Foreword

NSW offers one of the best health systems in the world. New technologies and services are embraced each year and there is a determined focus to continue improving the safety and quality of healthcare in NSW.

To help achieve this ongoing aim, in June 2001 the NSW Institute for Clinical Excellence (ICE) was established and constituted as a statutory health corporation under the Area Health Services Act 1997 on December 10, 2001.

Charged with helping to provide better systems, better training and better research for the people of NSW the Institute is helping drive a series of initiatives to continue the improvement of healthcare safety and quality.

NSW Health and ICE are working hand-in-hand implementing safety and quality improvement processes and NSW can now boast being the first in Australia to implement a state wide Quality Framework which provides structures for Area Health Services to monitor and measure quality care.

Clinician-led strategies are complemented by policies and procedures directed by NSW Health and the Institute. Together, substantial progress in improving the quality and safety of patient care in NSW is being made.

Health is moving from a system where hospitals and health services had separate approaches to complaints and clinical errors, to a system where uniform standards and processes have been introduced to ensure that the system learns from its mistakes and solutions are adopted system-wide.

The challenge in 2003/04 was to strengthen the commitment to patient safety through the faster implementation of a state wide system which could detect and analyse clinical errors and system weaknesses at an early stage.

This challenge led to the formation of the new Clinical Excellence Commission (CEC). Launched by the Minister for Health the Hon Morris Iemma MP on August 24, 2004, the CEC will build on the work of ICE and become the health system's next crucial step in frontline clinical care and improved safety and quality.

The Clinical Excellence Commission forms part of the new NSW Patient Safety and Clinical Quality Program. The CEC will be guided by the following set of principles:

- Openness about failures
- Emphasis on learning
- Obligation to act
- Accountability
- Just Culture
- Appropriate prioritisation of action
- Teamwork and information sharing

In line with these principles, the CEC will put in place the strongest support system it can for healthcare workers and their patients.

Reporting annually to the Minister for Health on initiatives in place across NSW, the Clinical Excellence Commission will focus on:

- Promoting and supporting improvement in clinical quality and safety in health services
- Consulting broadly with health professionals and members of the community
- Identifying and sharing information about safe practices in health care across the state
- Monitoring clinical quality and safety processes in Area Health Services

The CEC will help ensure that the NSW healthcare system is one that continually strives for ongoing improvement and offers the best quality and safety possible.

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Chairman's Report

New South Wales Institute for Clinical Excellence Annual Report 2003-2004

Enormous change has taken place at the Institute for Clinical Excellence during the past year. The most significant change is that the Institute will become the foundation of the new Clinical Excellence Commission, a new body starting work in August 2004 with a much expanded brief in relation to improving health care but also with the task of assuring the public care is as safe as it can possibly be. The very valuable work undertaken by the NSW Institute for Clinical Excellence (ICE) will continue and the Commission will employ the staff of ICE.

The ICE Board, during the last few months of the 2003 - 2004 year has been a transitional board, tasked with wrapping up the year's work for ICE and preparing the way for the Clinical Excellence Commission (CEC). It is anticipated that a number of the current ICE Board Members will nominate to be Members of the Board of the Commission. I am honoured to have been appointed Chair of the Board of the new Commission.

This is not the only change that has occurred during the past 12 months. All at ICE were devastated when our very effective and much valued CEO, Dr Ian O'Rourke, developed lung cancer. He continued to achieve great results at ICE while fighting the effects of the disease and its treatment in the only way he knew how - with great courage and determination. Since the establishment of ICE in November 2001, but particularly during this difficult time, Ian's people skills, boundless enthusiasm, tireless effort and commitment, enabled the development of a vast number of activities which have been implemented across the health system, making health care safer and better for people in NSW. Ian died peacefully at home, surrounded by his family on August 16, 2004. He still had much to contribute but should have been both content with, and very proud of, his achievements. If one was to look back on his life one learns about the value of commitment to the community, of determination to succeed, of compassion and caring. We learn about the components of great leadership. He led by example, he listened, he involved others and he was first amongst equals. Ian demonstrated a steady, calm, confident, optimistic approach to problem solving and he had the knowledge and skills to solve the problems confronting him. Ian always regarded the welfare of patients as more important than his own. By his actions he built trust. We remain inspired by his compassion and thankful for his life. All at ICE give their deepest sympathy to Ian's family. Ian died knowing that the team establishing the CEC would continue to build on his great work. We will all miss him.

