoconference sessions) was held in North Coast Area Health Service in November 2009 across ten sites. Key experts provided updates on research and best practice. A feature of the forum was to support the sharing of initiatives across Area Health Services. There were 178 participants who reported that the sessions changed their approach to falls prevention.

The 2010 NSW Falls Prevention Network Meeting was held in June 2010. The meeting was attended by 214 professionals from hospitals, community services, residential aged care, local government and the community. The focus this

year was on dementia and delirium as there have been many requests from the Network to provide information on the care of the confused older person across the continuum of care. Over 300 CDs of this event have been distributed.

CAREX: Aged Care Expo CAREX. The CEC and the NSW Falls Prevention Network exhibited at the CAREX in July 2009 at Rosehill. The CEC conducted a workshop session on *Safety and Quality Care of residents: Evidence Based Falls prevention*. The NSW Falls Prevention Network stand provided information and resources to over 250 people.



1 NSW Falls Prevention Program Co-ordinators – Back Row L-R: Kylie Kearns, Jacqui Kelly, Esther Vance, Mary-Clare Maloney, Kathy Richardson, Lorraine Dubois, Clare Monger, Jenny Bawden, Wendy Watson, Lorraine Lovitt – Front Row L-R: Patsy Bourke, Margaret Armstrong, Katika Siric. **2** NSCCAHS “Exercise Motivators” **3** The Hon Carmel Tebbutt, Deputy Premier and Minister for Health with members of NSCCAHS Exercise Motivators **4** St Vincent’s Tai Chi in Martin Place

Partnerships

In partnership with the Centre for Health Advancement, NSW Department of Health

CEC Project to develop a “Community Falls Prevention Resource: Staying Active and on Your Feet”. The new resource consolidates falls prevention information into a single 20 page resource with exercises that people can do at home and includes a home safety checklist. This is for Statewide distribution.

CEC Project to develop a falls prevention physical activity web-based resource directory

<http://www.activeandhealthy.nsw.gov.au>
This project started in February 2010. By entering a postcode, older people and their carers, General Practitioners, and other health professionals will be able to use the website facility to locate falls prevention programs available in their locality. This directory will also provide key falls information for the general public, exercise providers and health professionals. It is anticipated that this site will go live late 2010.

In partnership with Area Health Services

Annual April Falls Day and Month activities are developed and facilitated across NSW by the CEC, Area Falls Prevention Co-ordinators and the NSW Falls Prevention Network to raise awareness of the issues of falls prevention across the settings of Acute Care, Community and Residential Care.

The 2010 event was launched by Hon Carmel Tebbutt MP, NSW Minister for Health at the CEC April Falls Day activities in Martin Place, Sydney to promote the benefits of exercise in falls prevention. At this special event there were demonstrations of different types of exercise

with a Tai Chi group supported by St Vincent’s Community Health and the ‘Exercise Motivators’ from Northern Sydney Central Coast Area Health Service. A special bulletin of Statewide activities was circulated. This Statewide event includes both government and non-government partnerships. Other States and Territories have now adopted the name for similar falls prevention promotions.

In partnership with other agencies

Australian Commission on Safety and Quality in Health Care (ACSQHC) 2009, Falls Prevention Best Practice Guidelines. The CEC has worked closely with ACSQHC in consultation with the National Injury Prevention Working Group in supporting national printing and distribution of these guidelines. The guideline link is available at: <http://www.cec.health.nsw.gov.au/programs/falls-prevention.html>

The Ambulance Service NSW

The CEC Falls Prevention Program in collaboration with the Ambulance Research Institute (ARI) is undertaking a range of studies aimed at better understanding the epidemiology and outcomes of patients who have fallen and called for an emergency ambulance. Ambulance Service of New South Wales responds to approximately 90,000 emergencies classified as ‘falls’ annually, and approximately 25% of these are not transported to an emergency department.

The Agency for Clinical Innovation (ACI)

The CEC Falls Prevention Program Leader is a member of the ACI Musculoskeletal Working Group, and has a key role in ensuring that falls prevention initiatives are linked to the work of this Network. There are good working relationships with the Ophthalmology, Aged Care and Stroke Networks.

Future Directions

- Working with the Centre for Health Advancement, NSW Department of Health in finalising a new falls plan: *NSW Health Plan Prevention of Falls and Harm from Falls among Older People: 2010-2014*
- Establishing key strategic areas for which the CEC will have responsibility in the implementation of the new plan
- Distribution and implementation of the Australian Commission on Safety and Quality in Health Care (ACSQHC) 2009 *Preventing Falls and Harm from Falls best practice guidelines for Australian Hospitals, Community Care and Residential Aged Care in NSW*
- Working to engage with consumers in the development of key falls initiatives
- Distribution of *Staying Active and on your Feet* consumer resource and launch of the web-based falls prevention physical activity directory

Challenges

- Meeting the needs of the workforce in providing care to older people and, demonstrating improved clinical practice and outcomes in falls prevention
- Developing targeted services for people at medium to high falls risk across community, hospital and residential care aged care sectors and in particular within emergency departments

Teaching Quality and Safety to Undergraduates

ALIGNS WITH CEC KEY RESULT AREAS:

- 2 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



In January 2009 the CEC established a project to explore ways of delivering quality and safety education to New South Wales medical students.

This project is led by Professor Kim Oates. In 2010 it was extended to include Nursing and Allied Health Schools.

Key Achievements

Medical student teaching

- Notre Dame University School of Medicine
 - Teaching time negotiated for four interactive modules each of two hours for first-year medical students
 - Three modules delivered so far with excellent feedback
 - Teaching was delivered by Kim Oates with expert input from CEC staff for the discussion group components of each module
 - Notre Dame staff co-teach in the program with a view to taking over the teaching in subsequent years
 - Teaching this group will continue in 2011 (their second year) and beyond
- The 2011 first year intake will also receive this teaching, continuing into their subsequent years
- A pre-test post-test research design has been incorporated into the program
- In addition the students will be followed over time and compared with a similar cohort not exposed to this teaching
- University of Western Sydney (UWS) School of Medicine
 - Teaching first and second-year students starts in July 2010
 - Tutor guides and tutor manuals have been prepared and tutor training has been held with UWS teaching staff
 - Kim Oates will deliver the interactive lecture components of the course and take a tutorial group
- University of Newcastle School of Medicine
 - A new medical curriculum is being developed
 - Agreement has been reached to include quality and safety teaching from the CEC in 2011 when the new curriculum starts
- University of Wollongong Medical School
 - This school already has an interest in quality and safety and will use the CEC (mostly Kim Oates) as a resource in developing its curriculum and for guest lectures
- University of Melbourne
 - This Medical School is developing a new curriculum
 - Representatives from the university have visited the CEC to observe our medical school quality and safety teaching and will incorporate some aspects of the CEC program into its new student program

Nursing School Teaching

- University of Technology Sydney (UTS)
 - UTS set aside a full day for an “immersion” in quality and safety for first year students, delivered by the CEC.
 - Because of the large numbers (over 500) the lectures were delivered by podcast
 - CEC staff, accompanied by UTS co-teachers, gave four interactive tutorials each of two hours
 - A pre-test post-test design was used to assess knowledge transfer
 - A follow-up session with UTS showed high satisfaction and a desire to continue into 2011 and beyond
- University of Wollongong Nursing School
 - This nursing school is interested in developing an online nursing curriculum in quality and safety based on the CEC curriculum
 - It is likely to become part of a consortium of Wollongong, UTS and Newcastle nursing schools
- University of Newcastle
 - Negotiations have resulted in agreement to introduce face-to-face teaching in quality and safety, provided by the CEC from the beginning of 2011
 - Discussions have been held with Newcastle School of Medicine and School of Nursing about the feasibility of some of these sessions being joint teaching of nursing and medical students
- University of Sydney
 - Teaching in a post-registration nursing course (four modules) will commence September 2010

Allied Health Teaching

- University of Sydney
 - Cumberland College is developing a new curriculum for several of its Allied Health courses to commence in 2011
 - Agreement has been reached to incorporate CEC quality and safety teaching into these courses

Partnerships

- Teaching quality and safety to undergraduates is done in partnership with the host university as classes are co-taught with CEC and university staff. This involves the host university in the teaching and is a way of transferring knowledge to the staff so that they will later be able to do the teaching themselves, needing CEC only for advice
- At Hanoi Medical University, in partnership with the University of Sydney, Professor Oates will be teaching patient safety and clinical handover to recent graduates from the Hanoi Medical University, the major medical school in Vietnam
- A partnership is currently being developed between the CEC, the Royal Australasian College of Physicians (RACP) and Institute for Healthcare Improvement (IHI), Boston, for Quality and Safety Units from the IHI Open School to become part of RACP training. Agreement has been reached between IHI and RACP to proceed
- Liaison with the Institute for Healthcare Improvement (IHI) to gain free access to their Open School, an on-line course in quality and safety designed specifically for students. This can be available to any medical, nursing and Allied health students involved in CEC teaching
- A research study looking at the amount and type of quality and safety teaching in medical schools across Australia, conducted in collaboration with Professor Jeffrey Braithwaite and Professor Alan Spigelman from the University of New South Wales
- Organisation of a CEC workshop for medical and nursing teachers on “Undergraduate education in quality and safety” conducted by Dr David Mayer and Dr Tim McDonald from the University of Illinois, Chicago

Future Directions

- Teaching Allied Health students in 2011
- Developing teaching modules for students in their second and subsequent years
- Working with University of Wollongong School of Nursing in developing an on-line course
- Building a research program to evaluate changes in learning and behaviour with UTS nursing
- Adding more medical and nursing schools to the program
- As part of a University of Sydney teaching program for recent graduates in Hanoi and Ho Chi Minh City, Professor Oates will be teaching clinical handover in late 2010 and 2011 using the ISBAR (Identification, Situation, Background, Assessment, Request) method
- Enrolling a PhD student to do a culture survey looking at longer term change in attitudes as result of undergraduate quality and safety teaching
- Development of a Fellowship proposal for quality and safety training in the postgraduate years as a way of producing future leaders in this area. Funding is required

Challenges

- Securing funding for the Fellowship program
- Managing the growth of this program as more universities become involved and as teaching occurs in more than one year of each university course. There is the potential for the growth to be exponential so that significant resources will be required
- Recruiting additional suitably trained teachers from the pool associated with the CEC
- Training the teachers at the Universities so they can continue this teaching while at the same time maintaining quality control monitored by the CEC

Chartbook

ALIGNS WITH CEC KEY RESULT AREAS:

- 1 Public reporting
- 4 Information management

ALIGNS WITH STATE HEALTH PLAN OBJECTIVES:

- 1 Make prevention everybody's business
- 3 Strengthen primary health care and continuing care in the community
- 5 Make smart choices about the costs and benefits of health services
- 7 Be ready for new risks and opportunities

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, *Chartbook 2007*, containing 63 indicators and accompanying text – was released on 6 May 2008 and was well received by the NSW health system.

Following the success of the first edition, and with the benefit of clinician feedback, the CEC released the *Chartbook on Safety and Quality in Health Care in NSW 2008 (Chartbook 2008)* in March 2010. *Chartbook 2008* contained 84 indicators. Expert analysis has been provided by the placement within the CEC of a trainee biostatistician from NSW Health's biostatistical training program, and the creation of a permanent biostatistical position. Expert advice was provided by clinical experts for individual indicators.

The *Chartbook* provides analysis and commentary on a broad range of indicators of safety and quality. It shows where the health system is doing well, but also highlights areas for improvement. The ultimate test of the *Chartbook* is that it will stimulate discussion and informed action across the health care system to improve the quality and safety of health care services.

Work on the third edition (*Chartbook 2009*) started in August 2009. In common with previous years, expert analysis is being provided by a trainee biostatistician, and the CEC's biostatistician. Expert advice is again being provided by clinical experts for individual indicators.

Key Achievements

The second edition expands the analysis via new chapters on Aboriginal health, neonatal intensive care, ambulance and indicators of safety and quality. Among the 84 indicators, the second edition also introduces thematic maps for selected indicators and a range of new indicators within existing chapters.

The CEC Chartbook series 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 health care services in NSW for use by the public and non-specialist audiences
- relevant time-series information in tabular and graphical formats with interpretive text that explain the findings, and describes the importance and implications for Area Health Services and clinical governance units
- reports on outcomes of key initiatives of the CEC and NSW Health that address safety and quality issues

Future Directions

Preparation of the third edition – *Chartbook 2009* – is underway. Several proposals regarding how this publication can be made more relevant to clinicians, the health system and the public have been incorporated. Suggestions included different analyses, different 'views' of the analyses and different ways of presenting the data. The more relevant it is, the more health professionals will be enabled to identify and take up opportunities for improvement. Importantly, the more accessible it is, the more the public – the people we serve – will be informed about the safety and quality issues of health care in NSW and how the health system is responding to these challenges over time.

This is a tool to drive change, to facilitate self-examination by doctors, nurses and health professionals and managers of our health care system.

Challenges

Ensuring that the information contained in Chartbook is fresh and relevant for clinicians and accessible to the public without over simplifying important issues.

Information management and information technology initiatives

ALIGNS WITH CEC KEY RESULT AREAS:

- 1 Public reporting
- 4 Information management

ALIGNS WITH STATE HEALTH PLAN OBJECTIVES:

- 1 Make prevention everybody's business
- 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



Supporting CEC's information initiatives and reporting activities

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.

Key Achievements

The CEC Information Directorate has provided support and advice regarding:

- QSA, Blood Watch, CLAB-ICU, CHASM and SCIDUA databases
- records management and TRIM
- privacy, security, secure storage and disposal of paper and electronic record collections

Future Directions

The CEC Information Directorate continues to have a key support role for all functional areas within CEC.

IT and IM planning and development

IAB Services were contracted to audit CEC's IT and IM compliance, beginning in August 2009. Based on the findings of that audit, CEC is considering a range of revised and expanded options for Information/Communication Technology (ICT) to provide renewed capacity, sustainability and compliance over the next five years. This is a timely opportunity given the CEC has grown significantly in the last five years, our operations have changed accordingly and we are planning a move to new premises. To achieve this, the ICT Strategic Plan has been developed and will be implemented via 19 key projects through CEC's ICT Steering Committee. This will assist CEC to meet ICT best practice and ensure compliance with NSW Government ICT directives into the future (e.g. by defining ISO 27001 ISMS, reviewing Records Management, specifying upgrades of desktops and back office functionality, and enabling better access to eLearning, collaboration and survey tools). Taken together, these initiatives improve CEC's ICT capacity, and therefore significantly enhance our opportunities to use ICT more effectively and innovatively to support our business.

Future Directions

The projects within the ICT Strategic Plan, and the move to new premises represents an ideal opportunity to optimally reconfigure CEC's ICT, which will happen throughout 2010–11. To facilitate deployment and rollout of the ICT Strategic Plan, new IT and IM policies and procedures will be developed, along with an ongoing staff education plan.

CEC Website

The CEC website is our corporate portal to the world: www.cec.health.nsw.gov.au

Key Achievements

The CEC launched a new-look website in September 2009. The revisions to the website particularly concerned functionality, corporate presence, ease of access and ease of use. The CEC website receives thousands of unique visitors and download requests every month. It is a key component of our ability to readily disseminate our work and make it easily available to clinicians and the public.

Future Directions

Continue to improve our web presence and to augment it with additional internet capabilities, along with internal capacities focused on intranet and extranet-type capacity.

The Collaborating Hospitals' Audit of Surgical Mortality (CHASM)

ALIGNS WITH CEC KEY RESULT AREAS:

- 2 Clinical improvement
- 4 Information management
- 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

The Collaborating Hospitals' Audit of Surgical Mortality (CHASM) is a systematic peer review audit of deaths of patients who were under the care of a surgeon at some time during their hospital stay in NSW.

CHASM is overseen by a Committee, which was established under Section 20 of the *Health Administration Act 1982* and appointed by the Minister for Health. Its terms of reference are to review hospital deaths that occur within 30 days after an operation or during the last hospital admission under the care of a surgeon, irrespective of whether or not an operation has been performed.

The CHASM audit methodology is based on the Scottish Audit of Surgical Mortality established in 1994. Information collected for CHASM is privileged from subpoena under Section 23 of the same Act and protected by the Commonwealth Qualified Privilege Scheme under Part VC of the *Health Insurance Act 1973* (gazetted 6 November 2006).

Key Achievements

From 1 July 2009 to 30 June 2010, CHASM:

- Recorded 2303 deaths notified by all Area Health Services
- Received 1483³ completed surgical case forms from surgeons
- Completed the audit of 1084⁴ notified deaths

At 30 June 2010, 738 surgeons were participating in CHASM, with 318 of them also agreeing to be first line assessors and 234 to be second line assessors. The following figure shows the participation level of surgeons in NSW who are active fellows of the Royal Australasian College of Surgeons (RACS) by surgical specialty. Just over half (52%) of the active fellows of RACS were participating in CHASM in NSW at 30 June 2010. Vascular, neurosurgery, general and cardiothoracic were the top four participating specialties.

CHASM sent out an individualised feedback report to 386 participating surgeons in April 2010. It gave a summary of the data provided by the surgeon and compared it with aggregated data of peers in the same surgical specialty, as well as NSW surgeons in all specialties.

