CLINICAL
EXCELLENCE
COMMISSION

Caring for patients by continuing to enhance the health system.

ANNUAL
REPORT
2010–2011

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Introduction

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 NSW Clinical Excellence Commission (CEC) was established to promote and support improved clinical care, safety and quality across the NSW health system.

CLINICAL
EXCELLENCE
COMMISSION

The Hon Jillian Skinner
Minister for Health
Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

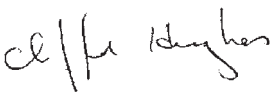
Dear Minister

We have pleasure in submitting the Clinical Excellence Commission's 2010–2011 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

A/Professor Brian McCaughan AM
Chair



Professor Clifford Hughes AO
Chief Executive Officer

PROFILE, PURPOSE AND GOALS

The NSW Clinical Excellence Commission (CEC) 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 NSW public hospitals. It is a board governed statutory corporation led by clinicians for the benefit of patients.

The CEC operates as an independent agency which 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 2010–2011

The CEC's major activities during the year have focused on the key areas of Patient Safety, Education and Training and Clinical Practice Improvement. In addition, the CEC supported research projects and regularly published material documenting its work.

Patient Based Care

We have established a Directorate under the leadership of Dr Karen Luxford to bring together the elements that ensure that all we do is based on the needs, expectations, and desires of patients.

We have launched a program entitled *"Partnering with Patients"* to actively look for more opportunities to engage the community in each of our projects and programs.

Patient Safety

The Patient Safety Team led by Dr Tony Burrell continues to provide six monthly reports on the Incident Information Management System. To these we have added two Clinical Focus Reports addressing urgent and statewide clinical issues.

The Deteriorating Patient

- The *"Between the Flags"* program has gained widespread and enthusiastic support. Advances in this program include, the development of observation charts for age specific paediatric patients, charts for mothers at risk in maternity units and a specific training manual "DETECT Junior" has been prepared for the use of clinicians managing paediatric patients in any setting
- Launch of the *Clinical Emergency Response Systems Assist* (CERS Assist) program by NSW Ambulance Service. Staff in rural and remote facilities can request assistance from Ambulance paramedics to stabilise patients and commence a transfer process if required

Health Care Associated Infections

- The *Hand Hygiene* initiative of the Federal government has been championed in NSW by the CEC and we can now demonstrate compliance rates for hand washing above the national average. All health facilities continue to audit this most basic of safety measures
- The *Central Line Associated Bacteraemia* project has published the impact of this program on patient safety and also shown significant reduction in unnecessary waste associated with avoidable infection
- A *Sepsis* program emphasising the need for rapid diagnosis and commencement of antibiotic therapy was launched in May and all Local Health Districts are participating

Education and Training

- In 2010–2011, 252 participants completed the *Clinical Leadership Program* (CLP) with all participants undertaking an individual or team clinical improvement initiative

designed to improve patient safety and clinical quality. At the end of the 2011 CLP over 1000 participants will have completed the program since its inception in 2007

- During the year we conducted a total of 22 ***Clinical Practice Improvement*** (CPI) workshops both at the CEC and at facilities across the State. The CPI e-learning module is available on the NSW GEM platform for all NSW public health employees and there has been an increase of participants from 225 in July 2010 to 650 at the end of June 2011
- Approximately 2500 medical, nursing and allied health students are being taught each year by the CEC ***Teaching Quality and Safety to Undergraduates*** program
- Over 19000 NSW registrants have successfully completed the modules on blood administration and safety in the ***BloodSafe*** e-learning program

Commencement of a two year project to examine the usage and compliance with ***NSW Health Paediatric Clinical Practice Guidelines in Emergency Departments*** across the State with the view to implement systems for ongoing quality improvement in the future.

The CEC managed a project to develop a web-based directory of physical activity programs that have a ***Falls Prevention*** focus, in partnership with the Health Department's Centre for Health Advancement.

Research

Carolyn Der Vartanian, our Program Leader Transfusion Medicine, was awarded one of three Hospitals Alliance Research Collaboration (HARC) Scholarships in 2010. ***"From Facebook to blogs: the role of social marketing and social media to engage clinicians and fast track evidence into practice."***

The inaugural Ian O'Rourke Scholar, Dr David Peiris completed his PhD ***"Building better primary care systems for Indigenous peoples: A multimethods analysis"*** in December 2010.

The second Ian O'Rourke scholarship recipient, Ms Elizabeth Rix, began her study in March 2010 and is researching ***the experiences and perceptions of Aboriginal people receiving haemodialysis in regional NSW.***

Publications

- Annual Report 2010
- Chartbook 2009
- Clinical Focus reports from Review of RCAs and/or IIMS Data
- Clinical Supervision at the Point of Care
- Inpatient Suicide
- Eleven Area Health Service specific (IIMS) reports (NSW IIMS Data Report for XX Health Service) for January – December 2009
- Incident Information Management in the NSW Public Health System July – December 2009
- Collaborating Hospitals' Audit of Surgical Mortality Annual Report January 2008 – June 2009
- Collaborating Hospitals' Audit of Surgical Mortality Case Book July 2009 – June 2010
- Clinical Leadership Program project summary booklet 2009
- Between the Flags – DETECT Manual
- Between the Flags Tool Kit
- Partnering with Patients program brochure
- Women's experience of early pregnancy care in five emergency departments in Hunter New England Area Health Service
- Structures and Processes to Support the Quality of Antimicrobials in NSW Intensive Care Units Status Report October 2010 – web publication
- Intensive Care Unit Empirical Antimicrobial Treatment Guidelines November 2010 – web publication
- Fact sheet 1: Quality Use of Lincosamide Antibiotics – web publication
- More information on CEC publications can be found on our website **www.cec.health.nsw.gov.au**

OVERVIEW OF PERFORMANCE AGAINST STRATEGIC PLAN 2010–2011

Plan Name	Objective	Strategies 2010–2011
PUBLIC REPORTING	Report publicly to the Minister and the community on quality and safety in NSW Health	↗ Develop and deliver, in collaboration with the Department of Health, a bi-annual Public Report on adverse events ↗ To engage the community in an informed discussion around the quality and safety of healthcare ↗ Coordinate reporting schedules with the Bureau of Health Information and other State wide agencies
CLINICAL PRACTICE IMPROVEMENT	Assist Local Health Networks and specialist networks to implement effective clinical improvement programs working closely with the Agency for Clinical Innovation, its networks and clinical groups, Department of Health, and Health Service Performance Improvement Branch	↗ 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 ↗ Engage lead clinician groups in Local Health Networks and specialist networks ↗ Develop a clearly defined research policy for the CEC which reflects evidence based best practice and supports the priorities of the CEC
QUALITY SYSTEMS ASSESSMENT	Continue Quality Systems Assessment (QSA) program across NSW, including identification of assessment criteria that allow themselves to be measured, benchmarked and trended over time	↗ 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/Local Health Districts to develop improvement plans to address particular issues
INFORMATION MANAGEMENT	Build a robust and integrated information base and reporting for use by decision makers	↗ Continue to measure and report on safety and quality by producing a Chartbook annually ↗ Continue to expand the Collaborating Hospitals Audit of Surgical Mortality ↗ Continue to service and improve Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) ↗ Undertake to support the management of CEC-based Mental Health Drug and Alcohol Clinical Incident Review Committee

Key
Completed ✓
Not Completed ✗
Ongoing →

Outcomes 2010–2011	Status	Future Directions
↗ Bi-annual report of incident (IIMS) data **p 26**	✓	↗ Continue to focus on public reporting as a tool to inform and engage the community in discussions around quality and safety of health care
↗ Collaborating Hospitals Audit of Surgical Mortality (CHASM) reports **p 50**	✓	
↗ Quality Systems Assessment Statewide Reports **p 24**	✓	↗ Coordinate reporting schedules with the Bureau of Health Information and other State wide agencies
↗ Annual Report 2009–2010	✓	
↗ Coordinate reporting schedules with the Bureau of Health Information and other State wide agencies	✗	
↗ Clinical Practice Improvement (CPI) workshops conducted for staff from all Local Health Networks **p 36**	→	↗ Ensure that there is equity in access to education in clinical practice improvement methods for all clinicians
↗ Clinical Leadership Program continued with increased enrolments **p 34**	→	↗ Continue to actively promote continuation of the clinical leadership program, building on the linkages it makes between leadership, and patient safety.
↗ Statewide programs in place	→	↗ Continue to provide opportunities for CLP alumni to gather to network and reinforce their commitment to patient safety and quality
— Between the Flags **p 20**		↗ Continue current programs and investigate and implement new clinical improvement initiatives
— Hand Hygiene **p 28**		↗ Explore ways to develop e-learning package for Hand Hygiene
— Medication Safety **p 32**		
— Transfusion Medicine **p 40**		
— Falls Prevention **p 42**		
— Sepsis **p 22**		
↗ e-learning package around Hand Hygiene	✗	
↗ The 2010 QSA focused on three topics **p 24**	✓	↗ Continue the QSA program to provide on going contemporary insights to the health system regarding key risks to patient safety and clinical quality
↗ The 2011 QSA self assessment will focus on four themes **p 24**	✓	
↗ Statewide report makes eight key recommendations on which Local Health District improvement plans are based **p 25**	✓	
↗ Chartbook 2009 released **p 48**	✓	↗ Continuing to ensure that the information contained in Chartbook is relevant for clinicians and accessible to the public
↗ Chartbook 2010 in preparation **p 48**	✓	
↗ Review of Information Technology and Information Management environments	✓	↗ Continue shared quality and safety reporting function with the Department of Health
↗ Shared quality and safety reporting function with Department of Health continues	✓	↗ Continue to ensure increased participation by surgeons in the audit of surgical mortality reporting processes
↗ Increased participation by surgeons in the Collaborating Hospitals Audit of Surgical Mortality (CHASM) continues **p 50**	✓	↗ Review of TRIM records management system
↗ Development and Implementation of ICT Strategic Plan	✓	
↗ 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	✗	
↗ Review of TRIM records management system	✗	

	Objective	Strategies 2010–2011
HEALTH SYSTEM IMPROVEMENT	Design and lead the implementation of systems for improving the quality and safety of health care, in partnership with clinicians, the Department of Health and Local Health Districts, based on a clear framework and priorities	↗ Identify effective clinical practice improvement projects that should be developed into state-wide programs ↗ Prioritise the major system problems and effective solutions to these problems ↗ Establish, in collaboration with ACI, clinical advisory groups and networks to help design programs for NSW-wide improvement in health care systems to address the priority problems, such as sepsis, delirium, antibiotic stewardship and the roll out of the Between the Flags program ↗ Be a source of expert advice on the evidence to support the prioritisation process, including evidence on the scale of problems and the effective solutions to these problems ↗ Lead the implementation of state-wide systems for improving the quality and safety of health care
ORGANISATIONAL DEVELOPMENT	Design and build the Clinical Excellence Commission as an organisation characterised by excellence in governance	↗ 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 ↗ Strengthen links with regional coordinators of clinical governance and clinical governance units in Local Health Districts and specialist networks
COMMUNITY ENGAGEMENT	Be a leader in promoting improved care experience and patient engagement in safety and quality in health care	↗ 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 ↗ Implement CEC programs to improve patient care experience and initiatives to promote partnering with patients, families and carers ↗ Continue relationships with emerging primary care health networks to ensure coordination of CEC programs and projects across the primary and aged care sectors where relevant

Key
Completed ✓
Not Completed ✗
Ongoing →

Outcomes 2010–2011	Status	Future Directions
↗ A Sepsis project has been implemented in partnership with ACI to address the specific issues of blood stream infection identified in both the IIMS reports and the Between the Flags program **p 22**	✓	↗ Inclusion of Sepsis recognition and management as a key theme in the 2011 Quality Systems Assessment ↗ The Sepsis program will work further with NSW Ambulance Service to promote staff awareness and links between pre-hospital and in-hospital recognition and management of sepsis
↗ In partnership with ACI and GP NSW a project to enhance care and minimise harm to the confused older person (Care of the Hospitalised Older Person) CHOPS was launched	✓	↗ Refinement of Oncology Medication Safety Self Assessment tool for wide-spread use in Australia in 2012 ↗ In Safe Hands, a project to release the potential of clinical teams will be launched
↗ Two Clinical Focus Reports were finalised and distributed **p 26**	✓	
↗ The CEC manages the NSW component of the National Hand Hygiene initiative **p 28**	✓	
↗ New staff are trained in project management processes	✓	↗ Continue to 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 strengthen relationships with the other members of the Four Agencies — Agency for Clinical Innovation (ACI) — Health Education and Training Institute (HETI) — Bureau of Health Information (BHI) ↗ Continue to strengthen relationships with other stakeholders in promoting the quality and safety agenda
↗ Risk management framework incorporated into the Audit and Risk Management committee schedule	✓	
↗ Regular internal professional development courses and workshops are held for CEC staff **p 76**	✓	
↗ CEC staff are encouraged to undertake external professional development activities	✓	
↗ Continued to strengthen relationships already established and develop partnerships with new stakeholders **p 14**	✓	
↗ Established Patient Based Care Directorate **p 38**	✓	↗ Development of strategies to promote patient/family engagement in open disclosure when adverse events occur and medication management to avoid errors ↗ Development of strategies to engage patients and family in bedside handover ↗ Development of strategies to promote real time feedback within health care services about patient concerns ↗ Supporting service assessment to identify and reduce health literacy barriers within care delivery services
↗ Launched "Partnering with Patients" program to actively look for more opportunities to engage the community in each of our projects and programs **p 38**	✓	
↗ Consumer advisor panel established to facilitate input from patients, families and carers on CEC safety and quality initiatives	✓	
↗ Health Literacy Network established **p 39**	→	
↗ The Falls Prevention program works across the settings of acute care, community and residential care **p 42**	✓	
↗ Membership of Citizens Engagement Advisory Council reviewed **p 63**	✓	

	Objective	Strategies 2010–2011
CAPACITY BUILDING	Provide clinical leaders and the CEC with skills and tools to effectively lead quality improvement	↗ Continue to deliver clinical leadership development program ↗ Support rural Area Health Services/ Local Health Districts by targeting rural participation in clinical practice improvement programs ↗ Build the capacity of CEC staff to lead quality improvement through professional development practices and relationship management ↗ Develop capacity within the CEC to respond to emerging crises and referred issues ↗ Develop and promote safety and quality as a core component in undergraduate health care curricula
COMMUNICATION AND CULTURE CHANGE	Influence current and future decision makers, at all levels of the NSW Health system to apply improvement programs and methodologies	↗ 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 Local Health District, Specialist Networks and the NSW Department of Health in effective uptake and implementation of workplace cultural change relating to clinical improvement strategies ↗ 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 ↗ Develop relationships with primary care services to enable expansion of CEC programs and projects into areas of primary care

Key
Completed ✓
Not Completed ✗
Ongoing →

Outcomes 2010–2011	Status	Future Directions
↗ Enrolment figures for Clinical Leadership Program have increased every year since the program began **p 34**	✓	↗ To meet increased demand, a second cohort of the executive program will be again offered, commencing in August 2011
↗ CEC staff support participation of rural Area Health Service Local Health Districts staff in all capacity building programs	✓	↗ The CEC will continue to actively promote continuation of its clinical leadership program
↗ Regular internal professional development courses and workshops are regularly held for CEC staff **p 76**	✓	↗ Continue to ensure that rural Area Health Service/Local Health District staff are able to participate in CEC programs by conducting training programs across the state
↗ Undergraduates in medical, nursing and allied health are being taught about safety and quality **p 46**		↗ Working to develop an on-line course
		↗ Building a research program to evaluate changes in learning and behaviour
		↗ Continue to add medical and nursing schools to the undergraduate education program
↗ Communications officer in place	✓	↗ Regularly review website to ensure information is current and meets legislative requirements
↗ Website regularly reviewed **p 49**	✗	↗ Continue to work on relationships with all stakeholders to promote the quality and safety agenda
↗ Continual liaison with Local Health Districts through Clinical Council, Directors of Clinical Governance, Citizens Engagement Advisory Council **p 63**	✓	↗ Continue to provide the Minister, CEC Board and other stakeholders with reliable evidence based information to support key safety and quality messages
↗ Partnerships developed over time with various stakeholders have been instrumental in ensuring that clinical practice improvement projects are taken up and implemented **p 14**	✓	↗ The Clinical Leadership and Clinical Practice Improvement programs will continue to work with staff across NSW to ensure the effective uptake of clinical improvement strategies
↗ Patient Based Care Directorate established	✓	↗ The Partnering with Patients program will foster the importance of patient engagement to drive quality improvement
↗ Joint meeting with Citizens Engagement Advisory Council and Clinical Council	✓	

CHAIR'S REPORT

It was an honour to take over as Chair of the Board of the Clinical Excellence Commission (CEC) from Professor Carol Pollock in January 2011. My sincere thanks go to Professor Pollock for her leadership during a time of transition in the NSW Health system.

The past year has been one of change with the restructure from eight area health services into seventeen local health districts, each with its own governing council and chief executive. In addition there are projected significant changes at the Federal level in health care delivery.

A constant throughout the year has been the dedication and exemplary teamwork performed by all of the staff at the CEC. So passionately led by Professor Cliff Hughes with the great support of his deputy, Dr Peter Kennedy the CEC is showing great results for patients and the health system through its wide program of quality and safety improvement projects. As the Chair, and on behalf of all Board members, I thank the entire staff at CEC for their work ethic and tireless efforts.

Education and Training

The CEC continues to drive education and training with the highly respected Clinical Leadership Program, as well as the evolving Undergraduate Education project, both of which play an important role in training clinical leaders of the future. In addition, clinical practice improvement training is provided to front line clinicians in health facilities across NSW.

Clinical Practice Improvement

Two examples of CEC programs that have been embraced by front line clinicians are firstly, the Between the Flags Program which lays the foundations for a comprehensive system in every hospital to recognise and respond to deteriorating patients. Secondly a joint project with the Agency for Clinical Innovation to reduce the risk and complications of severe infection and sepsis.

Public Reporting

Public reporting of accurate data is an essential element in changing behaviour to improve health outcomes. The CEC continues to work with the Bureau of Health Information and the Agency for Clinical Innovation to improve public reporting to ensure its relevance to patients, clinicians and policy makers. It is the aim to have timely, accurate and meaningful information available to all stakeholders.

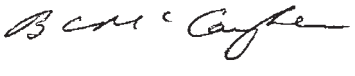
The Board

The Clinical Excellence Commission and the Agency for Clinical Innovation share a common board. Although each organisation has its own focus of activity, the two organisations work closely together and are committed to improving quality and safety in health care for the people of NSW.

I take this opportunity to thank all Board members for their commitment to achieving the mission of the CEC to build confidence in health care in NSW by making it demonstrably better and safer for patients and a more rewarding workplace.

The Future

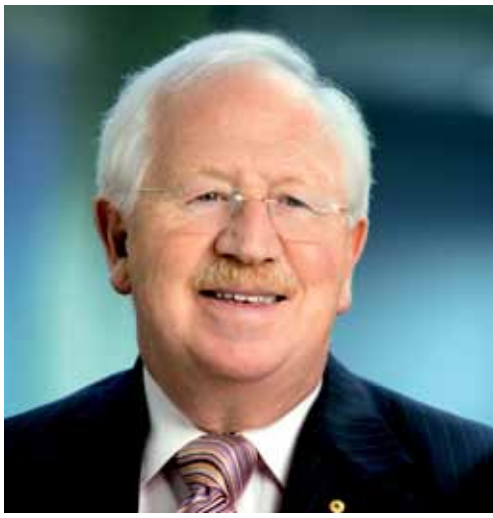
The Board will develop a strategic plan to set the direction for the next three years as the transition phase in NSW Health is better defined. The CEC will be well placed to continue its pivotal role in driving the quality and safety agenda in NSW.



Associate Professor Brian McCaughan AM
Board Chair

CHIEF EXECUTIVE OFFICER'S REPORT

Purposeful direction and focussed commitment best describe the 2010–11 year at the Clinical Excellence Commission (CEC).



Our second strategic plan was in mid-term and our board underwent a significant change. It became a joint board, now also responsible for the Agency for Clinical Innovation (ACI) as well as the CEC. The joint board reviewed the strategic plan and endorsed it. Clinical Associate Professor Brian McCaughan, AM now leads the board, following Professor Carol Pollock's decision to stand down from the chairmanship. We welcome Professor McCaughan to this challenging role.

The organisation continued to grow and required new premises at 227 Elizabeth Street, Sydney. The staff, now numbering 44, remain focussed on their primary task, despite the upheaval of a major move, the excitement of a new government and the increasing challenges posed by the advent of 17 local health districts (LHDs) replacing the old eight area health services. That task remains to make health care in NSW demonstrably safer for patients and a more rewarding workplace.

This report provides a synopsis of our major activities during the year. I commend the reader to the CEC website – **www.cec.health.nsw.gov.au** – and to each of the project reports published therein.

Education and Training

Clinical Leadership

Two hundred and fifty-two participants completed the Clinical Leadership Program in 2010. Clinicians enrolled in the program have together presented or published 180 clinical practice improvement projects as part of their course work.

Undergraduate Education

Approximately 2,500 medical, nursing and allied health students are being taught about quality and safety each year by this program.

Clinical Practice Improvement

The ***Between the Flags*** program, to assist in the recognition and management of the deteriorating patient, is now in to its second year. It has been adopted in all public hospitals across the State and a number of private hospitals are adopting its principles. Other advances include:

- The implementation of age-specific observation charts for paediatric patients
- The development of standardised observation charts for mothers at risk in maternity units
- The preparation of a specific training manual, "DETECT Junior"
- The CEC has become a key component of the Federal government's program on the recognition and management of the deteriorating patient

The CEC conducted 22 ***Clinical Practice Improvement*** (CPI) workshops for clinicians across NSW.

The targeted strategies implemented by the ***Blood Watch*** program demonstrate a reduction in unnecessary blood transfusions by 12,000 units, which equates to over $4 million saving, based on the direct costs associated with red cell transfusion.

The ***Central Line Associated Bacteraemia*** project has completed its evaluation. It has demonstrated a dramatic reduction in these life-threatening infections. The final results of the project equate to world's best practice.

The CEC manages the NSW component of the ***National Hand Hygiene Initiative*** for the Australian Commission for Safety and Quality in Health Care. NSW has now demonstrated overall compliance rates for hand hygiene above the national average.

One hundred and eighty health care facilities now provide regular audit data on hand hygiene compliance.

Patient Safety

The Patient Safety team draws on data from many sources to prioritise activities and projects for the CEC:

- The Incident Information Management System (IIMS) recorded its one-millionth notification from NSW Health staff in May of this year
- Annual reports to local health districts and six-monthly reports to the public indicate learnings from all adverse events and incidents
- Two clinical focus reports address urgent and Statewide clinical problems

New Project Focus Areas

Patient-based Care

We have formalised a Patient-based Care directorship, under the leadership of Dr Karen Luxford, to both lead and support each of our projects. This group brings together our staff and partners around the needs, expectations and desires of patients.

We have strengthened the Citizens Engagement Advisory Council and brought together professional colleagues, community participants and our staff in a program entitled Partnering with Patients.

- A review of communications in emergency departments by the Southern Cross University has been completed

- A program to engage patients and their families in activating escalation responses to deterioration has been developed, with eight lead sites engaged. This is a direct link to the Between the Flags program

A ***Sepsis*** project ***(Recognise Resuscitate and Refer)*** has been implemented, in partnership with the Agency for Clinical Innovation, to address the specific issues of bloodstream infection, identified in both the Incident Information Management Systems reports and the Between the Flags program.

Public Reporting

The CEC continues to exercise its role as a respected voice for quality and safety in NSW. A third edition of the ***Chartbook*** has been published, with 98 indicators and discussion of their implications.

The Collaborating Hospitals' Audit of Surgical Mortality (CHASM) has published an annual report, and individual reports to all participating surgeons and a case booklet describing individual cases of educational value to surgeons.

The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) celebrated 50 years of continuous activity, one of the longest such audits in the world.

Both CHASM and SCIDUA have provided annual reports to the Minister for Health.

The CEC and staff have published 21 reports or journal articles.

Engaging with Others

The CEC does not act alone in improving the safety and quality of health care services.

- The Citizens Engagement Advisory Council directly engages with community and with the consumers of health care
- The Clinical Council continues to advise the board of emerging clinical issues such as the Sepsis program and a joint program with the Agency for Clinical Innovation on delirium
- We continue to advise and participate on programs designed to enhance medication safety with the NSW Department of Health
- The Australian Commission for Safety and Quality in Health Care has been an effective partner in many of our projects, in particular the Recognition and Management of the Deteriorating Patient, Healthcare Acquired Infections and Medication Safety
- Formation of 17 local health districts has provided us with an enormous opportunity to educate the chairs, boards and executives of each district of potential partnerships in safety and quality

Research

We congratulate Dr David Peiris on the award of his PhD thesis under the auspices of the Ian O'Rourke Scholarship. It is entitled ***"Building better primary care systems for Indigenous peoples: A multimethods analysis".***

Elizabeth Rix has been appointed as the second PhD scholar and is in the second year of her research project, ***"The experiences and perceptions of Aboriginal people receiving haemodialysis in Regional NSW".***

The CEC continues to collaborate in partnership with the Bureau of Health Information, the Australian Commission on Safety and Quality in Health Care, Ambulance Service of NSW and the Australian Institute of Health Innovation (University of NSW).

Carolyn Der Vartanian was awarded a HARC Research Scholarship on ***From Facebook to blogs: the role of social marketing and social media to engage clinicians and fast-track evidence into practice.***

Bernie Harrison has also started a PhD with the University of NSW, entitled ***Clinical Practice Improvement methods in elective red cell transfusion in stable post-operative cardiac surgical patients: can they improve the uptake of evidence-based transfusion practice?***

Financial Sustainability

The CEC achieved a Net Cost of Services result of $9.969 million against the budget approved by the Department of Health of $9.957 million, resulting in a slight variation of some $12,000 or 0.1%.

Expenditure for the year increased from $9.795 million in the previous year to $10.297 million, an increase of 5%. The increased expenditure includes costs of additional staff required to support projects that had previously been in the early stages of development and are now in their full delivery stage.

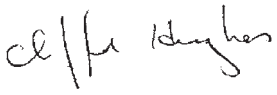
The liquidity position is now stable with a working capital of $5.4 million compared to 2010 of $4.7 million. The current asset ratio increased from 2.91 (2010) to 4.35 (2011) which highlights the CEC's favourable liquidity position and the ability to pay our liabilities when they become due.

Strategic Planning and Development

The second strategic plan continues to provide stable advice in a changing environment. It is to be expected that we will have more tasks to perform on behalf of the Minister when the new governance and management arrangements are finalised. To that end, the engagement of our board in strategic programming is essential.