The Board of ICE also lost the service of Professor Mary Chiarella, who resigned from the Board and from her position as Chief Nurse of NSW in order to move to the United Kingdom. Her contribution to the Board was significant and was always given in an easy-going, bright, charming way. We wish Mary well in the UK.

It is difficult to describe in a brief way the extensive achievements of ICE through the great efforts of Dr Ian O'Rourke and his staff in collaboration with thousands of managers and health professionals across NSW. Our most far-reaching and important project is the Safety Improvement Program where 20 patient safety managers have been appointed to implement the program - one in each area health service.

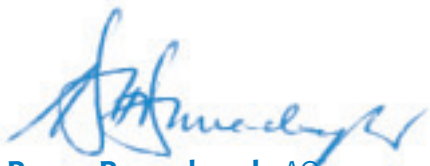
Following the training of over 2,000 health care professionals in Root Cause Analysis and in Human Factors there has been a dramatic increase in the centralised reporting of severe reportable incidents with root cause analysis methodology now being the routine methodology for dealing with severe adverse events, Severity Assessment Code 1, in NSW. This then leads to thousands of recommendations for improvement. The Patient Flow and Safety Collaborative was very successful with significant reduction in pressure ulcers and falls and with reduced access block and increased weekend discharge rates in the participating hospitals. A final report and a toolkit, built from the experiences of this collaborative, will be disseminated throughout the NSW Health system.

The Towards a Safer Culture (TASC) Project has also shown significant improvement in patient outcomes with increased utilisation of lifesaving medications, decreased length of stay and improved diagnosis time, with decreased re-admission rates. The Chronic and Complex Care Collaborative, funded by the NSW Department of Health but implemented as a joint exercise with ICE, is ongoing and has already created great enthusiasm for change. The Children's Emergency Care Project is progressing well with excellent involvement of both paediatric and emergency care clinicians. This project will continue over the next three years. The National Medication Safety Breakthrough Collaborative is progressing very well, as is our research project into safety and quality improvement activities. Numerous presentations and education seminars have been organised and contributed to by the team at ICE and by our clinical faculty. The Institute was a co-sponsor with the Australian Council for Safety and Quality in Health Care and NSW Health of a very successful workshop on Human Factors in Health Care, organised by the Australasian Aviation Psychology Association where lessons from the ICE experience were highlighted. The Australian Council for Safety and Quality in Health Care published the proceedings of that meeting.

During the year ICE was given a grant from NSW Health to support the infrastructure and activity of the Special Committees investigating deaths under anaesthesia and deaths associated with surgery. These two ministerial committees have been functioning successfully for many years and it is with pride that ICE takes up its task of supporting the work of these two groups and integrating the work from their activity, with the lessons learnt through the safety improvement program.

ICE, its Board and its staff are excited by the prospects for further improvement in patient safety and quality that come with the expanded responsibilities of the CEC. While the transition phase is both busy and complex there is no doubt the work of ICE will continue through this transitional time and the team will be ready to move into a new role as soon as the Board, the CEO and the Clinical and Community councils have been appointed.

On behalf of the ICE Board, and all ICE staff, I wish to record our heart felt thanks for all the help that has been received from the many thousands of clinicians, health care managers and consumers of health care in NSW and for the inspiration that we have felt from their eager and willing participation.



Bruce Barraclough AO
Chair

Dr Ian O'Rourke

MBBS MS (Syd Uni) FRACS FRCS (Eng)

Chief Executive Officer of the Institute For Clinical Excellence

Dr Ian O'Rourke had an international reputation in oesophageal surgery and was a fellow of the Royal Australasian College of Surgeons, the Royal College of Surgeons of England and Master of Surgery of the University of Sydney.

He was Chief Executive Officer of the Institute for Clinical Excellence from its inception in November 2001 until his death in August 2004.

On joining ICE Dr O'Rourke was charged with making health care safer and better for people in NSW.

He achieved great results at ICE and his commitment and leadership enabled the development of activities and programs which have been implemented across the state. Dr O'Rourke was honoured by the Royal Australasian College of Surgeons as the College Foundation, Rural Surgery Professor for 2002 and by the presentation of the prestigious ESR Hughes Award in 2003 for his distinguished contribution to surgery. Dr O'Rourke made many of these achievements while fighting the very severe effects of lung cancer.