CHASM also published a case booklet with short summaries of eleven (11) selected cases from those deaths in NSW which have gone through the full CHASM audit cycle. It included five illustrative cases on aspiration pneumonitis and commentary by Dr Allysian Armstrong-Brown, consultant anaesthetist at the John Hunter Hospital and CHASM committee member. It also included short summaries of the clinical features and learning points of cases from different specialities for surgeons' consideration.

Future Directions

- CHASM will submit its first program report to the Minister for Health
- CHASM is working with the Australian and New Zealand Audit of Surgical Mortality to set up the Fellow Interface, which is an online reporting facility, for NSW surgeons and to migrate the NSW data to the Bi-National Audit System
- CHASM will undertake research projects to examine preventable deficiency of care identified from the audit

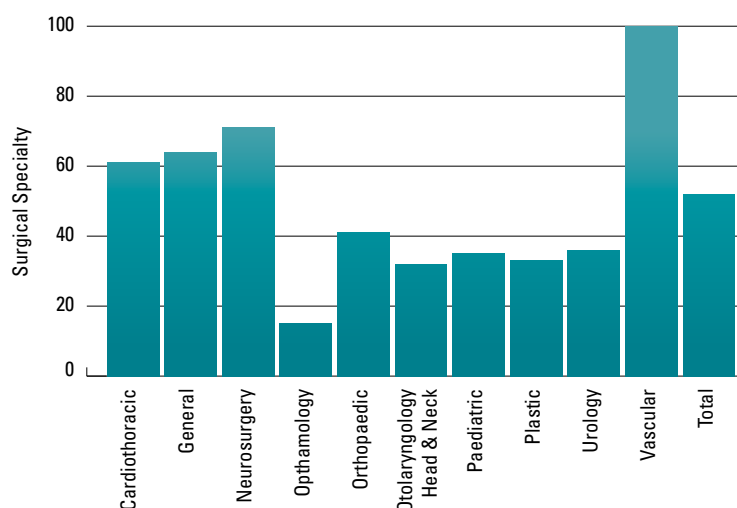
Challenges

- Encourage surgeon participation in and as assessors for CHASM
- Ensure that surgical deaths are notified to CHASM by Area Health Services
- Improve the efficiency and effectiveness of the business processes that support the auditing of an annual estimate of 2,500 deaths

Partnerships

CHASM is funded by the NSW Department of Health, administered by the Clinical Excellence Commission (CEC) and co-managed by the NSW State Committee of the Royal Australasian College of Surgeons (RACS). At the national level, CHASM is a partner of the Australian and New Zealand Audit of Surgical Mortality (ANZASM), which was formed by the Royal Australasian College of Surgeons in 2005 to coordinate the development and implementation of surgical mortality audits in the two countries.

Percentage of Surgeons participating in CHASM in NSW by Surgical Specialty (n=738)



Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)

ALIGNS WITH CEC KEY RESULT AREAS:

- 1 Public reporting
- 2 Clinical improvement
- 4 Information management

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



The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) was established in 1960, and is the longest serving committee of its kind in the world. It is an expert committee appointed by the Minister for Health under Section 20 of the *Health Administration Act 1982*.

SCIDUA reviews deaths which occur while under, as a result of, or within 24 hours after the administration of anaesthesia or sedation for procedures of a medical, surgical, dental or investigative nature to identify any area of clinical management where alternative methods could have led to a more favourable result. Information collected for SCIDUA is privileged from subpoena under Section 23 of the same Act.

Key Achievements

From 1 July 2009 to 30 June 2010, SCIDUA:

- Recorded 189 deaths notified via the coronial mechanism and by Area Health Services
- Completed the audit of 211 notified deaths
- Classified 180 notified deaths, with 45 being anaesthesia-related

SCIDUA worked successfully with NSW Department of Health to ensure that monitoring of anaesthesia related deaths continues following amendment of the *Coroners Act 1980*, which removed the reference to anaesthesia related deaths as a category of reportable deaths, and replaced it with deaths that were not the reasonably expected outcome of a health-related procedure carried out in relation

to the person. The *Public Health Act 1991* and *Public Health (General) Regulation 2002* were amended to make a death occurring

'while under, or as a result of, or within 24 hours after the administration of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure or an operation or procedure of a like nature (other than a local anaesthetic administered solely for the purpose of facilitating a procedure for resuscitation from apparent or impending death)' ('Anaesthesia Related Deaths')

a Category 1 Scheduled Medical Condition. Since January 2010, anaesthetists are required to notify anaesthesia related deaths to the Director-General by completing the notification form.

The SCIDUA database was upgraded to support the new reporting process.

Information about the change in legislative requirement for reporting, including a downloadable notification form, was published on the SCIDUA webpage.

Copies of the SCIDUA notification form were sent to the Chief Executives at Area Health Services and all the Departments of Anaesthesia at NSW hospitals.

The State Form Committee approved the SCIDUA form of notification.

Dr David Pickford, Chairman of SCIDUA provided a written submission to the draft *Public Health Bill 2010*, which proposes amendments to the *Public Health Act 1991* to include deaths within 24 hours following the administration of sedation as a notification requirement to SCIDUA.

Partnerships

SCIDUA is a long-standing partner of the Australian and New Zealand College of Anaesthetists and provides data annually for the College's triennial report on safety of anaesthesia in the two countries.

Future Directions

SCIDUA will examine the cost effectiveness of online reporting for an annual notification of 200 to 250 deaths.

Challenges

Ensure that anaesthesia-related deaths are notified to SCIDUA by anaesthetists.

Ensure that all completed SCIDUA notification forms are submitted.

Special Reviews and Audits

ALIGNS WITH CEC KEY RESULT AREAS:

- 1 Public reporting
- 2 Clinical improvement
- 4 Information management

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



There were no Special Reviews conducted under the *Health Services Act 1997* for the reporting period.

However, the NSW Department of Health engaged the CEC to conduct an audit on the implementation of the Improving Early Pregnancy Care Project which resulted from the Hughes/Walters Inquiry when a woman had a miscarriage in the emergency department at Royal North Shore Hospital.

Aim of the Improving Early Pregnancy Care Project

The aim of the project was to provide a coordinated and integrated Statewide service for women encountering problems in early pregnancy (prior 20 weeks gestation) with greater access to quality health care and support in a timely and sustained manner.

This included:

- Establishing a telephone advice line for women with problems in early pregnancy
- Evaluating the quality of care provided to women with problems in early pregnancy in emergency department by conducting a medical record audit and small qualitative study

Role of the CEC

The role of the CEC was to conduct an audit on the telephone advice line, and medical records in the Emergency Department. In addition, a small qualitative study on women's experience of early pregnancy care in emergency departments was started in Hunter New England Area Health Service.

Key Achievements

- Audit completed on the telephone advice line for women to call when they have a problem in early pregnancy
- Prevalence study completed on the service delivery characteristics of women who present with problems in early pregnancy
- Audit completed on medical records in the emergency department on women who present with problems in early pregnancy
- The small qualitative study on women's experience of early pregnancy care in emergency departments in Hunter New England Area Health Service will be completed in November 2010

Future Directions

- Complete the qualitative study in Hunter New England Area Health Service
- Communicate the findings on the Improving Early Pregnancy Care Project to the community and health care providers in NSW

Research



The Research Committee of the Board oversees the research activities of the CEC.

Specific research-related activities in which the CEC has been involved in the reporting period are highlighted below:

- Centre for Health Record Linkage (ChReL) and Data Linkage

The CEC's three-year commitment to ChReL concluded in 2009. Membership has provided:

- Support for the introduction of data linkage in NSW to enable longitudinal linked research (e.g. The 45 and up study) and publications in cancer and population health
- Indirect capacity for CEC (and others) to report linked mortality data. Currently eight charts in the ChartBook rely on this capacity via Health Outcomes Information and Statistical Toolkit (HOIST)
- Support for four healthcare research projects with a safety and quality focus that required linked data. Two of these projects involve:
 - A partnership between CEC, BHI and ACSQHC examining 30-day mortality, and contracted to University of Western Sydney (UWS)
 - A collaboration with Ambulance Service of NSW (see right)

Future Directions

As a former member, CEC retains favourable access for linkage projects only requiring access to the Master Linkage Key (MLK).

30-Day Mortality Data Linkage Project With BHI And ACSQHC

This project is a collaboration led by CEC, with the Australian Commission on Quality and Safety in Health Care (ACQSHC) and the Bureau of Health Information (BHI) to develop performance metrics for hospitals regarding unexpected death during and within 30 days after admission to hospital, and to target interventions to minimise these events. It will involve analysis of linked population-based data for NSW regarding admissions to hospital (overnight and day-only), emergency department presentations and mortality (fact and cause of death).

Key Achievements

- UWS appointed to run the project
- Ethics approval granted for data linkage
- First presentation provided to the Steering Committee

Future Directions

The project will be run by UWS on behalf of the collaboration during 2010-11 providing a report and publications against the five objectives.

Ambulance Service NSW Data Linkage

This project is a collaboration between CEC and Ambulance Service of NSW. Strategic questions concerning whether services are optimal, cost effective or even clinically correct are almost completely unanswerable, at present because Ambulance data is not linked with data from the rest of NSW Health. The project requires the internal linking of Ambulance computerised and paperbased data collections and external linking of this combined dataset to the emergency department, admitted patient and deaths data through ChReL, to understand the outcomes for these patients transported by Ambulance Service of NSW.

Key Achievements

- Team established at Ambulance Service of NSW to run the project, with CEC membership
- Ethics approval granted for data linkage

Future Directions

Such a linked data set would include everything from the outcomes of single interventions to the outcomes of changes to system-wide strategies, illuminating the effect and consequence of every change in patient management. There are, therefore, multiple, exceedingly important proposed uses for the dataset.



Community elder Ivan Wellington and Dr David Peiris
Photo courtesy of Tharawal Aboriginal Corporation

Ian O'Rourke Scholarship in Patient Safety

The Clinical Excellence Commission awards one Ian O'Rourke Scholarship every three years in NSW. The inaugural Ian O'Rourke PhD Scholar, Dr David Peiris has completed his research and will submit his thesis, *Building better primary care systems for Indigenous peoples: A multimethods analysis* to the University of Sydney in July 2010. In the thesis Dr Peiris explores strategies to building better primary health care systems for Indigenous peoples with a focus on management and prevention of vascular diseases. The thesis is conducted in two inter-related parts.

Part A explores the effectiveness of primary health care for Indigenous peoples. An initial focus of Dr Peiris' research was on health system monitoring by reviewing how adequately NSW Health reports, by Aboriginal status, against national performance chronic disease-related indicators. This work was conducted in collaboration with the Clinical Excellence Commission and resulted in a co-authored paper that was accepted for publication in the Australian and New Zealand Journal of Public Health (see p 66)

Part B of the research explores access to health care for Indigenous peoples. Dr Peiris conducted three studies that examine broader contextual factors that might influence the implementation of interventions to improve primary care system performance.

The two inter-related parts of the thesis produce a suite of qualitative, quantitative and mixed methods studies that sequentially build a greater understanding of what is needed to build better primary care systems. Dr Peiris contributes to our understanding of primary care system performance for Indigenous peoples and explores innovative interventions to improve that performance.

David Peiris has dedicated the thesis to the late Ian O'Rourke in honour of his dedication to building better systems of care for Indigenous peoples.

Future Directions

Ms Elizabeth Rix has been selected as the second Ian O'Rourke Scholar and will research the experiences and perceptions of Aboriginal people receiving haemodialysis treatment in regional NSW. Ms Rix will start fulltime research from July 2010.

CEC Board



The CEC is a board-governed, statutory health corporation established under the Health Services Act 1997. In March 2010, two separate Boards with common membership were appointed to oversee the Clinical Excellence Commission and the newly created Agency for Clinical Innovation (ACI). The new Board replaced the previous CEC Board and Committees which were dissolved on 31 December 2009.

CEC Board



Professor Bruce H Barraclough AO

- Dean of Education, Royal Australasian College of Surgeons
- Associate Dean (Clinical Strategy) of the University of Western Sydney Medical School
- Board Chair, Australian E-Health Research Centre
- Serves on working parties for World Health Organisation Patient Safety
- Past President of the International Society for Quality in Health Care
- Board Chair, NSW Clinical Excellence Commission 2005–2010
- Professor/Director of Cancer Services, Northern Sydney Health and the University of Sydney (2000–2005)
- Chair of the Australian Council for Safety and Quality in Health Care (2000–2005)
- President of the Royal Australasian College of Surgeons (1998–2001)

Board Chair since 1 February 2005

Appointment ended 31 December 2009



Professor Carol Pollock

- Trained in renal medicine at Royal North Shore Hospital (RNSH) after graduating from the University of NSW in 1981
- 1991 appointed as a senior lecturer at RNSH
- 2000 appointed Chair of Medicine
- 2000 Chair of Research in Northern Sydney Central Coast Area Health Service
- Chair of the Area Health Advisory Council for the Northern Sydney Central Coast Area Health Service
- A founding director and currently Chairperson of BioMed North, a company supporting the development of intellectual property out of Area Health Services
- Sits on the boards of several philanthropic organisations supporting medical research

Board Chair since 11 January 2010

Appointment expires 10 January 2014



Professor Clifford Hughes AO

- Chief Executive Officer of the Clinical Excellence Commission
- This appointment followed a 25-year career as a cardiothoracic surgeon in Sydney
- Has been Chairman or member of numerous State and federal committees associated with quality, safety and research in clinical practice for health care services
- Has held various positions in the Royal Australasian College of Surgeons, including Senior Examiner in Cardiothoracic Surgery and member of the College Council
- Member of four editorial boards and has published widely in books, journals and conference proceedings on cardiothoracic surgery, quality and safety
- Has a particular passion for patient-driven care, better incident management, quality improvement programs and development of clinical leaders
- Received a number of awards for his national and international work including an Alumni Award from the University of NSW
- In 1998, Australia recognised his contribution by making him an Officer in the Order of Australia for “service to cardiac surgery, international relations and the community”

Board member since 1 February 2005

Appointment expires 4 January 2014



Lee Ausburn

- Bachelors and Masters Degrees in Pharmacy; Diploma Hospital Pharmacy – University of Sydney
- Graduate, Australian Institute of Company Directors
- Non-executive Director, Australian Pharmaceutical Industries Ltd
- Vice President, Council, Pharmacy Foundation, University of Sydney
- 24 year career in the global pharmaceutical industry in a variety of roles including Vice President, Asia until 2007

Board member since 2 March 2010
Appointment expires 10 January 2014



Ken Barker

- Many years experience in NSW public sector and financial management, and strategic expertise
- Former Chief Financial Officer of the NSW Department of Health
- Expertise in the NSW public health system and its position within the Australian health care system
- Graduate of the Australian Institute of Company Directors and a Fellow of the National Institute of Accounts
- Currently the financial/business expert on the National Blood Authority Advisory Board and independent member of its Audit Committee

Board member since 2 March 2010
Appointment expires 10 January 2014



Melinda Conrad

- Melinda Conrad is a director and company advisor specialising in strategy and communications to the business, health and social services sectors
- She is a board member of the Garvan Institute Foundation and the Australian Brandenburg Orchestra
- Her professional training and executive experience is grounded in business, with particular emphasis on organisation design, change management, community engagement and systems improvement
- She holds a Masters in Business Administration from Harvard University

Board member since 2 March 2010
Appointment expires 10 January 2014



Dr Andrew Cooke

- Currently a Resident Medical Officer at the St George and Sutherland Hospitals
- Conjoint Associate Lecturer at the UNSW School of Medicine
- Master of Law (Hons) from the University of Cambridge
- Qualified solicitor with previous private and public sector experience in NSW and Victoria

Board member since 2 March 2010
Appointment expires 10 January 2014



Major General Peter Dunn AO (Retd)

- A consultant who specialises in the fields of leadership, change management and organisational design
- Was the inaugural Commissioner of the ACT Emergency Services Authority 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
- Was instrumental in restructuring the strategic Defence personnel organisation and has also worked in the fields of acquisition, logistics and information systems

Board member since 1 February 2005
Appointment expired 31 January 2010



Professor Phillip Harris AM

- Clinical Director of the Cardiovascular Service in Sydney South West Area Health Service
- Chair of the Patient Care Committee at Royal Prince Alfred Hospital and former Head of the Department of Cardiology and the Division of Medicine
- Clinical Professor of Medicine at the University of Sydney
- Former Board member of the Heart Foundation and Heart Research Institute
- 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 expired 31 January 2010



Dr Mark Henschke OAM

- Has been a Visiting Medical Officer (VMO) (GP/Obstetrician) at the Armidale Rural Referral Hospital since 1981
- Has taught medical students and worked as a supervisor in the GP training programs since 1990
- In 2007 was awarded RAMUS (Rural Australian Medical Undergraduate Scheme) Mentor of the Year for his work with medical graduates interested in a career in rural General Practice
- Has also been an examiner for the Diploma of Obstetrics (DRANZCOG) for more than 20 years
- In 2005, Dr Henschke was awarded the Order of Australia Medal (OAM) for his 'Services to medicine as a General Practitioner and to the community of Armidale'

Board member since 18 August 2008

Appointment expired 31 January 2010



Robyn Kruk AM

- Has extensive executive experience in human services, natural resources and central agencies
- Served as the Director-General of NSW Health (2002–2007)
- Director-General of NSW National Parks and Wildlife (1994–1998)
- Held executive positions in both the NSW Cabinet Office and the Department of Premier and Cabinet, culminating as Director-General of the Department of Premier and Cabinet (2007–2008)
- Deputy Chair of the Reforming States Group (RSG). The RSG is a US based not for profit organisation to support reform in the delivery of health services
- Currently Secretary of the Commonwealth Environment, Water, Heritage and the Arts portfolio