We look forward to working with a new Minister, a new Director-General and a newly structured NSW Health system, in delivering effective quality of care for our patients in a safe system.

It is anticipated that a strategic planning day will be held in late 2011, to plan our way forward through our third strategic plan.



Clifford F Hughes AO
Clinical Professor
Chief Executive Officer

FINANCE MANAGER'S REPORT

The Clinical Excellence Commission, for the year 2010–2011 financial year was allocated a Net Cost of services budget of $9.957 million by the Department of Health. Audited financial statements reported Net Cost of Services of $9.969 million, resulting in a slight variation of some $12,000 or 0.1%.

Total expenditure for the year is $10.297 million which is a 5% or $502,000 increase on 2009–10. This increased expenditure includes costs of additional staff required to support projects that had been in the early stages of development in 2009–10 and which are now in their full delivery stage.

The CEC's liquidity position is stable with a working capital of $5.4 million compared to $4.7 million as at 30 June 2010. This improved result reflects the Crown Acceptance of the Long Service Leave provision for 2010–2011 which has been reflected within the leave provision accounts being reduced from $1.760 million (2010) to $730K (2011).

The current asset ratio increased from 2.91 (2010) to 4.35 (2011) which highlights the Commission's favourable liquidity position and the ability to pay our liabilities when they become due.

During the year the CEC used its own cash reserves to invest in leasehold improvements of $947,000 to relocate its office accommodation from Martin Place and Sydney Hospital to Elizabeth Street, Sydney. This relocation was completed in accordance with the approved budget and endorsement of the Department of Health.

Total current assets are $6.944 million compared to $7.249 million in 2010. This decrease is due to the use of cash to cover capital leasehold improvements involved in the relocation to Elizabeth Street, Sydney.

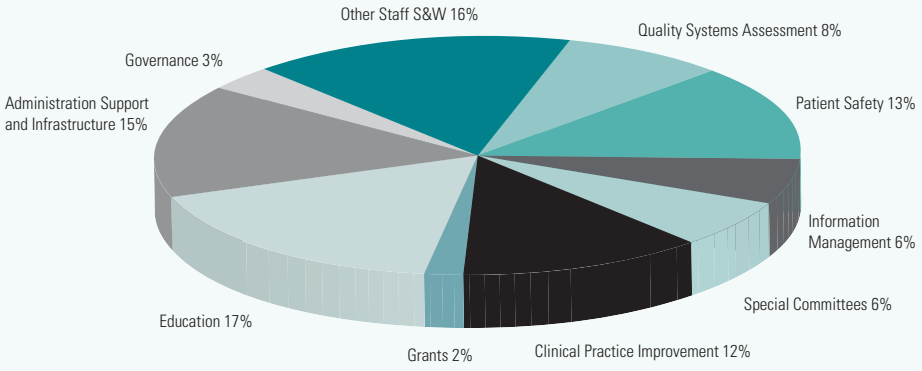
Total liabilities are $1.720 million compared to $2.570 million in 2010. The decrease in liabilities is due to the Crown Acceptance of the Long Service Leave provision as at 30 June 2011.

Nick Didnal
Finance Manager

Financial Summary

Financials ($000)	2010–11	2009–10	2008–09	2007–08	2006–07
Expenses	10,297	9,795	8,050	7,595	6,421
Revenue	721	633	564	254	565
Gain/(Loss) on Disposal	(393)	(2)	5	(9)	0
Government Contributions	9,592	8,511	7,837	10,187	7,925
Net Result for the Year	**(377)**	**(653)**	**356**	**2855**	**2069**
Total Assets	8,425	8,637	8,735	7,268	4,561
Total Liabilities	1,720	2,570	2,015	904	1,034
Equity	**6,705**	**6,067**	**6,720**	**6,364**	**3,527**

Clinical Excellence Commission Expenditure 2010–2011



- Other Staff S&W $1,864,383
- Quality Systems Assessment $1,108,936
- Patient Safety $1,446,587
- Information Management 657,397
- Special Committees $639,155
- Clinical Practice Improvement $1,339,172
- Grants $230,888
- Education $2,001,473
- Administration Support & Infastructure $1,770,183
- Governance $391,326

The difference between total expenses in the table and the pie chart relates to the transfer to Local Health Districts of Clinical Leadership Program budget of $1.15M.

ALLIANCE WITH THE STATE HEALTH PLAN'S STRATEGIC DIRECTIONS

The CEC's Strategic Plan and Key Result Areas align with 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 Prevention Program
- Management of the Deteriorating Patient – Between the Flags project
- Severe Infection and Sepsis project
- Hand Hygiene
- Medication Safety
- 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
- Severe Infection and Sepsis project
- Blood Watch
- Hand Hygiene
- NSW Falls Prevention Program
- Medication Safety
- Partnering with Patients program
- 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 Prevention 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

2

Performance

The CEC has partnered with the Department of Health, clinicians and the community to develop 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 2010–2011.

BETWEEN THE FLAGS

The **Between the Flags** (BTF) program lays the foundations for a comprehensive system in every hospital to recognise and respond to deteriorating patients. The program uses the analogy of Surf Lifesaving Australia where Lifesavers and lifeguards aim to keep people safe by ensuring they are under close observation and, should something go wrong, are rapidly rescued.

ALIGNS WITH CEC KEY RESULTS AREAS

2 Clinical practice improvement
8 Capacity building
9 Communication and culture change

ALIGNS WITH STATE HEALTH PLAN OBJECTIVES

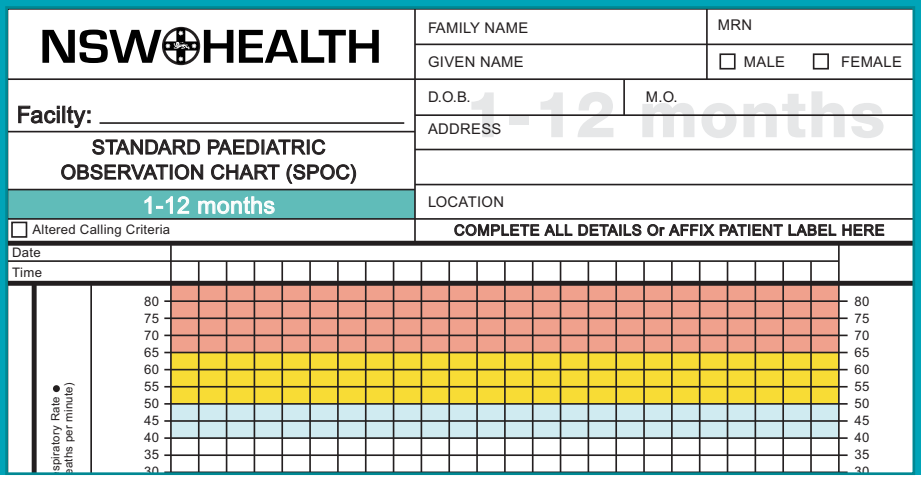
1 Make prevention everybody's business
2 Create better experiences for people using health services
4 Build regional and other partnerships for health
6 Build a sustainable health workforce
7 Be ready for new risks and opportunities

The five elements of the *Between the Flags* program aim to provide patients and staff with a safety net that helps them to recognise when clinical deterioration is occurring and ensures that appropriate escalation occurs.
The five elements are:

1. Governance structures to ensure that the program is implemented in all acute hospitals
2. Standard observation charts to assist staff with early recognition of deterioration in the clinical condition of a patient, using a 'track and trigger system'
3. Clinical Emergency Response Systems (CERS). This includes defined procedures for seeking Clinical Review and Rapid Response, including 'CERS Assist' by ambulance officers in rural and regional facilities
4. Evaluation, including Key Performance Indicators
5. Education aimed at developing skills, knowledge and confidence of clinicians to recognise and manage clinical deterioration, and operate the Rapid Response System (DETECT – Detecting Deterioration, Evaluation, Treatment, Escalation and Communication in Teams)

Key Achievements

- The five elements of the program have been implemented for adult patients across NSW
- The principle of early recognition, using a track and trigger system, is being applied to other clinical situations. Between the Flags escalation thresholds are being incorporated in a variety of clinical guidelines, e.g. the recognition of sepsis
- Work is continuing to develop a Between the Flags program for emergency departments
- Paediatric observation charts have been implemented in all facilities caring for paediatric patients
- Draft emergency department paediatric observation charts have been developed
- Worked with eMR (electronic medical record) advisory group to ensure easy transition from paper-based to electronic record and vice versa
- A multidisciplinary group of authors started developing a paediatric e-learning manual. It is called Detecting Deterioration Evaluation Treatment Escalation and Communication in Teams DETECT junior. Work began on the first four chapters and the first, *"When to Worry"* will be launched in July 2011
- Following state consultation with specialist clinicians a maternity observation chart has been developed and will be implemented before the end of 2011
- *Between the Flags* was evaluated as part of the 2010 Quality Systems Assessment with nearly 70% of respondents reporting that the program is improving patient safety


NSW HEALTH

Facilty: _____

STANDARD PAEDIATRIC OBSERVATION CHART (SPOC)

1-12 months

☐ Altered Calling Criteria

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS Or AFFIX PATIENT LABEL HERE

Date

Time

Respiratory Rate ● (breaths per minute)

80 75 70 65 60 55 50 45 40 35 30

Snapshot of an observation chart including colour coding

The various colour codes used on observation charts

- Adult – General Observation Chart
- Neonatal – Under 1 month (corrected)
- 1–12 months
- 1–4 years
- 5–11 years
- 12 years and over
- Maternity – Observation Chart

Partnerships

- Area Health Services/Local Health Districts Chief Executives:
  - Directors of Clinical Governance
  - Between the Flags Project Managers
  - Educators
  - Clinicians
- NSW Department of Health
- Chief Paediatrician
- Clinical Safety Quality and Governance Branch:
  - Child Health Networks
  - Statewide Services Branch
  - Clinical Redesign Unit
  - Primary Health and Community partnerships
  - Pregnancy and Newborn Services Network
  - Nursing and Midwifery Office
- Agency for Clinical Innovation
- Australian Commission on Safety and Quality in Health Care
- Ambulance Service of NSW
- Children's Hospital at Westmead IT
- Patient and Family Activated Rapid Response Committee

Future Directions

- Implementation of standard maternity observation chart (SMOC)
- Review of the adult standard observation chart, incorporating knowledge gained from research sites
- Finalisation of the newborn risk assessment tool
- Finalisation of the DETECT Junior manual, including the chapters for assessment and management of respiratory, cardiac and neurological deterioration and fluid balance status
- Development of a statewide database that is adapted for adult patients to record rapid response call data, based on the Children's Hospital Westmead database
- Implementation of paper-based standard observation charts for adult and paediatric patients, in emergency departments where the electronic medical record (eMR) has not been implemented
- Integration of DETECT training into pre-registration/enrolment training of health professionals at university and colleges of technical and further education
- Adaptation of DETECT training to meet the needs of assistants in nursing
- Expansion of the program to provide patients and their families with a process for active participation in the program such as activating Clinical Emergency Rapid Response system if required

Challenges

- Continue to embed processes developed as part of Between the Flags, as core business in all clinical units
- Integration of DETECT Junior into existing DETECT training for clinicians who care for both adult and paediatric patients
- Continuing to refine local processes for Clinical Emergency Response Systems (CERS) within existing resources

SEVERE INFECTION AND SEPSIS PROJECT

The joint Clinical Excellence Commission and Agency for Clinical Innovation Severe Infection and Sepsis Project is a new opportunity for clinicians to facilitate consistent improvement at State level in the recognition and management of severe infection and sepsis.

ALIGNS WITH CEC KEY RESULT AREAS

2 Clinical practice improvement
3 Quality systems assessment
6 Organisation development
8 Capacity building

ALIGNS WITH STATE HEALTH PLAN OBJECTIVES

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
6 Build a sustainable health workforce

Appropriate recognition and timely management of patients with severe infection and sepsis is a significant problem in health care. The highly successful ***Between the Flags*** program has demonstrated that early intervention is possible and very effective. Standardisation of care is key to good clinical outcomes.

The Severe Infection and Sepsis project has three key elements: ***Recognition, Resuscitation and Referral.*** They underpin the project goal to ***Reduce preventable harm to patients through early recognition of sepsis and prompt initiation of treatment.***

Phase 1, launched in May 2011, is focused on improving the recognition and management of sepsis in the Emergency Department setting. As part of the launch, 150 senior emergency department clinicians, ambulance officers, local health district executives and other interested stakeholders attended an orientation workshop.

Phase 2 will start in 2012 and focus on improvement initiatives in inpatient areas. Preliminary data suggests that 30% of deteriorating patients requiring a rapid response are septic and a number of these will be healthcare associated infections (HAIs). The Sepsis Project complements other work being done by the CEC in this area.

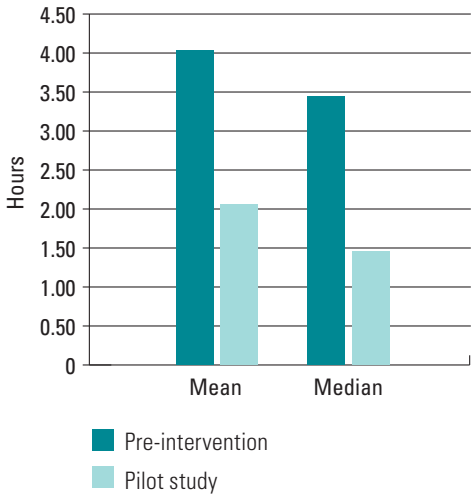
Key Achievements

- Development of a generic sepsis pathway to provide clear guidelines to support prompt recognition, resuscitation and referral to appropriate clinical teams
- Development of a Sepsis Toolkit to support project implementation and staff education at the hospital sites
- Development of a Sepsis Adult First Dose Empirical Intravenous Antibiotic Guideline to guide the timely prescription and administration of antibiotics for adult patients with sepsis
- Development of a web-based Sepsis Data Collection and reporting system to enable Emergency departments to monitor time to antibiotic and intravenous fluid administration
- A pilot study was conducted in Emergency Departments at John Hunter, Liverpool, Concord, Prince of Wales, and Wagga Wagga hospitals. Evaluation of the pilot study showed that implementation of the tools resulted in a 50% reduction in time to administration of intravenous antibiotics
- The Sepsis Project Team conducts monthly peer group teleconferences and site visits to support emergency department teams
- Work has begun to develop a project implementation strategy for smaller rural sites
- A Paediatric Between the Flags/Sepsis reference group has been established to develop a paediatric sepsis implementation strategy

- A consumer representative has joined the ACI/CEC Sepsis Advisory Group. She made a highly engaging presentation at the Sepsis launch detailing her experience of sepsis
- A communication network has been established with the ***Evidence to Excellence Sepsis Collaborative*** management team, British Columbia, Canada. This collaborative has been successfully implemented throughout 2010–2011 and has similar goals to the ACI/CEC.project

Sepsis Project Pilot Study

Time to commence antibiotic therapy in Emergency Departments



Partnerships

The Sepsis Project has worked closely with a range of health care providers and agencies, including:

- Clinical and executive staff in Local Health Districts throughout NSW
- Agency for Clinical Innovation and Clinical Networks
- Emergency Care Institute
- Ministerial Taskforce on Emergency Care
- Between the Flags project team
- Paediatric Between the Flags Sepsis Reference Group
- Rural Critical Care Taskforce
- Rural Critical Care Clinical Nurse Consultants Group
- Ambulance Service of NSW
- NSW Department of Health
- Clinical Education and Training Institute
- The Australasian Resuscitation in Sepsis Evaluation (ARISE) Investigators

Future Directions

- Inclusion of sepsis recognition and management as a key theme in the 2011 CEC Quality Systems Assessment
- Paediatric implementation in Emergency Departments
- Implementation of the sepsis pathway in small rural and remote hospitals
- Implementation of Phase 2 in 2012 in the inpatient areas, with development of further links with the Between the Flags project, to support the recognition and management of the deteriorating patient with sepsis
- Working further with the Ambulance Service of NSW to promote staff awareness and links between pre-hospital and in-hospital recognition and management of sepsis
- Clinical and economic evaluation of the project is being developed through data linkage with the Health Information Exchange, in collaboration with the ACI/CEC Policy and Technical Support Unit

Challenges

Project sustainability, including data collection and monitoring of time to start antibiotic therapy.

QUALITY SYSTEMS ASSESSMENT

The QSA involves all NSW public health organisations (PHOs) which include Local Health Districts, the Sydney Children's Hospitals Network, St Vincent's network , the Ambulance Service of NSW and Justice Health.

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

- The QSA program is comprised of four main elements:
  - *Self assessment:* Every level of each PHO completes an annual self assessment to identify areas of risk and vulnerability around patient safety and quality care
  - *Feedback and reporting:* Feedback is provided to all contributing respondents, the health system and the community
  - *Improvement plan development:* The improvement plan addresses the identified risks and means by which improvement will be achieved
  - *Verification:* Verifies the accuracy of a sample of the previous year's self assessment responses

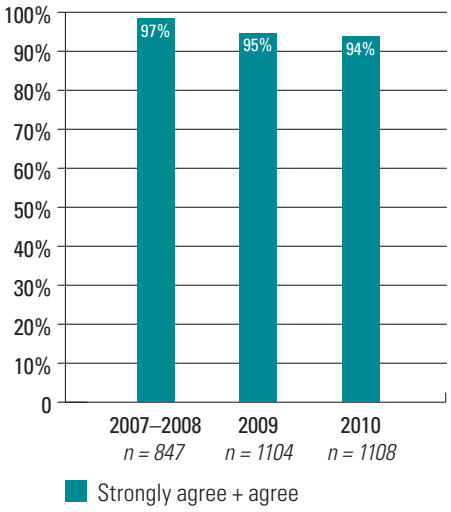
Key Achievements

1. Self assessment

- The 2010 QSA self assessment achieved an overall response rate of 93% and involved over 1100 clinical departments and 93 health facilities
- Specific areas of assessment were:
  - Safety and Quality Culture
  - Essentials of Care
  - Between the Flags
  - Clinical Handover
  - Healthcare Associated Infection (HAIs)
  - Open Disclosure
  - Teamwork
- Analysis of results provided an understanding of the system's performance in relation to areas assessed and showed:
  - HAIs are recognised as a threat to safe, high quality patient care
  - Open Disclosure occurs as required, however training needs to be available to appropriate staff
  - Teamwork is seen as important to the delivery of quality care
- The QSA provides the opportunity to monitor the effectiveness of Statewide quality and safety programs
- It was noted that while there were different methods and styles of implementation, all CEC programs have been well received by clinicians and can demonstrate improvement within the system

Response to Statement

"There is a positive patient safety and quality culture in your unit." 2007–2010



QSA
QUALITY SYSTEMS ASSESSMENT

Quality Systems Site Assessors from NSW Local Health Districts who attended the Verification Topic Training in March 2011.
Left to right: Prof Michael Fulham, Dr Brett Courtenay, Dr Vicky Ting, Jan Heiler, Robyn Schubert, Michelle Cuttler, Dr Marcel Leroi, Liz Harford, Andrew Dagg, Christine Hughes, Dr Trish Saccasan-Whelan, Mick Rowles, Sharon McKay, Alan Hall, Dr Nick Collins, Alan Morrison, Lee Silk, Pauline Gaetani, Rodney Smith, Amanda Walker, Catherine Turner, Jane Walsh and Deborah Elligett

2. Onsite verification program

- The on-site verification program was conducted for the second year in 2010
- A sample of questions from each of the three themes assessed in 2009 were verified. The themes were:
  - Management of the deteriorating patient
  - Clinical handover
  - Medication management
- 20,438 self-assessment responses were verified with an accuracy rate of 98.6%
- This result is comparable with the previous year's verification accuracy rate

3. Reporting

- The main feature of the QSA is to provide NSW Health with assurance about the quality of health services and to assist the CEC in identifying areas for improvement and promotion of better practice in patient safety management
- The 2010 report is available on CEC website: **www.cec.health.nsw.gov.au**

4. Improvement plans

- The Statewide Report makes key system-wide recommendations, with each PHO expected to develop an improvement plan to address these as well as any service specific issues raised in the self assessments
- It provides an integrated approach between the self assessment and recommendations
- Formal yearly review and onsite verification visits give accountability and ensure that processes are implemented and outcomes measured

Partnerships

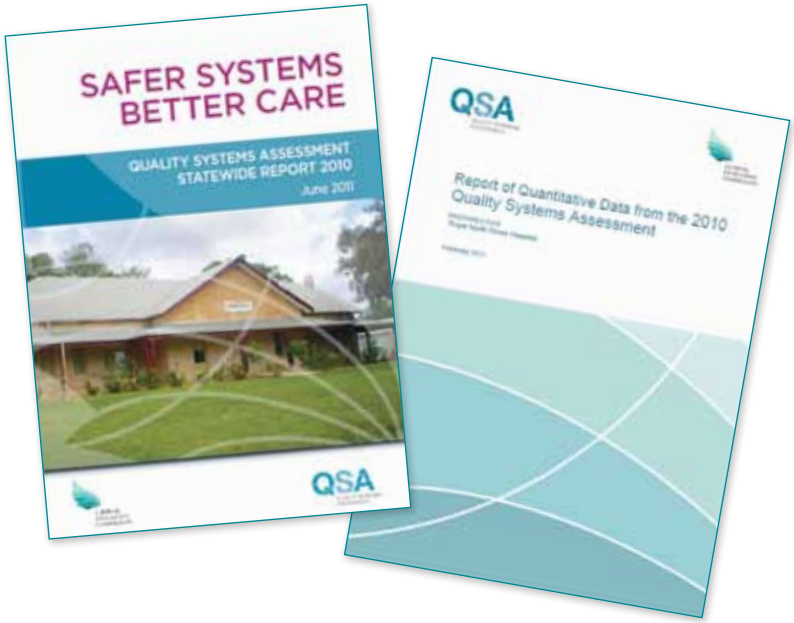
- Local Health Districts/Networks
- Clinical Governance
- Department of Health

Future Directions

- The 2011 QSA self assessment will start in September and will focus on four themes:
  - Mental Health
  - Delirium
  - Paediatrics
  - Sepsis

Challenges

- To make the QSA of increasing practical value to departments, facilities and local health districts
- To avoid duplication of effort



PATIENT SAFETY AND INCIDENT MANAGEMENT

The work of the patient safety team continues to be driven by issues identified by NSW Health staff in the Statewide Incident information Management System (IIMS), root cause analysis (RCA) reports as well as discussions with key clinical groups and Directors of Clinical Governance.

ALIGNS WITH CEC KEY RESULT AREAS

1 Public reporting
2 Clinical practice improvement
4 Information management
6 Organisational development
8 Capacity building
9 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 team also has responsibility for education and support of incident investigation processes and associated skills.

Key Achievements

Public reporting and feedback to clinical staff continue to be a focus of the patient safety team. Routine reporting processes include:

- Bi-annual reports to the Minister for Health and general public on incident management. The most recent of these, for the period July – December 2009 was released by the Minister in June 2011
- Annual reports on IIMS data to each health service. These contain comparable and health service-specific feedback about clinical incidents and RCA reports. They were provided to each health service in August 2010 (for the 2009, calendar year)
- Clinical Focus Reports and Patient Safety Reports:
  - These reports are now widely recognised and utilised as a case for change. They provide not only analysis of IIMS and RCA reports, but include recommendations developed in close consultation with LHDs and clinical staff. Two reports were finalised and distributed

Clinical Supervision at the Point of Care	December 2010
Inpatient Suicide	April 2011

The sepsis project, discussed earlier in this section, was recommended in the Clinical Focus Report – Recognition and Management of Sepsis (released December 2009). The team also commends the work of NSW Health in following up issues raised in other focus reports, including the development of a pathway for management of Acute Coronary Syndrome.

RCA Review Committees

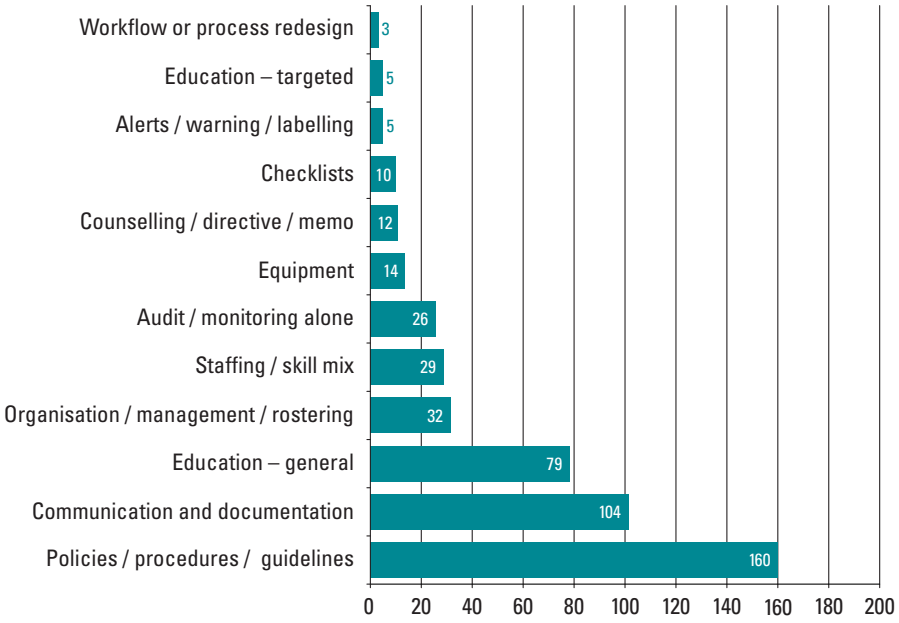
The Patient Safety Team supports three RCA Review Committees; sub-committees of the State Clinical Risk Review Committee (CRRC). Membership reflects the clinical areas of the RCAs reviewed (either general clinical management of physical illness, mental health, drug and alcohol or maternity and perinatal care). The committees review all clinical RCA reports, to identify trends and emerging themes and make recommendation about these to CRRC and other relevant agencies.

During 2010–11, the Clinical Management RCA Review Committee reviewed 374 RCAs. Patient identification and problems with clinical treatment were the most common issue identified. Management of patients whose condition was deteriorating was also frequently cited, highlighting the importance of the *Between the Flags* program.

The Mental Health, Drug and Alcohol RCA Review Committee reviewed 147 reports, mostly related to suspected suicide of mental health patients being managed in the community. The Committee found that care-planning and communication between care providers were the greatest system problems.

Recommendations made in Clinical Management RCAs

(n = 198) July – December 2010



Strength of Solutions/ RCA Recommendations

The Maternity and Perinatal RCA Review Committee reviewed 35 reports and identified that failure to recognise the significance of observations, particularly foetal monitoring was an emerging trend. A clinical focus report on this aspect of care was started and will be available to NSW Health staff once completed.