Posthumously, the NSW Minister for Health Morris Iemma paid tribute to "a man who was a pioneer in clinical quality improvement throughout the NSW Health System" with a $35,000 annual scholarship - the Ian O'Rourke PhD Scholarship in Patient Safety.

Dr O'Rourke's clinical activities, began at Royal North Shore Hospital in 1968 and were further developed working in the UK.

After his time in the UK, Dr O'Rourke settled in the central west of NSW where he was a visiting surgeon at Orange Base, Parkes, Forbes and Wellington Hospitals. In 1978 when Westmead Hospital opened, Dr O'Rourke was one of four surgeons to provide the founding surgical services. He stayed with the hospital for 17 years and was subsequently a Senior Staff Specialist, Clinical Senior Lecturer, Clinical Director of Medical Services and ultimately, Emeritus Consultant to Westmead Hospital. During 1993 he also served as acting Professor and Head of Academic Surgery at Royal North Shore Hospital.

Dr O'Rourke always had a very strong desire to help his fellow man, particularly those less privileged in our community. In 1992 he took leave from Westmead Hospital to serve as Medical Officer to the Aboriginal Medical Service at Redfern. He further served remote and Aboriginal communities in Cape York in 1996 and 1997 when he was a community surgeon based at Cairns Base Hospital and visited health clinics at Kowanyama, Lockhart River, Aurukun, Pomperow, Coen and Weipa in far north Queensland. In 1997 Dr O'Rourke was appointed Associate Professor of Surgery, Northern Territory Clinical School of Flinders University at the Royal Darwin Hospital. He held influential positions as the Director of Surgery, Director of Trauma at which time he set up a diabetic foot service and renal dialysis vascular access service. He greatly expanded the capability of surgery in the Northern Territory. He was influential in establishing the Specialist Outreach Service in the Northern Territory and as part of this program was visiting surgeon to remote and Aboriginal communities at Port Keats, Galiwinku and Gove Hospital. Dr O'Rourke also worked at the Danila Dilba clinic in Darwin.

Research activities of Dr O'Rourke included co-supervision of a PhD student studying the impact of a specialist outreach service on barriers to access of care, co-supervision of a master of surgery student

NT Clinical School, Flinders University studying vascular access and co-supervision of a BSc Med student at the University of Tasmania studying the outcomes of patients from remote locations who have required amputation.

He was awarded the Burns-Alpers teaching award of Flinders University when the graduating class of 2000 nominated him "in appreciation for his excellent and inspirational teaching of clinical skills and practice".

Dr O'Rourke collaborated in contributing to the Oxford Textbook of Surgery, 2nd Edition 2000 on Abscess Cellulitis and Necrotising Bacterial Infections as well as editing the Department of Surgery Westmead Hospital: 10 Year Commemorative Book - 1978-1988 and he was the author of over 20 journal articles. He carried out and published research on aspects of oesophageal and gastric surgery.

Much of his motivation to return to Sydney from the Northern Territory, was to be close to his family.

Many in our community, including his family and friends, mourn his passing but remain inspired by his work, compassion and skill and thankful for his life.

Board Members

Professor Bruce H Barraclough, AO

MB BS FRACS DDU FACS

Professor Bruce Barraclough chairs the Australian Council for Safety & Quality in Health Care and the Board of the NSW Institute for Clinical Excellence. He is an elected Member of the Executive Board and Treasurer of the International Society for Quality in Health Care. His other positions also include Medical Director of the Australian Cancer Network and past President of the Royal Australasian College of Surgeons (1998 - 2001). He is a member of multiple committees of Federal and State Governments and health related organisations and associations. Prof Barraclough's hospital appointments include Professor and Director of Cancer Services, Northern Sydney Area Health Service, and his clinical and research interests are in the field of endocrine surgery. He is based at Royal North Shore Hospital - a clinical school of the Faculty of Medicine, Sydney University.

Graham Beaumont

PhD

Graham Beaumont PhD joined Qantas Airways Ltd in 1966 as a cadet pilot and retired in 2003. During this time Dr Beaumont held several management and training captain positions within the Flight Operations Department. Dr Beaumont also held responsibility for the development and implementation of human factor training programs for Qantas aircrew for many years. Dr Beaumont's doctoral research concerned the human factors involved in the management of uncertain dynamic real time operational scenarios and the role of the human in safety management systems. Dr Beaumont is a Fellow of the Australian Institute of Company Directors. In addition to his ICE commitment, Dr Beaumont is a member of the Committee of Management of the Australian Aviation Psychology Association, a member of the External Advisory Committee, School of Management, UWS, and facilitates human factors training in healthcare and aviation settings.