Board member since 3 February 2009

Appointment expires 31 December 2014



Professor Ron McCallum AO

- Professor of Labour Law in the Faculty of Law of the University of Sydney
- Dean of Law University of Sydney from July 2002 to September 2007
- Blake Dawson Waldron Professor in Industrial Law from January 1993 to September 2007
- 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
- The inaugural President of the Australian Labour Law Association
- The Asian regional Vice-President of the International Society for Labour and Social Security Law from September 2006 to September 2009
- Has assisted with the drafting of labour legislation for the New South Wales and Queensland governments
- January 2009 commenced his two year term as a member of the United Nations Committee on the Rights of Persons with Disabilities whose function it is to monitor the United Nations Convention on the Rights of Persons with Disabilities
- February 2009 appointed as the General Rapporteur of this Committee
- 2010 Chair of the United Nations committee on the Rights of Persons with Disabilities

Board member since 3 December 2007
Appointment expired 31 January 2010



Associate Professor Brian McCaughan AM

- A cardiothoracic surgeon whose major clinical interest is the management of lung cancer
- Clinical Associate Professor at the University of Sydney
- Held a number of positions with the Royal Australasian College of Surgeons culminating in Chairmanship of the NSW State Committee from 1992 to 1994
- Was a Member of the Ministerial Advisory Committee on Quality in Health Care
- Was appointed to the NSW Health Council
- Served as President of New South Wales Medical Board from October 1999 until December 2004
- Currently Chair of the Sustainable Access Health Priority Taskforce and a member of the Health Care Advisory Council for NSW Health
- Awarded Member of the Order of Australia for his services to medicine

Board member since 2 March 2010
Appointment expires 10 January 2014



Dr Richard Matthews

- Deputy Director-General of the Strategic Development Division at NSW Department of Health
- Until June 2007, carried a dual role as Deputy Director-General and Chief Executive of Justice Health
- Started his career in general practice and developed a special interest in drug and alcohol. Worked for many years at St. Vincent's Hospital Rankin Court Methadone Stabilisation Unit
- Association with Justice Health (previously known as Corrections Health Service) began in 1992 when he assumed responsibility for administration of the Methadone Maintenance Program
- In 1993, appointed Director of Drug and Alcohol Services for Justice Health, in 1998 Director of Clinical Services, and Chief Executive Officer in 1999
- In current role at NSW Health has strategic planning responsibility for national health reform, statewide services development, primary health and community partnerships, mental health and drug and alcohol programs, inter-government and funding strategies, chronic disease and child, youth and family health

Board member since 2 March 2010
Appointment expires 10 January 2014



Noel O'Brien OAM

- Was chair of New England Area Health Service 2000–2004
- Chair of the NSW Association of Mining Related Councils 1999–2004
- Councillor of Gunnedah Shire 1991–2004 and has served two terms as mayor
- Participated in community consultation process co-chaired by Rt. Hon Ian Sinclair and Wendy McCarthy AO
- Member of board of directors of Westpac Rescue Helicopter Service, Hunter/New England/North West
- Managing director of a mining industry training company

Board member since 1 February 2005
Appointment expired 31 January 2010



Professor Janice Reid AM

- Vice-Chancellor and President of the University of Western Sydney since 1998
- Recipient of several awards and honours both in Australia and overseas
- Been a member of the boards of public agencies at State and Federal levels in the areas of health information and research, welfare, schools, arts, higher education, energy and international relations
- In January 1998 Professor Reid was made a Member of the Order of Australia for services to cross-cultural public health research and the development of health services for socio-economically disadvantaged groups in the community
- In 2003 received the Centenary Medal for service to Australian society through health and university administration

Board member since 3 December 2007
Appointment expires 10 January 2014



Associate Professor Gabriel Shannon

- Has practised as a General and Renal Physician at Orange in central western NSW since 1980
- Helped establish renal dialysis services and a diabetic education centre in Orange servicing surrounding area in the early 1980's
- In 2001 took a senior staff specialist position at Orange and became the Director of Physician Training at that site
- In 2002 appointed Sub Dean of the Orange Campus of the School of Rural Health, University of Sydney
- Is the Clinical Leader of the Clinical Governance Unit, Greater Western Area Health Service

Board Member since 19 August 2008
Appointment expires 10 January 2014



Tomas Ratoni

- Paediatric Clinical Nurse Consultant in the Northern sector of North Coast Area Health Service
- Background primarily in paediatric critical care and paediatric and neonatal retrieval medicine
- A passion for teaching and is an instructor for Advanced Paediatric Life Support (Australia)

Board member since 2 March 2010
Appointment expires 10 January 2014



Professor Debra Thoms

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

Board member since 3 December 2007
Appointment expired 31 January 2010

Table 1: Board Member Meeting Attendance 2009/10

The board meets bi-monthly.

Directors	18.8.09	3.11.09	15.12.09	18.3.10	15.4.10	17.6.10
Prof B Barraclough	✓	✓	✓	Term Ended 31.12.09		
Prof C Pollock	Appointed 11.1.10			✓	✓	✓
L Ausburn	Appointed 2.3.10			✓	✓	✓
K Barker	Appointed 2.3.10			✓	✓	✓
M Conrad	Appointed 2.3.10			✓		✓
Dr A Cooke	Appointed 2.3.10			✓	✓	✓
Maj Gen P Dunn	✓	✓	✓	Term ended 31.1.10		
Prof P Harris	✓	✓	✓	Term ended 31.1.10		
Dr M Henschke	✓	✓	✓	Term ended 31.1.10		
Prof C Hughes	✓	✓	✓	✓	✓	✓
R Kruk	✓	✓	✓	✓	✓	✓
Prof R McCallum	✓	✓	✓	Term ended 31.1.10		
Assoc Prof B McCaughan	Appointed 2.3.10			✓	✓	✓
Dr R Matthews	Appointed 2.3.10			✓		
N O'Brien	✓	✓	✓	Term ended 31.1.10		
T Ratoni	Appointed 2.3.10			✓		✓
Prof J Reid	✓	✓	✓	✓	✓	✓
Dr G Shannon	✓	✓	✓	✓	✓	✓
Prof D Thoms		✓	✓	Term ended 31.1.10		

Board Sub-Committee: Audit and Risk Management



Noel O'Brien



Major General Peter Dunn



Professor Debra Thoms

The Audit and Risk Management Committee was dissolved on 31 December 2009. With the restructure and appointment of a joint Board for CEC and ACI in March 2010 the Audit and Risk Management Committee was reconstituted to comply with Treasury Circular TC09/08, Treasury Policy and Guidelines Paper TPP09-05 and NSW Health Department Policy PD008_069 regarding independent Chair and membership of Audit and Risk Management Committees.

Membership

- Noel O'Brien OAM (chair) until 31 December 2009
- Major General Peter Dunn AO until 31 December 2009
- Professor Debra Thoms until 31 December 2009
- Professor Clifford Hughes AO

In attendance

- Deputy CEO, CEC
- Representatives from IAB Services
- Representatives from NSW Audit Office
- Manager Executive Support, CEC until 31 December 2009

The committee met quarterly until December 2009 when it was dissolved. Following the restructure Allan Cook was appointed Independent Chair of the Statutory Health Corporations Audit and Risk Management Committee. The new Committee will hold its first meeting in September 2010.

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 external auditor's findings

Audit and Risk Management Committee meetings during 2009–10

21 July 2009

15 September 2009

15 December 2009

Board Sub-Committee: Finance



Ken Barker



Lee Ausburn



Melinda Conrad



Noel O'Brien



Professor Ron McCallum

Membership

- Ken Barker – Chair from April 2010
- Lee Ausburn from April 2010
- Melinda Conrad from April 2010
- Noel O'Brien OAM until 31 December 2009
- Professor Ron McCallum until 31 December 2009
- Professor Clifford Hughes AO

CEC staff in attendance

- Deputy CEO until 31 December 2009
- Finance Officer
- Manager Executive Support until 31 December 2009

The committee usually 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 2009–10

21 July 2009

18 August 2009

15 September 2009

3 November 2009

17 November 2009

15 December 2009

20 May 2010

17 June 2010

Board Sub-Committee: Research



Professor Phillip Harris



Noel O'Brien



Professor Janice Reid



Dr Mark Henschke

The Research Committee was dissolved on 31 December 2009. With the restructure and appointment of a joint Board for the CEC and ACI it was resolved to establish a joint Research Committee for the two organisations.

Membership

- Professor Phillip Harris AM (Chair) until 31 December 2009
- Noel O'Brien OAM until 31 December 2009
- Professor Janice Reid AM
- Dr Mark Henschke OAM until 31 December 2009
- Professor Clifford Hughes AO

CEC staff in attendance

- Deputy CEO until 31 December 2009
- Manager Executive Support until December 2009

The committee met 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
- Oversee the Ian O'Rourke PhD Scholarship

Research Committee meetings during 2009–10

18 August 2009

17 November 2009

Future Directions

- Professor Janice Reid AM will Chair the CEC/ACI Research Committee
- The first meeting will be held in September 2010

Board Sub-Committee: Citizen's Engagement Advisory Council



Citizens Engagement Advisory Council (CEAC)

L-R: Peter Kennedy, Don Palmer, Maha Abdo, Sue West, Darren Ah See, Melinda Conrad, Michael Peterson, Sandra Gav, Ian Stewart, Eda Calabria, Cliff Hughes ABSENT: Ted Quan, Christian Damstra

Membership

- Major General Peter Dunn AO (Chair) until 31 December 2009
- Melinda Conrad (Chair) from May 2010
- Maha Abdo
- Darren Ah See
- Christian Damstra
- Sandra Gav
- Don Palmer
- Ted Quan
- Dr Ian Stewart
- Sue West
- Professor Clifford Hughes AO

In attendance

- Deputy CEO, CEC
- CEC Project Officer, CEC
- CEC Media Advisor

The primary function of the Citizens Engagement Advisory Council (CEAC) is to advise the CEC on how to best engage the community about quality and safety in health care. Members are recruited based on their skills and experience. As a subcommittee of the CEC Board, the CEAC is chaired by a Board member. Major General Peter Dunn AO was the inaugural chair of the CEAC and was instrumental in defining its purpose and strategy. With the appointment of a new CEC Board in March 2010, Melinda Conrad, has assumed the role of Chair.

Key achievements

The CEAC has informed the development of a consumer engagement policy which applies to all CEC staff.

The policy was developed to strengthen and guide the CEC's consumer engagement processes in its every day practice and to maximise consumer and community involvement in the development of a statewide approach to safety and quality improvement in NSW.⁵ It provides a framework which will be used to evaluate current CEC engagement practices and guide future consumer engagement strategies.

The policy is grounded on the principles that community engagement is legitimate and adds value and the CEC is committed to embrace the challenges that arise from the uncertainty of sharing power.

The CEAC continues to sponsor the Communication in Hospital Emergency Departments Project (CHED). The CHED Project has involved observation of behaviour and interactions in four NSW emergency department waiting rooms and interviews with emergency department staff. Its objective is to improve the experience of people waiting for treatment within emergency departments. Hospitality, tourism and patient based principles and practices will be used to inform the development of an education and training package.

In 2009 the CEAC maintained its focus on communication in health care and considered the implications of health literacy on patient clinician communication. Health literacy is defined as *'the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions'*.⁶ The CEC is working strategically and in partnership with other key government agencies to develop a co-ordinated approach to tackle this important issue.

CONSUMER ENGAGEMENT PRINCIPLES

- Consumers and the community have the right to participate in decisions that affect their care and influence quality and safety at a statewide level.
- Consumer engagement is legitimate and adds value.
- We are committed to informing and educating consumers and the community about quality and safety issues, in the interests of generating meaningful ongoing dialogue and partnerships to shape health care in NSW.
- We actively seek and are open to consumer and community views about our strategies, projects and communications.
- We are committed to learning from previous consumer engagement experiences and embrace the challenges and uncertainty that may arise as a consequence of sharing power with consumers and the community.

Future directions

In 2010 the CEAC will become a valued resource for the newly established Patient Based Care Directorate. Headed by Dr Karen Luxford, 2008-09 Harkness Fellow in Healthcare Policy and Practice, the Patient Based Care Directorate will work to further integrate patient, family and community involvement in the CEC's projects and programs.

The CEC's consumer engagement policy is driving the development of a consumer advisory panel. The panel will be comprised of community members whose interests in quality and safety will be matched to activities within the CEC. It is planned that the CEAC will mentor and support consumers new to the CEC.

Partnerships

Information about patient experiences of health care is available from a variety of sources. To ensure that the CEC optimises the use of existing sources of information, the CEAC has engaged with the Health Care Complaints Commission and the NSW Health Patient Experience program.

Challenges

Engaging the community in the early stages of project development can be challenging. The development of a consumer advisory panel will assist the CEC to capture important community feedback during a project's inception, when it is most flexible and responsive to change and throughout implementation.

⁵ Clinical Excellence Commission (2010) Consumer Engagement Policy

⁶ Institute of Medicine (2004). Health Literacy: a prescription to end confusion. Washington, DC, National Academies Press.

Membership

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

Dr Austin Curtin (Chair)
Patricia Bradd
Professor Patricia Davidson
Anthony Dombkins
Phillip Ebbs
Julie Gawthorne
Dr Bill Lancashire
Dr Sandy Middleton*
Anne Moehead
Dr Fenton O'Leary*
Dr Gabriel Shannon
Trent Taylor
Catriona Wilson

Description

The Clinical Council is a Board sub-committee comprised of medical, nursing, and allied health clinicians who work within the public health sector in NSW. Council's role is to advise the Board on matters of clinical relevance to the Clinical Excellence Commission. Under the stewardship of Council Chair, Dr Austin Curtin, Clinical Council met monthly via videoconference throughout the year and convened a face-to-face workshop on 1 October 2009. The activities of Council continue to be coordinated by Dr Annette Pantle, Director of Clinical Practice Improvement. Ms Teresa Mastroserio provides secretariat support.

Key achievements

- In response to issues raised by Council members a project for the improved care of hospitalised older people focusing on recognition and management of delirium and dementia was developed. This project was developed in partnership with the Greater Metropolitan Clinical Taskforce (GMCT) Aged Care Network and General Practice NSW and submitted to NSW Department of Health for funding via Department of Veterans Affairs (DVA) on 27 July 2009. The project was successful in passing the first round culling process and a full project submission was made on 21 October 2009

- In response to issues raised by Council members a position paper on the issues of transfer of patients from one hospital to another when they require a higher level of care was developed. This paper formed the basis for Council's face-to-face meeting in October which was convened as a half-day workshop

The workshop aimed to:

- Share information about current policy and initiatives around transfer of care
- Consider the broad issues associated with access to specialist services
- Identify problem areas and potential solutions
- Develop priorities for action
- Facilitated by Dr Jenny Bartlett, MBBS, FRACMA, AFCHSE was held at the CEC offices on 1 October 2009, attended by 43 leaders, managers and clinicians from the CEC, NSW Department of Health, Ambulance Service of NSW, Area Health Service Clinical Governance Units and hospitals from across the State
- The outcomes of the workshop were combined with a Clinical Focus report from a review of RCAs and IIMS data as "Retrieval and Inter-hospital Transfer" published in December 2009
- With the establishment of the new combined CEC/ACI Board in March 2010 the terms of reference for Clinical Council were revised in June 2010 and an Expression Of Interest (EOI) process begun for new membership to replace those lost through an expiration of their appointed term or natural attrition process. The maintenance of strong interest in and participation on Council by the existing members during a long period "on hold" awaiting the outcome of the Garling Inquiry has been extraordinary and much appreciated by the CEC

Future directions

- Undertake recruitment process for new members
- Seek involvement of consumers on Clinical Council
- Appoint a new co-Chair to assist the Board nominated Chair Dr Gabriel Shannon to continue the work of Council
- Expect to receive advice in August 2010 that the proposal for a project for the improved care of hospitalised older people focusing on management of delirium and dementia has been approved

Challenges

- Continuing to engage a variety of interests and priorities among a diverse range of clinicians

Partnerships

- With ACI and GP NSW in the development of project for the Care of the Hospitalised older person
- With NSW Department of Health, Ambulance Service of NSW, Newborn and Paediatric Emergency Transport Service (NETS) Medical Retrieval and Directors of Clinical Governance in developing solutions for the retrieval and inter-hospital transfer of patients

Corporate Governance Statement



This statement sets out the corporate governance practices in operation throughout the 2009-2010 financial year.



Corporate Governance Statement

The CEC Board

The CEC is a board-governed, statutory health corporation established under the *Health Services Act 1997*. In March 2010 two separate Boards with common membership were appointed to oversee the Clinical Excellence Commission and the newly created Agency for Clinical innovation (ACI). The new CEC/ACI Board was appointed in March 2010 following the dissolving of the previous CEC Board at 31 December 2009.

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

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

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 (IAB Services), 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 strong and positive leadership on patient safety and quality. In June 2010 the Board held a joint CEC/ACI strategic planning meeting to review each organisation's strategic plan and to determine areas of synergy for the future.