Each committee has sought consumer representation. Their input is highly valued.

Root Cause Analysis and Human Factors Training

The RCA training resource was revised and provided to all Local Health Districts (LHD) under a train-the-trainer, co-teaching model. It includes PowerPoint presentations, supporting resources and case studies for both physical health (a patient with sepsis who deteriorates and dies) and mental health (suspected suicide of a patient in the community).

The inaugural training cohort in human factors continues to be involved in CEC activities. Many attended the workshop in August 2010 conducted by Professor René Amalberti, a world leader in Human Factors, who was generous in sharing his insights into how complex health care systems, such as NSW Health function.

Patient Safety Managers also attended a health care incident investigation workshop with Professor Jan Davies from the University of Calgary, Canada in March 2011.

University Links

Members of the team have assisted in the undergraduate health professional teaching led by Professor Kim Oates. The Director and Manager were also involved in teaching a post-graduate Masters Course in safety and Quality at University of Technology Sydney.

Partnerships

In addition to the other CEC directorates, the patient safety team worked closely with:

- Directors of Clinical Governance and Patient Safety Managers
- The Agency for Clinical Innovation
- NSW Health – in particular, Clinical Safety Quality and Governance Branch, Mental Health Drug and Alcohol Office, Maternal and Perinatal Care, Statewide Services and Ambulance Service of NSW
- Clinical Groups – Intensive Care Coordinating Monitoring Unit (ICMU), Emergency Care Institute (ECI), Surgical Services Taskforce

Future Directions

- Further work on the rapid response to clinical incidents will continue in 2011–2012, as soon as the LHD Clinical Governance structures are finalised
- The team will continue to support and encourage health staff at all levels to understand and respond to patient safety issues, reported through IIMS or other sources. This will include feedback at many levels across the system and to the general public

The links with Canadian Human Factors experts will continue. In September 2011, this will include a webinar on developing user-friendly forms and a full-day forum with Nurse Educators and Procurement Advisors on assessing the useability of common medical devices from a patient safety perspective.

Challenges

The team faces many challenges in providing timely and comprehensive feedback to drive change across the system. They remain committed to working with clinical staff to provide patients with safe, effective, patient-focussed care.

HAND HYGIENE

Health Care Associated Infections (HAIs) are a significant problem in our health care system. Australian and international evidence demonstrates that improving hand hygiene compliance amongst health care workers (HCWs) is the single most effective intervention to reduce the risk of HAIs.

ALIGNS WITH CEC KEY RESULT AREAS

1 Public reporting
2 Clinical practice improvement
9 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

The Clinical Excellence Commission is leading the implementation of the National Hand Hygiene Initiative in NSW on behalf of the NSW Department of Health.

It is based on the **'5 moments for hand hygiene'** promoted by the World Health Organization (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 a patient's surrounds

Key Achievements

- The CEC delivered 16 Gold Standard Assessor (GSA) workshops between July 2010 and June 2011, with 91 new auditors validated as GSAs. Health care workers (HCWs) who have a clinical role attend GSA workshops to become validated hand hygiene compliance auditors. Through a combination of theory and practice, HCWs gain a detailed understanding of the 5 Moments and the Hand Hygiene Australia audit tool, which enables them to train local auditors. To gain validation, all auditors are required to attain a 90% pass mark in a series of assessments
- All Area Health Services/Local Health Districts are contributing hand hygiene compliance data, with many LHDs using the online Hand Hygiene compliance application (HCApp) to submit data
- Between July 2010 and June 2011 NSW reported a steady improvement in hand hygiene compliance from 67.8% to 71.8%. NSW represents 30–40% of the national data on hand hygiene compliance
- Following a successful pilot of the Medical Officer Leadership and Healthcare Associated Infections Strategy in one NSW healthcare facility, an impressive 18.2% increase in hand hygiene compliance was recorded for medical officers in the pilot facility (32.6% to 50.8%)

Partnerships

Through the Hand Hygiene Program, the CEC has successfully partnered with:

- Hand Hygiene Australia
- Australian Commission on Safety and Quality in Healthcare
- Queensland University of Technology by providing advice and guidance on the evaluation of the National Hand Hygiene Initiative
- Murrumbidgee Division of General Practice for the Medical Officer Leadership and Healthcare Associated Infections Strategy

Regional Hand Hygiene Forum, Dubbo 2011

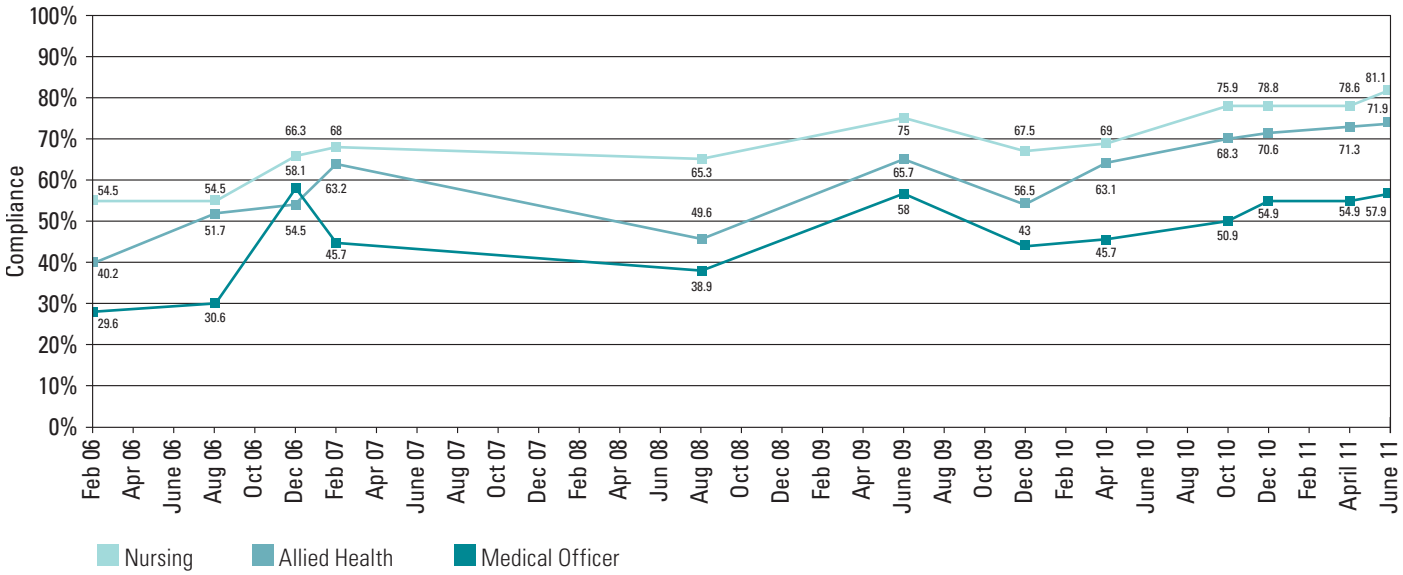
Future Directions

- Spread the Medical Officer Leadership and Healthcare Associated Infections Strategy
- Public display of hand hygiene and infection data in NSW facilities
- Use of web-enabled devices in the clinical environment, improving efficiency in data collection, verification and submission
- Implementing a system to recognise and reward facilities/LHDs which demonstrate sustained improvements in hand hygiene compliance and/or develop new initiatives to promote and embed the program

Challenges

- Ensuring that infection prevention and control is adequately resourced
- Enabling ward auditors to be released to collect hand hygiene compliance data
- Embedding the Hand Hygiene program within Local Health Districts and individual facilities to ensure sustainability of this essential initiative

NSW Hand Hygiene Compliance by Professional Group – 2006 to 2011



Notes: Fluctuation of hand hygiene compliance rates at the beginning of the 5 moments for hand hygiene initiative was due to the staged implementation of the Hand Hygiene Initiative where all AHSs collected and submitted data through credentialed ward auditors.

QUALITY USE OF ANTIMICROBIALS IN INTENSIVE CARE UNITS (QUAIC)

The CEC is partnering with the Intensive Care and Coordination Monitoring Unit (ICCMU) to **improve the quality of antimicrobial use in intensive care units** (QUAIC).

ALIGNS WITH CEC KEY RESULT AREAS

2 Clinical practice improvement
9 Communication and culture change

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

Potential benefits of improving antimicrobial use include a reduction in the development of multi-resistant organisms, reduced incidence of infection with ***Clostridium difficile,*** and reduction in the total expenditure on antimicrobials.

Principles of judicious or quality use of antimicrobials have been developed to help clinicians obtain the best possible results for individual patients while limiting the risk of further contributing to the development of multi-drug resistant organisms (MROs).

The aims of the project include:

- Analyse existing structures and processes to support quality use of antimicrobials in Intensive Care Units (QUAIC)
- Define structures and process that should be in place to support QUAIC
- Develop/obtain tools and resources for use in Intensive Care Units (ICU) to implement supportive structures and processes

Key Achievements

- An expert group has developed a position statement outlining seven structures and processes that should be implemented to facilitate quality use of antimicrobials in ICU
- A survey of NSW ICUs has been conducted to determine the current structures and processes that are in place to support antimicrobial use. A report on the findings of this survey has been published. **www.cec.health.nsw.gov.au/programs/quaic**
- Tools have been developed to assist units in achieving quality use of antimicrobials, including:
  1. An empiric guideline covering principles of good prescribing and diagnostic practices using information from the Therapeutic Guidelines 14 2010
  2. An antimicrobial education package targeted at junior medical staff
  3. Audit tools to assess the appropriateness of antimicrobial use
- All finalised tools are available in the toolkit on the CEC website **www.cec.health.nsw.gov.au/programs/quaic.html**
- Three ICUs are participating in a pilot program to improve antimicrobial use. The aim is to evaluate the effects of a series of interventions, including standard education of junior medical officers, collection and review of antimicrobial usage data and implementation of guidelines for the empiric use of antimicrobials

Partnerships

The CEC is working with the Intensive Care Coordination and Monitoring Unit, utilising relationships forged during the Central Line Associated Bacteraemia (CLAB)–ICU project.

Future Directions

- The QUAIC project will continue to support ICUs in NSW in implementing strategies to improve antimicrobial use by facilitating mentoring between like sites

Challenges

- NSW sites report limited microbiology and infectious diseases support, which is a clear barrier to improving quality of antimicrobial use in intensive care units
- Extracting data from Laboratory Information Systems in NSW, to provide a cumulative antibiogram, has been challenging

MEDICATION SAFETY

The Clinical Excellence Commission (CEC) continues to be a significant contributor to activities to improve the quality and safety of medicines used in NSW and throughout Australia.

ALIGNS WITH CEC KEY RESULT AREAS

2 Clinical practice improvement
5 Health system improvement

ALIGNS WITH STATE HEALTH PLAN OBJECTIVES

2 Create better experiences for people using health services
7 Be ready for new risks and opportunities

Tools adopted and supported by the CEC have been widely used throughout the Australian health care system and have become integral to the medication safety programs of numerous hospitals and health care organisations in both the public and private sectors.

The major tools supported by the CEC are the:

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

These provide hospitals with a method of assessing their medication management systems, to detect underlying risks to patient safety. The tools also allow de-identified comparison of performance between similar organisations. By supporting facilities to complete these tools and to respond to their findings, the CEC is contributing to improved patient care.

Key Achievements

The importance of the MSSA has been recognised by State and federal organisations who promote the safe and quality use of medicines. The Australian Commission on Safety and Quality in Health Care and South Australia (SA) Health have strongly supported and encouraged the use of the MSSA.

Two hundred and thirty one (231) health care facilities from across the country have now completed the MSSA and submitted data to the CEC. The program has been acknowledged as a driver for medication safety programs at many of these institutions. The ongoing growth of the program has demonstrated the continued value that the MSSA provides to health care facilities. Forty five facilities have repeated the self assessment, showing an average improvement of 11.4% in overall score. This indicates that the MSSA has been a significant driver for improvement.

Twenty one facilities have completed the MSSA-AT and submitted data to the CEC.

Partnerships

The CEC continues to support medication safety through contributing to various NSW Health committees, programs and advisory panels, providing expert advice on medication safety and quality issues. Where relevant, the CEC provides analyses of medication related incident data to NSW Health and Local Health Districts to help inform decisions and quality improvement activities.

The NSW Therapeutic Advisory Group (TAG) and the CEC are close partners, having worked together on the development of tools and resources for medication safety. The CEC continues to contribute to working groups within the NSW TAG, especially the SAFERx Medicines Group that focuses on reducing medication errors.

The medication safety work of the CEC is closely aligned to that of the Australian Commission on Safety and Quality in Health Care. The CEC has undertaken several pieces of work on behalf of and in collaboration with the Australian Commission on Safety and Quality in Health Care (ACSQHC) in this reporting period. The major contributions to the work of the ACSQHC have been in the delivery of the National Tall Man Lettering List (see http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-06_NTMS) and to other ongoing work, to reduce medication error caused by look or sound-alike medicines names, labelling or packaging.

The CEC continues to have a meaningful relationship with academics from the Faculty of Pharmacy, University of Sydney. The CEC is also on the reference group for a medication safety related research project at the University of Newcastle.

CEC are contributing to an international project to develop an Oncology Medication Safety Self Assessment. This project is being led by the Institute for Safe Medication Practices in the United States, enabled by a grant from the International Society of Oncology Pharmacy Practitioners.

Future Directions

- Piloting of the Oncology Medication Safety Self Assessment will occur in the second half of 2011. It is hoped that this tool will be refined and ready for more wide spread use in Australia in 2012
- The CEC will continue to support the MSSA program and to assist facilities with addressing gaps identified in their medicines use systems

Challenges

- The pending National Safety and Quality Health Service (NSQHS) Standards will require facilities to meet a number of standards related to medicines use. Should these standards be endorsed, it will be a challenge for the CEC to assist and support facilities and Local Health Districts in meeting them
- Following up those facilities which have completed the MSSA once, to ensure that they have taken action to address gaps and are preparing to repeat the self assessment
- Increasing the uptake of the Medication Safety Self Assessment for Antithrombotic Therapy in Australian Hospitals

CLINICAL LEADERSHIP PROGRAM

The CEC Clinical Leadership Program (CLP) has a focus on improving patient safety and clinical quality by supporting and developing clinical leaders in the workplace.

ALIGNS WITH CEC KEY RESULT AREAS

2 Clinical practice improvement
5 Health system improvement
6 Organisational development
8 Capacity building
9 Communication and culture change

ALIGNS WITH STATE HEALTH PLAN OBJECTIVES

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 health workforce

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

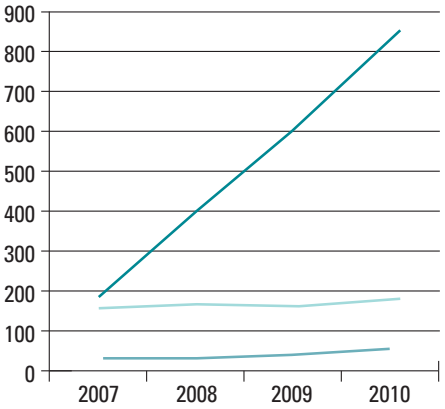
Interest in the program remains strong, with enrolment figures increasing over the past four years. For 2011, over 200 participants are enrolled in the foundational (Statewide) program and 77 in the executive (Modular). To meet increased demand, a second cohort of the executive program has been offered for the past two years. Retention levels are positive, with less than 5% withdrawals from the executive and around 10% from the foundational program.

The value of investing in clinical leadership programs is recognised at Statewide, national and international levels. The CEC's CLP links leadership with patient safety and governance to ensure that the interests of patients and staff remain at the heart of health care delivery.

Key Achievements 2010–2011

- ↗ Two hundred and fifty two participants completed the program in 2010, with all participants undertaking an individual or team clinical improvement initiative designed to improve patient safety and clinical quality
- ↗ At end of the 2011 CLP over 1000 participants will have completed the program since its inception. It is growing in numbers each year and continues to build a cohort of effective clinical leaders who progressively become the 'critical mass' needed for patient-centred system change

Participant Completion Numbers for CLP by Program and by Year



	2007	2008	2009	2010	Total
Executive Modular CLP	31	33	40	59	163
Foundational Statewide CLP	158	169	167	193	687
Cumulative Total	189	202	207	252	850

Clinical Leadership Program

A statewide initiative of the Clinical Excellence Commission

Participants of the 2010 (first intake) Executive Clinical Leadership Program at the presentation day held in Sydney in April 2011. Back row, left to right: Gerald Chew, Ben Milne, Paul Fischer, Damien Limberger, Sean Kearns, Mark Joyce, John Gale, Andrew Dagg, Patrick Farrell, Adam Martin, Paul Spillane. **Middle row, left to right:** Paul Clenaghan, David Mah, Helen Currow, Jennifer Bowen, William Pratt, Meegan Connors, Leanne Crittenden, Catherine O'Connor, Katherine Tucker, Pam Lane, Karen Munro, Heather Gough, Anne Capp, Kay Wright (CEC), Peter Wu. **Front row, left to right:** Richard Cohn, Brian Pezzutti, Anna Chapman, Jillian Roberts, Brian McCaughan (CEC Board), Bernie Harrison (CEC), Cliff Hughes (CEC), Margarett Terry, Megan Sherwood, Stephen Hampton, Cathy Vinters (CEC), Sharon McKay

- The executive (Modular) CLP graduations were attended by a number of senior health executives. Sessions included feedback by participants about the impact of the program on patient safety, clinical quality and on their own leadership development. Similar graduations were held at the local level for participants completing the foundational (Statewide) CLP
- Participants completing the 2010 program were surveyed on how well it met their expectations and key 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, Department of Health, Local Health Districts and external business partners. In addition to delivering specific program content, it links with associated programs at local and statewide levels to help build capacity and improve quality and patient safety at local levels
- Local partnerships have been strengthened within and between Local Health Districts, including between learning and development, clinical operations and clinical governance. Participants, including Ambulance staff involved in programs have developed beneficial linkages. This helps to promote an integrated health system where 'we are all responsible for patient safety'

Future Directions

The CEC will continue active promotion 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 network, collaborate and reinforce their commitment to patient safety are also being explored

Publications

A summary of all projects undertaken through the program is compiled by the CEC annually and made available in hard and electronic copy **(www.cec.health.nsw.gov.au)** to showcase projects undertaken in the program across the health system. The 2009 Clinical Leadership Program project summary booklet was published in 2010. The results of many of these projects clearly demonstrate a strong commitment to clinical practice improvement through effective clinical leadership.

Challenges

The challenge is to build on and sustain the momentum gained to date, while responding to broader challenges of funding.

CLINICAL PRACTICE IMPROVEMENT

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

ALIGNS WITH CEC KEY RESULT AREAS

2 Clinical practice improvement
5 Health system improvement
6 Organisational development
8 Capacity building

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 CEC also works closely with Local Health Districts (LHDs), the Sydney Children's Hospitals Network, Justice Health and Ambulance Service Quality Managers, in building capacity to enable them to support healthcare improvement projects and teams within their organisations.

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

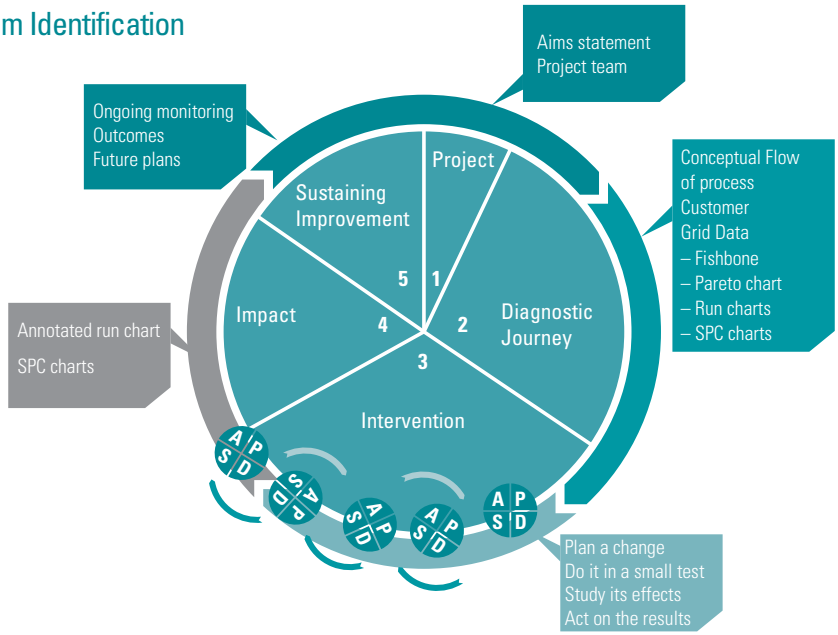
The basic principles of Clinical Practice Improvement include the following:

- 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'
- Multidisciplinary teamwork and the design of novel solutions are essential in effecting improvements in 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 Health's, Health Service Performance Improvement Branch (HSPIB), has developed e-Learning modules in health care improvement methods, including CPI methodology.

Problem Identification



CLINICAL PRACTICE IMPROVEMENT TRAINING PROGRAM

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

Throughout the reporting period the CEC conducted a total of 22 CPI workshops, which included:

- CEC Clinical Leadership Program and NSW Rural Institute Clinical Team Leadership program
- Two hundred and fifty two nursing, medical and allied health clinicians have undergone CPI training. All participants undertook an improvement project
- Two-day CPI workshops were offered to Local Health District Clinical Governance Units with 182 participants attending local workshops and undertaking local improvement projects
- Within the CPI facilitator network 20 participants undertook extended training in CPI to assist them building capacity for CPI training and support of improvement projects within the LHD
- The CPI e-learning module is available on the NSW GEM platform for all NSW public health employees. There has been an increase of participants from 225 in July 2010 to 650 at the end of June 2011
- An e-learning advisory group has been established to evaluate and propose future direction for the on-line modules
- An international video conference with Dr Brent James, Executive Director of the Institute for Healthcare Delivery Research Intermountain Healthcare, USA with all the LHD Chief Executives participating. The focus was on using quality improvement to increase patient safety and lower costs

Partnerships

- NSW Health Service Performance Improvement Branch – to review health care improvement initiatives
- Clinical Education and Training Institute (CETI) – improvement training initiatives
- Agency for Clinical Innovation (ACI) – work setting design and human factors training
- Bureau of Health Information (BHI) – improving measurement capability in the system
- Intermountain Healthcare, USA through Dr Brent James and his Institute for Health Care Delivery Research – a key adviser to the CPI program
- Institute for Healthcare Improvement, Boston, USA – quality and safety education for front line staff

Future Directions

- We will continue to provide training for LHDs and other groups as requested
- A facilitated CPI course on-line is being developed to better support staff from rural and remote LHDs to undertake CPI improvement projects
- The CEC will continue to meet monthly with the Health Service Performance Improvement branch (NSW Health) to promote the health care improvement training agenda within NSW
- Developing web-based information outlining health care improvement courses in NSW, through partnership between CEC, NSW HSPIB and Nursing and Midwifery Office (NaMO)

Challenges

- Increased coordination and communication of improvement training initiatives particularly between the 'peak bodies' running improvement training
- Ensuring improvement initiatives align with strategic intent of LHDs
- Greater involvement of patients and families in improvement of services

PARTNERING WITH PATIENTS

Improving patient-based care has a range of benefits for patients and carers, providers and health care services, including improving clinical outcomes, patient care experience, staff satisfaction and operational benefits.

ALIGNS WITH CEC KEY RESULT AREAS

7 Community engagement
9 Communication and culture change

ALIGNS WITH STATE HEALTH PLAN OBJECTIVES

2 Create better experiences for people using health services
3 Strengthen primary health care and continuing care in the community
4 Build regional and other partnerships for health

The Clinical Excellence Commission (CEC) has established a new Directorate of Patient Based Care, in recognition of the importance of patient engagement to drive quality improvement. The Directorate has engaged patients, family and carers on a new Consumer Advisor Panel through which consumers provide input to programs and projects of the CEC.

In this year, the Partnering with Patients program has been established to foster the inclusion of patients and family as care team members, to promote safety and quality. It recognises the importance of improving quality of care by responding to the needs and preferences of patients, while equally engaging staff in creating supportive environments for all.

The Partnering with Patients program promotes engagement at an individual care level as well as at a governance level across the health care organisation. The program aims to work with health care services across NSW to produce leading organisations focussed on improving patient based care. Strategies included in the program focus on building committed senior leadership, engagement of patient and families, active use of patient feedback, building staff capacity to deliver patient based care, and promoting redesign of care delivery.

Key Achievements:

- Consumer Advisor Panel established to facilitate input from patients, families and carers on safety and quality initiatives by the CEC
- Partnering with Patients Advisory Committee established, chaired by consumer advisor Alicia Wood, to provide strategic advice to the program and input from key stakeholders
- Stakeholder liaison conducted about the development of several streams within the Partnering with Patients program
- Patient and Family Activated Rapid Response program stream established to provide an avenue for care escalation for deteriorating patients
- Patient and Family Activated Rapid Response Working Group established to provide program stream governance and lead sites engaged within Local Health Districts
- REACH (**R**ecognise **E**ngage **A**ct **C**all **H**elp is on its way) model and toolkit developed to support implementation of patient and family activated escalation, along with an evaluation process to assess impact
- Junior Clinician Orientation program stream developed to promote patient-based values and associated communication skills to junior doctors and nurses entering health care services. Governance and Orientation Program developed along with engagement of initial lead site
- Module about patient based care values integrated into the undergraduate teaching curriculum for medicine and nursing

- Seminar planned for senior leaders about ***Building Leadership To Improve Patient Based Care,*** to be co-hosted by the Clinical Excellence Commission and the Australian Commission on Safety and Quality in Health Care
- Health Literacy Network established with key stakeholders and priorities identified, including development of guidance and support for health service assessment of health literacy barriers
- Study completed investigating service quality and communication in emergency department waiting rooms
- Partnering with Patients program featured in the US Institute for Patient and Family Centered Care – Guide for Leaders

Partnerships

- Local Health Districts:
  - Boards
  - Chief Executives
  - Directors of Clinical Governance
  - General Managers
  - Patient Safety and Quality Managers
  - Community Participation Managers
  - Carer Support Managers
- Patient and Carer Experience Portfolio, Health Services Performance Improvement Branch, NSW Health
- Health Consumers NSW
- Bureau of Health Information
- Agency for Clinical Innovation
- NSW Health Care Complaints Commission
- Australian Commission on Safety and Quality in Health Care
- WHO Patients for Patient Safety
- Expert advisors on Partnering with Patients committees and working groups
- Academic partners on collaborative grant applications

Future Directions

- Development, implementation and evaluation of practical guidance for health care services to assist with transforming patient-based care delivery
- Supporting service assessment to identify and reduce health literacy barriers within care delivery services
- Promoting implementation of recommendations from the report on ***Service quality and communication in emergency department waiting rooms***
- Disseminating emerging evidence about patient based care and contributing to the knowledge base
- Development of strategies to engage patients and family in bedside handover
- Development of strategies to promote real time feedback within health care services about patient concerns
- Development of strategies to promote patient/family engagement in open disclosure when adverse events occur and medication management to avoid errors

Challenges

- Gaining acceptance that patient-based care is 'not an add-on' to care delivery, but rather is critical to quality and safety
- Integrating approaches into patient-based care delivery beyond the initial 'toe in the water' – moving beyond the 'pilot project' approach
- Ensuring patient-based models developed are flexible to accommodate local processes

BLOOD WATCH – TRANSFUSION MEDICINE IMPROVEMENT PROGRAM

The Blood Watch program, which has been running for six years, works to improve and promote the provision of world-class transfusion medicine practice in NSW specifically with regard to fresh blood products, including red blood cells and fresh frozen plasma (FFP), cryoprecipitate and platelets.