Professor Mary Chiarella

RN, CM, LLB (Hons), PhD (UNSW)

Professor Mary Chiarella is a registered nurse and certified midwife with expertise in health law and ethics. Her Law PhD thesis was converted into a book The Legal and Professional Status of Nursing and she has co-authored several books on nursing and the law. From February 2003 until July 2004 Prof Chiarella held the position of Chief Nursing Officer for NSW while retaining a fractional position as Professor with the Faculty of Nursing, Midwifery and Health at University of Technology, Sydney. Prof Chiarella resigned from the board of ICE in July 2004. In addition to her ICE commitments during the year 2003/04, Prof Chiarella was the representative of the NSW Health Department on the Board of the College of Nursing. She held numerous other positions with a variety of working groups and professional nursing committees within NSW. She was recently appointed as a Member of the National Taskforce on Nursing and Nurse Education.

Professor Patricia Davidson

MD FRACS FRCS FRCP

Professor Patricia Davidson (Trish) is a Paediatric Surgeon and is the Area Director Kaleidoscope Hunter Children's Health Services. Prof Davidson is interested in education both for the training and the maintenance of professional skills and is currently a regular faculty member for the two-day Royal Australasian College of Surgeons Surgical Teacher's Course and a member of the Surgeon as Educators and Education Policy Board committees. In May 2003, Prof Davidson was elected Censor in Chief of the Royal Australasian College of Surgeons.

Major General Peter Dunn, AO (Rtd)

BA, M Def Studies, FAICD, FAIM, AFAHRI

In November 2003 the ACT Government appointed Major General Peter Dunn as the inaugural Commissioner of the ACT Emergency Services Authority. The Authority, consisting of Ambulance, Urban Fire Brigade, Rural Fire Brigade and ACT State

Emergency Service, was established as a result of recommendations made following the disastrous fires in Canberra in January 2003.

Major General Dunn has also worked in the Department of Defence and was responsible for major corporate and supply chain information systems. Immediately prior to these appointments, Major General Dunn served in the Australian Army where he saw active service in Vietnam and also served in Singapore, the United Kingdom and the United State of America. Highlights of Major General Dunn's military career were his command appointments in combat elements of the Army and heading the Australian Defence Force Personnel Executive. In senior military appointments Major General Dunn was especially engaged in major change management roles.

Professor John Dwyer AO

PhD, MB, BS, FRACP

Professor John Dwyer is currently the Clinical Dean and Chairman of the Division of Medicine at Prince of Wales Hospital and Professor of Medicine at the University of New South Wales. In addition to his ICE commitments Prof Dwyer is a member of the NSW Department of Health's Clinical Council and Chairman of the Medical Staff Executive Council of NSW. Prof Dwyer's research interests have concentrated on mechanisms associated with the control of the human immune response. In recent years his clinical and research work has been dominated by realities associated with the HIV epidemic. He is active as a consultant to the UN on AIDS and has travelled to more than 21 countries in the Asia Pacific region advising on the establishment of prevention and treatment strategies related to the HIV epidemic.

Professor Phillip J. Harris

BSc (Med) MB BS DPhil FRACP FACC

Professor Phillip Harris is a Senior Staff Specialist, Head of the Department of Cardiology at Royal Prince Alfred Hospital and Acting Director of Cardiovascular Services in Central Sydney Area Health Service. His other positions include Chair of the Patient Care Committee and Chair of the Clinical Training Committee also at Royal Prince Alfred Hospital. He is Clinical Professor of Medicine at the University of Sydney and member of the Quality Council, Central Sydney Area Health Service. In addition to his ICE commitments Prof Harris is a member of the Board of the National Heart Foundation of Australia and Heart Research Institute, Past President of the Cardiac Society of Australia and New Zealand and National Heart Foundation of Australia (NSW Division).

Dr Diana Horvath AO

FRACMA, FAFPHM, FCHSE

Dr Diana Horvath is Administrator of Central Sydney/South Western Sydney Area Health Service. She is a Fellow of many organisations including the Royal Australasian College of Medical Administrators, the Royal Australasian College of Physicians and the Australian College of Health Service Executives. In addition to her ICE commitments Dr Horvath is a member of the Centenary Institute for Cancer Medicine and Cell Biology, ANZAC Health and Medical Research Institute, Institute for International Health and the Sydney Cancer Institute. Dr Horvath was awarded the Sax Medal by the Australian Hospital Association in 1992 and Arthur Andersen/Dr Ed Crosby International Award for Managerial Innovation in 1997.