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. It 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, finance, research and community engagement. These sub-committees meet 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 it and the Director-General of the NSW Department of Health
- Regularly review the performance of the board through a process of self-appraisal

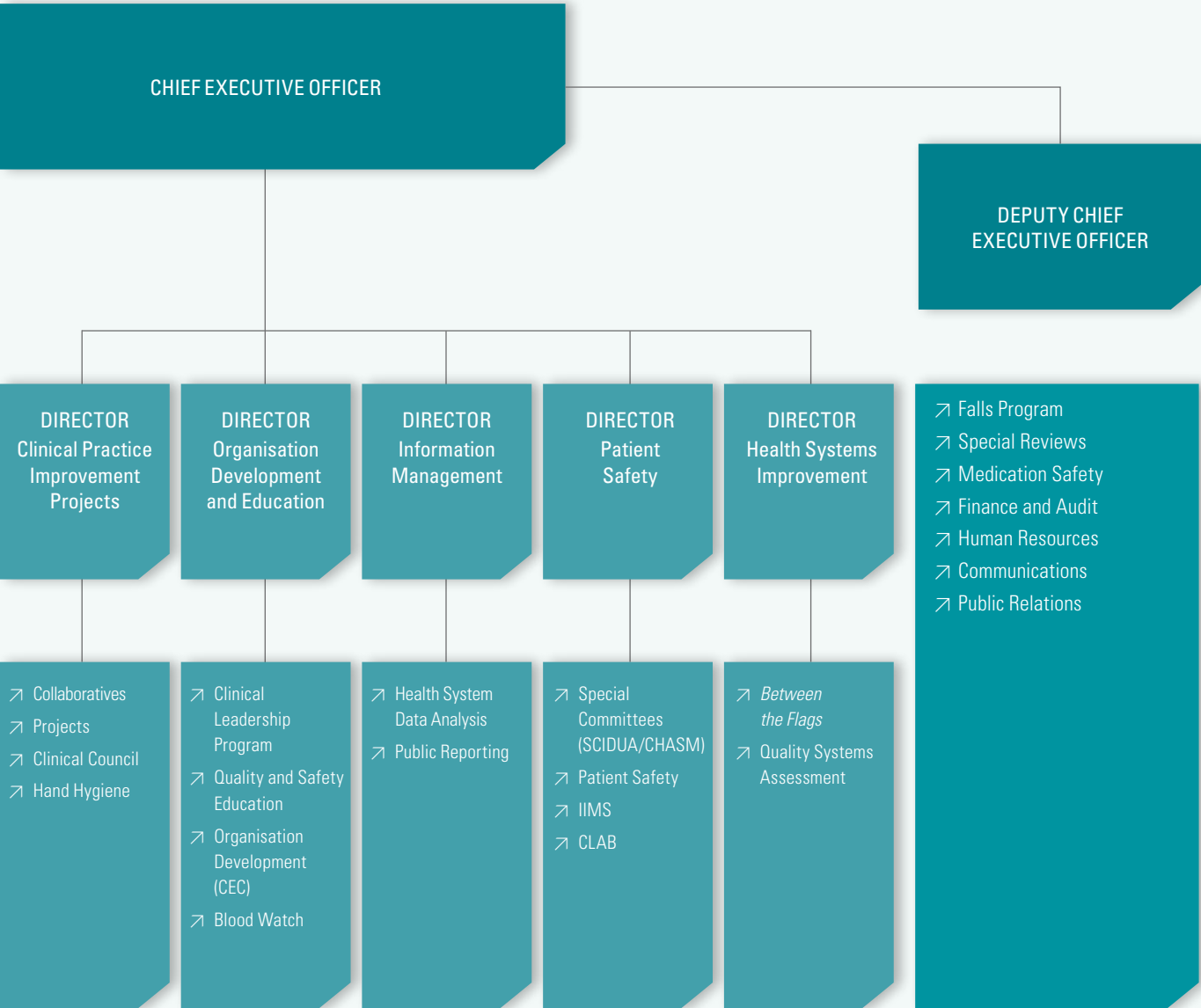
Our People



Our impact, and indeed our successes reflect the quality and dedication of our staff. They bring a wide variety of experience together with a strong commitment to patient care. Each has embraced the concept of teamwork in health care delivery with enthusiasm and hard work.

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

Organisation Chart





Dr Peter Kennedy



Dr Charles Pain



André Jenkins



Bernie Harrison



Adjunct Professor Tony Burrell



Dr Annette Pantle

Leadership Team

Chief Executive Officer

Professor Clifford Hughes AO MBBS, FRACS, FACC, FACS, FCSANZ, FIACS, FAAQHC, AdDipMgt

Deputy Chief Executive Officer

Dr Peter Kennedy MBBS, FRACP

Director Health Systems Improvement

Dr Charles Pain LRCP (Lond.), MRCS (Eng.), MSc, FFPH (UK), FAFPHM, AFCHSE

Director Information Management/ A/Director Corporate Services

André Jenkins BA (Hons)

Director Organisation Development and Education

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

Director Patient Safety

Adjunct Professor Tony Burrell MBBS, BA, FANZCA, FCICM

Director Clinical Practice Improvement Projects

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

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 2009-2012.

The CEC continues to recruit key positions in the strategic portfolios of

Patient Safety

Health System Improvement

Patient Based Care

The number of full-time equivalent staff at 30 June 2010 was 38.61, (4.5 of these medical)

Full-Time Equivalent Staff at 30 June:

2009–2010	38.61
2008–2009	35.30
2007–2008	29.87
2006–2007	29.63
2005–2006	23.76

Executive Reports

Name: Professor Clifford F Hughes AO

Health Service: Clinical Excellence Commission

Period in Position: 18 January 2005 to 30 June 2010

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 recognition and management of the deteriorating patient – *Between the Flags*, hand hygiene, falls; medication safety; transfusion medicine; CLAB-ICU
- 2009 QSA Statewide and individual public health organisation reports completed
- Continuation of Statewide Clinical Leadership Program
- Publication of bi-annual reports of IIMS Statewide data July-December 2008 and January-June 2009
- The second annual CEC *Chartbook* – 2008 containing NSW safety and quality indicators released and *Chartbook* distributed to all wards and workplaces across NSW Health
- *Chartbook* 2009 in preparation
- Blood Watch Transfusion Medicine Improvement Program has reduced inappropriate use of blood products by approximately 10%
- The Citizens Engagement Advisory Council continues to sponsor the Communication in Hospital Emergency Departments Project (CHED) through Southern Cross University
- Collaborating Hospitals' Audit of Surgical Mortality (CHASM) produced individualised feedback report to 386 participating surgeons



- Developed strong partnerships which include regular meetings with the Clinical Safety, Quality and Governance Branch of the Health Department; the other agencies of the "Four Pillars" – Agency for Clinical Innovation (ACI), Bureau of Health Information (BHI) and Clinical Education and Training Institute (CETI)
- The inaugural Ian O'Rourke Scholar, Dr David Peiris, has completed his three year doctoral research program and submitted his thesis. The second Ian O'Rourke Scholar has been selected
- The Board Committee, the Citizens Engagement Advisory Council visited an Area Health Service and it is intended to continue such visits to country health facilities
- Each month between 30-35 meetings are sponsored at the CEC bringing six to 35 attendees to various work programs

Management Accountabilities

- Ongoing management of CEC projects in collaboration with executive staff
- Engagement of IAB Services as Internal Auditor
- All statutory and financial reporting requirements completed
- Review of board governance
- Review of post migration to Health Support Services and fraud and corruption risk
- Review of Information Management and Information Technology processes
- Review of staff recruitment
- Continued review and development of corporate risk register
- Development of performance review process

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 and external consultants. Topic areas have included:

- Daniel Lalor – Medication Safety an International perspective
- Professor David Mayer, University of Illinois, Chicago – CEC Visiting Professor
- Dr Mark O'Brien, Cognitive Institute – Mastering Difficult Situations
- Dr Annette Pantle and Ann Young – Project Management Workshop

Membership of the Advisory Board

The CEC continued its membership of the Advisory Board Company in Washington DC, USA and our staff have used this valuable resource for research purposes.

Sponsorships

The CEC provided sponsorship to the Third International Conference on Safety, Quality Audits and Outcomes, Research and Intensive Care in Queenstown, New Zealand in August 2009.

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

- *Clinical Governance from a Train Drivers Perspective*, NSW Rural and Remote Clinical Leadership Training Workshop, Sydney, August 2009
- *Deaths under the care of a surgeon: Outcomes of Surgical Mortality Audit in NSW, Australia* Australasian Association for Quality in Health Care National Conference, Sydney, September 2009
- *Broken Windows, Tidy Wards and Keeping Score: Clinical Governance Does have a Human Face*, Australian Society of Cardiac and Thoracic Surgeons Annual Scientific Meeting, Noosa, November 2009
- *Quality and safety leadership*, Area Health Advisory Council, Sydney, November 2009
- *The Deteriorating Patient*, Australian Commission on Safety and Quality in Health Care, Sydney, November 2009
- *The Human Face of Clinical Governance*, Ballarat Health Services, Ballarat, November 2009
- *Clinical Excellence Commission's Clinical Leadership Program*, Victorian Health Council, Clinical Leadership in Quality and Safety, Program Development Forum, Melbourne, February 2010



- *Medication Safety, a numbers game*, Change Champions, Improving Medication Safety Conference, Sydney, March 2010
- *Drowning in Paper: The Deteriorating Patient*, Change Champions, The Deteriorating patient Conference, Sydney, March 2010
- *Safety and Quality of Care in NSW*, Regional Communities Consultative Council, Sydney, March 2010
- *Patient journeys, patient safety and quality of care*, Medicine 1 Lecture, Faculty of Medicine, University of New South Wales, Kensington, April 2010
- *Leadership in Health Care: Facing the Obvious*, Health Care Human Factors Seminar, 9th International Symposium of the Australian Aviation Psychology Association, Sydney, April 2010
- *The Need for Training in Private*, Royal Australasian College of Surgeons, Annual Scientific Congress, Perth, May 2010
- *Multi-Disciplinary Communication*, Royal Australasian College of Surgeons, Annual Scientific congress, Perth, May 2010
- *Leaders in our Health Services – How do we find them*, Royal Australasian College of Surgeons, Annual Scientific congress, Perth, May 2010
- *Technical Expertise – Credentialling Vs. Certification*, Royal Australasian College of Surgeons, Annual Scientific congress, Perth, May 2010

Dr Charles Pain
Director Health System Improvement

- *Between the Flags*, Australasian Association for Quality in Health Care, Sydney, September 2009
- *Managing the Deteriorating Patient – A Team Function*, Australian Commission on Safety and Quality in Health Care/Clinical Excellence Commission National Deteriorating Patient Conference, Sydney, November 2009

Dr Annette Pantle
Director Clinical Practice Improvement Projects

- *Quality Improvement Standards, Safety and plan of action for Australia's Health Care System* – Southern Medical Association, Australasian Association for Quality in Health Care (AAQHC), Sydney, July 2009
- *Putting Logic into Project Management*, Leadership and Change Management in Hospitals Conference, Sydney, December 2009
- *Healthcare Human Factors Seminar*, 9th International Symposium of the Australian Aviation Psychology Association, Sydney, April 2010
- *Quality Around the World*, 5th International Conference in Health Care, Melbourne, May 2010

Bernie Harrison
Director Organisation Development and Education

- *Patient Consent and Blood Transfusion*, Royal Melbourne Hospital, August 2009
- *Clinical Practice Improvement*, Australasian Association for Quality in Health Care, Sydney, September 2009
- *The Quality Systems Assessment Program – A Whole of System Approach to Identifying Clinical Risk*, 7th Australasian Conference on Safety and Quality in Health Care, Sydney September 2009
- *Improving Fresh Blood Product Transfusion in NSW* – Australasian Association for Quality in Health Care Conference, Sydney September 2009
- *Fast Tracking Evidence into Practice*, Australian Red Cross Blood Service Transfusion Medicine Scientific Meeting, Melbourne, May 2010

Adjunct Professor Tony Burrell
Director Patient Safety

- *Fire in the Belly: effecting change by Committee*, Australasian Association for Quality in Health Care Conference, Sydney, September 2009

Carolyn Der Vartanian
Program Leader Transfusion Medicine

- *Patient Consent and Blood Transfusion*, Royal Melbourne Hospital, August 2009



Bronwyn Shumack Manager Patient Safety

- *One size fits all – or does it?* (A review of the RCA methodology in NSW, Australasian Association for Quality in Health Care Sydney September 2009

Daniel Lalor Project Manager Medication Safety

- Poster – *Medication Safety Self Assessment for Australian Hospitals: an analysis of baseline data*, Society of Hospital Pharmacists Conference, Perth, November 2009
- *Medication Safety – Multidisciplinary Teamwork for Safety*, Facilitator at Australian Council on Healthcare Standards/Australian Commission on Safety and Quality in Health Care Safety and Quality workshop series – Ballarat, Adelaide, Sydney, Gold Coast – October/November 2009
- *Improvements in medication safety systems in response to undertaking the Medication Safety Self Assessment for Australian Hospitals*, Change Champions 3rd Improving Medication Safety Conference, Sydney, March 2010
- Recipient of competitive peer reviewed grant from the Society of Hospital Pharmacists of Australia – the Roche Research Grant on Quality and Safety to complete a project entitled – *Analysis of patient Safety Culture in Australian Hospital Pharmacies*

Official Overseas Travel by CEC Staff

Professor Clifford Hughes AO Chief Executive Officer

- *Improving Fresh Blood Product Transfusion in NSW*, International Society for Quality in Health Care 26th International Conference, Dublin, Ireland, October 2009
- *'Between the Flags' Improving Recognition and Management of the Deteriorating Patient*, International Society for Quality in Health Care 26th International Conference, Dublin, Ireland, October 2009
- *A Framework for Safety and Quality in Australia: The NSW Perspective*, International Society for Quality in Health Care 26th International Conference, Dublin, Ireland, October 2009
- *Reverse Engineering Disasters: What can we learn from other Industries?*, International Society for Quality in Health Care 26th International Conference, Dublin, Ireland, October 2009
- *The Quality Systems Assessment Program: A Whole of System Approach to Evaluating Patient Safety and Clinical Quality Programs in the NSW Public Health System*, International Society for Quality in Health Care 26th International Conference, Dublin, Ireland, October 2009
- *But Surely I'm competent...*, Halifax9, Canadian Healthcare Safety Symposium, Montreal, Canada, October 2009

Dr Charles Pain Director Health Systems Improvement

- **Quality Systems Assessment (QSA): an accurate and efficient means of assessing clinical quality and patient safety systems*, 7th Biennial International Conference in Organisational Behaviour in Health Care, Birmingham, April 2010

Visits marked with an asterisk (*) were funded from staff specialist TESL entitlement

CEC Visiting Professor

In 2009 the CEC introduced a Visiting Professorship to bring the expertise of world leaders in quality and safety to Sydney and disseminate the knowledge throughout the health system. Professor David Mayer of the University of Illinois, Chicago was the inaugural CEC Visiting Professor. During his two week visit in September 2009 Professor Mayer participated in activities including:

- World Surgical Congress in Adelaide – a joint presentation with the Chair of the CEC Board, Professor Bruce Barraclough AO and the Chief Executive Officer, Professor Cliff Hughes AO
- AAQHC Conference in Sydney – keynote presentation *Honesty and Trust in Healthcare – The Importance of Patients and Families in Helping Move the Safety Agenda*
- An interactive session at the CEC with Area Health Service Directors of Clinical Governance and Patient Safety Managers
- Clinical Leadership Program – Main speaker at a one day session for the Modular Group

There was very positive feedback from participants in all the forums in which David Mayer participated but particularly those activities held at the CEC where he was able to interact and exchange views with smaller groups including CEC project staff.