ALIGNS WITH CEC KEY RESULT AREAS

2 Clinical practice improvement
6 Organisational development
9 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

It is underpinned by the Patient Blood Management framework which aims to improve clinical outcomes by avoiding unnecessary transfusion. It includes the three pillars of optimisation of blood volume and red cell mass, minimisation of blood loss, and optimisation of patient's anaemia, which are now advocated in the National Patient Blood Management Guidelines.

The Blood Watch program has also focussed on the reduction of costs associated with red blood cell transfusion by reducing the number of inappropriate transfusions, inappropriate usage of platelets and FFP and more effective management of inventory based on improved clinical practice.

Key improvements have been facilitated by local systems redesign using a collaborative clinical practice improvement methodology. Local transfusion improvement teams, made up of nursing, science and medical clinicians with expertise in transfusion, drive and support local initiatives to sustain transfusion best practice.

Key Achievements

- An extensive analysis of elective surgical blood use across five specialities (cardiothoracic, colorectal, gynaecology/obstetrics, orthopaedics and general surgery) was undertaken in collaboration with the Simpson Centre for Health Services Research, University of NSW to determine the impact of the Blood Watch program on blood usage in NSW public hospitals
- Analysis of elective surgical blood usage in NSW from a population-based linkage showed there was an overall 27.4% reduction following the introduction of the Blood Watch program for the five surgical specialties. These results indicate that the targeted strategies implemented by the Blood Watch program were effective and that the reduction in the number of units transfused between 2008–09 equated to a $4.325 million saving, based on the direct costs associated with a red blood cell (RBC) transfusion
- The BloodSafe e-Learning program, endorsed by the CEC, has been supported and implemented across most NSW public hospitals. Over 19,000 registrants have successfully completed the modules on blood administration and safety

BLOOD WATCH
every drop counts

- Over 40 senior clinical leaders attended a meeting with international health economist Axel Hoffman from Austria, to learn about the true costs, risks and benefits of transfusion based on emerging evidence. Mr Hoffman also spoke about his international experiences with Patient Blood Management programs which place the optimisation of the patient's own blood at the core of transfusion practice. The NSW Blood Watch program will be adopting a patient blood management framework in its future work

Partnerships

- Continuous collaboration with the National Blood Authority in the areas of haemovigilance and data linkage
- Continuous partnerships with all Area Health Service/Local Health Districts 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
- Strategic collaboration with the University of NSW and the Simpson Centre for Health Services Research in the analysis of red cell usage in surgery in NSW public hospitals
- Sharing of information and methodologies with other jurisdictions. For example we have advised and worked with the Queensland Department of Health on its new patient Blood Management program

Future Directions

- Implementation of Blood Watch work plan 2011–15, with particular emphasis on the recognition and treatment of iron deficiency anaemia as a way of reducing inappropriate red cell transfusion
- Continuation of work to establish a statewide haemovigilance reporting system
- Dissemination and implementation of the new National Patient Blood Management Guidelines

Challenges

- Continuous improvement of transfusion practice and sustaining those improvements

FALLS PREVENTION PROGRAM

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.

ALIGNS WITH CEC KEY RESULT AREAS

2 Clinical practice improvement
9 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

Key Achievements Working With Partners

NSW Falls Prevention Network

NSW Falls Prevention Network Forum 27 May 2011
Three hundred and forty health professionals from Local Health Districts across the state, as well as partners from community services and residential aged care, attended the annual forum. A highlight of the meeting was the launch of The New Falls Plan: *Prevention of Falls and Harm from Falls among Older People 2011–2015* by Hon Jillian Skinner MP, Minister for Health, and Minister for Medical Research. http://www.health.nsw.gov.au/policies/pd/2011/PD2011_029.html

For the first time, web streaming of the plenary sessions allowed health professionals from the Rural Health Districts to participate where they could gain access. The forum was recorded and CDs were distributed across the NSW health system.

Rural Falls Forum (with 2 x 2hr video conference sessions) was held across the four rural Area Health Services to 12 sites, in November 2010. The CEC provides the hub for the transmission of these sessions. The overall attendance was 393 participants.

Key experts provided updates on research and the key aspects of the Australian Commission on Safety and Quality in Health Care 2009, falls prevention best practice guidelines.

CEC Patient Based Care and the NSW Falls Prevention Network

Working with Consumers – This is a new initiative. To date two scenarios have been filmed. These stories highlight the importance of engaging with the person, family and carers in falls prevention and are to be used to support education initiatives. They were presented at the NSW Falls Prevention Network Forum in May 2011.

Centre for Health Advancement, NSW Department of Health

Falls prevention physical activity web–based resource directory

www.activeandhealthy.nsw.gov.au

A web-based directory of falls prevention physical activity programs was launched in March 2011. By entering a suburb, older people and their carers, General Practitioners, and other health professionals can locate registered falls prevention physical activity programs in their locality. The website also provides key falls information for the general public, exercise providers and health professionals. At 30 June 2011, there have been 10,654 hits and 45,132 page views to the website and 334 physical activity providers registered, with 815 physical activity programs running across the State.

A Community Falls Prevention Resource: Staying Active and on Your Feet.

A new falls prevention booklet for older people has been available since March 2011. Demand for this resource by health professionals, community services and the general community has been overwhelming.

View of the active & healthy website homepage.

Local Health Districts

APRIL FALLS DAY

April Falls Day and Month activities are developed and facilitated across NSW by the CEC, Falls Prevention Co-ordinators and the NSW Falls Prevention Network. This has become a regular annual event to raise awareness of the issues of falls prevention across the settings of Acute Care, Community and Residential Care. It is listed in the NSW Health State Calendar of Events and has print and radio media to promote it.

Falls Prevention Presentation on Community Network TVs in Hospitals. The CEC supported a falls prevention presentation screened on 44 TV monitors in hospitals across the State.

Other Agencies

Agency for Clinical Innovation

Musculoskeletal Network: Musculoskeletal Working Group and Osteoporosis Working Group

Aged Health Care Network: Care of the Confused Hospitalised Older Person Study (CHOPS) – Steering Committee

Statewide Ophthalmology Service: Vision and Stroke Working Group

Australian Commission on Safety and Quality in Health Care: Consultation on the development of the new National Safety and Quality Health Service National Standard 10, Preventing Falls and Harm from Falls (PFHF)

Future Directions

- Working with NSW Department of Health, Local Health Districts, Falls Co-ordinators and other agencies to implement strategies as identified in the new falls plan
- Engaging with consumers in falls prevention initiatives

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 – in particular, within emergency departments

PAEDIATRIC CLINICAL PRACTICE GUIDELINES

Implementation of evidence-based guidelines is one method of improving the standards of clinical practice and increasing the safety and quality of health care for children by reducing the incidence of preventable adverse events.

ALIGNS WITH CEC KEY RESULT AREAS

2 Clinical practice improvement
8 Capacity building

ALIGNS WITH STATE HEALTH PLAN OBJECTIVES

2 Create better experiences for people using health services
7 Be ready for new risks and opportunities

The CEC has begun a two-year project to develop sustainable strategies for monitoring implementation and evaluating the outcome of the NSW Paediatric Clinical Practice Guidelines (CPGs) developed by NSW Health. The initial aim is to develop sustainable models of evaluation. The CEC will also have an active role in the ongoing review of existing, and the development of new, CPGs.

Capacity building through educating clinicians in the use of CPGs is an important component of the project. This will result in improved quality and safety and better experiences for all children (and their parents/carers), when accessing health care services in NSW.

A key element of the project is developing local partnerships with clinicians and facilities within Local Health Districts. Building affiliations with CETI (Clinical Education and Training Institute) and ECI (Emergency Care Institute – part of the Agency for Clinical Innovation) will be integral to the ongoing success of initiatives implemented as part of this project.

Key Achievements

The key achievements in the initial few months of the project have been:

- Partnership building with key stakeholders in Paediatrics and Emergency Care
- Development of the various Audit tools through a consultative process
- Site visits to a variety of emergency departments across NSW for small informal focus groups with key staff

Partnerships

The project is a partnership between the CEC, NSW Health and the Child Health Network Coordinators. Each of the three Child Health Networks (CHNs) has a tertiary children's hospital within their domain. They are the Greater Eastern and Southern (GESCHN), the Western (WCHN) and the Northern (NCHN). Utilising the expertise of clinicians the CHNs endeavour to provide the highest quality paediatric health care services in the most appropriate location. This means that all children around NSW, even those living in rural and remote communities, have access to the required health care, with minimisation of travel times.

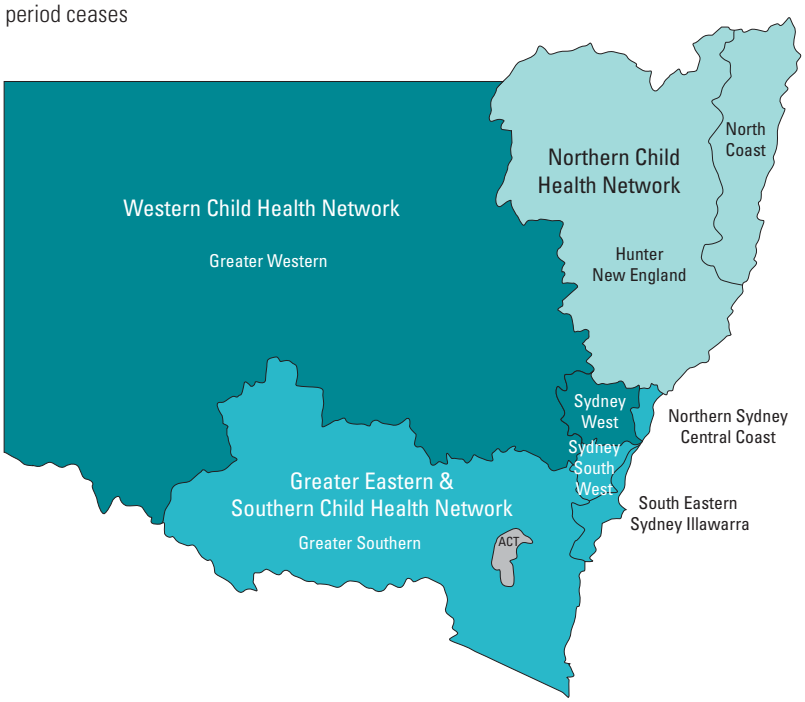
Future Directions

Over the next 18 months the CEC will:

- Develop education and training resources to support implementation of Paediatric CPGs
- Support implementation and evaluate the uptake of the Paediatric CPGs
- Develop audit processes to measure clinical outcomes related to use of the CPGs
- Provide support for systematic audits/surveys to be developed, tested and implemented, to assess guideline implementation and integration into clinical practice
- Develop and implement audit processes to monitor compliance with the CPGs, ensuring there is appropriate feedback to clinicians and the Steering Group
- Ensure that recommendations for system improvement are made where appropriate, and provide advice regarding quality improvement projects to improve CPG uptake and compliance
- Participate in the ongoing review of existing CPGs, and the development of new CPGs

Challenges

- Engaging Local Health Districts at all levels of the organisation in the audit activities
- Ensuring sustainability of the key indicators, by designing them with the view to ease of ongoing collection by staff within LHDs on an ongoing basis once the project ceases
- Creating and implementing Statewide initiatives which can be continued without additional support after the two-year project period ceases



TEACHING QUALITY AND SAFETY TO UNDERGRADUATES

The project established in 2009 to explore ways of delivering quality and safety education to NSW medical students has been extended to include teaching safety and quality in Nursing and Allied Health schools. Approximately 2,500 students are being taught each year by this CEC program.

ALIGNS WITH CEC KEY RESULT AREAS

2 Clinical practice improvement
8 Capacity building
9 Communication and culture change

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

Key Achievements
Medical Student Teaching

University of Notre Dame

- Four interactive modules each of two hours have been created for first-year medical students with an additional four modules developed for second-year students. The fourth of these modules has a focus on involving patients in their own care and was developed in conjunction with the CEC Director of Patient Based Care, Dr Karen Luxford
- Notre Dame staff co-teach in the program, with a view to taking over the teaching in subsequent years
- A pre-test/post-test research design has been incorporated into the program to assess knowledge. A control group of Notre Dame medical students who started their course before the commencement of quality and safety teaching, will be followed over time and compared with the students who have received this teaching

University of Western Sydney (UWS)

- Teaching first and second-year students started in 2010 and extended to year 5 (final year) medical students in 2011
- Tutor guides and manuals have been prepared and training is regularly provided for the UWS teaching staff, who help lead the discussion groups
- These modules have a clear focus on safety in the intern and resident years (safe prescribing, clinical documentation and handover, fatigue and stress, reporting adverse events)

Sydney Medical School (University of Sydney)

In 2011 the CEC was asked to co-teach in the patient safety component of the course.

University of Newcastle

- A revision of some aspects of the medical curriculum has been recently completed
- Discussions are underway to include quality and safety teaching from the CEC in 2012

University of Wollongong

- This medical school already has an interest in quality and safety and will use the CEC as a resource in developing its curriculum and for guest lectures

University of Melbourne

- This medical school is developing a new curriculum and has visited the CEC to observe medical school quality and safety teaching, with the aim of incorporating concepts into its new student program

Nursing School Teaching

University of Technology Sydney (UTS)

- Four quality and safety modules were delivered by CEC staff in 2010
- Because of the large numbers (over 500) the lectures were delivered by podcast. CEC staff, accompanied by UTS co-teachers, gave the interactive tutorials, each of two hours
- A pre-test/post-test design is being used to assess knowledge transfer. The first draft of the research paper (a co-publication between UTS and CEC) is currently being reviewed
- A follow-up session with UTS showed high satisfaction. As a result, teaching was continued in 2011, with the podcasts being used and the CEC providing tutor training to UTS academic staff

University of Newcastle

- Teaching in quality and safety started in 2011 using pre-recorded lectures from the CEC
- Tutor training for academic staff was provided by CEC

University of Wollongong

- 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 Sydney

- Teaching in a post-registration nursing course (four modules) started in September 2010 and continued in 2011

Allied Health Teaching

University of Sydney – Cumberland College of Health Sciences

- Three Quality and Safety interactive modules have been delivered as evening classes to Physiotherapy, Occupational Therapy, Radiography and Orthoptic students at Cumberland College

Other activities:

- Agreement with the Boston-based Institute for Healthcare Improvement to gain free access to their Open School, an on-line course in quality and safety, free for any medical, nursing and allied health students involved in CEC teaching
- Negotiations with the Royal Australasian College of Physicians (RACP) to have CEC input into the design of its patient safety teaching

Young Doctors Group

A group of young doctors with a commitment to patient safety has been established to meet regularly at the CEC, to share ideas and provide mutual support.

Consortium of Medical Educators

A group of educators in developing tools in on-line teaching has been established. There are representatives from Hong Kong, Brisbane and Sydney. It is expected that the group will grow. It has a commitment to sharing ideas and resources.

Challenges

- Securing funding for a Fellowship program to develop skills in the next generation of leaders in patient safety
- 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 significant resources will be required
- Recruiting additional suitably trained teachers from the pool associated with the CEC
- Training teachers at the universities to continue this teaching, while maintaining quality control monitored by the CEC

Future Directions

- 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
- Publishing details of the program and the research results as they become available

CHARTBOOK

As part of its goal to provide assurance through credible public reporting annually, the CEC publishes *The Chartbook* of health system safety and quality indicators.

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

In December 2010 the CEC released the third edition, ***Chartbook on Safety and Quality in Healthcare in NSW 2009 (Chartbook 2009),*** containing 98 indicators. The Chartbook is produced annually by calendar year using retrospective five-year trend analysis model. ***Chartbook 2009*** builds on the successful first and second editions as well as utilising the benefit of clinician feedback.

The Chartbook series provides:

- A tool for measuring and reporting safety and quality in the NSW health system at a State and Area Health Service/Local Health District level
- A key resource for clinicians to use to monitor and influence key trends in safety and quality in NSW
- A tool for driving change in our health care system
- An 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
- Reports on outcomes of key initiatives of the CEC and NSW Health that address safety and quality issues

Key Achievements

- ***Chartbook 2009*** includes two new chapters on Patient Experience and Cancer Services (incidence and mortality)
- Several existing chapters that were presented either in the first or second edition have been expanded. These are:
  - Population Health
  - Mental Health Services
  - Ambulance Services
  - CEC initiatives in safety and quality
- Clinician engagement and feedback has contributed to the increase in indicators reported and improved the relevance of the commentary
- New presentation formats have been introduced
- ***Chartbook 2009*** continues to provide an expert-informed overview of key safety and quality issues and trends in the NSW public health system. Along with other recently released reports, it confirms that NSW residents have access to an excellent health care system
- The second and third editions of Chartbook have expanded the number of indicators reported on. The first edition of Chartbook contained 63 indicators, the second edition contained 84 indicators, Chartbook 2009 published in December 2010 contained 98 indicators

Future Directions

Preparation of the fourth edition – ***Chartbook 2010*** – is underway. Proposals regarding how this publication can be made more relevant to clinicians, the health system and the public have been incorporated. The more relevant it is, the more health professionals will 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.

Challenges

- Finding ways to deliver more timely and more immediately actionable data to the clinical coalface where it can be a catalyst to drive change
- Ensuring that the information contained in ***Chartbook*** is fresh and relevant for clinicians and accessible to the public without over simplifying important issues
- Ensuring that clinicians continue to have input into development of ***Chartbook*** indicators and their analysis and interpretation
- Finding an appropriate balance between number of indicators and size and utility of the publication

INFORMATION MANAGEMENT & INFORMATION TECHNOLOGY INITIATIVES

Supporting CEC's Information Management Initiatives and Reporting Activities

The Information Management (IM) Directorate supports all CEC programs in their acquisition, use and management of information. This includes providing advice about data collections, collection methodologies, data sources, privacy and confidentiality issues and data analysis. The team is responsible for overseeing the CEC website and intranet and the final preparation of project, program and special reviews' documents for external publication, as well as records management activities.

Key Achievements

The CEC Information Directorate has provided support and advice regarding:

- Medication Safety Self Assessment (MSSA), Sepsis Project, Quality Systems Assessment (QSA), BloodWatch, Collaborating Hospitals Audit of Surgical Mortality (CHASM) and Special Committee Investigating Deaths Under Anaesthetic (SCIDUA) databases
- Risk management and records management
- CEC peer-reviewed publications repository and corporate library
- Privacy, security, secure storage and disposal of paper and electronic record collections

Key Partnerships

- Bureau of Health Information
- Department of Health Centre for Epidemiology and Research
- Demand, Performance and Evaluation Branch
- Centre for Health Record Linkage (CHeReL)
- Health Support Services

Future Directions

- The IM Directorate continues to have a key support role in information management, ICT knowledge management and health system reporting for all functional areas within CEC
- Enabling CEC to help monitor the health system, especially the recently announced Local Health Districts and assisting them to improve their safety and quality performance

IT and IM Planning and Development

- The move to new offices in January 2011 represented an ideal opportunity to reconfigure CEC's ICT
- As part of the rollout of the ICT Strategic Plan the CEC's information and communication technology was reconfigured. Under the plan nineteen key ICT projects will be implemented over the next five years and will provide renewed capacity, sustainability and compliance
- To ensure CEC meets ICT best practice and enables compliance with NSW Government ICT directives into the future, new or revised policies and procedures are now in place for Business Continuity, GIPA, records management, enterprise architecture standards, information security management and procurement
- The Director is a member of the NSW Health Chief Information Officer's Forum

Future Directions

Several key remaining projects within the ICT Strategic Plan started in late 2010–11, including the project to upgrade records management systems, which will happen throughout 2011–12, as well as the further development of bespoke business applications and databases.

CEC Internet Presence

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

Key Achievements

- The CEC launched an intranet to complement its website in April 2011 as part of its information management and knowledge management goals

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

- The website continues to receive thousands of unique visitors and download requests every month. It is a key component of CEC's ability to readily disseminate work and make it easily available to clinicians and the public. It is also the entry point to several CEC online data collections and education and collaboration tools
- In recognition of the increasing relevance of social media in everyday work life, in May 2011 CEC staff was given access to a range of social media tools. This has led to increased awareness of the value of social media in the work environment

Future Directions

- CEC will continue to improve its web presence and to augment it with additional internet capabilities, such as additional intranet, and extranet capacities and a social media presence
- In late 2011 an international expert in social media will visit the CEC to conduct workshops for staff

THE COLLABORATING HOSPITALS' AUDIT OF SURGICAL MORTALITY (CHASM)

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.

ALIGNS WITH CEC KEY RESULT AREAS

2 Clinical practice improvement
4 Information management
6 Organisational development
9 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

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 2010 to 30 June 2011, CHASM:

- ↗ Recorded 2290 deaths notified by all local health districts
- ↗ Received 1593 completed surgical case forms from surgeons
- ↗ Completed the audit of 1359 notified deaths

Figure 1 shows the number of recorded deaths by CHASM, proportion of deaths with returned surgical case forms and proportion of deaths that had completed the audit, from the start of data collection in January 2008 to June 2011.

At 30 June 2011, 923 (60.5%) surgeons were participating in CHASM, with 374 of them also agreeing to be first line assessors and 277 to be second line assessors.

Figure 2 shows the participation level of active surgical fellows of the Royal Australasian College of Surgeons (RACS) in NSW by surgical specialty.

Sixty per cent of active surgical fellows of RACS were participating in CHASM in NSW at 30 June 2011.

Vascular, neurosurgery, urology, general and cardiothoracic were the top four participating specialties.

The first CHASM annual report was published and distributed to all surgical fellows and trainees in NSW. It reported on all audited deaths between 1 January 2008 and 30 June 2009 by surgical specialty and area health services.

CHASM also published its second case book featuring 14 surgical cases for reflective learning. The theme of the case book is venous thromboembolism prophylaxis, with three illustrative cases and a narrative by Dr Mauro Vicaretti, Senior Lecturer, Vascular and Endovascular Surgery, Sydney Medical School and CHASM committee member.

The second batch of individualised annual feedback reports was released to 463 surgeons who completed a surgical case form during the reporting period of 1 July 2009 to 30 June 2010. Evaluation of the report indicated high satisfaction with 74 per cent of respondents (n=71) stated that the report was useful.

The Project Coordinator presented a poster on the roles of clinical audit managers in assisting data collection for CHASM at the Australasian Mortality Data Interest Group Workshop, which was held in Melbourne on 17th and 18th November 2010.

[1]This figure includes 345 returned forms for deaths recorded in the previous financial years.
[2]This figure includes 534 deaths that were recorded in the previous financial years

In May 2011, CHASM conducted a survey using a self-administered questionnaire to seek feedback from surgeons on their participation experience. A total of 449 questionnaires were returned, i.e. a response rate of 29 per cent. Three-quarters of the respondents (n=334) are participating in CHASM. Most of them (189, 74%) have found the surgical case form easy to complete, and about a quarter (n=82) indicated that the feedback was useful. Among those who are assessors for CHASM (160, 36%), many reported that the experience has been positive and rewarding. For the non-participants, the main reasons are retirement, no patient deaths and too busy.

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). CHASM works collaboratively with local health districts, which notify CHASM of surgical deaths and provide medical notes for assessment and local support to surgeons. 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.

Future Directions

Over the next 12 months, CHASM will:

- Publish its second annual report, third case book and third batch of individualised annual feedback reports to surgeons
- Recruit private hospitals to participate in CHASM
- Improve the audit process based on feedback from surgeons through the participation survey
- Re-organise its committee due to expiry of its current appointment term on 31 December 2011
- Work with the Australian and New Zealand Audit of Surgical Mortality to set up online reporting facilities for NSW surgeons and to migrate the NSW data to the Bi-National Audit System, subject to approval by the Minister for Health

Challenges

- Encourage surgeons to participate in CHASM as assessors
- Expand CHASM to private hospitals
- Provide online reporting facilities for surgeons in NSW

Figure 1: CHASM Output Data June 2008 to June 2011

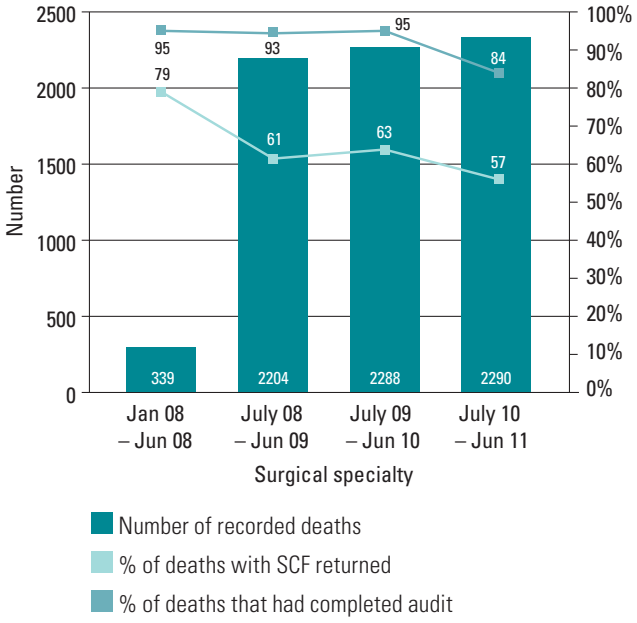
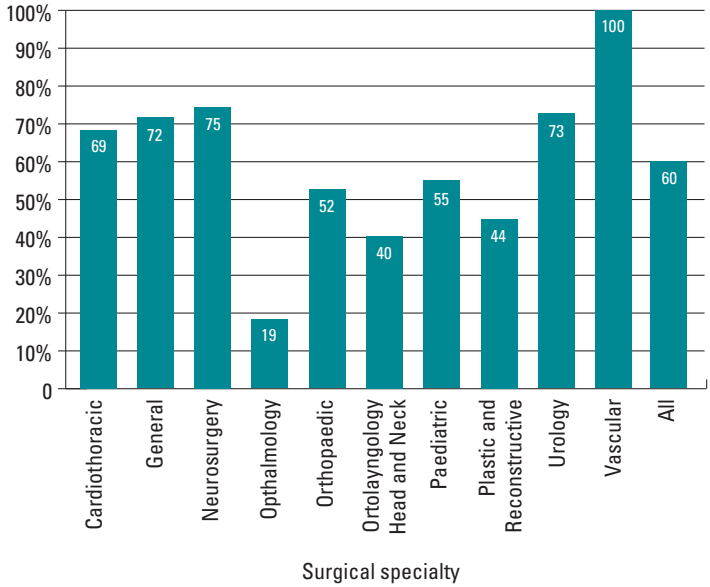


Figure 2: Percentage of Surgeons* Participating in CHASM by Surgical Specialty



* Active surgical fellows of the Royal Australasian College of Surgeons as reported at 30 April 2011.