Board Member Meeting Attendance

Board	8.7.03	12.8.03	9.9.03	14.10.03	11.11.03	9.12.03	10.2.04	9.3.04	13.4.04	11.5.04	8.6.04
Professor B. Barraclough AO	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Captain G. Beaumont	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Professor M. Chiarella			✓	✓		✓	✓		✓		
Professor P. Davidson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Major General P. Dunn AO	✓	✓	✓		✓		✓	✓	✓	✓	✓
Professor J. Dwyer AO		✓	✓	✓		✓	✓	✓	✓	✓	✓
Professor P. Harris		✓	✓	✓		✓	✓	✓	✓	✓	✓
Dr. D. Horvath AO	✓		✓	✓	✓	✓	✓	✓	✓	✓	
Dr. I. O'Rourke		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Audit Committee			9.9.03		11.11.03		10.2.04			11.5.04	
Major General P. Dunn			✓		✓		✓			✓	
Professor P. Davidson			✓		✓		✓			✓	
Professor P. Harris							✓			✓	
Dr. I. O'Rourke			✓		✓		✓			✓	

Corporate Plan

Our Mission

The mission of the Institute for Clinical Excellence is:

To change health care across NSW to make it safer and better for patients

To achieve this ICE will:

- Work collaboratively on high priority clinical projects across multiple sites being orientated solely on improved patient outcomes.
- Drive implementation of Clinical Practice Improvement and champion the lessons learned across the system
- Provide education and training to support the implementation of improvement projects
- Support targeted health services research

Principles

In pursuing its mission, the following principles have been adopted:

Patient Centred
The best interests of the patient will be kept at the forefront throughout the process of planning and implementation of activities.

Evidence Based
Evidence based medicine will provide the foundation on which all activities are developed.

System Focused
Improvements in safety and quality need to be transferable and sustainable across the health system.

Point of Delivery Focused
Implementation of activities is to be designed around the point of delivery of care.

Outcome Focused
All endeavours will be designed to achieve outcomes, in terms of:

- Clinical improvement
- Resource utilisation (globally) / cost outcomes
- Patient perception

Transparency
Business activity will be conducted in an open, transparent and fully accountable manner.

Values

The values held by the Institute for Clinical Excellence will underpin the way in which we conduct our work to achieve our goals. These values are listed below together with the behaviours they will engender:

Respect
Through a continuing focus on the patient
Through collaborative team work

Innovation
Through producing new ideas and change for the better

Courage
Through challenging the existing system

Teamwork
Through working collaboratively
Through building clinical teams
Through communicating with stakeholders

Professionalism
Through being skilled in all we do
Through being self starters

Equity of Outcomes
Through working to reduce inequalities
Through working to reduce outcome disparities

Scientific Method
Through using measurement and evaluation
Through decisions based on evidence and reporting

Goals and Objectives

The mission and values of the Institute form the core around which all that we do will occur. They guide the process of setting goals and objectives. What we do to achieve them will be governed by the application of the principles outlined above.

High Priority Clinical Issues

The Institute will undertake, in collaboration with area health services and others, strategies to achieve improvement, with an emphasis on sustainability and system wide dissemination.

Objectives

- To develop and implement projects in high priority clinical areas using the *Breakthrough Collaborative* model.
  The key areas are:
  - Inappropriate use of Red Blood Cells
  - Pressure ulcers
  - Health care acquired infections
  - Postoperative complications and deaths
  - Adverse drug events
  - Acute care of stroke and coronary syndromes
  - Falls
- To develop and implement a comprehensive patient safety program.
- To develop strategies for ensuring superseded practices cease permanently when new best practice is introduced.
- To develop strategies for highly visible transfer of knowledge, systems and skills from one unit or organisation to others.

Education and Training Programs

The Institute will develop, provide and promote education and training programs that will equip clinicians and managers with the requisite knowledge and skills in patient safety and quality.

Objectives

- Develop a comprehensive education and training program for the education of health care workers in principles and practices of patient safety and quality by a combination of interactive courses and supervised "hands on" practical projects.
  - Develop and maintain a web site to support the education and training program.
  - Develop a newsletter to disseminate information about best practice in health care on a state wide basis.