Visits by International Delegations

- July 2009 – Health Bureau of Zhejiang Province, People's Republic of China – six delegates
- November 2009 – Hospital Authority Hong Kong – five delegates
- June 2010 – Qingdao Public Health Bureau, Shandong Province, People's Republic of China – seven delegates

Articles/Papers Written by CEC Staff and Accepted for Publication

Professor Clifford Hughes AO Chief Executive Officer

- Title: *A statewide approach to systematising hand hygiene behaviour in hospitals: clean hands save lives, part I*
Authors: Pantle, A.C., Fitzpatrick, K.R., McLaws, M.L., Hughes, C.F. (2009)
Journal: *Medical Journal of Australia*. 191(8 Suppl):S8-12
- Title: *Culture change for hand hygiene: clean hands save lives, part II*
Authors: Fitzpatrick, K.R., Pantle, A.C., McLaws, M.L., Hughes, C.F. (2009)
Journal: *Medical Journal of Australia*. 191(8 Suppl):S13-7
- Title: *Improvements in hand hygiene across New South Wales public hospitals: clean hands save lives, part III*
Authors: McLaws, M.L., Pantle, A.C., Fitzpatrick, K.R., Hughes, C.F. (2009).
Journal: *Medical Journal of Australia*. 191(8 Suppl):S18-24
- Title: *More than hand hygiene is needed to affect methicillin-resistant Staphylococcus aureus clinical indicator rates: clean hands save lives, part IV*
Authors: McLaws, M.L., Pantle, A.C., Fitzpatrick, K.R., Hughes, C.F. (2009).
Journal: *Medical Journal of Australia*. 191(8 Suppl):S26-31

- Title: *Endothelial activation after coronary bypass surgery: comparison between on-pump and off-pump techniques*
Authors: Valley, M.P., Bannon, P.G., Bayfield, M.S., Hughes, C.F., Kritharides, L. (2010)
Journal: *Heart, Lung and Circulation*. 19(8):445-52
- Title: *Improving use of medicines with clinician-led use of validated clinical indicators*
Authors: Lowinger, J.S., Stark, H.E., Kelly, M., Hughes, C.F., Gazarian, M., Kaye, K.I. (2010)
Journal: *Medical Journal of Australia*. 192(4):180-1
- Title: *Cultural and associated enablers of, and barriers to, adverse incident reporting*
Authors: Braithwaite, J., Westbrook, M.T., Travalgia, J.F., Hughes, C. F. (2010)
Journal: *Quality and Safety in Health Care*. 19(3):229-33
- Title: *Bad stars or guiding lights? Learning from disasters to improve patient safety*
Authors: Hughes, C.F., Braithwaite, J., Travaglia, J. (2010)
Journal: *Quality and Safety in Health Care*. 19(4):332-6

Abstracts Published

- Deaths in New South Wales (NSW) under the care of surgeon: outcomes from a peer review process of surgical mortality audit in Australia*
Mohsin, M., Hughes, C.F., Fearnside, M., Jenkins, A., Cheng, P. (2009).
7th Australasian Conference on Safety and Quality in Health Care, 'Bridging the Gap' Conference Program and Abstract Book, Australasian Association for Quality in Health Care. p34.
- The quality systems assessment program – a whole of system approach to identifying clinical risks*
Harrison, B., King, B., Hughes, C.F. (2009).
7th Australasian Conference on Safety and Quality in Health Care, 'Bridging the Gap' Conference Program and Abstract Book, Australasian Association for Quality in Health Care. p44.
- Blood watch: improving evidence based fresh blood product transfusion in NSW public hospital*
Harrison, B., der Vartanian, C., Hughes, C.F. (2009).
7th Australasian Conference on Safety and Quality in Health Care, 'Bridging the Gap' Conference Program and Abstract Book, Australasian Association for Quality in Health Care. p49.

Keeping patients safe! – improving the recognition and management of the deteriorating patient – lessons from the beach

Pantle, A.C., Fitzpatrick, K.R., Hughes, C.F. (2009)
Abstract Book, International Society for Quality in Health Care Ltd, 26th International Conference, "Designing for Quality", 11-14 October 2009, Dublin, Ireland. p106.

Deaths under the care of surgeon: outcomes from a peer review process of surgical mortality audit in Australia

Hughes, C.F., Fearnside, M., Jenkins, A., Mohsin, M., Cheng, P. (2009)
Abstract Book, International Society for Quality in Health Care Ltd, 26th International Conference, "Designing for Quality", 11-14 October 2009, Dublin, Ireland. p133.

Quality systems assessment: a program to evaluate the patient safety and clinical quality programs in the NSW public hospital system

Harrison, B., King, B., Hughes, C.F. (2009)
Abstract Book, International Society for Quality in Health Care Ltd, 26th International Conference, "Designing for Quality", 11-14 October 2009, Dublin, Ireland. p31.

Reverse engineering disasters: what can healthcare learn from other industries?

Travaglia, J., Hughes, C.F., Braithwaite, J. (2009)
Abstract Book, International Society for Quality in Health Care Ltd, 26th International Conference, "Designing for Quality", 11-14 October 2009, Dublin, Ireland. p52.

A new approach to educating senior clinicians: review of Clinical Excellence Commission's Bloodwatch Program, "The Transfusion Question" campaign

Harrison, B.T., der Vartanian, C., Hughes, C.F. (2009).
Abstract Book, International Society for Quality in Health Care Ltd, 26th International Conference, "Designing for Quality", 11-14 October 2009, Dublin, Ireland. p87.

Is home warfarin self-management superior to the usual care? Results of the warfarin SMART study

Dignan, R., Keech, A., Powell, C., Turner, L., Mann, K., Hughes, C.F., Gebeski, V. (2010).
European Heart Journal. 12(Suppl A):S1

Dr Mohsin Mohammed Biostatistician

- Title: Robust data to close the gap: how current vascular and maternal/newborn indicators perform as measures of progress in Aboriginal health in New South Wales
Authors: Peiris D, **Mohsin M**, Jenkins A, Cass A, Hughes CF
Journal: *Australian and New Zealand Journal of Public Health*
Status: Accepted (in press)
Manuscript No. 09-11-4113
- Title: *Evaluation of a comprehensive tobacco control project targeting Arabic-speakers residing in south west Sydney, Australia*
Authors: Perusco, A, Poder N, **Mohsin M**, Rikard-Bell G, Rissel C, Williams M, Hua M, Millen E, Sabry M, Guirguis S
Journal: *Health Promotion International UK*
Status: Published in 2010
Ref: Health promot Int.2010 June;25(2): 153-65. Epub 2010 Feb 26
- Title: *Socio economic correlates and Trends in Smoking in Pregnancy in New South Wales, Australia*
Authors: **Mohsin M**, Bauman AE, Forero F
Journal: *Journal of Epidemiology and Community Health*
Status: Published 2010 September 15 (Epub ahead of print)
PMID; 20841373 (pubMed – as supplied by publisher)
- Title: *Alcohol consumption and injury risk: a case-crossover study in Sydney, Australia*
Authors: Williams M, **Mohsin M**, Weber D, Jalaludin B, Crozier J
Journal: *Drug and Alcohol review*
Status: Published (first online published – ahead of print_ Aug 2010 (DOI: 0.1111/j.1465-3362.2010.00226.x))

Daniel Lalor Project Manager Medication Safety

- Letter to the Editor of the Journal of Pharmacy Practice and Research
Lalor DJ, *Durg Nmae Cnofsiuon or Drug Name Confusion?*
Journal of Pharmacy Practice and Research 2009 Sep;39(3), 245

Lorraine Lovitt Program Leader Falls Program

- Title: *The right care for the elderly*
Authors: **Lorraine Lovitt** and Bronwyn Wilkinson (Director Catch Consulting)
Journal: *The Health Advocate*, April 2010

Dr Peter Kennedy Deputy Chief Executive Officer

- Title: *Multiple Accountabilities in Incident Reporting and Management*
Authors: Hor S, Iedema, R, Williams K, White L, **Kennedy P**, Day A
Journal: *Qualitative Health Research* XX(X) 1-10

Dr Annette Pantle Director Clinical Practice Improvement Projects

- Title: *A statewide approach to systematising hand hygiene behaviour in hospitals: clean hands save lives, part I*
Authors: **Pantle, A.C.**, Fitzpatrick, K.R., McLaws, M.L., Hughes, C.F. (2009)
Journal: *Medical Journal of Australia*. 191(8 Suppl):S8-12
- Title: *Culture change for hand hygiene: clean hands save lives, part II*
Authors: Fitzpatrick, K.R., **Pantle, A.C.**, McLaws, M.L., Hughes, C.F. (2009)
Journal: *Medical Journal of Australia*. 191(8 Suppl):S13-7
- Title: *Improvements in hand hygiene across New South Wales public hospitals: clean hands save lives, part III*
Authors: McLaws, M.L., **Pantle, A.C.**, Fitzpatrick, K.R., Hughes, C.F. (2009)
Journal: *Medical Journal of Australia*. 191(8 Suppl):S18-24
- Title: *More than hand hygiene is needed to affect methicillin-resistant Staphylococcus aureus clinical indicator rates: clean hands save lives, part IV*
Authors: McLaws, M.L., **Pantle, A.C.**, Fitzpatrick, K.R., Hughes, C.F. (2009)
Journal: *Medical Journal of Australia*. 191(8 Suppl):S26-31

Kimberley Fitzpatrick Senior Project Officer, Clinical Practice Improvement Projects

- Title: *A statewide approach to systematising hand hygiene behaviour in hospitals: clean hands save lives, part I*
Authors: Pantle, A.C., **Fitzpatrick, K.R.**, McLaws, M.L., Hughes, C.F. (2009)

Journal: *Medical Journal of Australia*. 191(8 Suppl):S8-12

- Title: *Culture change for hand hygiene: clean hands save lives, part II*
Authors: **Fitzpatrick, K.R.**, Pantle, A.C., McLaws, M.L., Hughes, C.F. (2009)
Journal: *Medical Journal of Australia*. 191(8 Suppl):S13-7
- Title: *Improvements in hand hygiene across New South Wales public hospitals: clean hands save lives, part III*
Authors: McLaws, M.L., Pantle, A.C., **Fitzpatrick, K.R.**, Hughes, C.F. (2009).
Journal: *Medical Journal of Australia*. 191(8 Suppl):S18-24
- Title: *More than hand hygiene is needed to affect methicillin-resistant Staphylococcus aureus clinical indicator rates: clean hands save lives, part IV*
Authors: McLaws, M.L., Pantle, A.C., **Fitzpatrick, K.R.**, Hughes, C.F. (2009).
Journal: *Medical Journal of Australia*. 191(8 Suppl):S26-31

Sustainability/Social Programs

- Again this year, as a staff health initiative, the CEC arranged a program of lunchtime, evening and weekend walks. While leaving the desk for even a short break can be a challenge, many staff joined the group's activities and felt better for it. A group of sixteen staff and family members took part in City2Surf2009 with one enthusiastic staff member, Charles Pain, running the 14 kilometres from the City to Bondi. Both the Chief Executive Officer and Deputy led by example and were active participants in the initiative
- For the second year CEC staff took part in the annual ABC Radio Knit-In for Wraps with Love and the busy fingers of staff members and family and friends produced a total of nine rugs each made up of 28 multicoloured squares
- In association with the Knit In when the rugs have all been completed and delivered CEC staff gather together for a special lunch. The male members of staff prepare or procure the food and all staff enjoys delicious food from a wide variety of international cuisines
- CEC staff are committed to caring for the environment and everyone is encouraged to participate
 - We have a recycling bin in the kitchen for glass, aluminium cans, plastic bottles, milk and juice cartons
 - Used printer cartridges are recycled through Planet Ark
 - Waste paper is recycled



1 Some examples of the rugs knitted by CEC staff and family and friends for Wraps with Love.

2 Margaret Scrimgeour and Lesley Harvey lead home a large group of walkers in the 2009 City to Surf.

Occupational Health and Safety

At 30 June 2010, the CEC had received one workers compensation claim.

There was one reported incident and first aid was performed.

During the year Alex Warner retired from her role of OH and S representative. Professor Hughes warmly thanked Alex for her work over four years to educate staff, improve the safety of the CEC work environment and ensure compliance with the OHS Act. Under consultation guidelines, staff have agreed to elect a representative annually.

Disability Action Plan

The Clinical Excellence Commission (CEC) is committed to achieving the outcomes for people with a disability as set out in the NSW State Plan and Guidelines for Disability Action Planning by NSW Government agencies.

The overall aim of our disability action planning process is to ensure that people with a disability in NSW are able to access our services, facilities and jobs on an equitable basis through the delivery of better services that promote fairness and opportunity for all citizens.

Within the CEC, no one has identified as being a person with a disability. The CEC is committed to providing a work environment which supports the needs of all our staff.

Equal Employment Opportunity (EEO)

Table 1: Trends in the representation of EEO Groups¹

A) Statistical Information on EEO target groups

EEO Group	% of Total Staff ²	
	Benchmark or target %	2009-2010 %
Women	50	67
Aboriginal people and Torres Strait Islanders	2.6 ³	—
People whose first language was not English	19	18
People with a disability	12	—
People with a disability requiring work-related adjustments	7	—

Table 2: Trends in the distribution of EEO Groups⁴

EEO Group	Distribution index ⁵	
	Benchmark or target	2009-2010
Women	100	100
Aboriginal people and Torres Strait Islanders	100	—
People whose first language was not English	100	95
People with a disability	100	—
People with a disability requiring work-related adjustments	100	—

B) Commentary on initiatives to eliminate discrimination in employment and promote equal employment opportunity

The CEC applies Department of Health 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.

¹ Staff members as at 30 June 2010 = 39

² Excludes casual staff

³ Minimum target by 2015

⁴ A distribution of 100 indicates that the centre of distribution of the EEO group across salary levels is equivalent to that of other staff. Values less than 100 mean that the EEO group tends to be more concentrated at lower salary levels than is the case for other staff. The more pronounced this tendency is, the lower the index will be. An index of more than 100 indicates that the EEO group is less concentrated at the lower salary levels.

⁵ Excludes casual staff

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:

- Continuing to fund 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 agencies, and identifies strategies to enable the CEC to engage effectively with its diverse community
- Including representatives from multicultural communities to participate in project steering committees

Freedom Of Information (FOI) Report

A. New Applications

During the 2009–2010 financial year the Clinical Excellence Commission received one request for information under the *Freedom of Information Act 1989 (FOI)*. No request was brought forward from the previous year.

B. Discontinued Applications

No applications were discontinued in the previous or current years.

C. Completed Applications

In 2008–2009, no application was granted in full. One application was granted in part. In the current year one application was granted in full.

D. Applications Granted or Otherwise Available in Full

In the current year one application was granted in full and the information provided in a letter to the applicant.

E. Applications Granted or Otherwise Available in Part

In the 2008–2009 one application was granted in part and the documents were provided to the applicant. In the current year no applications were granted or otherwise in part.

F. Refused FOI Applications

No applications were refused in 2008–2009 or 2009–2010.

G. Exempt Documents

In 2008–09 one application was granted in part due to exempt documents under G7 (Documents affecting business affairs). In 2009–2010 there were no exempt documents.

H. Ministerial Certificates (S.59)

No Ministerial Certificates were issued in 2008–2009 or 2009–2010.

I. Formal Consultations

In the 2008–2009 year one application required formal consultation and ten persons were formally consulted. In the current year no application required formal consultation.

J. Amendment of Personal Records

No personal records were amended in 2008–2009 or 2009–2010.

K. Notation of Personal Records

There were no applications for notation of personal records in 2008–2009 or 2009–2010.

L. Fees and Costs

In the financial year 2008–2009 assessed costs relating to FOI requests were \$210 and \$210 was received. In 2009–2010 assessed costs were \$30 and \$30 was received.

M. Fee Discounts

There were no fee waivers or discounts in 2008–2009 or 2009–2010.

N. Fee Refunds

There were no fees refunded in 2008–2009 or 2009–2010 as a result of significant correction of personal records.

O. Days Taken to Complete Request

In 2008–2009 one application was completed in the statutory determination period and one application took 22–35 days to complete consultations. In 2009–2010 one application was completed in the statutory determination period.

P. Processing Time – Hours

In 2008–2009 one application was processed in less than ten hours and one application was processed in 11–20 hours. In 2009–2010 one application was processed in 11–20 hours.

Q. Number of Reviews

There were no reviews undertaken in 2008–2009 or 2009–2010.

R. Results of Internal Reviews

Not applicable – see Q above.

Financial Statements



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Financial Overview

For the Year Ended 30 June 2010

The Clinical Excellence Commission for the 2009-2010 financial year was allocated a Net Cost of Services budget of \$9,484 million by the Department of Health. Audited financial statements reported \$9.164 million, a favourable variation of \$0.320 million, or 3.4%.

Activity has increased during this financial year and has resulted in higher expenditure than in previous years. This was mainly due to increased staff required to support projects that had previously been in their early stages of development and are now in their full delivery stage. The result also reflects a higher than expected actual investment revenue which has contributed to the favourable Net Cost of Services result compared to budget.

In achieving this result, the Clinical Excellence Commission is satisfied that it has operated with 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.

The following tables compare actual results 2009–2010 to 2008–2009:

	2008-2009	2009-2010	Comparison	Movement
	\$000	\$000	\$000	%
Expenses excluding losses				
Employee Related	5,618	6,579	961	17
Other Operating Expenses	1,847	2,345	498	27
Depreciation and Amortisation	494	490	(4)	(1)
Grants and Subsidies	91	381	290	319
Total Expenses	8,050	9,795	1,745	22
Sale of Goods and Services	80	33	(47)	(59)
Investment Income	352	337	(15)	(4)
Grants and Contributions	132	263	131	99
Total Revenue	564	633	69	12
Gain/(Loss) on Disposal	5	(2)	(7)	(140)
Net Cost of Services	7,481	9,164	1,683	22

Certification of Parent/Consolidated Financial Statements

For the Year Ended 30 June 2010

The attached financial statements of the Clinical Excellence Commission for the year ended 30 June 2010:

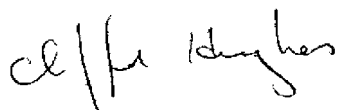
- i) Have been prepared in accordance with the requirements of applicable Australian Accounting Standards (which include Australian Accounting Interpretations), the requirements of the *Public Finance and Audit Act 1983* and its regulations, the *Health Services Act 1997* and its regulations, the Accounts 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 Carol Pollock

Chairman

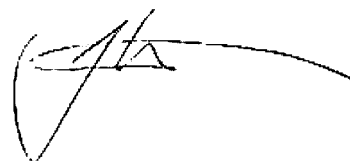
19 October 2010



Professor Clifford Hughes, AO

Chief Executive Officer

19 October 2010



Mr André Jenkins

A/Director, Corporate Services

19 October 2010

Independent Audit Report

For the Year Ended 30 June 2010



GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

Clinical Excellence Commission

To Members of the New South Wales Parliament

I have audited the accompanying financial statements of the Clinical Excellence Commission (the Commission), which comprise the statement of financial position as at 30 June 2010, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, a summary of significant accounting policies and other explanatory notes for both the Commission and the consolidated entity. 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 statements:

- present fairly, in all material respects, the financial position of the Commission and the consolidated entity as at 30 June 2010, and of their financial performance for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- are in accordance with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2010

My opinion should be read in conjunction with the rest of this report.