SPECIAL COMMITTEE INVESTIGATING DEATHS UNDER ANAESTHESIA (SCIDUA)

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.

ALIGNS WITH CEC KEY RESULT AREAS

1 Public reporting
2 Clinical practice 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

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 2010 to 30 June 2011, SCIDUA:

- Recorded 188 deaths notified under the *Public Health Act 1991*
- Completed the audit of 218 notified deaths
- Classified 204 notified deaths, with 50 being anaesthesia-related

A convention to celebrate the 50th anniversary of SCIDUA was successfully held on 14 August 2010 and attended by 350 guests invited by the Australian and New Zealand College of Anaesthetists. At the convention, the CEC presented an award for distinguish contribution to safety and quality in health care to Professor Ross Holland for his devotion to anaesthesia safety.

SCIDUA worked successfully with the Department of Health on revising the policy directive on Coroners Cases and the Coroners Act 2009 (PD2010_054). The revised policy directive was released on 1 September 2010 and provides information about the requirement to notify anaesthesia-related deaths, with the new form of notification to SCIDUA included as an attachment.

SCIDUA submitted a special report on its audit activities and findings from 2006 to 2009 to the Minister for Health.

In 2009, SCIDUA proposed to the Minister for Health the notification and review of deaths after the administration of a sedative drug. The proposal was operationalised in the *Public Health Act 2010*, which was assented on 7 December 2010 and includes the requirement to notify deaths arising after anaesthesia or sedation for operations or procedures. The maximum penalty for non-compliance is 50 penalty units. The Department of Health has yet to announce the commencement date of the *Public Health Act 2010.*

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. SCIDUA works collaboratively with local health districts to ensure notification of anaesthesia-related deaths as stipulated in the *Public Health Act 1991.*

Future Directions

SCIDUA will:

- Pursue the development of online reporting facilities for notification of deaths
- Work with the Department of Health to develop policy guidelines on notification of deaths arising after anaesthesia or sedation for operations or procedures

Challenges

- Ensure that anaesthetists and other health practitioners are aware of the legal requirement to notify anaesthesia or sedation-related deaths to SCIDUA
- Provide online reporting facilities for notification to SCIDUA

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.

CEC strongly supported the introduction of data linkage in NS W to enable longitudinal linked research. CEC funded CHeReL until 2009, and continues a strong relationship. Specific research-related activities in which the CEC has been involved in the reporting period are highlighted below, including:

- Ongoing capacity for CEC (and others) to report linked mortality data. Currently several charts in The Chartbook rely on this capacity via the 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, Bureau of Health Information (BHI) and examining 30-day mortality, and contracted to University of Western Sydney (UWS)
  - A collaboration with Ambulance Service of NSW

Future Directions

CEC will continue to support selected core research in the safety and quality of healthcare. CEC's involvement in both of these major linkage-based projects will continue until their conclusion.

30-Day Mortality Data Linkage Project with Bureau of Health Information (BHI) and Australian Commission on Safety and Quality in Health Care (ACSQHC)

This project is a collaboration led by CEC, with ACSQHC and BHI to develop performance metrics for examining deaths within and up to 30 day post hospital discharge. It involves analysis of linked population-based data for NSW regarding admissions to hospital, emergency department presentations and mortality (fact and cause of death), answering a series of five questions about the use and applicability of hospital standardised mortality ratios (HSMRs). Ethics approval for the study has been obtained and the University of Western Sydney was appointed to run the project.

Key Achievements

- Linked data obtained, cleaned and analysed
- Two face-to-face presentations to the Steering Committee (objectives 1–3)
- Two draft presentations (Objectives 4–5)
- Draft report provided to the funding bodies
- Conference abstract acceptance for poster presentation at the World Congress of Epidemiology, Scotland

Future Directions

The team will provide a final report and peer-review publications against the five objectives. The findings will be presented at national and international conferences.

Ambulance Service NSW Data Linkage

The Australian Pre-Hospital Outcomes Study Of Longitudinal Epidemiology (APOStLE) project is a novel and important initiative that examines the prehospital or Emergency Medical Services (EMS) patient journey in a large, statewide, probabilistically linked dataset. APOStLE can help Ambulance:

- Gain insight into how paramedic care affects patient outcomes
- Assess which calls may be safely moved to lower dispatch priorities
- Assess which patients may safely be assessed, treated and not transported
- Establish prehospital indicators that predict patient outcomes

Linkage for this project was funded by CEC.

Key Achievements

- Ethics approval granted for data linkage
- Six datasets linked: 6 databases included in the APOStLE linked database; Ambulance CAD and PHCR; Emergency Department Data Collection (EDDC); Admitted Patient Data Collection (APDC); NSW Births, Deaths and Marriages (RBDM); and Australian Bureau of Statistics Mortality Data (ABS)
- A total of 8,968,331 records are now available for APOStLE Research projects, representing 1,408,352 individuals. Overall, 83.9% of the Ambulance records were linked to at least one other record from another collection
- A Scientific Advisory Committee (SAC) has been established to ensure that the dataset is utilised to its fullest extent and that studies are undertaken in the most rigorous manner
- An epidemiologist and project manager have been recruited and recruitment is underway for a biostatistician

RESEARCH

An Aboriginal patient receives a haemodialysis treatment in a local hospital based renal unit. Many Aboriginal patients choose to cover themselves with a blanket during treatment.

Future Directions

The ability to examine questions such as the effect of EMS interventions, including dispatch priority, to elucidate the outcomes of a whole range of specific clinical entities, and to construct predictive models to inform both clinical practice and operational planning, will result in an unparalleled and unique resource.

Ian O'Rourke Scholarship in Patient Safety

The Clinical Excellence Commission awards one Ian O'Rourke Scholarship every three years in NSW and supports a graduate for three years to undertake a program of full time health services research, leading to a PhD, to improve patient safety and quality in Indigenous health.
The scholarship is named in honour of the late Dr Ian O'Rourke AO, in his many roles in health as a surgeon, educator, academic and researcher. Ian O'Rourke was the Chief Executive Officer of the Institute for Clinical Excellence which preceded the Clinical Excellence Commission.

The inaugural Ian O'Rourke Scholar, Dr David Peiris completed his PhD *"Building better primary care systems for Indigenous peoples: A multimethods analysis"* in December 2010.

The second Ian O'Rourke scholarship recipient, Ms Elizabeth Rix, began her study in March 2010 and is researching the experiences and perceptions of *Aboriginal people receiving haemodialysis in regional NSW.*

The research is using a qualitative approach with an Indigenous methodology to gather patients' stories using a yarning and storytelling approach. The study incorporates principles of Community Based Participatory Research.

Hospitals Alliance Research Collaboration (HARC)

Carolyn Der Vartanian, our Program Leader Transfusion Medicine, was awarded one of three HARC Research Scholarships in 2010. *"From Facebook to blogs: the role of social marketing and social media to engage clinicians and fast track evidence into practice"* involved a literature review, meetings with leaders at The Mayo Clinic Center for Social Media and Kaiser Permanente, attendance at key international conferences, a series of presentations in NSW about her findings and a final report submitted to the HARC committee. Carolyn examined whether engagement with, and between clinicians can be enhanced by utilising a social marketing framework to influence behaviour change. It also examined whether there is a role for social media tools in strategies aimed at influencing or changing clinical practice. Recommendations have been made regarding ways to progress the use of these tools to engage clinicians and fast track evidence into practice.

Future Directions

The CEC will continue to encourage and support staff to apply for HARC scholarships.

3

CEC Board

The CEC is a board-governed, statutory health corporation established under the Health Services Act 1997 responsible for improving safety and quality in NSW health.

The Chair of the Board is Associate Professor Brian McCaughan AM and the Chief Executive Officer is Professor Cliff Hughes AO.

CEC BOARD

Associate Professor Brian McCaughan AM

- A cardiothoracic surgeon and his major clinical interest is the management of lung cancer
- Clinical Associate Professor at Sydney Medical School
- 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 the President of the 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
- Currently Chair of the Board of the Agency for Clinical Innovation
- Currently a member of the Judicial Commission of NSW
- Holds honours undergraduate degrees in medicine and surgery and is a Fellow of the Royal Australasian College of Surgeons
- Awarded Member of the Order of Australia for services to medicine

Board member since: 2 March 2010
Board Chair since: 1 January 2011
Appointment expires: 10 January 2014

Professor Clifford Hughes AO

- Chief Executive Officer of the Clinical Excellence Commission
- The appointment follows 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
- Currently member of the Board of the Agency for Clinical Innovation

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
- Chair of the NSW Treasury Managed Fund Advisory Board for sixteen years
- Awarded the Public Service Medal in 2002
- Currently member of the Board of the Agency for Clinical Innovation
- 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

- Director and company advisor, specialising in strategy and communications to the business, health and social services sectors
- Board member of the Garvan Institute Foundation, the Australia New Zealand Breast Cancer Trials Group (ANZBCTG), and the Australian Brandenburg Orchestra
- Professional training and executive experience is grounded in business, with particular emphasis on organisation design, change management, community engagement and systems improvement
- Currently a member of the Board of the Agency for Clinical Innovation
- Holds a Masters in Business Administration from Harvard University

Board member since: 2 March 2010
Appointment expires: 10 January 2014

Dr Andrew Cooke

- Is an Emergency Medicine Trainee at St George Hospital
- He is a conjoint Associate Lecturer at the UNSW School of Medicine
- Also holds a LLB (Hons) and a Masters of Law (Hons) from the University of Cambridge (Commonwealth Scholarship) and has worked as a solicitor in both NSW and Victoria
- Presents regularly on medico-legal issues, in particular in the context of emergency medicine, negligence and risk management
- Currently a member of the Board of the Agency for Clinical Innovation

Board member since: 2 March 2010
Appointment expires: 10 January 2014

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)
- Former Director-General of NSW National Parks and Wildlife (1994–1998) and Secretary of the Commonwealth Environment, Water, Heritage and Art portfolio (2009–2011)
- Held executive positions in both the NSW Cabinet Office and 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 chief executive officer designate of the recently announced National Mental Health Commission
- Currently a member of the Board of the Agency for Clinical Innovation

Board member since 3 February 2009
Appointment expires: 31 December 2014

Dr Richard Matthews AM

- 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
- Commenced his career in general practice and developed a special interest in drug and alcohol
- Association with Justice Health 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 & funding strategies, chronic disease, and child, youth and family health
- Currently a member of the Board of the Agency for Clinical Innovation
- Awarded Member of the Order of Australia for services to the health sector through leadership roles

Board member since: 2 March 2010
Appointment expires: 10 January 2014

Professor Carol Pollock

- Trained as a specialist in Renal Medicine and gained her PhD in renal physiology in 1992
- 2000, appointed Chair of Medicine, University of Sydney, Royal North Shore Hospital
- Inaugural Chair of the Board of the Northern Sydney Local Health District
- Immediate past Chair of the boards of Clinical Excellence Commission and the Agency for Clinical Innovation
- Chair of Research for the Northern Health District and Associate Director of the Kolling Institute of Medical Research
- Previously been a member of the NSW Ministerial Advisory Council for Science and Medical Research and regularly serves on the National Health and Medical Research Council Committees, both as a member and panel Chair
- Member of the Executive Committee of the International Society of Nephrology
- Currently a member of the Board of the Agency for Clinical Innovation
- Serves on the Board of several not-for-profit organisations in the Health and Medical Research sector

Board member since 11 January 2010
Appointment expires 10 January 2014

Tomas Ratoni

- Paediatric Clinical Nurse Consultant in the Northern NSW Local Health District
- Graduate certificate in paediatric critical care medicine
- Background primarily in paediatric critical care and paediatric and neonatal retrieval medicine
- An instructor for Advanced Paediatric Life Support (Australia)
- An active participant in CEC programs, Paediatric Between the Flags and Paediatric Clinical Practice Guidelines
- Currently a member of the Board of the Agency for Clinical Innovation

Board member since: 2 March 2010
Appointment expires: 10 January 2014

Professor Janice Reid AM

- Vice-Chancellor of the University of Western Sydney since 1998
- Recipient of several awards and honours, both in Australia and overseas
- Has 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, 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
- Currently a member of the Board of the Agency for Clinical Innovation

Board member since: 3 December 2007
Appointment expires: 10 January 2014

Adjunct A/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 the 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
- Clinical Leader of the Clinical Governance Unit, Western NSW Local Health District
- Chair of the Clinical Council of the Clinical Excellence Commission
- Currently a member of the Board of the Agency for Clinical Innovation

Board member since: 19 August 2008
Appointment expires: 10 January 2014

Table 1: Board Member Meeting Attendance 2010–2011 The board meets bi-monthly.

Directors	19.8.10	21.10.10	18.11.10	16.12.10	17.2.11	14.4.11	23.6.11
A/Professor Brian McCaughan	✓		✓	✓	✓	✓	✓
Lee Ausburn	✓	✓	✓	✓	✓	✓	✓
Ken Barker	✓	✓	✓	✓	✓	✓	✓
Dr Andrew Cooke		✓	✓		✓	✓	✓
Melinda Conrad		✓		✓	✓	✓	✓
Professor Clifford Hughes	✓	✓	✓	✓	✓		✓
Robyn Kruk		✓	✓	✓	✓	✓	✓
Dr Richard Matthews	✓	✓	✓	✓		✓	
Professor Carol Pollock	✓	✓		✓		✓	
Tomas Ratoni	✓	✓	✓		✓	✓	✓
Professor Janice Reid	✓	✓	✓		✓	✓	
Adjunct A/Prof Gabriel Shannon	✓	✓	✓	✓	✓	✓	✓

BOARD SUB-COMMITTEE: AUDIT AND RISK MANAGEMENT

In March 2010, the Director-General announced that the NSW Department of Health would be adopting ***NSW Treasury's Internal Audit and Risk Management Policy for the NSW Public Sector,*** with the variation that the Chief Executive would be a member of the Committee.

A requirement of the Treasury Policy is that each organisation must have an Audit and Risk Management Committee, comprising of independent and non-independent members. The Director-General determined that a single Statutory Health Corporations Audit and Risk Management Committee would be established to service the four "Pillars" – The Clinical Excellence Commission, Agency for Clinical Innovation, Bureau of Health Information and the Clinical Education and Training Institute.

Membership

- Allan Cook (Chair – independent)
- Gerry Brus (independent member)
- Robyn Kruk (CEC board member)
- Professor Clifford Hughes AO (Chief Executive Officer)

In Attendance

- Deputy CEO, CEC Chief Audit Executive

Objective

The objective of the Committee is to provide independent assistance to the Corporations' Boards in respect of the three Statutory Health Corporations (Clinical Excellence Commission, Agency for Clinical Innovation and Bureau of Health Information), and to the Chief Executive of the Clinical Education and Training Institute by overseeing and monitoring the Statutory health Corporation's governance, risk and control frameworks, and its external accountability requirements.

Functions

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

- Act as a forum for communication between the Board, senior management and internal and external audit
- Review and approval of the internal audit charter
- Review the internal audit coverage and annual work plan
- Oversee the coordination of audit programs conducted by internal and external audit and other review functions
- Review all audit reports and provide advice to the relevant Corporations Boards on significant issues identified in audit reports and action taken on issues
- Monitor management's implementation of internal audit recommendations
- Co-ordination with the external audit plan

External Audit

- Act as a forum for communication between the Board, senior management and internal and external audit
- Provide input and feedback on the financial statements and performance audit coverage proposed by external audit and provide feedback on the audit services provided
- Review all external plans and reports in respect of planned or completed audits and monitor management's implementation of audit recommendations
- Provide advice to the Board on action taken on significant issues raised in external audit reports and better practice guides

Audit & Risk Management Committee Meetings During 2010–2011

6 October 2010

25 November 2010

16 February 2011

21 April 2011

25 May 2011

BOARD SUB-COMMITTEE: FINANCE AND PERFORMANCE COMMITTEES

Membership

- Ken Barker – Chair
- Lee Ausburn
- Melinda Conrad
- Professor Clifford Hughes AO

CEC Staff in Attendance

- Deputy CEO
- Finance Officer
- Manager Executive Support

Until the end of 2010 the committee met monthly. From February 2011 it meets bi-monthly.

Objective

The primary role of the Finance Committee is to ensure that the operating funds, and service outputs required of the CEC 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 2010–2011

19 August 2010

16 September 2010

21 October 2010

18 November 2010

16 December 2010

17 February 2011

17 March 2011

19 May 2011

BOARD SUB-COMMITTEE: RESEARCH

With the restructure and appointment of a common Board for the CEC and ACI, it was resolved to establish a joint Research Committee for the two organisations. The committee met during the second half of 2010. From 2011 it was resolved to revert to separate Research committees for the two organisations.

Membership

- Professor Janice Reid AM (Chair)
- Professor Phillip Harris AM
- Professor Clifford Hughes AO
- Professor Glen Salkeld
- Dr Andrew Cooke
- Dr Hunter Watt (CE of Agency for Clinical Innovation)

In Attendance

- Deputy CEO
- Manager Executive Support

Objective

- To advise the Board on the priority, quality and relevance of research undertaken or proposed to be undertaken by, on behalf, or in partnership with, the organisation
- When providing this advice specific regard will be had to the roles and responsibilities of the CEC as set out in the Determination of Functions

Functions

- Oversee the selection and progress of the Ian O'Rourke Scholar
- Oversee and provide advice on CEC research activities, in particular those involving applications for grants from third parties and partnerships with funding implications for either organisation
- Ensure that research is consistent with the mission of the Clinical Excellence Commission, relevant and undertaken in accordance with applicable guidelines and ethical clearance
- Provide ongoing review of the research activities of the CEC and ensure appropriate peer review and quality assurance of research proposals and projects
- Provide advice on the funding of research activities
- Have a governance role in regard to the publication of research findings and the protection of intellectual property
- Review and advise on the communication strategy for research outcomes, including communication with government, the community, clinicians, health managers and consumers
- Receive timely reports from the CEC and such third parties as may be appropriate on the progress and outcomes of funded research projects and programs
- The committee will meet in a face-to-face meeting or via teleconference at least three times per year or as often as deemed necessary by the Chair

Research Committee Meetings During 2010–2011

19 August 2010

16 September 2010

18 November 2010

17 February 2011

19 May 2011

Future Directions

- Membership will be expanded to enable the committee to have the benefit of expertise from the wider research community

BOARD SUB-COMMITTEE: CITIZENS ENGAGEMENT ADVISORY COUNCIL

Joint CEAC/Clinical Council Meeting; Darren Ah See – CEAC, Sue West – CEAC, Dr Austin Curtin – Clinical Council, Professor Cliff Hughes, John Ross – CEAC, June Heinrich – CEAC, Anne Moehead – Clinical Council, Trent Taylor – Clinical Council, A/Prof Steven Katz – Clinical Council, Anthony Dombkins – Clinical Council, Trish Bradd – Clinical Council, A/Prof Charles McCusker – Clinical Council

Members

- Melinda Conrad (Chair)
- Maha Abdo
- Darren Ah See
- Christian Damstra (until February 2011)
- Sandra Gav (until February 2011)
- June Heinrich (from February 2011)
- Don Palmer
- Ted Quan (until February 2011)
- John Ross (from February 2011)
- Dr Ian Stewart (until August 2010)
- Sue West
- Professor Clifford Hughes AO

In Attendance

- Deputy Chief Executive Officer, CEC
- Media Advisor, CEC
- Director Patient Based Care, CEC
- Community Involvement Project Officer, CEC

The Citizens Engagement Advisory Council (CEAC) is a committee of the Board of the CEC. Since it was established in 2006 the council has been advising the CEC on how best to engage the community about quality and safety in health care.

The central role of CEAC is to provide community insight and advice to the Board. An integral component of this role is to advise about avenues and methods for disseminating CEC messages within the community. CEAC is supported by the CEC Directorate of Patient Based Care.

As a committee of the board, the CEAC is chaired by board member – Melinda Conrad. Members are recruited based on their skills and experience in engaging and consulting with the community and in community development.

Key Achievements

In 2010, a new strategic plan for CEAC was approved by the Board to guide the work of this Board Committee.

In the previous year, the CEAC informed the development of a consumer engagement policy to guide the CEC's engagement of community members and consumers. In 2010, one of the key elements of the policy was implemented. The CEC Consumer Advisor Panel was established – interested consumers whose interests in quality and safety are matched to activities within the CEC.

Seven members have been appointed to the Consumer Advisor Panel and five have been integrated into CEC activities. CEC staff have embraced the opportunities that come from partnering with patients and the community in health care. A number of personal stories by consumers have been filmed for use in CEC seminars and educational activities.

Partnerships

The CEAC is a dynamic representation of the CEC's contribution to partnering with the community to improve safety and quality. In 2010–2011, the CEAC membership was reviewed and new members welcomed. Activities of the CEC's Partnering with Patients Program are reported to CEAC to ensure that members are informed of progress. CEC continues to engage with the Health Care Complaints Commission, the NSW Health Patient Experience program and the Bureau of Health Information regarding patient survey feedback.

Future Directions

The CEAC has identified six areas it will focus on in the next two years:

- To become a model community and consumer engagement in health care governance
- To continue to identify consumer groups to engage with about community issues in health and to promote CEC agenda
- To inform strategies for communication with lay audiences about trends in safety and quality
- To support improvement in health literacy in partnership with other organisations
- To oversee alignment of CEC initiatives with patient identified areas for quality improvement
- Support improving communication in emergency departments

The CEAC continues to sponsor research conducted by the Southern Cross University about communication and service quality in emergency department waiting rooms. It has involved observation of behaviour and interactions in four NSW emergency department waiting rooms and interviews with emergency department staff.

The project's objective is to improve the experience of people waiting for treatment within the emergency department. Hospitality, tourism and patient based principles and practices will be used to inform the development of an education and training package. A report has been prepared and outcomes of this research will be published in late 2011.

Challenges

The effects of engaging consumers within the CEC are yet to be evaluated. To ensure that the CEC uses the most effective methods the Patient Based Care Directorate will implement an evaluation plan. This will aim to gauge the 'value add' of patient engagement in safety and quality.

CLINICAL COUNCIL

Membership

- Adjunct A/Professor Gabriel Shannon (Chair)
- Patricia Bradd
- Rosemary Burke
- Dr Austin Curtin
- Prof Patricia Davidson
- Anthony Dombkins
- Phillip Ebbs (Deputy Chair from 4 May 2011)
- A/Prof Steven Katz
- Dr Bill Lancashire (resigned effective 4 May 2011)
- A/Prof Charles McCusker
- Anne Moehead
- Trent Taylor
- Catriona Wilson

The Clinical Council is a Board sub-committee, comprised of medical, nursing, and allied health clinicians who currently work within the public health sector across NSW. Council's role is to advise the Board on matters of clinical relevance to the CEC. The Council is chaired by a Board member, Dr Gabriel Shannon, with the support of the Deputy Chair, Phillip Ebbs. The activities of Council are supported by Dr Charles Pain, Director, Health Systems Improvement and Ms Teresa Mastroserio provides the secretariat.

Key Achievements

1. The Chair and Deputy Chair have led a process for prioritising initiatives to be supported by the Clinical Council to ensure that their energies are directed towards a manageable number of important issues.
2. The Agenda for the committee was modified to include standing items which align more directly with the Terms of Reference, and which reinforce the Council's role in providing advice to the CEC on existing programs and new priorities.
3. The Council met via video conference throughout the year and convened a face-to-face workshop in March 2011.
4. The project for the improved care of hospitalised older people focusing on recognition and management of delirium and dementia, developed in 2009, was approved in August 2010 and is now underway. This has also influenced the choice of questions in the Quality Systems Assessment, with delirium being chosen as a key theme for 2011.
5. In March 2011, a joint meeting of the Clinical Council and the Citizens Engagement Advisory Committee (CEAC) was held with the following purpose:
   - To familiarise the CEC board committees' membership with each other's terms of reference, issues and activities
   - To consider strategic approaches to priority areas that will result in improved organisational impact and improved patient care
   - To progress strategic issues of mutual concern that fall within the brief of the CEC

   The outcome of the meeting was:
   - To establish a communication sub-group to analyse Incident Information Management Systems and progress development of strategies to address the problem of poor communication. This committee was subsequently established under the chairmanship of Dr Karen Luxford, Director of Patient Based Care and is continuing its work
   - To liaise with Nursing and Midwifery Office (NaMO) about Essentials of Care and the contribution this program can make to improving patient safety and quality of care. Subsequent discussions have occurred between CEC and NaMO, which have been very positive and agreement has been reached to link the work of the two bodies, particularly in relation to improving multi-disciplinary teamwork
6. In May 2011, the Clinical Council received a presentation on a new program that the CEC is developing for improving multidisciplinary teamwork. This followed discussion at the March meeting prior to the joint Council/CEAC meeting. This program is called ***In Safe Hands: Releasing the Potential of Clinical Teams.*** Following this presentation, the Council agreed that this should become a major priority and will provide an opportunity for Council to give direct input and advice to the CEC, as the program develops. Members of Council will take part in a Forum on the program in September 2011.

Future Directions

- A recruitment process to renew membership of the Council that began in June will be completed in August 2011
- Continue the partnership with CEAC and joint meetings and programs
- Support the CEC with the development and implementation of the In Safe Hands Program

Partnerships.

- With CEAC on improving communication
- With NaMO on Essentials of Care
- With clinical colleagues, managers and administrators on implementing the In Safe Hands Program

Challenges

- Ensure the Council continues to focus on priority areas
- Continue to engage a variety of interests and priorities among a diverse range of clinicians

4

Corporate Governance Statement

This statement sets out the main corporate governance practices in operation throughout the 2010–2011 financial year.