Research

The Institute will identify priorities for and promote the conduct of research about better practices in the context of patient safety and quality of health care.

Objectives

- Initiate and fund targeted research that will have a direct influence on the activities of the Institute.
- Give practical effect to the results of research through the activities of the Institute.

Relationships

The Institute will develop sound working relationships with all bodies and groups with whom we work.

Objectives

- To consult broadly with health professionals with an emphasis on engaging clinicians in patient safety and quality.
- To develop close links with individuals, groups and bodies representing views of the patient.
- To work collaboratively with public health organisations and the Department of Health.
- To develop close links with educational bodies and professional colleges and bodies.

Institute
for Clinical
Excellence

PROJECTS

Towards a Safer Culture - TASC Project

Key Team Members:

- Dr Ian O'Rourke
  CEO, ICE
- Assoc Prof Drew Fitzpatrick
  TASC Clinical Director
- Prof Chris Levi
  Clinical Leader - Stroke
- Ms Cate Ferry
  TASC Program Manager
- Mr Paul Long
  Royal Australasian College of Physicians
- Ms Celia Mahoney
  Administrative Officer

Project Aim:

The Toward A Safer Culture (TASC) project is a joint initiative of the NSW Institute for Clinical Excellence (ICE) and the Royal Australasian College of Physicians (RACP).

TASC is a project that seeks to improve the acute management of patients who present with chest pain or stroke. Its aim is to ensure that all patients with these two conditions receive the best emergency treatment and secondary prevention that is both evidence based and expeditiously provided.

In a clinical sense the TASC aims to achieve the following:

- Patients will be assessed, diagnosed and treated according to the best available evidence;
- Standardised care for Acute Coronary Syndrome (ACS) and stroke patients in the emergency departments of participating hospitals;
- There will be better functional outcomes after stroke;
- Dangerous discharges will be avoided; and
- Inappropriate admissions will be avoided reducing demand on emergency beds in hospitals.

In Phase One (Nov 2000 to Nov 2002), four hospitals participated: John Hunter and Nepean, in NSW, Townsville, in Queensland, and Frankston, in Victoria. In Phase Two (February 2003 - present), 30 hospitals in 12 Area Health Services in NSW are participating.

The project is co-ordinated by a steering group and supported by local multidisciplinary teams. Each multidisciplinary team includes senior administrators, medical, nursing and allied health staff representing the emergency department, general medicine, cardiology, neurology, and consumers from local support groups.

Local teams seek guidance from the ACS and Stroke Expert Working Parties on clinical issues such as risk stratification, application of clinical guidelines to pathway design and minimum data set indicators.

Methodology:

TASC is implementing a model that integrates the methodologies of Clinical Practice Improvement (CPI) and Evidence Based Medicine (EBM) to enable clinicians to embed best practice routinely in clinical care. TASC is about implementing evidence which already exists and already demonstrates benefits for patients.

The key tools used to transfer methodology to participating hospitals are evidence-based clinical pathways and a measurement system to promote clinical practice improvement.

The focus for change within TASC resides in the local multidisciplinary teams. A key strategy is to support team building and empower clinicians to adopt leadership roles in initiating practice improvement within their own work culture.

A strong emphasis of the project has been to support clinician leadership by providing training and education in CPI, EBM, leadership, data analysis and information technology systems.

The effective involvement of consumers in healthcare has been challenging. TASC has provided an opportunity for health professionals and consumers

to explore how the role of consumers in health might be developed. It revealed how the perspective of former patients can be useful for planning systems of care. Their participation helped to identify effective methods to involve consumers, their families and carers in decision-making about their care.

Key Achievements:

There are 30 participating hospitals across 12 Area Health Services.

Clinical pathways for ACS and stroke have been developed and are in use in the participating hospitals. The pathways replace the handwritten medical record notes, improve documentation of clinical findings and enable risk stratification to guide subsequent management.

There has been a 50 per cent reduction in patients with a diagnosis of stroke/transient ischaemic attack receiving inappropriate food or fluids prior to speech pathology review in the emergency department at a metropolitan hospital within three months following the implementation of the clinical pathways.