Chief Executive's Responsibility for the Financial Statements

The Chief Executive is responsible for the preparation and fair presentation of the financial statements 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 financial statements that are 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 statements 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 statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, 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 statements 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 statements.

I believe 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 statements.

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
- 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.



Peter Achterstraat
Auditor-General

20 October 2010
SYDNEY

Statement of Comprehensive Income

For the year ended 30 June 2010

		PARENT		CONSOLIDATION				
	Notes	Actual 2010	Budget 2010	Actual 2009	Actual 2010	Budget 2010	Actual 2009	
		\$000	\$000	\$000	\$000	\$000	\$000	
Expenses excluding losses								
Operating Expenses								
Employee Related	3	0	5,272	0	6,579	5,272	5,618	
Personnel Services	4	6,579	0	5,618	0	0	0	
Other Operating Expenses	5	2,345	3,672	1,847	2,345	3,672	1,847	
Depreciation and Amortisation	2(h), 6	490	490	494	490	490	494	
Grants and Subsidies	7	381	50	91	381	50	91	
Total Expenses excluding losses		9,795	9,484	8,050	9,795	9,484	8,050	
Revenue								
Sale of Goods and Services								
Investment Revenue	8	33	0	80	33	0	80	
Grants and Contributions	9	337	0	352	337	0	352	
	10	263	0	132	263	0	132	
Total Revenue		633	0	564	633	0	564	
Gain/(Loss) on Disposal	11	(2)	0	5	(2)	0	5	
Net Cost of Services		23	9,164	9,484	7,481	9,164	9,484	7,481
Government Contributions								
NSW Health Department								
Recurrent Allocations	2(d)	8,379	8,379	7,723	8,379	8,379	7,723	
Acceptance by the Crown								
Entity of employee benefits	2(a)(ii)	132	55	114	132	55	114	
Total Government Contributions		8,511	8,434	7,837	8,511	8,434	7,837	
RESULT FOR THE YEAR		(653)	(1,050)	356	(653)	(1,050)	356	
Other Comprehensive Income								
Net Increase/(Decrease) in								
Property, Plant & Equipment		0	0	0	0	0	0	
Asset Revaluation Reserve		0	0	0	0	0	0	
Available for Sale Financial Assets		0	0	0	0	0	0	
– Valuation Gains/(Losses)		0	0	0	0	0	0	
– Transferred to Result For Year on Disposal		0	0	0	0	0	0	
Net Change in the Asset Revaluation		0	0	0	0	0	0	
Reserve Arising from a Change in the Restoration Liability		0	0	0	0	0	0	
Other Net Increases/(Decreases) in Equity (SPECIFY)		0	0	0	0	0	0	
Other Comprehensive Income for the year		0	0	0	0	0	0	
TOTAL COMPREHENSIVE INCOME		0	0	0	0	0	0	
FOR THE YEAR		(653)	(1,050)	356	(653)	(1,050)	356	

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2010

		PARENT			CONSOLIDATION		
		Actual 2010	Budget 2010	Actual 2009	Actual 2010	Budget 2010	Actual 2009
	Notes	\$000	\$000	\$000	\$000	\$000	\$000
ASSETS							
Current Assets							
Cash and Cash Equivalents	12	6,827	546	5,647	6,827	546	5,647
Receivables	13	294	514	539	294	514	539
Financial Assets at Fair Value	14	128	5,170	669	128	5,170	669
Total Current Assets		7,249	6,230	6,855	7,249	6,230	6,855
Non-Current Assets							
Plant and Equipment	15	514	882	569	514	882	569
Intangible Assets	16	874	668	1,311	874	668	1,311
Total Non-Current Assets		1,388	1,550	1,880	1,388	1,550	1,880
Total Assets		8,637	7,780	8,735	8,637	7,780	8,735
LIABILITIES							
Current Liabilities							
Payables	17	736	619	660	736	619	660
Provisions	18	1,756	1,404	1,284	1,756	1,404	1,284
Total Current Liabilities		2,492	2,023	1,944	2,492	2,023	1,944
Non-Current Liabilities							
Provisions	18	78	71	71	78	71	71
Total Non-Current Liabilities		78	71	71	78	71	71
Total Liabilities		2,570	2,094	2,015	2,570	2,094	2,015
Net Assets		6,067	5,686	6,720	6,067	5,686	6,720
EQUITY							
Accumulated Funds		6,067	5,686	6,720	6,067	5,686	6,720
Total Equity		6,067	5,686	6,720	6,067	5,686	6,720

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

For the year ended 30 June 2010

	Accumulated Funds	Total
Notes	Actual 2010	Budget 2010
Balance at 1 July 2009	\$000	\$000
Restated Total Equity at 1 July 2009	6,720	6,720
Result For The Year	(653)	(653)
Other Comprehensive Income:		
Net Increase/(Decrease) in Property, Plant & Equipment	0	0
Available for Sale Financial Assets:	0	0
-Valuation Gains/(Losses)	0	0
-Transfers on Disposal	0	0
Changes in Restoration Liability	0	0
Other (SPECIFY)	0	0
Total Other Comprehensive Income	0	0
Total Comprehensive Income For The Year	6,067	6,067
Transactions With Owners In Their Capacity As Owners		
Increase/(Decrease) in Net Assets From Equity Transfers		
Balance at 30 June 2010	6,067	6,067
Balance at 1 July 2008	6,364	6,364
Changes in Accounting Policy	0	0
Correction of Errors (SPECIFY)	0	0
Restated Total Equity at 1 July 2008	6,364	6,364
Result For The Year	356	356
Other Comprehensive Income:		
Net Increase/(Decrease) in Property, Plant & Equipment	0	0
Available for Sale Financial Assets:	0	0
-Valuation Gains/(Losses)	0	0
-Transfers on Disposal	0	0
Changes in Restoration Liability	0	0
Other (SPECIFY)	0	0
Total Other Comprehensive Income	0	0
Total Comprehensive Income For The Year	6,720	6,720
Transactions With Owners In Their Capacity As Owners		
Increase/(Decrease) in Net Assets From Equity Transfers		
Balance at 30 June 2009	6,720	6,720

The accompanying notes form part of these financial statements.

Cash Flow Statement

For the year ended 30 June 2010

	Notes	PARENT			CONSOLIDATION		
		Actual 2010	Budget 2010	Actual 2009	Actual 2010	Budget 2010	Actual 2009
		\$000	\$000	\$000	\$000	\$000	\$000
CASH FLOWS FROM OPERATING ACTIVITIES							
Payments							
Employee Related		0	(5,217)	0	(5,855)	(5,217)	(4,836)
Other Operating Expenses		(8,367)	(3,672)	(6,266)	(2,512)	(3,672)	(1,430)
Grants and Subsidies		(251)	(50)	(91)	(251)	(50)	(91)
Total Payments		(8,618)	(8,939)	(6,357)	(8,618)	(8,939)	(6,357)
Receipts							
Sale of Goods and Services		55	0	(112)	55	0	(112)
Interest Received		405	0	90	405	0	90
Grants and Contributions		260	0	132	260	0	132
Other		151	0	290	151	0	290
Total Receipts		871	0	400	871	0	400
Cash Flows From Government							
NSW Health Department Recurrent Allocations		8,379	8,379	7,723	8,379	8,379	7,723
Net Cash Flows from Government		8,379	8,379	7,723	8,379	8,379	7,723
NET CASH FLOWS FROM OPERATING ACTIVITIES	21	632	(560)	1,766	632	(560)	1,766
CASH FLOWS FROM INVESTING ACTIVITIES							
Proceeds from Sale of Land and Buildings, Plant and Equipment and Infrastructure Systems		23	0	36	23	0	36
Purchases of Land and Buildings, Plant and Equipment, Infrastructure Systems and Intangible Assets		(25)	0	(53)	(25)	0	(53)
Purchases of Investments		550	0	(600)	550	0	(600)
NET CASH FLOWS FROM INVESTING ACTIVITIES		548	0	(617)	548	0	(617)
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		1,180	(560)	1,149	1,180	(560)	1,149
Opening Cash and Cash Equivalents		5,647	5,647	4,498	5,647	5,647	4,498
CLOSING CASH AND CASH EQUIVALENTS	12	6,827	5,087	5,647	6,827	5,087	5,647

The accompanying notes form part of these financial statements.

Notes to and forming part of the Financial Statements

For the year ended 30 June 2010

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, 18 and 24 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 financial statements prepared for both the NSW Department of Health and 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 19 October 2010.

2 Summary of Significant Accounting Policies

The Clinical Excellence Commission's Financial Report are a general purpose financial report which has been prepared in accordance with applicable Australian Accounting Standards, (which include Australian Accounting Interpretations), 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 statements."

Except when an Australian Accounting Standard permits or requires otherwise, comparative information is disclosed in respect of the previous period for all amounts reported in the financial statements.

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 statements of the Clinical Excellence Commission.

Accounting Standard/Interpretation

AASB 9, Financial Instruments and AASB 2009-11, Amendments to Australian Accounting Standards arising from AASB 9, have application from 1 July 2013 and focus on simplifying the classifications of financial assets into those carried at amortised cost and those carried at fair value. They also simplify the requirements for embedded derivatives and remove the tainting rules associated with held-to-maturity assets. They have been assessed as having no material impact on the Health Service.

AASB 1053, Application of tiers of Australian Accounting Standards, has application from 1 July 2013 and establishes a differential reporting framework consisting of two tiers of reporting requirements. Tier 1 entities will continue to apply existing Australian Accounting Standards. Tier 2 entities will apply the same recognition, measurement and presentation requirements but reduced disclosure requirements. Tier 2 entities include the majority of public sector entities. This standard has been assessed as having no material impact on the Health Service.

AASB 2009-5, Further Amendments to Australian Accounting Standards arising from the Annual Improvements Project, has application from 1 July 2010 and comprises accounting changes for presentation, recognition or measurement purposes. This standard has been assessed as having no material impact on the Health Service.

AASB 2009-8, Amendments to Australian Accounting Standards – Group Cash-settled Share-based Payment Transactions, has application from 1 July 2010 and makes amendments which clarify the scope of AASB 2 by requiring an entity that receives goods or services in a share-based payment arrangement to account for those goods or services no matter which entity in the group settles the transaction, and no matter whether the transaction is settled in shares or cash. This standard has been assessed as having no impact on the Health Service.

AASB 2009-9, Amendments to Australian Accounting Standards- Additional Exemptions for First-time Adopters, has application from 1 July 2010 and makes amendments to ensure that entities applying Australian Accounting Standards for the first time will not face undue cost or effort in the transition process in particular situations. This standard has been assessed as having no impact on the Health Service

AASB 2009-10, Amendments to Australian Accounting Standards- Classification of Rights Issues, has application from 1 July 2010 and provides clarification concerning equity instruments. This standard has been assessed as having no material impact on the Health Service. AASB 124, Related Party Disclosures and AASB 2009-12, Amendments to Australian Accounting Standards, have application from 1 July 2011 and simplify the definition of a related party. They have been assessed as having no impact on the Health Service.

Interpretation 19, Extinguishing Financial Liabilities with Equity Instruments and AASB 2009-13, Amendments to Australian Accounting Standards arising from Interpretation 19, have application from 1 July 2010 and addresses the accounting by an entity when the terms of a financial liability are renegotiated and result in the entity issuing equity instruments to a creditor to extinguish all or part of the financial liability. They have been assessed as having no impact on the Health Service.

AASB 2009-14, Amendments to Australian Interpretation- Prepayments of a Minimum Funding Requirement, has application from 1 July 2011 and makes limited-application amendments to Interpretation 14 AASB 119 - The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction. This standard has been assessed as having no impact on the Health Service.

AASB 2010-1, Amendments to Australian Accounting Standards- Limited Exemption from Comparative AASB 7 Disclosures for First-time Adopters, has application from 1 July 2010 and provides additional exemption on IFRS transition in relation to AASB 7 Financial Instruments: Disclosures, to avoid the potential use of hindsight and to ensure that first-time adopters are not disadvantaged as compared with current IFRS-compliant preparers. This standard has been assessed as having no impact on the Health Service.

AASB 2010-2, Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements, has application from 1 July 2013 and determines disclosures in Australian Accounting Standards from which Tier 2 entities are exempt. This standard has been assessed as having no material impact on the Health Service.

AASB 2010-3 and AASB 2010-4, Amendments to Australian Accounting Standards arising from the Annual Improvements Project, have application from 1 January 2011 and amend a number of different Australian Accounting Standards. These standards have been assessed as having no material impact on the Health Service.

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 are due to be settled within 12 months after the end of the period in which the employees render the service 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 2010, such on-costs being consistent with actuarial assessment (Comparable on-costs for 30 June 2009 were also 17%).

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 17.2 % (9.8% at 30 June 2009) for all employees with five or more years of service. The escalation applied is consistent with actuarial assessment and is affected in the main by the fall in the Commonwealth Government 10 year bond yield which is used as the discount rate.

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 17 "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 in accordance with Departments's Mandate to not-for-profit general government sector agencies.

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.

Notes to and forming part of the Financial Statements

For the year ended 30 June 2010

Sale of Goods and Services

Revenue from the sale of goods is recognised as revenue when the agency transfers the significant risks and rewards of ownership of the assets.

Rendering of Services

Revenue from the rendering of services is generally recognised as revenue when the service is provided

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 Clinical Excellence Commission 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 Clinical Excellence Commissions and approved enhancement projects. This allocation is included in the Statement of Comprehensive Income before arriving at the "Result for the Year" on the basis that the allocation is earned in return for the Clinical Excellence Commission provided on behalf of the Department. Allocations are normally recognised upon the receipt of Cash.

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

Income, expenses and assets are recognised net of the amount of GST, except where:

- the amount of GST incurred by the Health Service as a purchaser that is not recoverable from the Australian Taxation Office is recognised as part of the cost of acquisition of an asset or as part of an item of expense;
- receivables and payables are stated with the amount of GST included.

Cash flows are included in the Statement of Cash Flows on a gross basis. However, the GST components of cash flows arising from investing and financing activities which is recoverable from, or payable to, the Australian Taxation Office are classified as operating cash flows.

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 (See also assets transferred as a result of an equity transfer Note 2(t) refers).

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

Where payment for an asset is deferred beyond normal credit terms, its cost is the cash price equivalent, ie the deferred payment amount is effectively discounted at an asset-specific rate

g) Capitalisation Thresholds

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

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 Health Service. Land is not a depreciable asset. All material separately identifiable components of assets are depreciated over their shorter useful lives.

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%
Linen	25.0%
Furniture, Fittings and Furnishings	5.0%

"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.

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 Health Service 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 only capitalised 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 Health Service's intangible assets, the assets are carried at cost less any accumulated amortisation.

Intangible assets are tested for impairment where an indicator of impairment exists. If the recoverable amount is less than its carrying amount the carrying amount is reduced to recoverable amount and the reduction is recognised as an impairment loss.

l) Maintenance

Day-to-day servicing costs or maintenance are charged as expenses as incurred, except where they relate to the replacement of a part or 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 Statement of Comprehensive Income 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 recognised in the Result for the Year 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) Investments

Investments are initially recognised at fair value plus, in the case of investments not at fair value through profit or loss, transaction costs. The Clinical Excellence Commission determines the classification of its financial assets after initial recognition and, when allowed and appropriate, re-evaluates this at each financial year end.

➤ *Fair value through profit or loss* – The Clinical Excellence Commission subsequently measures investments classified as “held for trading” or designated upon initial recognition “at fair value through profit or loss” at fair value. Financial assets are classified as “held for trading” if they are acquired for the purpose of selling in the near term. Derivatives are also classified as held for trading. Gains or losses on these assets are recognised in the Result for the Year.

The Hour-Glass Investment facilities are designated at fair value through profit or loss using the second leg of the fair value option i.e. these financial assets are managed and their performance is evaluated on a fair value basis, in accordance with a documented risk management strategy, and information about these assets is provided internally on that basis to the agency's key management personnel.

The risk management strategy of the The Clinical Excellence Commission has been developed consistent with the investment powers granted under the provision of the Public Authorities (Financial Arrangements) Act. T Corp investments are made in an effort to improve interest returns on cash balances otherwise available whilst also providing secure investments guaranteed by the State market exposures.

The movement in the fair value of the Hour-Glass Investment facilities incorporates distributions received as well as unrealised movements in fair value and is reported in the line item ‘investment revenue’.

➤ *Held to maturity investments* – Non-derivative financial assets with fixed or determinable payments and fixed maturity that the Clinical Excellence Commission has the positive intention and ability to hold to maturity are classified as “held to maturity”. These investments are measured at amortised cost using the effective interest method. Changes are recognised in the Result for the Year when impaired, derecognised or through the amortisation process.

➤ *Available for sale investments* – Any residual investments that do not fall into any other category are accounted for as available for sale investments and measured at fair value in other comprehensive Income until disposed or impaired, at which time the cumulative gain or loss previously recognised in other comprehensive income is recognised in the Result for the Year. However, interest calculated using the effective interest method and dividends are recognised in the Result for the Year.