CORPORATE GOVERNANCE STATEMENT

This statement sets out the main corporate governance practices in operation throughout the 2010–2011 financial year.

The CEC Board

The CEC is a board-governed, statutory health corporation established under the ***Health Services Act 1997,*** with the Chief Executive Officer reporting directly to the NSW Minister for Health. The Board of the Clinical Excellence Commission and the Agency for Clinical Innovation (ACI) share a common membership.

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

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

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

Board membership consists of a chair, ten other non-executive members and the chief executive officer.

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. The CEC is currently working to Strategic Plan 2010–2011.

Code of Ethical Behaviour

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

Risk Management

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

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

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 the board and the Director-General of the NSW Department of Health
- Regularly review the performance of the board through a process of self-appraisal

Credit Card Use

It is affirmed that for the 2010–2011 financial year credit card use within the Clinical Excellence Commission was in accordance with Department of Health requirements.

Consultants

A total of four consultants were engaged during the year. The total cost of all engagements was $3,790.82.

5

Our People

The CEC is a people focussed organisation and our staff are supported by the executive management group of the Chief Executive Officer, the Deputy Chief Executive Officer and five portfolio directors.

OUR PEOPLE

Dr Peter Kennedy

Dr Charles Pain

André Jenkins

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

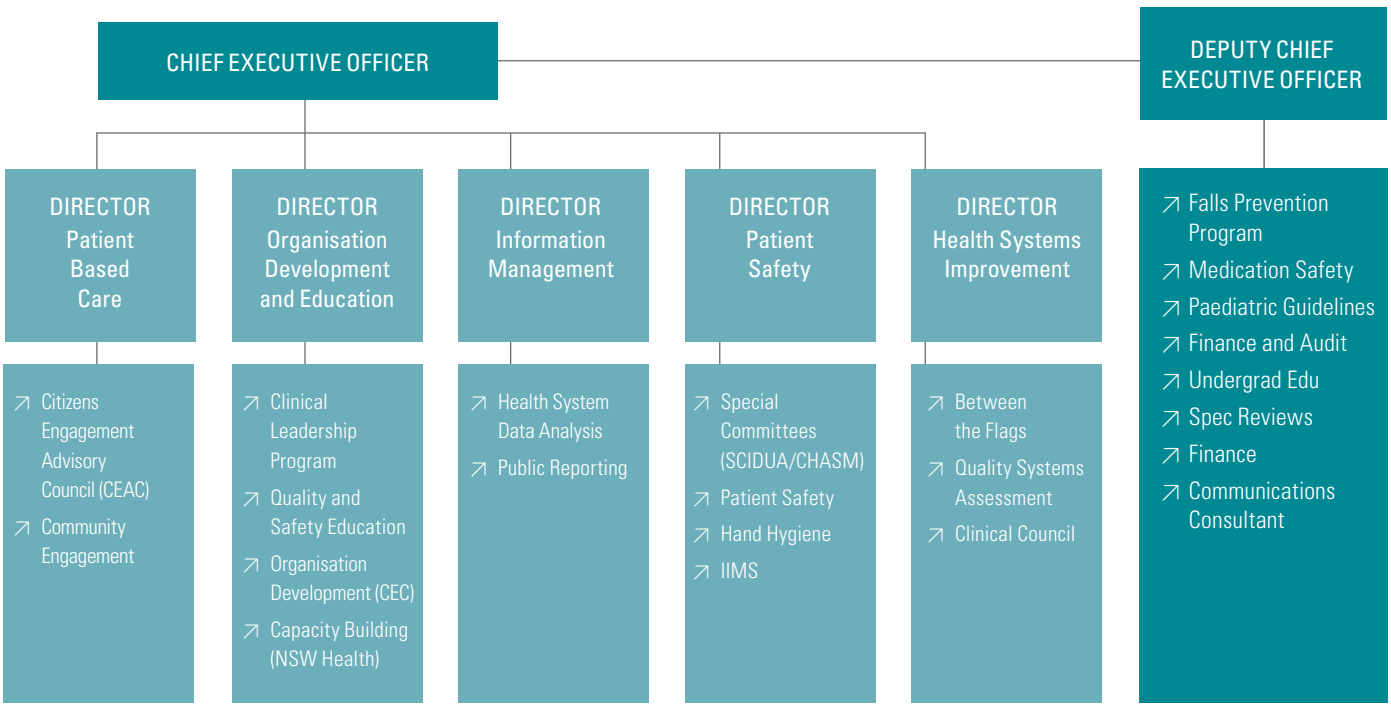
Director Patient Safety

Adjunct Professor Tony Burrell
MBBS, BA, FANZCA, FCICM

Director Patient Based Care

Dr Karen Luxford BSc (Hons 1), PhD, FAIM

Organisation Chart



Bernie Harrison

Adjunct Professor Tony Burrell

Dr Karen Luxford

Staff Profile

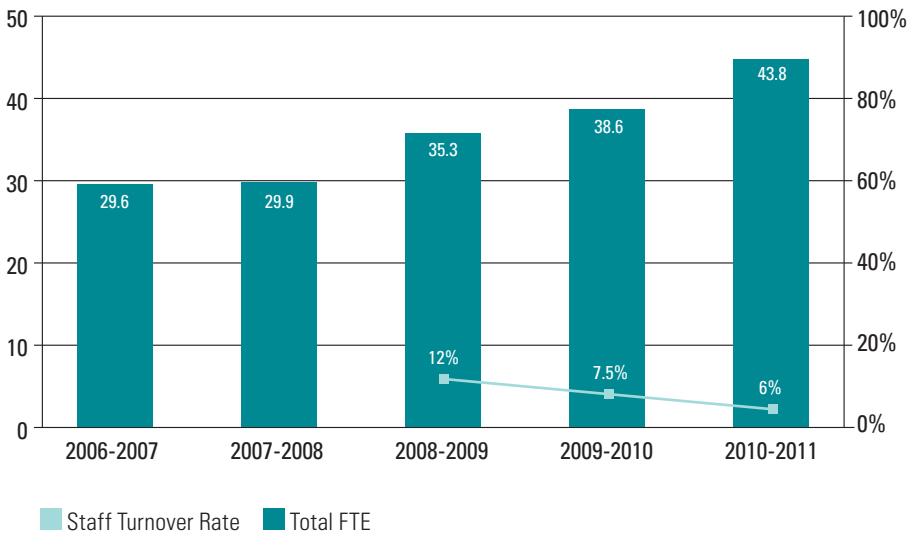
The CEC is committed to having a skilled and valued workforce, to enable it to meet key objectives in its Strategic Directions and Strategic Plan 2010–2011.

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

- Patient Safety
- Health System Improvement
- Patient Based Care
- Data Management

The number of full-time equivalent staff at 30 June 2011 was 43.8 (4 of these medical).

CEC Staffing



Retaining Our Staff

Our commitment to creating a culture that nurtures and values individuals is reflected in our staff turnover figures which are decreasing while our overall staff numbers are increasing. Our turnover rate for permanent staff this year was 6% (last year 7.5%).

Executive Reports

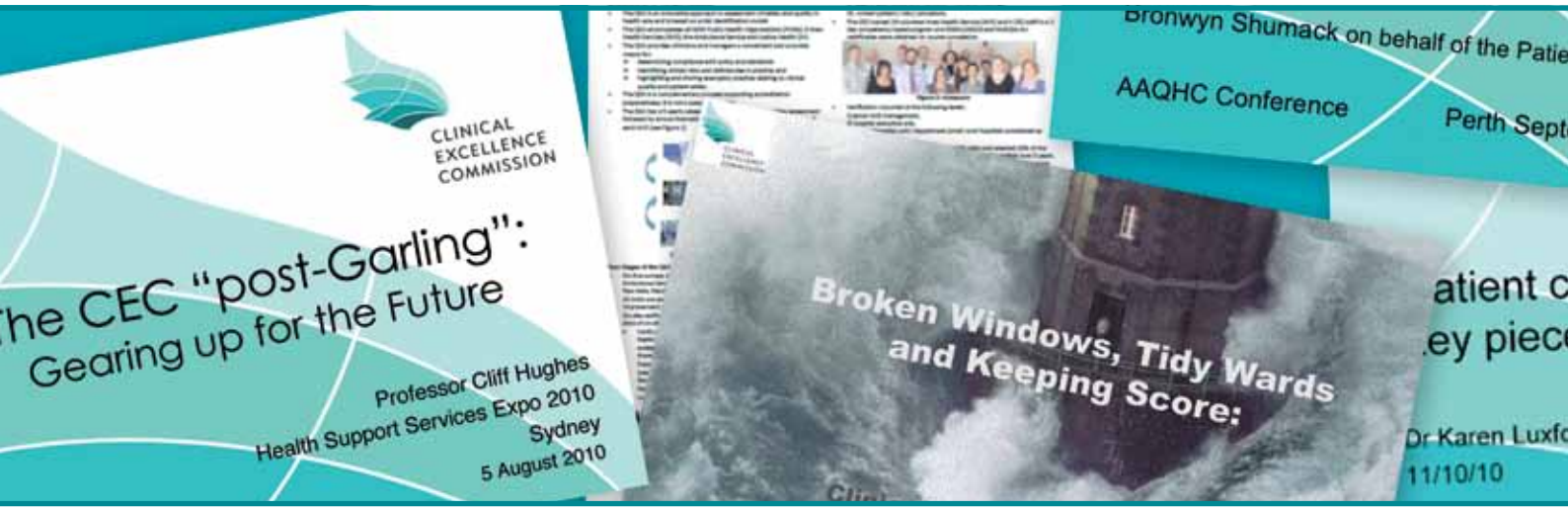
Name: Professor Clifford F Hughes AO

Health Service: Clinical Excellence Commission

Period in Position: 18 January 2005 to 30 June 2011

Strategic Initiatives

- Continued development of additional strategies in key portfolios of Quality Systems Assessment, Clinical Practice Improvement Projects, Patient Based Care, 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
- 2010 QSA state-wide and individual public health organisation reports completed
- Continuation of Statewide Clinical Leadership Program
- Publication of bi-annual report of IIMS Statewide data July-December 2009
- The third annual CEC Chartbook – 2009 containing 98 NSW safety and quality indicators released and ***Chartbook*** distributed to all wards and workplaces across NSW Health
- Chartbook 2010 in preparation
- Blood Watch Transfusion Medicine Improvement Program has reduced inappropriate use of blood products by approximately 8%
- Collaborating Hospitals Audit of Surgical Mortality (CHASM) produced individualised feedback report to 463 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. The second Ian O'Rourke Scholar is in the second year of her three year research program
- 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 post migration to Health Support Services and fraud and corruption risk finalised
- Review of staff recruitment finalised
- Risk Management Review

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 sponsorships to the following conferences/meetings:

- 11th Rural Critical Care Conference, Port Macquarie, August
- Safety and Quality Audit and Outcomes Research in Intensive Care, Hunter Valley, August
- 6th world Congress on Pediatric Critical Care, March

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

- *"Involving Clinicians in the delivery of Safe and Effective Health Care"* 2010 SESIAHS Patient Safety and Clinical Excellence Conference, Pyrmont, July 2010
- *"The CEC 'Post-Garling': Gearing up for the Future"* Health Support Services Expo 2010, Sydney, August 2010
- *"But Wait! There's More!"* [Opening Address] Education Seminar: Deaths Under Anaesthesia, Fifty Years of the Special Committee Investigating Deaths Under Anaesthesia (SCIDAU), Sydney, August 2010
- *"Clinical Leadership: Link to Quality and Safety"* Clinical Team Leadership Program, Workshop 2. NSW Institute of Rural Clinical Services and Teaching, NSW Health, Sydney, August 2010
- *"Clinical Governance from a Train Drivers Prospective"* Clinical Team Leadership Program, Workshop 2. NSW Institute of Rural Clinical Services and Teaching, NSW Health, Sydney, August 2010
- *"From a Distance the World Looks Blue and Green"* [Keynote Address] 10th Rural Critical Care Conference, Orange Ex-Services Club, Orange, August 2010
- *"Patient Safety: where are we now?"* [opening address]. The Challenge of Human Factors in Patient Safety Workshop with Professor René Amalberti, Clinical Excellence Commission, Sydney, August 2010
- *"Lessons from Rail"* SimTecT Health 2010: Education and Innovation in Healthcare Conference, Melbourne, September 2010
- *"Dartboards, Wheels and Silos Underpinning Patient Care"* In the Spotlight, Patient Centred Care, Change Champion, Brisbane, September 2010
- *"Safety and Quality: From Zero to 180 Degrees"* 8th Australasian Conference on Safety and Quality in Health Care, Australasian Association for Quality in Health Care, Perth, September 2010
- *"CHASM in NSW"* 8th Australasian Conference on Safety and Quality in Health Care, Australasian Association for Quality in Health Care, Perth, September 2010
- *"Clinical Governance: Safety and Quality PHCOs"* GP NSW, NSW Division of General Practice, DEN Meeting, Sydney, September 2010
- *"The Clinician as a Major Stakeholder in the Planning and Execution of Design"* Informa 13th Annual Healthcare Facilities Planning and Design Summit, Sydney, September 2010
- *"Developing Clinical Indicators for Jurisdictional Monitoring of the Healthcare System"* Measuring for Improvement Workshop, Royal Australasian College of Physicians, Quality Expert Advisory Group, Gold Coast, October 2010

- *"The Value of Feedback in Healthcare Systems: Carrots, Cakes or Crumbs?"* National Forum on Safety and Quality in Health Care, The Australian Council on Healthcare Standards, Canberra, October 2010
- *"The CEC's Role in Building Capacity for Quality and Safety Improvement in Health Services Health Informatics – International Perspectives and World-wide Health Challenges"* Health Informatics Society of Australia (NSW Branch), Centre for Health Systems and Safety Research, University of NSW, November 2010
- *"Broken Windows, Tidy Wards and Keeping Score: Clinical Governance does have a Human Face"* [opening address] The Sydney Children's Hospital Randwick Network Advisory Council, Sydney, February 2011
- *"Setting patient flow in a Quality & Safety Framework"* Improving patient flow: Whole system approaches to managing capacity and demand. Melbourne, February 2011
- *"Identifying and Assessing Clinical Risks"* Clinical Governance 2011, Australian Healthcare Week, Sydney, February 2011
- *"Clinical Governance and Culture Change in NSW"* [keynote address] Statewide Clinical Leadership Program Graduation, Royal North Shore Hospital, March 2011
- *"The Blue Peter: patient quality begins today!"* [Opening Address] Clinical Leadership Program, Module 1, Clinical Excellence Commission, Sydney, March 2011
- *"The role of the Clinical Excellence Commission"* Local Health Network Governing Council Members' Induction, NSW Health, Sydney, March 2011
- *Closing Address, Clinical Leadership Program,* Clinical Excellence Commission, Sydney, April 2011

Dr Karen Luxford
Director Patient Based Care

- *The role of health executives in driving patient-centred care.* Health Care Reform. Sydney, July 2010
- *….But what about the 'hard edged' outcomes? The link between patient experience, safety and clinical outcomes.* Improving the Health Care Experience Conference, Sydney, September 2010
- *Patients as Partners in Healthcare Quality.* Australasian Conference for Safety and Quality in Health Care, Perth, September 2010
- *Patient-centred care: moving beyond the rhetoric?* Patient Centred Care – In the Spotlight, Brisbane, September 2010
- *Meeting consumer expectations: the missing piece of the quality puzzle.* National Forum on Safety and Quality in Healthcare, Canberra, October 2010
- *Performance reporting from the patient's perspective.* Inaugural Harkness Alumni Conference, Canberra, November 2010
- *Beyond the rhetoric – patient based care.* Clinical Governance 2011, Sydney, February 2011
- *The patient experience.* 2011 Australian e-Health Research Colloquium, Brisbane, March 2011
- *Falls – a consumer perspective.* NSW Falls Prevention Network Forum, Sydney, May 2011
- *We've come a long way...but we're not there yet.* Victorian Healthcare Quality Association Conference, Melbourne, May 2011

Dr Charles Pain
Director Health System Improvement

- *"Handling Patient Complaints and Open Disclosure"* Austrauma: Trauma, Critical Care & Emergency Surgery Conference 2011, February 2011

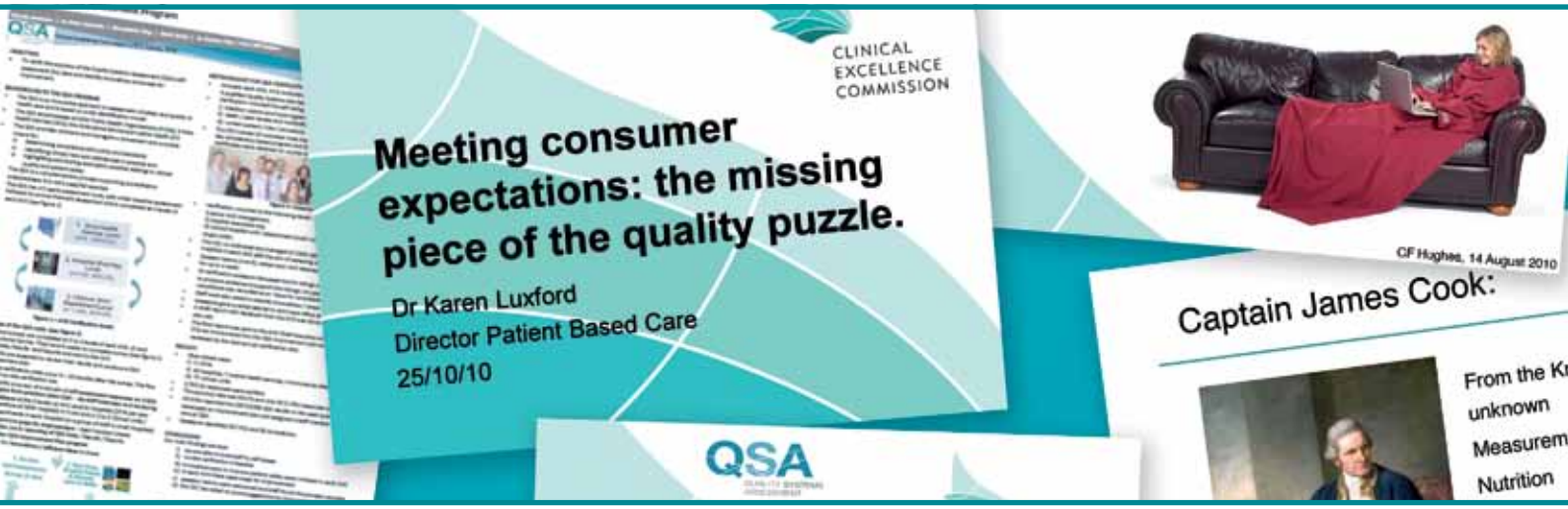
Bernie Harrison
Director Organisation Development and Education

- *"NSW data collection and its meaning for transfusions"* Critical Bleeding Seminar, Melbourne, November 2010

Patient Safety

Adjunct Professor Tony Burrell,
Director Patient Safety

- Care of the ventilated patient. 4th International Meeting on Safety, Quality, Audit & Outcomes in Intensive Care, Creswick, August 2010



Bronwyn Shumack,
Manager Patient Safety

Dr Peter Kennedy,
Deputy Chief Executive Officer

- *Human factors investigation – the next piece of the jigsaw.* SimTecT Health 2010: Education and Innovation in Healthcare Melbourne, August, 2010

Bronwyn Shumack,
Manager Patient Safety

Margaret Scrimgeour,
Program Analyst Patient Safety

Adjunct Professor Tony Burrell –
Director Patient Safety

- Identifying Human Factors in Health Care Incidents. *Proceedings of the 8th Australasian Conference on Safety and Quality in Health Care; Back to the Future – Unlocking the Potential, Perth, Western Australia.* September, 2010

Official Overseas Travel by CEC Staff

Professor Clifford Hughes AO
Chief Executive Officer

- *"Quality in Data or Data in Quality"* My patient: my care, doing the right things and doing things right. 7th Healthcare Quality Improvement Conference 2010, Singapore, October 2010
- *"From Ship to Shore – Lessons for Health from Great Sea Captains"* My patient: my care, doing the right things and doing things right. 7th Healthcare Quality Improvement Conference 2010, Singapore, October 2010
- *"Simply the Best – A Study of Order and Disorder in Health"* My patient: my care, doing the right things and doing things right. 7th Healthcare Quality Improvement Conference 2010, Singapore, October 2010
- *"WHO Patient safety: Where to from here?"* Quality outcomes: Achieving patient improvement. 27th International Conference, The International Society for Quality in Health Care, Paris, October 2011
- *"Governance and Leadership – Driving Quality Improvement"* Quality outcomes: Achieving patient improvement. 27th International Conference, The International Society for Quality in Health Care, Paris, October 2010
- *"Dilemmas surrounding Medical Errors and Adverse Events: Teaching Providers Effective Communication Skills to Overcome the Multiple Barriers to transparency"* Kim Oates and Cliff Hughes, Telluride, June 2011

Adjunct Professor Tony Burrell
Director Patient Safety

- British Medical Journal, Quality and Safety Conference, Amsterdam April 2011*

Dr Karen Luxford
Director Patient Based Care

- *Patient care experience – a key piece of the quality puzzle.* International Society for Quality in Health Care, Paris, October 2010
- *Quality improvement and control in cancer services.* International Society for Quality in Health Care, Paris, October 2010

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

CEC Visiting Professor

The 2010 CEC Visiting Professor was Professor René Amalberti who is an international leader in the field of human error and human factors. He holds half time positions as Senior Adviser Patient Safety at the Haute Autorité de Santé (the French medical accreditation agency) and risk manager in a medical insurance (MACSF). During his two week visit in August/ September 2010 René Amalberti participated in activities including:

- Keynote speaker at the SimTecT meeting in Melbourne 30.8.10 – 2.9.10
- Keynote speaker at the AAQHC meeting in Perth 6–8 September
- He also spent a week working with CEC staff
- The highlight of his time in Sydney was a two day seminar which was really a Masterclass with René Amalberti on Human Factors, attended by over fifty senior staff from the NSW health system

There was extremely positive feedback from participants in all the fora in which René Amalberti 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

Throughout the year the CEC hosted delegations from hospitals in China. Each group consisted of between ten and 15 doctors and health managers. The visitors attended presentations by senior CEC staff where they learned about quality and safety and hospital management in the NSW health system.

- Zhe Jian Health Department
- Beijing/Tiangjing Health Delegation
- Zhe Jian Hospital Delegation
- Chinese Health Bureau
- Gansu Health Dept
- Shandong Health Delegation
- Qing Dao Health Delegation
- Hubei Health Delegation
- Shandong Health Delegation
- Hospital Forum Delegation
- Cheng Du Health Delegation
- Jiang Shu Health Delegation
- Xingjiang Health Delegation
- Nanjing Health Delegation
- Hubei Health Delegation

Articles/Papers Written by CEC Staff and Accepted for Publication

Professor Cliff Hughes AO
Chief Executive Officer

- *Is home warfarin self-management effective? Results and implications of the warfarin S.M.A.R.T. study.,* Dignan, R., Keech, A., Powell, C., Turner, L., Bayfield, M., Hendel, N., Bannon, P., McCaughan, B., **Hughes, C.,** Gebski, V., 2011, Heart, Lung and Circulation, 2011, 20(4):257-8
- *Readmissions after cardiac surgery: a 10-year study.,* Bianco, A.C., Chan, J.Y., **Hughes, C.F.**, McCaughan, B.C., Bayfield, M.S., Hendel, P.N., Bannon, P.G., Wilson, M.K., Vallely, M.P., 2011, Heart, Lung and Circulation, 2011, 20(4):272
- *Mandatory performance reporting as part of health care reform: but where are the clinical data?,* Watterson. L.., Holland, R., Davies, J., **Hughes, C. F.,** Medical Journal of Australia, 2010, 193(5):253-4
- *Measuring hospital performance – 2008 forum summary.,* Leathley, C.M., Gilbert, R., **Kennedy, P.J., Hughes, C.F.,** Medical Journal of Australia, 2010, 193(8):S95-6
- *Clinical practice variation.,* **Kennedy, P.J., Leathley, C.M., Hughes, C.F.,** Medical Journal of Australia, 2010, 193(8):S97-9
- *Bad stars or guiding lights? Learning from disasters to improve patient safety* [Republished]., **Hughes, C.F.,** Braithwaite, J., Travaglia, J., Postgraduate Medical Journal , 2010, 86(1021):675-9
- *Multiple accountabilities in incident reporting and management.,* Hor, S-Y., Iedema, R., Williams, K., **Kennedy, P.,** Day, A.S., Qualitative Health Research, 2010, 20(8):1091-1100
- *Bad stars or guiding lights? Learning from disasters to improve patient safety.,* **Hughes, C.F.,** Braithwaite, J., Travaglia, J., Quality and Safety in Health Care, 2010, 19(4):332-6
- *Surgical Audit – Still an Eccentric View?,* **Hughes, C.F.,** Fearnside, M.R., Maddern, G.J., The Australian and New Zealand Journal of Surgery, 2010, 80(12):864
- *Learning from disasters to improve patient safety: applying the generic disaster pathway to health system errors.,* Travaglia, J.F., **Hughes, C.,** Braithwaite, J., BJM Quality & Safety, 2011, 20(1):1-8
- *In Martinez, J.C. (Ed). Innovations, technical solutions, and patient safety: pulse oximetry, health care checklists, and the international classification for patient safety* [Workshop facilitator and comments quoted]., **Hughes, C.F.,** JCInsight, 2011, Joint Commission International 6(1)

Abstracts Published

Predicting disasters: identifying and learning from precursors to errors and adverse events. Abstract Book, ISQua 27th International Conference, Quality outcomes: Achieving patient improvement Travaglia, J., **Hughes, C.F.,** Braithwaite, J. (2010). ISQua 27th International Conference 10–13 October 2010, Paris, France. DP178.

Dr Peter Kennedy
Deputy Chief Executive Officer

- *Measuring hospital performance – 2008 forum summary.,* Leathley, C.M., Gilbert, R., **Kennedy, P.J., Hughes, C.F.,** Medical Journal of Australia, 2010, 193(8):S95-6
- *Clinical practice variation.,* **Kennedy, P.J., Leathley, C.M., Hughes, C.F.,** Medical Journal of Australia, 2010, 193(8):S97-9
- *Bad stars or guiding lights? Learning from disasters to improve patient safety* [Republished]., **Hughes, C.F.,** Braithwaite, J., Travaglia, J., Postgraduate Medical Journal , 2010, 86(1021):675-9
- *Multiple accountabilities in incident reporting and management.,* Hor, S-Y., Iedema, R., **Williams, K.,** Kennedy, P., Day, A.S., Qualitative Health Research, 2010, 20(8):1091-1100

Dr Karen Luxford
Director Patient Based Care

- *Luxford K.* (2011) From the Board to the Ward: Partnership at the 'sharp end'. *Health Issues.*107: 15-16

↗ *Luxford K, S*afran D, Delbanco T (2011) Promoting patient-centered care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. *Int J for Qual in Health Care* Vol 23(5): 510-515.

↗ *Luxford K.* (2010) The forgotten tenet: client focus and quality improvement in health care. *Building Quality in Health Care.* 4(2): 10-13

Ms Alex Warner
Special Reviews

↗ *Emergency department presentations for problems in early pregnancy.,* Indig, D., **Warner, A.,** Saxton, A., Australian and New Zealand Journal of Obstetrics and Gnyaecology, 2011, 51(3):257-61

Ms Marghie Murgo
Project Officer Medication Safety

↗ *Aseptic insertion of central venous lines to reduce bacteraemia.,* Burrell, A.R., McLaws, M-L., **Murgo, M.,** Pantle, A.C., Herkes, R., Medical Journal of Australia, 2011, 194(11):583-7

Dr Anthony Burrell
Director Patient Safety

↗ *Aseptic insertion of central venous lines to reduce bacteraemia.,* Burrell, A.R., McLaws, M-L., Murgo, M., Pantle, A.C., Herkes, R., Medical Journal of Australia, 2011, 194(11):583-7

↗ *Sepsis kills.*, Burrell, T., Fullick, M., Cetiscape, 2011, (2):6, 2011-3 Cetiscape Burrell T Sepsis kills

Dr Mohammed Mohsin
Biostatistician

↗ Alcohol consumption and injury risk: a case-crossover study in Sydney, Australia., Williams, M., **Mohsin, M.,** Weber, D., Jalaludin, B., Crozier, J., Drug and Alcohol Review, 2011, 30(4):334-54

↗ *Socioeconomic correlates and trends in smoking in pregnancy in New South Wales, Australia.,* **Mohsin, M.,** Bauman, A.E., Forero, R., Journal of Epidemiology in Community Health, 2011, First published online 14 Sep 2010

Dr Karen Luxford
Director Patient Based Care

↗ *Promoting patient-centred care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience.,* Luxford, K., Safran, D.G., Delbanco, T., International Journal for Quality in Health Care, 2011, First published online 16 May 2011

Dr Charles Pain
Director Health System Improvement

↗ Letter to the editor eMJA : *"Using the CEC paediatric calling criteria in emergency department triage"* Pain, C. H., Hughes, C. F., Festa, M., Ekholm, J., O'Meara, M.

Ms Colleen Leathley
Special Projects Officer

↗ *Measuring hospital performance — 2008 forum summary.,* Leathley, C.M., Gilbert, R., **Kennedy, P.J., Hughes, C.F.,** Medical Journal of Australia, 2010, 193(8):S95-6

↗ *Clinical practice variation.,* Kennedy, P.J., Leathley, C.M., Hughes, C.F., Medical Journal of Australia, 2010, 193(8):S97-9

Ms Mary Fullick
Sepsis Project Manager

↗ *Sepsis kills.,* Burrell, T., **Fullick, M.,** Cetiscape, 2011, (2):6, 2011-3 Cetiscape Burrell T Sepsis kills

Quality Systems Assessment Team

Jamieson, W.E., King, B., Zacka, M., Hughes, C.F. (2010) Can we trust a health system to self assess? On-site verification of a self rating Quality Systems Assessment (QSA) program. *Abstract Book, ISQua 27th International Conference, Quality outcomes: Achieving patient improvement. 10-13 October 2010, Paris, France.* PP049.

King, B., Zacka, M., Jamieson, W.E., Hughes, C.F. Can a quality systems assessment program provide a strategic approach to inform and develop improvement plans across complex health jurisdictions? *Abstract Book, ISQua 27th International Conference, Quality outcomes: Achieving patient improvement. 10-13 October 2010, Paris, France.* PP085.

6

Sustainability

The CEC is committed to supporting a happy and healthy workplace that encourages professional and personal development. All staff are able to participate in programs to ensure a sustainable environment.

SUSTAINABILITY

CEC Fire Wardens; Lesley Harvey, John Carrick, Bronwyn Shumack, Cathy Vinters

Learning and Organisational Development

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 and personal development courses and workshops have been held in the CEC – including presentations/workshops by CEC staff and external consultants. Topic areas have included:

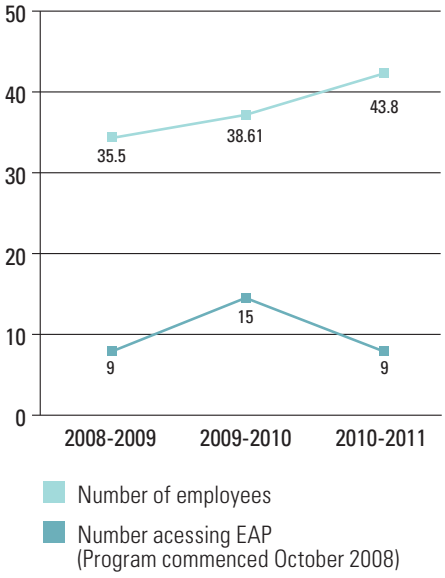
July 2010	*How to Apply for a Fullbright Scholarship* – Bernie Harrison
August	*The transfusion question* – Dr Bruce Spiess
August	*CIAP + ARCHI* – Marie Pryer
August	*Human Factors* – René Amalberti, CEC Visiting Professor
October	*Patient Safety* – Professor Jan Vesseu
October	*Using "Work in Progress" documents to Manage work flow* – Cathy Vinters
November	*Social Marketing* – Joan Young, Colmar Brunton
November	*Using Survey Monkey* – Marghie Murgo
February	*Performance Agreement Workshop* – Nick Gerrand
March	*Fire Evacuation Training* – Cathy Vinters, John Carrick, Lesley Harvey, Bronwyn Shumack
March	*Media Training Skills* – Mike Peterson
April	*Quality and Safety* – Jo Travaglia, UNSW
April	*Surgical Outcomes* – Justin Dimmick, Johns Hopkins University
May	*Transformational Change* – Helen Bevan/Anthea Penny, UK NHS
May	*Dispatch from the world of social media* – Carolyn Der Vartanian
May	*Quality Systems Assessment Update* – Mark Zacka
June	*CHASM update* – CHASM Team

Wellness and Wellbeing Activities

- To enhance staff wellness, the CEC walking group continues to walk on week ends and after work. The goal this year was to build the fitness required to complete the Sydney Harbour Bridge Run in September. The run was completed by 10 CEC staff and family members, with many reaching their personal time target
- Karaoke has proven to be a successful way to bring people together after work, enhancing camaraderie within the CEC team. Participants have attended a number of karaoke evenings, developing their performance skills in a fun and supportive environment
- In association with the annual Knit In, after the rugs have all been completed and delivered, CEC staff gather together for a special lunch. The lunch was held in our main meeting room in September and male members of staff prepare or procure the food and all staff enjoys delicious food from a wide variety of international cuisines
- We provide access to an ***employee assistance program*** for employees and their immediate families. The program provides confidential counselling and support and is not confined to work related issues. The program commenced in October 2008. The figures show that while staff levels have increased over the period of the program, numbers of consultations have actually decreased in the current reporting period

CEC staff who took part in the Sydney Running Festival 2010;
Mary Fullick, Kay Wright, Daniel Lalor, Lesley Harvey, Bronwyn Shumack

Employee Assistance Program Use



The Community

- For the third 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 December staff unanimously agreed to forego the usual "Kris Kringle" gift exchange, and instead, make a donation to charity. Two charities, ***Aboriginal Literacy Foundation*** and ***Hope Street Urban Compassion*** were chosen by popular vote and each organisation benefited from the generosity of our staff

Occupational Health & Safety

In the reporting period 1 July 2010 to 30 June 2011, no workers compensation claims were received compared to one in 2010 and no claims in 2009.

Staff elected Bronwyn Shumack as the OH&S representative.

Prior to the move to new premises in January 2011 manual handling and risk assessment training was conducted for all staff over two sessions.

There were several reported incidents of staff losing footing on the kitchen floor and action was taken to make the floor safe.

Once we had settled into the new premises all work stations were assessed from an OH&S viewpoint. Any issues that were raised were addressed including footstools, document readers and shelving.

At the onset of winter flu vaccinations were offered to all staff and most staff participated in the program.

A quiet room was included in the new offices. This room, which can be locked, is equipped with a fridge and sink for the convenience of staff members who are nursing mothers.

Environmental Sustainability

We have worked to raise staff awareness about how they can help our organisation be part of the NSW Government's commitment to being carbon neutral by 2020. With the move to new premises in January 2011 we took the opportunity to incorporate environmentally sound practices into the design of our new offices. Some of these features include motion sensor lighting in the offices and meeting rooms and recycling bins for bottles and cans built into the kitchen benches. Other sustainability measures include :

- Recycling waste paper and cardboard: We have recycle boxes at every workstation and large recycle bins in printing rooms
- Recycling toner cartridges
- Using 20% E10 fuel for the CEC's two pool cars
- Using double sided printing
- Using online payment of accounts
- Publishing internal policies on our intranet

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. No staff have identified themselves as being a person with a disability.

The CEC is committed to providing a work environment which supports the needs of all our staff. We included an adjustable work station in the fit out of our new offices and our office is accessible via ramps and lifts.

Equal Employment Opportunity (EEO)

A) Statistical Information on EEO target groups

Table 1: Trends in the representation of EEO Groups[1]

	% of Total Staff[2]		
EEO Group	Benchmark or target %	2009–2010 %	2010–2011 %
Women	50	67	73
Aboriginal people and Torres Strait Islanders	2.6[3]	–	–
People whose first language was not English	19	18	20
People with a disability	12	–	–
People with a disability requiring work-related adjustments	7	–	–

Table 2: Trends in the distribution of EEO Groups[4]

	Distribution index[5]		
EEO Group	Benchmark or target	2009–2010	2010–2011
Women	100	100	95
Aboriginal people and Torres Strait Islanders	100	–	–
People whose first language was not English	100	95	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 2011 = 44
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

Government Information (Public Access) Act 2009

The Government Information (Public Access) Act 2009 (NSW) replaced the Freedom of Information Act 1989 (NSW) on the 1st July 2010. Under Section 125 (1) of the Act, each agency must prepare an annual report on the agency's obligations under this Act.

Under the GIPA Act the CEC and all other NSW government agencies are required to publish a range of open access information.

This information, published on our website **www.cec.health.nsw.gov.au,** includes our disclosure log, details of information not disclosed, details of documents tabled in Parliament, policy documents, publication guide and a register of government contracts.

We conducted a review under section 7(3) of the Act during the reporting year and after feedback from the Office of the Information Commissioner amended our publication guide.

In the financial year 2010–2011 the CEC did not receive any access applications under the Government Information (Public Access) Act 2009 (GIPA Act).

As access applications are received that are likely to be of interest to members of the public, the CEC will publish a Disclosure Log, which will detail our response to applications for information about the CEC.

Statutory obligations require the following tables to be included in this report.

Table A: Number of applications by type of applicant and outcome*

	Access granted in full	Access granted in part	Access refused in full	Information not held	Information already available	Refuse to deal with application	Refuse to confirm /deny whether information is held	Application withdrawn
Media	0	0	0	0	0	0	0	0
Members of Parliament	0	0	0	0	0	0	0	0
Private sector business	0	0	0	0	0	0	0	0
Not for profit organisations or community groups	0	0	0	0	0	0	0	0
Members of the public (application by legal representative)	0	0	0	0	0	0	0	0
Members of the public (other)	0	0	0	0	0	0	0	0

More than one decision can be made in respect of a particular access application. If so, a recording must be made in relation to each such decision. This also applies to Table B.

Table B: Number of applications by type of application and outcome

	Access granted in full	Access granted in part	Access refused in full	Information not held	Information already available	Refuse to deal with application	Refuse to confirm/deny whether information is held	Application withdrawn
Personal information applications*	0	0	0	0	0	0	0	0
Access applications (other than personal information applications)	0	0	0	0	0	0	0	0
Access applications that are partly personal information applications and partly other	0	0	0	0	0	0	0	0

* A personal information application is an access application for personal information (as defined in clause 4 of Schedule 4 to the Act) about the applicant (the applicant being an individual).

Table C: Invalid applications

Reason for invalidity	No of applications
Application does not comply with formal requirements (section 41 of the Act)	0
Application is for excluded information of the agency (section 43 of the Act)	0
Application contravenes restraint order (section 110 of the Act)	0
Total number of invalid applications received	0
Invalid applications that subsequently became valid applications	0

Table D: Conclusive presumption of overriding public interest against disclosure: matters listed in Schedule 1 to Act

	Number of times consideration used*
Overriding secrecy laws	0
Cabinet information	0
Executive Council information	0
Contempt	0
Legal professional privilege	0
Excluded information	0
Documents affecting law enforcement and public safety	0
Transport safety	0
Adoption	0
Care and protection of children	0
Ministerial code of conduct	0
Aboriginal and environmental heritage	0

* More than one public interest consideration may apply in relation to a particular access application and, if so, each such consideration is to be recorded (but only once per application). This also applies in relation to Table E.

Table E: Other public interest considerations against disclosure: matters listed in table to section 14 of Act

	Number of occasions when application not successful
Responsible and effective government	0
Law enforcement and security	0
Individual rights, judicial processes and natural justice	0
Business interests of agencies and other persons	0
Environment, culture, economy and general matters	0
Secrecy provisions	0
Exempt documents under interstate Freedom of Information legislation	0

Table F: Timelines

	Number of applications
Decided within the statutory timeframe (20 days plus any extensions)	0
Decided after 35 days (by agreement with applicant)	0
Not decided within time (deemed refusal)	0
Total	**0**

Table G: Number of applications reviewed under Part 5 of the Act (by type of review and outcome)

	Decision varied	Decision upheld	Total
Internal review	0	0	0
Review by Information Commissioner*	0	0	0
Internal review following recommendation under section 93 of Act	0	0	0
Review by ADT	0	0	0
Total	**0**	**0**	**0**

* The Information Commissioner does not have the authority to vary decisions, but can make recommendations to the original decision-maker. The data in this case indicates that a recommendation to vary or uphold the original decision has been made by the Information Commissioner.

Table H: Applications for review under Part 5 of the Act (by type of applicant)

	Number of applications for review
Applications by access applicants	0
Applications by persons to whom information the subject of access application relates (see section 54 of the Act)	0


45,8
52,4
49,1
54,0
61,5
64,3
66,9
67,1
69,8
72,4

7

Financial Reports

FINANCIAL OVERVIEW

For the Year Ended 30 June 2011

The audited financial statements for the Clinical Excellence Commission for 2010–2011 identifies a Net Cost of Services (NCOS) result of $9,957 million which is a variation of some $12,000 or a 0.1% variation to budget.

Activity increases in 2010–11 of the CEC contributed to a 4% increase in expenditure compared to 2009–10.

This activity increase is mainly due to additional staffing costs to support projects which commenced in 2009–10 and are now in full delivery. The NCOS result benefited from higher investment revenue of some $99,000 or 29% compared to prior year, which has been used to cover the increased expenditure needs.

In achieving the 2010–11 result the Clinical Excellence Commission has operated within the level of government cash payments and managed its operating costs to the budget available. It has also ensured that no general creditors exist at the end of the month in excess of levels agreed with the NSW Department of Health.

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

	2009–2010	2010–2011	Comparison	Movement
	$000	$000	$000	%
Expenses excluding losses				
Employee Related	6,579	7,431	852	13
Other Operating Expenses	2,345	2,127	(218)	(9)
Depreciation and Amortisation	490	585	95	19
Grants and Subsidies	381	154	(227)	(60)
Total Expenses	**9,795**	**10,297**	**502**	**5**
Sale of Goods and Services	33	118	85	258
Investment Income	337	436	99	29
Grants and Contributions	263	167	(96)	(37)
Total Revenue	**633**	**721**	**88**	**14**
Gain/(Loss) on Disposal	(2)	(393)	(391)	>100
Net Cost of Services	**9,164**	**9,969**	**805**	**9**

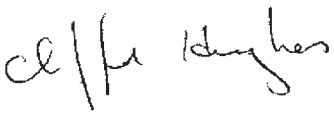
CERTIFICATION OF PARENT/ CONSOLIDATED FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

Pursuant to Section 45F of the *Public Finance and Audit Act,* 1983, I state that in my opinion:

1) The financial statements have been prepared in accordance with:
   - Australian Accounting Standards (which include Australian Accounting Interpretations)
   - *Public Finance and Audit Act 1983,* the *Public Finance and Audit Regulations 2010* and the Treasurer's Directions
2) The financial statements exhibit a true and fair view of the financial position and the financial performance of the Clinical Excellence Commission.
3) There are no circumstances which would render any particulars included in the financial statements to be misleading or inaccurate.

I further state the financial statements have been prepared in accordance with the NSW Department of Health's Accounts and Audit Determination for Public Health Organisations.



Professor Clifford Hughes, AO
Chief Executive
29 September 2011

A/Professor Brian McCaughan AM
Chairman
29 September 2011

INDEPENDENT AUDIT REPORT

For the Year Ended 30 June 2011

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 comprises the statement of financial position as at 30 June 2011, the statement of comprehensive income, the statement of changes in equity and the statement of cash flow for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information of 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.

Opinion

In my opinion, the financial statements:

- give a true and fair view of the financial position of the Commission and the consolidated entity, as at 30 June 2011, and of the financial performance for the year then ended in accordance with Australian Accounting Standards
- 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 does not extend to the budget information. I have not audited the budget figures disclosed in the Statement of Comprehensive Income, Statement of Financial Position and Statement of Cashflows.

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

Board's Responsibility for the Financial Statements

The Board is responsible for the preparation and fair presentation of financial statements that give a true and fair view in accordance with Australian Accounting Standards and the PF&A Act, and for such internal control as the Board determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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. Those standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about 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 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 control 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 control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Board, 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 the consolidated entity
- that they have carried out their activities effectively, efficiently and economically
- about the effectiveness of their internal control
- about the security and controls over the electronic publication of the audited financial statements on any website where they may be presented
- about any other information which may have been hyperlinked to/from the financial statements.

Independence

In conducting my audit, I have complied with the independence requirements of the Australian Auditing Standards and other relevant ethical pronouncements. 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

30 September 2011
SYDNEY

STATEMENT OF COMPREHENSIVE INCOME

For the Year Ended 30 June 2011

	Notes	PARENT Actual 2011	PARENT Budget (unaudited) 2011	PARENT Actual 2010	CONSOLIDATION Actual 2011	CONSOLIDATION Budget (unaudited) 2011	CONSOLIDATION Actual 2010
		$000	$000	$000	$000	$000	$000
Expenses excluding losses							
Operating Expenses							
Employee Related	3	0	6,537	0	7,431	6,537	6,579
Personnel Services	4	7,431	0	6,579	0	0	0
Other Operating Expenses	5	2,127	2,880	2,345	2,127	2,880	2,345
Depreciation and Amortisation	2(h), 6	585	490	490	585	490	490
Grants and Subsidies	7	154	50	381	154	50	381
Total Expenses excluding losses		**10,297**	**9,957**	**9,795**	**10,297**	**9,957**	**9,795**
Revenue							
Sale of Goods and Services	8	118	0	33	118	0	33
Investment Revenue	9	436	0	337	436	0	337
Grants and Contributions	10	167	0	263	167	0	263
Total Revenue		**721**	**0**	**633**	**721**	**0**	**633**
Gain/(Loss) on Disposal	11	(393)	0	(2)	(393)	0	(2)
Net Cost of Services	**25**	**9,969**	**9,957**	**9,164**	**9,969**	**9,957**	**9,164**
Government Contributions							
NSW Health Department							
Recurrent Allocations	2(d)	9,175	9,175	8,379	9,175	9,175	8,379
Acceptance by the Crown Entity of employee benefits	2(a)(ii)	417	187	132	417	187	132
Total Government Contributions		**9,592**	**9,362**	**8,511**	**9,592**	**9,362**	**8,511**
RESULT FOR THE YEAR		**(377)**	**(595)**	**(653)**	**(377)**	**(595)**	**(653)**
Other Comprehensive Income							
Other Comprehensive Income for the year		**0**	**0**	**0**	**0**	**0**	**0**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**0**	**0**	**0**	**0**	**0**	**0**
FOR THE YEAR		**(377)**	**(595)**	**(653)**	**(377)**	**(595)**	**(653)**

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION

For the Year Ended 30 June 2011

	Notes	PARENT Actual 2011	PARENT Budget (unaudited) 2011	PARENT Actual 2010	CONSOLIDATION Actual 2011	CONSOLIDATION Budget (unaudited) 2011	CONSOLIDATION Actual 2010
		$000	$000	$000	$000	$000	$000
ASSETS							
Current Assets							
Cash and Cash Equivalents	12	6,286	5,507	6,827	6,286	5,507	6,827
Receivables	13	523	294	294	523	294	294
Financial Assets at Fair Value	14	135	128	128	135	128	128
Total Current Assets		**6,944**	**5,929**	**7,249**	**6,944**	**5,929**	**7,249**
Non-Current Assets							
Plant and Equipment	15	932	1,839	514	932	1,839	514
Intangible Assets	16	437	231	874	437	231	874
Other	17	112	0	0	112	0	0
Total Non-Current Assets		**1,481**	**2,070**	**1,388**	**1,481**	**2,070**	**1,388**
Total Assets		**8,425**	**7,999**	**8,637**	**8,425**	**7,999**	**8,637**
LIABILITIES							
Current Liabilities							
Payables	18	866	736	736	866	736	736
Provisions	19	727	1,713	1,756	727	1,713	1,756
Total Current Liabilities		**1,593**	**2,449**	**2,492**	**1,593**	**2,449**	**2,492**
Non-Current Liabilities							
Provisions	19	3	78	78	3	78	78
Other	20	124	0	0	124	0	0
Total Non-Current Liabilities		**127**	**78**	**78**	**127**	**78**	**78**
Total Liabilities		**1,720**	**2,527**	**2,570**	**1,720**	**2,527**	**2,570**
Net Assets		**6,705**	**5,472**	**6,067**	**6,705**	**5,472**	**6,067**
EQUITY							
Accumulated Funds		**6,705**	**5,472**	**6,067**	**6,705**	**5,472**	**6,067**
Total Equity		**6,705**	**5,472**	**6,067**	**6,705**	**5,472**	**6,067**

STATEMENT OF CHANGES IN EQUITY

For the Year Ended 30 June 2011

	Notes	Accumulated Funds 2011	Total 2011
		$000	$000
Balance at 1 July 2010		6,067	6,067
Restated Total Equity at 1 July 2010		**6,067**	**6,067**
Result For The Year		(377)	(377)
Other Comprehensive Income:			
Total Other Comprehensive Income		**0**	**0**
Total Comprehensive Income For The Year		**5,690**	**5,690**
Transactions With Owners In Their Capacity As Owners			
Increase/(Decrease) in Net Assets From Equity Transfers	26	1,015	0
Balance at 30 June 2011		**6,705**	**5,690**
Balance at 1 July 2009		6,720	6,720
Restated Total Equity at 1 July 2009		**6,720**	**6,720**
Result For The Year		(653)	(653)
Other Comprehensive Income:			
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		0	0
Balance at 30 June 2010		**6,067**	**6,067**

The accompanying notes form part of these financial statements.

CASH FLOW STATEMENT

For the Year Ended 30 June 2011

	Notes	PARENT Actual 2011	PARENT Budget (unaudited) 2011	PARENT Actual 2010	CONSOLIDATION Actual 2011	CONSOLIDATION Budget (unaudited) 2011	CONSOLIDATION Actual 2010
		$000	$000	$000	$000	$000	$000
CASH FLOWS FROM OPERATING ACTIVITIES							
Payments							
Employee Related		0	(6,350)	0	(7,065)	(6,350)	(5,855)
Other Operating Expenses		(9,079)	(2,880)	(8,367)	(2,014)	(2,880)	(2,512)
Grants and Subsidies		(149)	(50)	(251)	(149)	(50)	(251)
Total Payments		**(9,228)**	**(9,280)**	**(8,618)**	**(9,228)**	**(9,280)**	**(8,618)**
Receipts							
Sale of Goods and Services		(125)	0	55	(125)	0	55
Interest Received		409	0	405	409	0	405
Grants and Contributions		167	0	260	167	0	260
Other		8	0	151	8	0	151
Total Receipts		**459**	**0**	**871**	**459**	**0**	**871**
Cash Flows From Government							
NSW Health Department Recurrent Allocations		9,175	9,175	8,379	9,175	9,175	8,379
Net Cash Flows from Government		**9,175**	**9,175**	**8,379**	**9,175**	**9,175**	**8,379**
NET CASH FLOWS FROM OPERATING ACTIVITIES	**23**	**406**	**(105)**	**632**	**406**	**(105)**	**632**
CASH FLOWS FROM INVESTING ACTIVITIES							
Proceeds from Sale of Land and Buildings, Plant and Equipment and Infrastructure Systems		(26)	0	23	(26)	0	23
Purchases of Land and Buildings, Plant and Equipment, Infrastructure Systems and Intangible Assets		(921)	(1,215)	(25)	(921)	(1,215)	(25)
Purchases of Investments		0	0	550	0	0	550
NET CASH FLOWS FROM INVESTING ACTIVITIES		**(947)**	**(1,215)**	**548**	**(947)**	**(1,215)**	**548**
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		(541)	(1,320)	1,180	(541)	(1,320)	1,180
Opening Cash and Cash Equivalents		6,827	6,827	5,647	6,827	6,827	5,647
CLOSING CASH AND CASH EQUIVALENTS	**12**	**6,286**	**5,507**	**6,827**	**6,286**	**5,507**	**6,827**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

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 statement 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), and the consolidated financial statements of the economic entity". Separate financial statements of the special purpose entity are not presented in the consolidated statements.

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 consolidated financial statements for the year ended 30 June 2011 have been authorised for issue by the Chief Executive on 29 September 2011.

2. Summary of Significant Accounting Policies

The Clinical Excellence Commission's financial statements are general purpose financial statements which has been prepared in accordance with applicable Australian Accounting Standards (which include Australian Accounting Interpretations), the requirements of the ***Public Finance and Audit Act 1983, Public Finance and Audit regulation 2010,*** and the Financial Reporting Directions published in the Financial Reporting Code for Budget Dependent General Government Sector Agencies or issued by the Treasurer under Section 9(2) (n) of the Act. The requirements of the Health Services Act 1997 and its regulations including the Accounts and Audit Determination for Public Health Organisations have also been observed.