Purchases or sales of investments under contract that require delivery of the asset within the timeframe established by convention or regulation are recognised on the trade date; i.e. the date the Health Service commits to purchase or sell the asset.

The fair value of investments that are traded at fair value in an active market is determined by reference to quoted current bid prices at the close of business on the Statement of Financial Position.

p) 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 Result for the Year.

When an available for sale financial asset is impaired, the amount of the cumulative loss is removed from equity and recognised in the Result for the Year, 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 Result for the Year.

Notes to and forming part of the Financial Statements

For the year ended 30 June 2010

Any reversals of impairment losses are reversed through the Result for the Year, 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.

q) 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 Clinical Excellence Commission has not transferred substantially all the risks and rewards, if the entity has not retained control.”

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

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

r) 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.

s) 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 Result for the Year on derecognition.

t) 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 or required by Accounting Standards to be treated as contributions by owners and is recognised as an adjustment to “Accumulated Funds”. This treatment is consistent with AASB1004, Contributions and Australian Interpretation 1038 Contributions by Owners Made to Wholly Owned Public Sector Entities.

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.

All other equity transfers are recognised at fair value, except for intangibles. Where an intangible has been recognised at (amortised) cost by the transferor because there is no active market, the agency recognises the asset at the transferor’s carrying amount. Where the transferor is prohibited from recognising internally generated intangibles, the agency does not recognise that asset.

aa) Equity and Reserves

(i) Asset Revaluation Reserve

The asset revaluation reserve is used to record increments and decrements on the revaluation of non current assets. This accords with the Health Service’s policy on the revaluation of property, plant and equipment as discussed in Note 2(i).

(ii) Accumulated Funds

The category “accumulated funds” includes all current and prior period retained funds.

(iii) Separate Reserves

Separate reserve accounts are recognised in the financial statements only if such accounts are required by specific legislation or Australian Accounting Standards.

u) 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.

v) Service Group Statements

The Clinical Excellence Commission only operates under one program, that program being 6.1 Teaching & Research (see below). Separate group statements are 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.

	PARENT		CONSOLIDATION	
	2010	2009	2010	2009
	\$000	\$000	\$000	\$000
3. Employee Related				
Employee related expenses comprise the following:				
Salaries and Wages	0	0	5,252	4,365
Awards	0	0	0	0
Superannuation – defined benefit plans	0	0	132	114
Superannuation – defined contributions	0	0	324	260
Long Service Leave	0	0	254	364
Annual Leave	0	0	403	411
Sick Leave and Other Leave	0	0	198	105
Workers Compensation Insurance	0	0	16	15
Fringe Benefits Tax	0	0	0	(16)
	0	0	6,579	5,618
4. Personnel Services				
Personnel Services comprise the purchase of the following:				
Salaries and Wages	5,252	4,365	0	0
Superannuation – defined benefit plans	132	114	0	0
Superannuation – defined contributions	324	260	0	0
Long Service Leave	254	364	0	0
Annual Leave	403	411	0	0
Sick Leave and Other Leave	198	105	0	0
Workers Compensation Insurance	16	15	0	0
Fringe Benefits Tax	0	(16)	0	0
	6,579	5,618	0	0

Notes to and forming part of the Financial Statements

For the year ended 30 June 2010

	PARENT		CONSOLIDATION	
	2010	2009	2010	2009
	\$000	\$000	\$000	\$000
5. Other Operating Expenses				
Domestic Supplies and Services	12	6	12	6
Food Supplies	49	61	49	61
Fuel, Light and Power	0	1	0	1
General Expenses (See (a) below)	738	664	738	664
Information Management Expenses	230	100	230	100
Maintenance (See (b) below)				
Maintenance Contracts	16	6	16	6
New/Replacement Equipment under \$10,000	15	29	15	29
Repairs	7	24	7	24
Postal and Telephone Costs	89	61	89	61
Printing and Stationery	287	199	287	199
Rates and Charges	3	0	3	0
Rental	311	358	311	358
Special Service Departments	48	41	48	41
Staff Related Costs	184	25	184	25
Travel Related Costs	356	272	356	272
	2,345	1,847	2,345	1,847
(a) General Expenses include:-				
Advertising	101	2	101	2
Audio Visual	12	51	12	51
Books, Magazines and Journals	5	14	5	14
Consultancies	44	148	44	148
Courier and Freight	3	4	3	4
Sitting Allowance Committee Membership Fees	13	7	13	7
Auditor's Remuneration - Audit of financial reports	25	26	25	26
Auditor's Remuneration - Other Services	107	48	107	48
Legal Services	6	30	6	30
Membership/Professional Fees	29	102	29	102
Motor Vehicle Expenses	19	19	19	19
Other Management Services	311	178	311	178
Other	63	35	63	35
	738	664	738	664
(b) Maintenance				
Reconciliation Total Maintenance				
Maintenance (non employee Maintenance expense - contracted labour and other related), included in Note 5	38	59	38	59
Total maintenance expenses included in Notes 3, 4 and 5	38	59	38	59

	PARENT		CONSOLIDATION	
	2010	2009	2010	2009
	\$000	\$000	\$000	\$000
6. Depreciation and Amortisation				
Depreciation – Plant and Equipment	53	57	53	57
Amortisation – Intangible Assets	437	437	437	437
	490	494	490	494
7. Grants and Subsidies				
Research Organisations	113	56	113	56
Australasian Cardiac Surgery Research Institution	130	0	130	0
Ian O'Rourke Scholarship Fund (University of Sydney)	35	35	35	35
Other	13	0	13	0
Falls Program Funding	90	0	90	0
	381	91	381	91
8. Sale of Goods and Services				
(a) Sale of Goods comprise the following:-				
Commercial Activities	28	19	28	19
Other	5	61	5	61
	33	80	33	80
9. Investment Revenue				
Interest	328	283	328	283
T Corp Hour Glass Investment Facilities designated at Fair Valuetrough profit & loss	9	69	9	69
	337	352	337	352
10. Grants and Contributions				
NSW Government grants	60	0	60	0
Other grants	203	132	203	132
	263	132	263	132
11. Gain/(Loss) on Disposal				
Property Plant and Equipment	40	59	40	59
Less Accumulated Depreciation	15	28	15	28
Written Down Value	25	31	25	31
Less Proceeds from Disposal	23	36	23	36
Gain/(Loss) on Disposal of Property Plant and Equipment	(2)	5	(2)	5
Total Gain/(Loss) on Disposal	(2)	5	(2)	5

Notes to and forming part of the Financial Statements

For the year ended 30 June 2010

	PARENT		CONSOLIDATION	
	2010	2009	2010	2009
	\$000	\$000	\$000	\$000
12. Cash & Cash Equivalent Assets				
Cash at bank and on hand	407	1,147	407	1,147
Short Term Deposits	6,420	4,500	6,420	4,500
	6,827	5,647	6,827	5,647
Cash & cash equivalent assets recognised in the Statement of Financial Position are reconciled at the end of the financial year to the Statement of Cash Flows as follows:				
Cash and cash equivalents (per Statement of Financial Position)	6,827	5,647	6,827	5,647
Closing Cash and Cash Equivalents (per Statement of Cash Flows)	6,827	5,647	6,827	5,647

Refer to Note 24 for details regarding credit risk, liquidity risk and market risk arising from financial instruments.

13. Receivables

Current

(a) Sale of Goods and Services :

NSW Health Department	58	83	58	83
Debtors Intra Health	30	120	30	120
Goods & Services Tax	50	107	50	107
Other Debtors	123	198	123	198
Sub Total	261	508	261	508

Sub Total	261	508	261	508
Prepayments S&W	5	6	5	6
Prepayments Rent	28	25	28	25
Total	294	539	294	539

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

14. Financial Assets at Fair Value

Current

Treasury Corporation – Hour Glass Investment Facilities (Cash)	128	669	128	669
	128	669	128	669

15. Plant and Equipment

Plant and Equipment				
At Fair Value	754	756	754	756
Less Accumulated depreciation and impairment	(240)	(187)	(240)	(187)
Net Carrying Amount	514	569	514	569
Total Plant and Equipment At Net Carrying Amount	514	569	514	569

	2010		2009	
PARENT AND CONSOLIDATION	Plant and Equipment	Total	Plant and Equipment	Total
	\$000	\$000	\$000	\$000
15. Plant and Equipment – Reconciliations				
Carrying amount at start of year	569	569	604	604
Additions	23	23	53	53
Disposals	(25)	(25)	(31)	(31)
Depreciation expense	(53)	(53)	(57)	(57)
Carrying amount at end of year	514	514	569	569
	PARENT		CONSOLIDATION	
	2010	2009	2010	2009
	\$000	\$000	\$000	\$000
16. Intangible Assets				
Software				
Cost (Gross Carrying Amount)	2,390	2,390	2,390	2,390
Less Accumulated Amortisation and Impairment	(1,516)	(1,079)	(1,516)	(1,079)
Net Carrying Amount	874	1,311	874	1,311
Total Intangible Assets at Net Carrying Amount	874	1,311	874	1,311
	2010		2009	
PARENT AND CONSOLIDATION	Plant and Equipment	Total	Plant and Equipment	Total
	\$000	\$000	\$000	\$000
16. Intangibles – Reconciliation				
Net Carrying amount at start of year	1,311	1,311	1,747	1,747
Additions (from internal development or acquired separately)	0	0	0	0
Amortisation (recognised in depreciation and amortisation)	(437)	(437)	(436)	(436)
Net Carrying amount at end of year	874	874	1,311	1,311
	PARENT		CONSOLIDATION	
	2010	2009	2010	2009
	\$000	\$000	\$000	\$000
17. Payables				
Current				
Accrued Salaries and Wages	122	126	122	126
Taxation & Payroll Deductions	5	113	5	113
PAYG	74	0	74	0
Creditors	386	291	386	291
– Intra Health Liability	149	130	149	130
	736	660	736	660

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

For the year ended 30 June 2010

	PARENT		CONSOLIDATION	
	2010	2009	2010	2009
	\$000	\$000	\$000	\$000
18. Provisions				
Current Employee Benefits and Related On-Costs				
Employee Annual Leave – Short Term Benefit	0	0	318	287
Employee Annual Leave – Long Term Benefit	0	0	403	259
Employee Long Service Leave – Short Term Benefit	0	0	36	39
Employee Long Service Leave – Long Term Benefit	0	0	999	699
Provision for Personnel Services Liability	1,756	1,284	0	0
Total Current Provisions	1,756	1,284	1,756	1,284
Non Current Employee benefits and Related On-Costs				
Employee Long Service Leave – Conditional	0	0	78	71
Provision for Personnel Services Liability	78	71		0
Total Non Current Provisions	78	71	78	71
Aggregate Employee Benefits and Related On-Costs				
Provisions – Current	1,756	1,284	1,756	1,284
Provisions – Non-Current	78	71	78	71
Accrued Salaries and Wages and On-Costs (Note 17)	122	126	122	126
	1,956	1,481	1,956	1,481
Tax and Payroll Deductions (\$5,000)				
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	207	448	207	448
Later than one year and not later than five years	440	0	440	0
Later than five years	0	0	0	0
Total Other Expenditure Commitments (Including GST)	647	448	647	448
(b) Operating Lease Commitments				
Commitments in relation to non-cancellable operating leases are payable as follows:				
Not later than one year	416	319	416	319
Later than one year and not later than five years	2,006	26	2,006	26
Later than five years	0	0	0	0
Total Operating Lease Commitments (Including GST)	2,422	345	2,422	345

The operating lease commitments above are for rental payments lease still in negotiation

(c) Contingent Asset related to Commitments for Expenditure

The total of "Commitments for Expenditure" \$3,139M as at 30 June 2010 includes input tax credits of \$285,364 that are expected to be recoverable from the Australian Taxation Office.

	PARENT		CONSOLIDATION	
	2010	2009	2010	2009
	\$000	\$000	\$000	\$000
20. Contingent Liabilities				
There are no contingent liabilities.				
21. Reconciliation Of Net Cash Flows from Operating Activities To Net Cost Of Services				
Net Cash Used on Operating Activities	632	1,766	632	1,766
Depreciation	(490)	(494)	(490)	(494)
Acceptance by the Crown Entity of Employee Superannuation Benefits	(132)	(114)	(132)	(114)
(Increase)/ Decrease in Employee Provisions	(479)	(548)	(479)	(548)
(Increase) / Decrease in Goods and Services Debtors	(133)	265	(133)	265
(Increase) / Decrease in Other Debtors (Intra Hlth)	(115)	(170)	(115)	(170)
Increase / (Decrease) in Prepayments	2	25	2	25
(Increase)/ Decrease in Creditors	(77)	(563)	(77)	(563)
Net Gain/ (Loss) on Sale of Property, Plant and Equipment	(2)	5	(2)	5
(NSW Health Department Recurrent Allocations)	(8,379)	(7,723)	(8,379)	(7,723)
Fair Value (T-Corp)	9	70	9	70
Net Cost of Services	(9,164)	(7,481)	(9,164)	(7,481)

22. Unclaimed Moneys

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.

23. Budget Review – Parent and Consolidated

Net Cost of Services

The actual Net Cost of Services was lower than budget by \$320K.. This was primarily due to the non-cash budget adjustment of \$600K which assisted the Clinical Excellence Commission achieve its tighter budget surplus this financial year. Greater than budgeted actual revenue of \$633K represents mainly investment income from short term fixed deposits. Additional project funding from various NSW Health Organisations for short term projects had been brought to account in the Net Cost of Services for this financial year. 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 \$397K due to the favourable Net Cost of Services position.

Assets and Liabilities

Current Assets

Current Assets were greater than budget by \$1.02M. This was primarily due to the cash investments of fixed term deposits. 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 \$162K reflecting the IIMS increase in depreciation to reflect its true value.

Current Liabilities

The current creditors are less than budget due to the settlement of all outstanding suppliers as at 30 June 2010.

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

Notes to and forming part of the Financial Statements

For the year ended 30 June 2010

Non-Current Liabilities

Non- Current Liabilities were more than budget due to an increase in staff leave transfers in.

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. Short Term Investments have significantly increased to budget

Financing Activities

There are no Financing activities currently undertaken by the Clinical Excellence Commission.

Movements in the level of the NSW Health Department Recurrent Allocation that have occurred since the time of the initial allocation on 30th July 2008 are as follows:

	2010	2009
	\$000	\$000
Initial Allocation, 30th July 2009	8,720	7,581
Collaborating Hospital Audit Surgical Mortality	250	169
Central Line Associated Bloodstream Infection	0	157
Statewide Clinical Leadership Program	(1,231)	(547)
DETECT Education	106	90
Paediatric Clinical Practice Guidelines	264	0
Falls Prevention Program	269	271
Super Guarantee Charge	1	2
Balance as per Statement of Comprehensive Income	8,379	7,723

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 these financial statements.

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.

a) Financial Instrument Categories

		Total carrying amounts as per Statement of Financial Position			
		PARENT		CONSOLIDATION	
		2010	2009	2010	2009
Financial Assets		\$000	\$000	\$000	\$000
Class:	Category				
Cash and Cash Equivalents (note 12)		6,827	5,647	6,827	5,647
Receivables (note 13) ¹	Loans and receivables (at amortised cost)	211	401	211	401
Financial Assets at Fair Value (note 14)	At fair value through profit & loss (designated as such upon initial recognition)	128	669	128	669
Total Financial Assets		7,166	6,717	7,166	6,717
Financial Liabilities					
Payables (Note 17) ²	Financial liabilities measured at amortised cost	657	547	657	547
Total Financial Liabilities		657	547	657	547

Notes

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

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

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 including cash, receivables or authority deposits. 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 4.51% in 2009/10 compared to 3.03% in the previous year. The TCorp Hour Glass cash facility is discussed in para (d) below.

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 all 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.

Of the total trade debtors balance at year-end, \$0.181M (\$2009: \$0.315M) related to debtors that were not past due and not considered impaired and debtors of \$0.03M (2009: \$0.015M) were past due but not considered impaired.

Together these represent 100% (2009: 82%) of 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.

Notes to and forming part of the Financial Statements

For the year ended 30 June 2010

	Total	Past due but not impaired	Considered impaired
		\$000	\$000
2010			
< 3 months overdue	0	0	0
3 months – 6 months overdue	30	30	0
> 6 months overdue	0	0	0
	30	30	0
2009			
< 3 months overdue	15	15	0
3 months – 6 months overdue	71	71	0
> 6 months overdue	0	0	0
	86	86	0

1 Each column in the table reports "gross receivables".

2 The ageing analysis excludes statutory receivables, as these are not within the scope of AASB 7 and excludes receivables that are not past due and not impaired. Therefore, the "total" will not reconcile to the receivables totals recognised in the statement of financial position.

Authority Deposits

The Clinical Excellence Commission has placed funds on deposit with TCorp, which has been rated "AAA" by Standard and Poor's. These deposits are similar to money market or bank deposits and can be placed "at call" or for a fixed term. For fixed term deposits, the interest rate payable by TCorp is negotiated initially and is fixed for the term of the deposit, while the interest rate payable on at call deposits vary.

None of these assets are past due or impaired.

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 loans outside of arrangements with the NSW Department of Health or the Sustainable Energy Development Authority.