Apart from the basis for the Clinical Excellence Commission's budget figures, the financial statements comply with the Financial Reporting Code for Budget Dependent General Government Sector Agencies. Further information on the budget figures can be found at Note 2(u).

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 2010-07, Financial Instruments, arising from the issuance of AASB 9, Financial Instruments, in AASB 2009-5 in December 2010, has mandatory application from 1 July 2013 and will not be early adopted by the Health Service.

AASB 124 and AASB2009-12, Related Party Transactions, have application from 1 July 2011 but are assessed as having no material impact on the Health Service.

AASB 2009-14, Amendments to Australian Interpretation – Prepayment of a Minimum Funding Requirement, has application from 1 July 2011 and principally addresses contributions relating to future service. It has no impact on the Health Service.

AASB 1053 and AASB 2010-2, Application of Tiers of Australian Accounting Standards, have application from 1 July 2013 and may result in a lessening of reporting requirements, dependent on the mandate of Treasury.

AASB 2010-04, Annual Improvements, has application from 1 July 2011 and is assessed as having no material impact on the Health Service.

AASB 2010-5, Editorial Corrections, applies from 1 July 2011 and principally addresses editorial amendments to a range of Australian Accounting Standards and Interpretations. It is assessed as having no impact on the Health Service.

AASB 2010-6 , Disclosures on Transfers of Financial Assets, has mandatory application from 1 July 2011 and is assessed as having no impact on the Health Service.

AASB 2010-8, Deferred Tax:Recovery of Underlying Assets, has mandatory application from 1 July 2012 but will have no impact on the Health Service.

AASB 2010-9, Severe Hyperinflation and Removal of Fixed Dates for First Time Adopters, has application from 1 July 2011 and is assessed as having no impact on the Health Service.

AASB 2010-10, Removal of Fixed Dates for First Time Adopters, has application from 1 July 2013 and is assessed as having no 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 2011, such on-costs being consistent with actuarial assessment (Comparable on-costs for 30 June 2010 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 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

Responsibility for Long Service Leave liability transferred to the Crown Entity with effect from 31 December 2010. As is the case with other Budget Sector agencies both the Defined Benefit Superannuation (State Authorities Superannuation Scheme and State Superannuation Scheme) and Long Service Leave liabilities are now assumed by the Crown Entity.

Long Service Leave is measured at present value in accordance with AASB119, Employee Benefits. This is based on the application of certain factors (specified in NSW Treasury Circular 11/06) to employees with five or more years of service, using current rates of pay. These approximate present value.

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 reporting period is determined by using the formulae specified by Treasury and communicated via the NSW Department of Health. The expense for certain superannuation schemes (i.e. Basic Benefit and First State Super) 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.

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' 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.

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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

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.

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. 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 Clinical Excellence Commission 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 refer to Note 2(t).

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%
Computer Equipment	20.0%
Motor Vehicle Sedans	12.5%
Office Equipment	10.0%
Furniture, Fittings and Furnishings	20.0%

"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. The Clincal Excellence Commission has chosen 7 years for its intangible assets.

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. TCorp 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 though 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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

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.

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) 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.

t) 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 Clinical Excellence Commission'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. The budget figures are unaudited.

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	
	2011	2010	2011	2010
	$000	$000	$000	$000
3. Employee Related				
Employee related expenses comprise the following:				
Salaries and Wages	0	0	6,028	5,252
Superannuation – defined benefit plans	0	0	105	132
Superannuation – defined contributions	0	0	378	324
Long Service Leave	0	0	375	254
Annual Leave	0	0	399	403
Sick Leave and Other Leave	0	0	123	198
Workers Compensation Insurance	0	0	22	16
Fringe Benefits Tax	0	0	1	0
	0	**0**	**7,431**	**6,579**

These consolidated financial statements for the year ended 30 June 2011 have been authorised for issue by the Chief Executive on 29 September 2011.

4. Personnel Services				
Personnel Services comprise the purchase of the following:				
Salaries and Wages	6,028	5,252	0	0
Superannuation – defined benefit plans	105	132	0	0
Superannuation – defined contributions	378	324	0	0
Long Service Leave	375	254	0	0
Annual Leave	399	403	0	0
Sick Leave and Other Leave	123	198	0	0
Workers Compensation Insurance	22	16	0	0
Fringe Benefits Tax	1	0	0	0
	7,431	**6,579**	**0**	**0**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

	PARENT		CONSOLIDATION	
	2011	2010	2011	2010
	$000	$000	$000	$000
5. Other Operating Expenses				
Domestic Supplies and Services	6	12	6	12
Food Supplies	24	49	24	49
General Expenses (See (a) below)	329	738	329	738
Information Management Expenses	316	230	316	230
Maintenance (See (b) below)				
Maintenance Contracts	15	16	15	16
New/Replacement Equipment under $10,000	95	15	95	15
Repairs	24	7	24	7
Postal and Telephone Costs	117	89	117	89
Printing and Stationery	213	287	213	287
Rates and Charges	1	3	1	3
Rental	554	311	554	311
Special Service Departments	114	48	114	48
Staff Related Costs	49	184	49	184
Travel Related Costs	270	356	270	356
	2,127	**2,345**	**2,127**	**2,345**
(a) General Expenses include:				
Advertising	5	101	5	101
Audio Visual	3	12	3	12
Books, Magazines and Journals	31	5	31	5
Consultancies	4	44	4	44
Courier and Freight	25	3	25	3
Sitting Allowance Committee Membership Fees	0	13	0	13
Auditor's Remuneration – Audit of financial reports	31	25	31	25
Other Services	0	107	0	107
Legal Services	0	6	0	6
Membership/Professional Fees	26	29	26	29
Motor Vehicle Expenses	15	19	15	19
Other Management Services	121	311	121	311
Other	68	63	68	63
	329	**738**	**329**	**738**
(b) Maintenance				
Reconciliation Total Maintenance				
Maintenance (non employee Maintenance expense – contracted labour and other related), included in Note 5	134	38	134	38
Total maintenance expenses included in Notes 3, 4 and 5	**134**	**38**	**134**	**38**

	PARENT		CONSOLIDATION	
	2011	2010	2011	2010
	$000	$000	$000	$000
6. Depreciation and Amortisation				
Depreciation – Plant and Equipment	136	53	136	53
Amortisation – Intangible Assets	437	437	437	437
Amortisation – Leased Premises Make Good	12	0	12	0
	585	**490**	**585**	**490**
7. Grants and Subsidies				
Research Organisations	134	113	134	113
Australasian Cardiac Surgery Research Institution	0	130	0	130
Ian O'Rourke Scholarship Fund (University of Sydney)	8	35	8	35
Other	12	13	12	13
Falls Program Funding	0	90	0	90
	154	**381**	**154**	**381**
8. Sale of Goods and Services				
(a) Sale of Goods comprise the following:				
Commercial Activities*	107	28	107	28
Salary Packaging Fee	3	0	3	0
Other	8	5	8	5
	118	**33**	**118**	**33**
9. Investment Revenue				
Interest	430	328	430	328
TCorp Hour-Glass Investment Facilities designated at Fair Valuethrough profit & loss	6	9	6	9
	436	**337**	**436**	**337**

*Commercial Activities consists of confererence & training rececipts & profesional fees.

10. Grants and Contributions				
NSW Government grants	25	60	25	60
Personnel Services – Superannuation Defined Benefits	0	0	0	0
Research grants:				
– National Blood Authority Australia grants (TMIP)	18	0	18	0
– Austin Health (Hand Hygiene Program grants)	104	0	104	0
– Australian Commission grants (Mortality Data Project)	20	0	20	0
Other grants	0	203	0	203
	167	**263**	**167**	**263**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

	PARENT		CONSOLIDATION	
	2011	2010	2011	2010
	$000	$000	$000	$000
11. Gain/(Loss) on Disposal				
Property Plant and Equipment	587	40	587	40
Less Accumulated Depreciation	194	15	194	15
Written Down Value	**393**	**25**	**393**	**25**
Less Proceeds from Disposal	0	23	0	23
Gain/(Loss) on Disposal of Property Plant and Equipment	**(393)**	**(2)**	**(393)**	**(2)**
Total Gain/(Loss) on Disposal	**(393)**	**(2)**	**(393)**	**(2)**
12. Cash & Cash Equivalent Assets				
Cash at bank and on hand	656	407	656	407
Short Term Deposits	5,630	6,420	5,630	6,420
	6,286	**6,827**	**6,286**	**6,827**
Cash & cash equivalent assets recognised in the Statement of Financial Position at the end of the financial year to the Statement of Cash Flows as follows:				
Cash and cash equivalents (per Statement of Financial Position)	6,286	6,827	6,286	6,827
Closing Cash and Cash Equivalents (per Statement of Cash Flows)	**6,286**	**6,827**	**6,286**	**6,827**

Refer to Note 27 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	0	58	0	58
Debtors Intra Health	9	30	9	30
Goods & Services Tax	189	50	189	50
Other Debtors	317	123	317	123
Sub Total	**515**	**261**	**515**	**261**
Sub Total	**515**	**261**	**515**	**261**
Prepayments Salary & Wages	5	5	5	5
Prepayments GST	3	28	3	28
Total	**523**	**294**	**523**	**294**

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

	PARENT		CONSOLIDATION	
	2011	2010	2011	2010
	$000	$000	$000	$000
14. Financial Assets at Fair Value				
Current				
Treasury Corporation – Hour-Glass Investment Facilities (Cash)	135	128	135	128
	135	**128**	**135**	**128**

Refer Note 27 for further information regarding credit risk, liquidity risk and market risk arising from financial investments.

15. Plant and Equipment				
Plant and Equipment				
At Fair Value	1,293	754	1,293	754
Less Accumulated depreciation and impairment	(361)	(240)	(361)	(240)
Net Carrying Amount	**932**	**514**	**932**	**514**
Total Plant and Equipment At Net Carrying Amount	**932**	**514**	**932**	**514**

	2011		2010	
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	514	514	569	569
Additions	947	947	23	23
Disposals	(393)	(393)	(25)	(25)
Depreciation expense	(136)	(136)	(53)	(53)
Carrying amount at end of year	**932**	**932**	**514**	**514**

	PARENT		CONSOLIDATION	
	2011	2010	2011	2010
	$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	(1,953)	(1,516)	(1,953)	(1,516)
Net Carrying Amount	**437**	**874**	**437**	**874**
Total Intangible Assets at Net Carrying Amount	**437**	**874**	**437**	**874**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

PARENT AND CONSOLIDATION	2011 Software	2011 Total	2010 Software	2010 Total
	$000	$000	$000	$000
16. Intangibles – Reconciliation				
Net Carrying amount at start of year	874	874	1,311	1,311
Additions (from internal development or acquired separately)	0	0	0	0
Amortisation (recognised in depreciation and amortisation)	(437)	(437)	(437)	(437)
Net Carrying amount at end of year	**437**	**437**	**874**	**874**

	PARENT		CONSOLIDATION	
	2011	2010	2011	2010
	$000	$000	$000	$000
17. Other Non-Current Assets				
Make Good Provision Leased Premises (Elizabeth St)	112	0	112	0
Total	**112**	**0**	**112**	**0**
18. Payables				
Current				
Accrued Salaries and Wages	150	122	150	122
Taxation & Payroll Deductions	10	5	10	5
FBT	1	0	1	0
PAYG	133	74	133	74
Accrued Liability – Purchase of Personnel Services	0	0		
Creditors	184	386	184	386
Other Creditors				
– Capital Works	0	0	0	0
– Intra Health Liability	330	149	330	149
– Other	58	0	58	0
	866	**736**	**866**	**736**

Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired are disclosed in Note 27.

19. Provisions				
Current Employee Benefits and Related On-Costs				
Employee Annual Leave – Short Term Benefit	0	0	430	318
Employee Annual Leave – Long Term Benefit	0	0	245	403
Employee Long Service Leave – Short Term Benefit	0	0	0	36
Employee Long Service Leave – Long Term Benefit	0	0	0	999
Long Service Leave On-Costs	0	0	52	0
Provision for Personnel Services Liability	727	1,756	0	0
Total Current Provisions	**727**	**1,756**	**727**	**1,756**

	PARENT		CONSOLIDATION	
	2011	2010	2011	2010
	$000	$000	$000	$000
Non Current Employee Benefits and Related On-Costs				
Employee Long Service Leave – Conditional	0	0	0	78
Long Service Leave On-Costs			3	0
Provision for Personnel Services Liability	3	78	0	0
Total Current Provisions	**3**	**78**	**3**	**78**
Aggregate Employee Benefits and Related On-Costs				
Provisions – Current	727	1,756	727	1,756
Provisions – Non-Current	3	78	3	78
Accrued Salaries and Wages and On-Costs (Note 18)	150	122	150	122
	880	**1,956**	**880**	**1,956**

Tax and Payroll Deductions ($10,000).

20. Other Non-Current Liabilities

Make Good Provision Leased Premises (Elizabeth St)	124	0	124	0
	124	**0**	**124**	**0**

21. 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	190	207	190	207
Later than one year and not later than five years	440	440	440	440
Later than five years	0	0	0	0
Total Other Expenditure Commitments (Including GST)	**630**	**647**	**630**	**647**

(b) Operating Lease Commitments

Commitments in relation to non-cancellable operating leases are payable as follows:				
Not later than one year	0	416	0	416
Later than one year and not later than five years	0	2,006	0	2,006
Later than five years	0	0	0	0
Total Other Expenditure Commitments (Including GST)	**0**	**2,422**	**0**	**2,422**

(c) Contingent Asset related to Commitments for Expenditure

The total of "Commitments for Expenditure" $4,025M as at 30 June 2011 includes input tax credits of $365,893 that are expected to be recoverable from the Australian Taxation Office.

22. Contingent Liabilities

There are no contingent liabilities.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

	PARENT		CONSOLIDATION	
	2011	2010	2011	2010
	$000	$000	$000	$000
23. Reconciliation Of Net Cash Flows from Operating Activities To Net Cost Of Services				
Net Cash Used on Operating Activities	406	632	406	632
Depreciation	(585)	(490)	(585)	(490)
Acceptance by the Crown Entity of Employee Superannuation and LSL Benefits	(418)	(132)	(418)	(132)
(Increase)/Decrease in Employee Provisions	1,105	(479)	1,105	(479)
(Increase)/Decrease in Goods and Services Debtors	335	(133)	335	(133)
(Increase)/Decrease in Other Debtors (Intra Hlth)	(79)	(115)	(79)	(115)
Increase/(Decrease) in Prepayments	(25)	2	(25)	2
(Increase)/Decrease in Creditors	(131)	(77)	(131)	(77)
Net Gain/(Loss) on Sale of Property, Plant and Equipment	(393)	(2)	(393)	(2)
(NSW Health Department Recurrent Allocations)	(9,175)	(8,379)	(9,175)	(8,379)
Assumption by the Crown for Long Service leave	(1,015)	0	(1,015)	0
Fair Value (TCorp)	6	9	6	9
Net Cost of Services	**(9,969)**	**(9,164)**	**(9,969)**	**(9,164)**

24. 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.

25. Budget Review – Parent and Consolidated

Net Cost of Services

The actual Net Cost of Services was higher than budget by only $12K. This was primarily due to the non-cash budget adjustment of $600K which assisted the Clinical Excellence Commission achieve its tighter budget variance this year compared to last year's surplus. Greater than budget actual revenue of $721K represents mainly investment income from short term fixed deposits. Once again assisting the Clinical Excellence Commission in its $12K variance.

Employee Related Expenditure increased during the year compared to budget due to leave expenses and additional staffing positions. This expenditure was funded by savings in Other Operating expenditure and increased revenue.

Result for the Year

The result for the year was higher than budget by $218K due to the slightly unfavourable Net Cost of Services position.

Assets and Liabilities

Current Assets

The decrease in actuals compared to last year can be attributed to our fixed term deposits as we had to call on these funds for various capital costs. Current assets were greater than budget primarily due to our cash investments of fixed term deposits.

Non-Current Assets

There was significant movement within non-current assets due to the refurbishment of the new premises and disposal of assets including write back on depreciation for the old premises & equipment. Non current assets were less than budget by $589K.

Current Liabilities

A significant reduction in actuals in comparison to last year as the LSL component has now been accepted by the crown. There is now a budget surplus of $856k.

Non-Current Liabilities

A reduction in actual non-current provisions in comparison to last year as the LSL component has now been accepted by the crown. We have now provided for the make good provision in terms of our lease. The result of the make good provision is an increase of $49K higher than budget.

Cash Flows

Operating Activities
The actual expenditure result has increased in comparison to last year with a budget variance result of $52K under budget for 2010–11. This can be attributed to the increase in service delivery by the Clinical Excellence Commission for the financial year.

Investing Activities
Actual capital expenditure has increased compared to last year due to the refurbishment of the new premises. The result is a budget surplus of $294K for 2010–11.

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 2010 are as follows:

	2011	2010
	$000	$000
Initial Allocation, 30th July 2010	9,583	8,720
Government Cash Payments	270	0
Collaborating Hospital Audit Surgical Mortality	0	250
DVA Innovative Funding Project	145	0
Statewide Clinical Leadership Program	(1,153)	(1,231)
DETECT Education	0	106
Paediatric Recognition of the Sick Child and Resuscitation Project	137	264
Falls Prevention Program	211	269
Super Guarantee Charge	3	1
Crown Acceptance LSL	(21)	0
Balance as per Statement of Comprehensive Income	**9175**	**8379**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

26. Increase/(Decrease) in Net Assets from Equity Transfers

Consistent with Treasury approval Long Service Leave liability of $1.015 Million transferred from the Clinical Excellence. Commission with effect from 31 December 2010 from which time the Crown Entity assumed responsibility for Long Service Leave.

	2011	2010
	$000	$000
Assets and Liabilities transferred are as follows:		
ASSETS		
Liabilities		
Long Service Leave Current/Non-Current	(1015)	(0)
Increase/(Decrease) in Net Assets From Equity Transfers	**(1015)**	**0**

27. 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 continous basis.

(a) Financial Instrument Categories

		Total carrying amounts as per Statement of Financial Position			
		PARENT		CONSOLIDATION	
		2011	2010	2011	2010
Financial Assets		$000	$000	$000	$000
Class:	Category				
Cash and Cash Equivalents (note 12)	Loans and receivables	6,286	6,827	6,286	6,827
Receivables (note 13)[1]	(at amortised cost)	326	211	326	211
Financial Assets at Fair Value (note 14)	At fair value through profit & loss (designated as such upon initial recognition)	135	128	135	128
Total Financial Assets		**6,747**	**7,166**	**6,747**	**7,166**
Financial Liabilities					
Payables (Note 17)[2]	Financial liabilities measured at amortised cost	664	657	664	657
Total Financial Liabilities		**664**	**657**	**664**	**657**

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 4.62% in 2010–11 compared to 4.51% 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, $306K ($2010: $181K) related to debtors that were not past due and not considered impaired and debtors of $20K (2010: $30K) were past due but not considered impaired. Together these represent 100% (2010:100%) 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.

	Total	Past due but not impaired	Considered impaired
		$000	$000
2011			
< 3 months overdue	20	20	0
3 months – 6 months overdue	0	0	0
> 6 months overdue	0	0	0
	20	**20**	**0**
2010			
< 3 months overdue	0	0	0
3 months – 6 months overdue	30	30	0
> 6 months overdue	0	0	0
	30	**30**	**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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

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.

Maturity Analysis and interest rate exposure of financial liabilities

	Interest Rate Exposure					Maturity Dates			
	Fixed Interest Rate	Variable Interest Rate	Nominal Amount [1]	Variable Interest Rate	Non – Interest Bearing	< 1 Yr	1–5 Yr	> 5 Yr	Weighted Average Effective int rate
	%	%	$	$000	$000	$000	$000	$000	%
2011									
Payables:									
Accrued salaries			150		150	150			
Creditors			184		184	184			
Intra-Health Creditors			330		330	330			
			664		**664**	**664**			
2010									
Payables:									
Accrues salaries			122		122	122			
Creditors			386		386	386			
Intra-Health Creditors			149		149	149			
			657		**657**	**657**			

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 2011. 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 rstes 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 2011

	$'000				
	Carrying Amount	-1%		+1%	
		Profit	Equity	Profit	Equity
2011					
Financial assets					
Cash and cash equivalents	6,286	-63	-63	63	63
Financial assets at fair value	135	-1	-1	1	1
Other financial assets					
Financial liabilities					
Borrowings					
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					

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	2011	2010
			$000	$000
Cash facility	Cash, money market instruments	Up to 2 years	135	128

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	2011	2010
		$'000	$'000
Hour-Glass Investment – Cash Facility	+ 1%	1.4	1.3

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:

	2011		2010	
	$'000	$'000	$'000	$'000
	Carrying amount	Fair value	Carrying amount	Fair value
Financial assets				
TCorp (Hour-Glass on call)	135	135	128	128
Fixed cash Investment	0	0	0	0
Financial liabilities				
	135	**135**	**128**	**128**

(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).

	Level 1	Level 2	Level 3	2011 Total
	$'000	$'000	$'000	$'000
TCorp Hour-Glass Investment Facilities		135		135

(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 2011.

28. Post Balance Date Events

No matters have arisen subsequent to balance date that would require these financial statements to be amended.

However, the function of CEC will be expanded in 2011–12 with the Commission assuming responsibility for most quality and safety functions and resources managed to date by the NSW Department of Health including representing NSW at national safety and quality forums.

END OF AUDITED FINANCIAL STATEMENTS

CERTIFICATION OF SPECIAL PURPOSE

For the Year Ended 30 June 2011

Pursuant to Section 45F of the *Public Finance and Audit Act,* 1983, I state that in my opinion:

1) The financial statements have been prepared in accordance with:
   - Australian Accounting Standards (which include Australian Accounting Interpretations)
   - *Public Finance and Audit Act 1983,* the *Public Finance and Audit Regulations 2010* and the Treasurer's Directions
2) The financial statements exhibit a true and fair view of the financial position and the financial performance of the Clinical Excellence Commission Special Purpose Service Entity.
3) There are no circumstances which would render any particulars included in the financial statements to be misleading or inaccurate.

I further state the financial statements have been prepared in accordance with the NSW Department of Health's Accounts and Audit Determination for Public Health Organisations.

Professor Clifford Hughes, AO
Chief Executive
29 September 2011

A/Professor Brian McCaughan AM
Chairman
29 September 2011

INDEPENDENT AUDIT REPORT

For the Year Ended 30 June 2011

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 2011, the statement of comprehensive income, the statement of changes in equity and the statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information.

Opinion

In my opinion, the financial statements:

- give a true and fair view of the financial position of the Entity, as at 30 June 2011, and of the financial performance for the year then ended in accordance with Australian Accounting Standards
- 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 financial statements that give a true and fair view in accordance with Australian Accounting Standards and the PF&A Act, and for such internal control as the Chief Executive determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

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. Those standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about 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 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 control 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 control. 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.

INDEPENDENT AUDIT REPORT

For the Year Ended 30 June 2011

My opinion does *not* provide assurance:

- about the future viability of the Entity
- that they have carried out their activities effectively, efficiently and economically
- about the effectiveness of their internal control
- about the security and controls over the electronic publication of the audited financial statements on any website where they may be presented
- about any other information which may have been hyperlinked to/from the financial statements.

Independence

In conducting my audit, I have complied with the independence requirements of the Australian Auditing Standards and other relevant ethical pronouncements. 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

30 September 2011
SYDNEY

STATEMENT OF COMPREHENSIVE INCOME

For the Year Ended 30 June 2011

	2011	2010
	$000	$000
Income		
Personnel Services	7,014	6,447
Acceptance by the Crown Entity of Employee Benefits	417	132
Total Income	**7,431**	**6,579**
Expenses		
Salaries and Wages	6,028	5,252
Defined Benefit Superannuation	105	132
Defined Contribution Superannuation	378	324
Long Service Leave	375	254
Annual Leave	399	403
Sick Leave and Other Leave	123	198
Workers Compensation Insurance	22	16
Fringe Benefits Tax	1	0
Total Expenses	**7,431**	**6,579**
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 2011

	Notes	2010	2009
		$000	$000
ASSETS			
Current Assets			
Receivables	2	877	1878
Total Current Assets		**877**	**1878**
Non-Current Assets			
Receivables	2	3	78
Total Non-Current Assets		**3**	**78**
Total Assets		**880**	**1956**
LIABILITIES			
Current Liabilities			
Payables	3	150	122
Provisions	4	727	1756
Total Current Liabilities		**877**	**1878**
Non-Current Liabilities			
Provisions	4	3	78
Total Non-Current Liabilities		**3**	**78**
Total Liabilities		**880**	**1956**
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 2011

	2011	2010
	$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	**0**	**0**

The accompanying notes form part of these Financial Statements.

STATEMENT OF CASH FLOWS

For the Year Ended 30 June 2011

	2011	2010
	$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 2011

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 29 September 2011. 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 statement.

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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

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 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 deteminable 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

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

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

All Annual Leave employee benefits are reported as "Current" as there is an unconditional right to payment. Current liabilities are then 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.

	2011	2010
	$000	$000
2. Receivables		
Current		
Accrued Income – Personnel Services Provided	877	1878
Non-Current		
Accrued Income – Personnel Services Provided	3	78
Total Receivables	**880**	**1956**

Details regarding credit risks, liquidity risk and market risk are disclosed in Note 5.

3. Payables		
Current		
Accrued Salaries and Wages and On Costs	150	122
Total Payables	**150**	**122**
4. Provisions		
Current Employee benefits and related on-costs		
Annual Leave – Short Term Benefit	430	318
Annual Leave – Long Term Benefit	245	403
Long Service Leave – Short Term Benefit	0	36
Long Service Leave – Long Term Benefit	0	999
Long Service Leave On-Costs	52	0
Total Current Provisions	**727**	**1756**
Non-Current Employee Benefits and Related On Costs		
Long Service Leave – Conditional	3	78
Total Non-Current Provisions	**3**	**78**
Aggregate Benefits and Related On Costs		
Accrued Salary & Wages & on-costs	150	122
Provision – Current	727	1756
Provision – Non-Current	3	78
Total	**880**	**1956**

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year Ended 30 June 2011

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	
		2011	2010
Financial Assets		$000	$000
Class:	Category		
Receivables (Note 2)[1]	Receivables measured at amortised cost	880	1,956
Total Financial Assets		**880**	**1,956**
Financial Liabilities			
Class:			
Payables (Note 3)[2]	Financial liabilities measured at amortised cost	150	122
Total Financial Liabilities		**150**	**122**

1 Excludes statutory receivables and prepayments (i.e. not within the scope of AASB7).

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.

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

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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