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	Variable Interest Rate	Non - Interest Bearing	< 1 Yr	1-5 Yr	> 5Yr	
	%	%	\$	\$000	\$000	\$000	\$000	\$000	%
2010									
Payables:									
Accrued salaries		122		122	122				
Creditors		386		386	386				
Intra-Health Creditors		149		149	149				
		657		657	657				
2009									
Payables:									
Accrued salaries		126		126	126				
Creditors		291		291	291				
Intra-Health Creditors		130		130	130				
		547		547	547				

Notes:

¹ The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities based on the earliest date on which the Health Service can be required to pay. The tables include both interest and principal cash flows and therefore will not reconcile to the Statement of Financial Position.

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 investments 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 Statement of Financial Position date. The analysis is performed on the same basis for 2008. 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. The Clinical Excellence Commission does not account for any fixed rate financial instruments at fair value through profit or loss or as available-for-sale. Therefore, for these financial instruments, a change of interest rates would not affect profit or loss or equity.

A reasonably possible change of +/-1% is used consistent with current trends in interest rates. The basis will be reviewed annually and amended where there is a structural change in the level of interest rate volatility. The Clinical Excellence Commission exposure to interest rate risk is set out below.

Notes to and forming part of the Financial Statements

For the year ended 30 June 2010

		\$'000			
	Carrying Amount	-1% Profit	Equity	+1% Profit	Equity
2010					
Financial assets					
Cash and cash equivalents	6,827	-68	-68	68	68
Financial assets at fair value	128	-1	-1	1	1
Other financial assets					
Financial liabilities					
Borrowings					
2009					
Financial assets					
Cash and cash equivalents	5,647	-56	-56	56	56
Financial assets at fair value	669	-7	-7	-7	-7
Other financial assets					
Financial liabilities					

Other price risk – TCorp Hour Glass facilities

Exposure to 'other price risk' primarily arises through the investment in the TCorp Hour Glass

Investment facilities, which are held for strategic rather than trading purposes. The Clinical Excellence Commission has no direct equity investments. The Clinical Excellence Commission holds units in the following Hour-Glass investment trusts:

Facility	Investment Sectors	Investment horizon	2010 \$000	2009 \$000
Cash facility	Cash, money market instruments	Up to 2 years	128	669

The unit price of each facility is equal to the total fair value of net assets held by the facility divided by the total number of units on issue for that facility. Unit prices are calculated and published daily.

NSW TCorp as trustee for each of the above facilities is required to act in the best interest of the unitholders and to administer the trusts in accordance with the trust deeds. As trustee, TCorp has appointed external managers to manage the performance and risk of each facility in accordance with a mandate agreed by the parties. However, TCorp, acts as manager for part of the Cash facility. A significant portion of the administration of the facilities is outsourced to an external custodian.

Investment in the Hour Glass facilities limits the Clinical Excellence Commission exposure to risk, as it allows diversification across a pool of funds, with different investment horizons and a mix of investments.

NSW TCorp provides sensitivity analysis information for each of the facilities, using historically based volatility information. The TCorp Hour Glass Investment facilities are designated at fair value through profit or loss and therefore any change in unit price impacts directly on profit (rather than equity).

A reasonable possible change is based on the percentage change in unit price multiplied by the redemption price as at 30 June each year for each facility of 1% (as advised by TCorp).

	Impact on profit/loss		
	Change in unit price	2010	2009
		\$'000	\$'000
Hour Glass Investment – Cash Facility	+ 1%	1.3	7

e) Fair Value compared to Carrying Amount

Financial instruments are generally recognised at cost, with the exception of the TCorp Hour Glass facilities, which are measured at fair value. As discussed, the value of the Hour Glass Investments is based on the Clinical Excellence Commission's share of the value of the underlying assets of the facility, based on the market value. All of the Hour Glass facilities are valued using 'redemption' pricing.

Except where specified below, the amortised cost of financial instruments recognised in the balance sheet approximates the fair value because of the short term nature of many of the financial instruments. The following table details the financial instruments where the fair value differs from the carrying amount:

	2010		2009	
	\$'000	\$'000	\$'000	\$'000
	Carrying amount	Fair value	Carrying amount	Fair value
Financial assets				
T-Corp (Hour glass on call)	128	128	669	669
Fixed cash Investment	0	0	0	0
Financial liabilities				
	128	128	669	669

(f) Fair Value recognised in the Statement of Financial Position

The Health Service uses the following hierarchy for disclosing the fair value of financial instruments by valuation technique:

Level 1 – derived from quoted prices in active markets for identical assets/liabilities.

Level 2 – derived from inputs other than quoted prices that are observable directly or indirectly.

Level 3 – derived from valuation techniques that include inputs for the asset/liability not based on observable market data (unobservable inputs).

	2010		2009	
	Level 1	Level 2	Level 3	2010 Total
	\$'000	\$'000	\$'000	\$'000
TCorp Hour-Glass Invt.Facility		128		128

(The table above only includes financial assets as no financial liabilities were measured at fair value in the Statement of Financial Position.)

There were no transfers between level 1 and 2 during the period ended 30 June 2010.

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.

END OF AUDITED FINANCIAL STATEMENTS

Certification of Special Purpose

For the Year Ended 30 June 2010

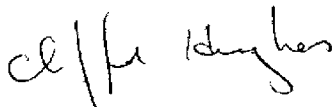
The attached financial statements of the Clinical Excellence Commission Special Purpose Service Entity for the year ended 30 June 2010:

- i) Have been prepared in accordance with the requirements of applicable Australian Accounting Standards (which include Australian Accounting Interpretations), 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.



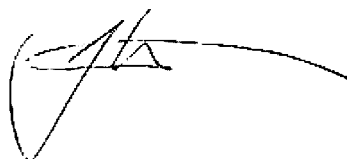
Professor Carol Pollock

Chairman
19 October 2010



Professor Clifford Hughes, AO

Chief Executive Officer
19 October 2010



Mr André Jenkins

A/Director, Corporate Services
19 October 2010

Independent Audit Report

For the Year Ended 30 June 2010



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 statements of the Clinical Excellence Commission Special Purpose Service Entity (the Entity), which comprises the statement of financial position as at 30 June 2010, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, a summary of significant accounting policies and other explanatory notes.

Auditor's Opinion

In my opinion, the financial statements:

- present fairly, in all material respects, the financial position of the Entity as at 30 June 2010, and its financial performance for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- are in accordance with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2010

My opinion should be read in conjunction with the rest of this report.

Chief Executive's Responsibility for the Financial Statements

The Chief Executive is responsible for the preparation and fair presentation of the financial statements 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 the financial statements that are 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 statements 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 statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, 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 statements 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 statements.

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

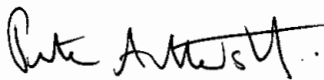
My opinion does *not* provide assurance:

- about the future viability of the 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.



Peter Achterstraat
Auditor-General

20 October 2010
SYDNEY

Statement of Comprehensive Income

For the year ended 30 June 2010

	2010	2009
	\$000	\$000
Income		
Personnel Services	6,579	5,618
Acceptance by the Crown Entity of Employee Benefits	132	114
Total Income	6,711	5,732
Expenses		
Salaries and Wages	5,252	4,365
Defined Benefit Superannuation	132	114
Defined Contribution Superannuation	324	260
Long Service Leave	254	364
Annual Leave	403	411
Sick Leave and Other Leave	198	105
Workers Compensation Insurance	16	15
Fringe Benefits Tax	0	(16)
Grants & Subsidies	132	114
Total Expenses	6,711	5,732
Result For The Year	0	0
Total Comprehensive Income for The Year		

The accompanying notes form part of these Financial Statements.

Statement of Financial Position

For the year ended 30 June 2010

	Notes	2010 \$000	2009 \$000
ASSETS			
Current Assets			
Receivables	2	1878	1410
Total Current Assets		1878	1410
Non-Current Assets			
Receivables	2	78	71
Total Non-Current Assets		78	71
Total Assets		1956	1481
LIABILITIES			
Current Liabilities			
Payables	3	122	126
Provisions	4	1756	1284
Total Current Liabilities		1878	1410
Non-Current Liabilities			
Provisions	4	78	71
Total Non-Current Liabilities		78	71
Total Liabilities		1956	1481
Net Assets		0	0
EQUITY			
Accumulated funds		0	0
Total Equity		0	0

The accompanying notes form part of these Financial Statements.

Statement of Changes in Equity

For the year ended 30 June 2010

	2010	2009
	\$000	\$000
Balance at 1 July	0	0
Result for the Year	0	0
Total Comprehensive Income for the year	0	0
Balance at 30 June		

The accompanying notes form part of these Financial Statements.

Statement of Cash Flows

For the year ended 30 June 2010

	2010	2009
	\$000	\$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
Opening Cash and Cash Equivalents	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

For the year ended 30 June 2010

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 statements were authorised for issue by the Chief Executive Officer on 19 October 2010. The report will not be amended and reissued as it has been audited.

b) Basis of Preparation

The Entity's financial statements are general purpose financial statements which have been prepared in accordance with the requirements of Australian Accounting Standards (which include Australian Accounting Interpretations), 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 (i).

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

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 statements of the Clinical Excellence Commission Special Purpose Service Entity.

Accounting Standard/Interpretation

AASB 9, Financial Instruments and AASB 2009-11, Amendments to Australian Accounting Standards arising from AASB 9, have application from 1 July 2013 and focus on simplifying the classifications of financial assets into those carried at amortised cost and those carried at fair value.

They also simplify the requirements for embedded derivatives and remove the tainting rules associated with held-to-maturity assets. They have been assessed as having no impact on the Entity.

AASB 2009-5, Further Amendments to Australian Accounting Standards arising from the Annual Improvements Project, has application from 1 July 2010 and comprises accounting changes for presentation, recognition or measurement purposes. This standard has been assessed as having no material impact on the Entity.

AASB 2009-8, Amendments to Australian Accounting Standards – Group Cash-settled Share-based Payment Transactions, has application from 1 July 2010 and makes amendments which clarify the scope of AASB 2 by requiring an entity that receives goods or services in a share-based payment arrangement to account for those goods or services no matter which entity in the group settles the transaction, and no matter whether the transaction is settled in shares or cash. This standard has been assessed as having no impact on the Entity.

AASB 2009-9, Amendments to Australian Accounting Standards- Additional Exemptions for First-time Adopters, has application from 1 July 2010 and makes amendments to ensure that entities applying Australian Accounting Standards for the first time will not face undue cost or effort in the transition process in particular situations. This standard has been assessed as having no impact on the Entity.

AASB 2009-10, Amendments to Australian Accounting Standards- Classification of Rights Issues, has application from 1 July 2010 and provides clarification concerning equity instruments. This standard has been assessed as having no impact on the Entity.

AASB 124, Related Party Disclosures and AASB 2009-12, Amendments to Australian Accounting Standards, have application from 1 July 2011 and simplify the definition of a related party. They have been assessed as having no material impact on the Entity.

Interpretation 19, Extinguishing Financial Liabilities with Equity Instruments and AASB 2009-13, Amendments to Australian Accounting Standards arising from Interpretation 19, have application from 1 July 2010 and addresses the accounting by an entity when the terms of a financial liability are renegotiated and result in the entity issuing equity instruments to a creditor to extinguish all or part of the financial liability. They have been assessed as having no impact on the Entity.

AASB 2009-14, Amendments to Australian Interpretation- Prepayments of a Minimum Funding Requirement, has application from 1 July 2011 and makes limited-application amendments to Interpretation 14 AASB 119 - The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction. This standard has been assessed as having no impact on the Entity.

AASB 2010-1, Amendments to Australian Accounting Standards- Limited Exemption from Comparative AASB 7 Disclosures for First-time Adopters, has application from 1 July 2010 and provides additional exemption on IFRS transition in relation to AASB 7 Financial Instruments: Disclosures, to avoid the potential use of hindsight and to ensure that first-time adopters are not disadvantaged as compared with current IFRS-compliant preparers. This standard has been assessed as having no impact on the Entity.

AASB 1053, Application of tiers of Australian Accounting Standards, has application from 1 July 2013 and establishes a differential reporting framework consisting of two tiers of reporting requirements. Tier 1 entities will continue to apply existing Australian Accounting Standards. Tier 2 entities will apply the same recognition, measurement and presentation requirements but reduced disclosure requirements. Tier 2 entities include

Notes to and forming part of the Financial Statements

For the year ended 30 June 2010

the majority of public sector entities. This standard has been assessed as having no material impact on the Health Service.

AASB 2010-2, Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements, has application from 1 July 2013 and determines disclosures in Australian Accounting Standards from which Tier 2 entities are exempt. This standard has been assessed as having no material impact on the Health Service.

AASB 2010-3 and AASB 2010-4, Amendments to Australian Accounting Standards arising from the Annual Improvements Project, have application from 1 January 2011 and amend a number of different Australian Accounting Standards. These standards have been assessed as having no material impact on the Health Service

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

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.

g) 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.

h) 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.

i) Employee benefit provisions and expenses

ij) 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 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 2010, such on costs being consistent with actuarial assessment (comparable on costs for 30 June 2009 were also 17%).

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 17.2% above the salary rates immediately payable at 30 June 2010 (9.8% at 30 June 2009) for all employees with five or more years of service. The escalation applied is consistent with the actuarial assessment and is affected in the main by the fall in the Commonwealth Government 10 year bond yield which is used as the discount rate.

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.

	2010	2009
	\$000	\$000
2. Receivables		
Current		
Accrued Income – Personnel Services Provided	1878	1410
Non-Current		
Accrued Income - Personnel Services Provided	78	71
Total Receivables	1956	1481
Details regarding credit risks, liquidity risk and market risk are disclosed in Note 5.		
3. Payables		
Current		
Accrued Salaries and Wages and On Costs	122	126
Total Payables	122	126
4 Provisions		
Current Employee benefits and related on-costs		
Annual Leave – Short Term Benefit	318	287
Annual Leave – Long Term Benefit	403	259
Long Service Leave – Short Term Benefit	36	39
Long Service Leave – Long Term Benefit	999	699
Total Current Provisions	1756	1284
Non-Current Employee Benefits and Related On Costs		
Long Service Leave – Conditional	78	71
Total Non-Current Provisions	78	71
Aggregate Benefits and Related On Costs		
Accrued Salary & Wages & on-costs	122	126
Provision – Current	1756	1284
Provision – Non-Current	78	71
Total	1956	1481

Notes to and forming part of the Financial Statements

For the year ended 30 June 2010

5. Financial Instruments

The Clinical Excellence Commissions 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 Clinical Excellence Commissions main risks arising from financial instruments are outlined below, together with the Entity's objectives, policies and processes for measuring and managing risk. Further quantitative and qualitative disclosures are included throughout these financial statements.

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.

a) Financial Instruments Categories

		Total carrying amounts as per Statement of Financial Position	
		2010	2009
Financial Assets		\$000	\$000
Class:	Category		
Receivables (note 2) ¹	Receivables measured at amortised cost	1,956	1,481
Total Financial Assets		1,956	1,481
Financial Liabilities			
Class:			
Payables (Note 3) ¹	Financial liabilities measured at amortised cost	122	126
Total Financial Liabilities		122	126

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

2 Excludes statutory payables and unearned revenue (i.e. not within scope of AASB7).

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.

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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.

END OF AUDITED FINANCIAL STATEMENTS

Abbreviations

ACI	Agency for Clinical Innovation	HAI	Health Care Acquired Infection
ARC	Australian Research Council	HARC	Hospital Alliance for Research Collaboration
ACSQHC	Australian Commission on Safety and Quality in Health Care	HSQPI	Health System Quality, Performance and Innovation Branch of DoH
ACHS	Australian Council of Healthcare Standards	ICT	Information/Communication Technology
ARCHI	Australian Resource Centre for Healthcare Innovations	ICU	Intensive Care Unit
BHI	Bureau of Health Information	IIMS	Incident Information Management System
BTF	Between the Flags	ISMP	Institute for Safe Medicine Practices (Canada)
CEAC	Citizens Engagement and Advisory Council	MRO	Multi-resistant organisms
CEC	Clinical Excellence Commission	MSSA	Medication Safety Self Assessment
CEO	Chief Executive Officer	NICS	National Institute of Clinical Studies
CETI	Clinical Education and Training Institute	NSW	New South Wales
CGU	Clinical Governance Unit	OH&S	Occupational Health and Safety
CFCC	Communicating for Clinical Care project	QSA	Quality Systems Assessment
CHASM	Collaborating Hospitals' Audit of Surgical Mortality	RCA	Root Cause Analysis
CheReL	Centre for Health Record Linkage	SAC	Severity Assessment Code
CIAP	Clinical Information Access Project (online information resource)	SCIDUA	Special Committee Investigating Deaths Under Anaesthesia
CLAB	Central Line Associated Bacteraemia	TAG	Therapeutic Advisory Group
CLP	Clinical Leadership Program	TESL	Training, Education and Study Leave for salaried medical practitioners
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		

Glossary

Adverse Event

Unintended 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.

Collaborating Hospitals' Audit of Surgical Mortality (CHASM)

CHASM is an external independent peer review audit of surgically related deaths in NSW.

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.

DETECT

Detecting Deterioration Evaluation Treatment Escalation and Communication in Teams is a learning package for all clinical staff who are first line responders.

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.

Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)

An expert committee appointed by the Minister for Health that reviews deaths which occur while under, as a result of, or within 24 hours after the administration of anaesthesia or sedation for procedures of a medical, surgical, dental or investigative nature to identify any area of clinical management where alternative methods could have led to a more favourable result.

Statutory (Health) Corporation

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

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