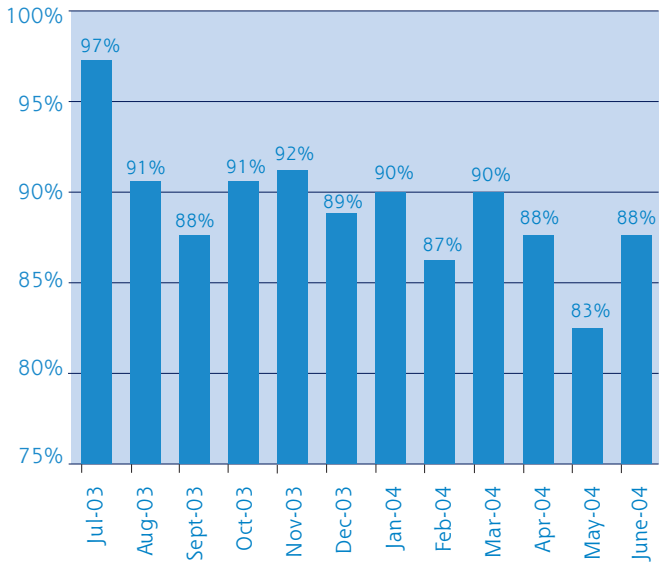
Timely radiological investigation of high-risk stroke patients has enabled early identification and transfer of a number of patients from a rural hospital to a metropolitan hospital with intracranial haemorrhage for surgical intervention. Agreement among clinicians for early computed tomography scanning was facilitated through the use of the risk stratification incorporated into the clinical pathway.

There has been an increase in the capacity to provide exercise stress testing service within six of the nine Area Health Services focusing on the acute coronary syndrome presentations.

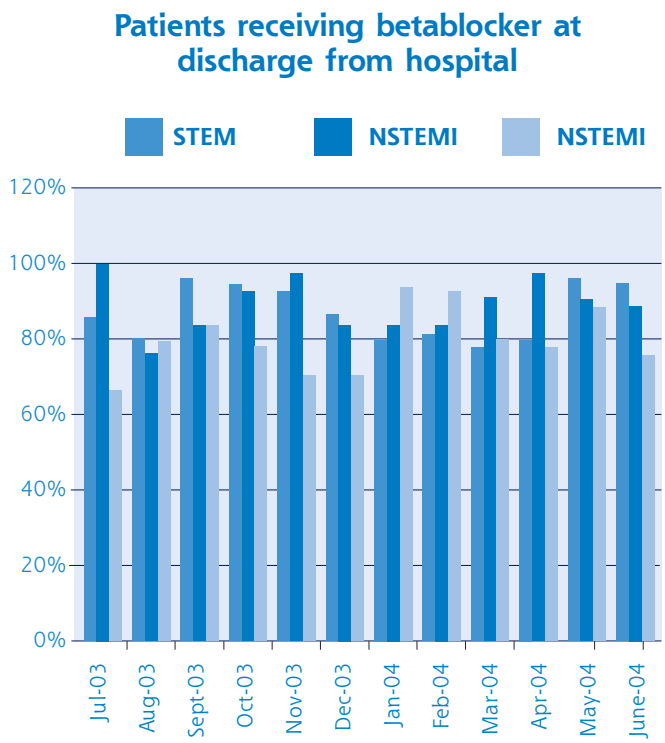
In one rural Area Health Service an additional five smaller hospitals are now participating in TASC in 2004, bringing the total to seven hospitals.

A number of hospitals have found that pathway adaptation has identified the opportunity to reallocate resources. This has led to the creation of liaison nursing positions, provision of additional after-hours medical registrars, the availability of weekend exercise stress tests for ACS patients and after-hours CT scanning for stroke patients.

Patients receiving Aspirin at discharge from hospital



This table indicates the monthly percentage of patients with a diagnosis of ST Elevation Myocardial Infarction (STEMI), non - STEMI and unstable angina that were given aspirin on discharge from participating TASC hospitals from July 2003 to June 2004.



TASC Lessons Learnt Workshops were conducted in August and September 2003 and another is due in July 2004. The workshops provided the opportunity for clinicians to:

- learn from external professionals and participating teams;
- communicate ideas and acquire successful strategies to implement in their hospital; and
- reinforce the integral role of clinicians in promoting the use of data to drive change and clinical practice improvement .

100 per cent of participants found the workshops valuable.

Ian Nicholas, TASC Project Officer for Hunter Area Health Service at the July 2004 Lessons Learnt workshop explaining the progress of the clinical practice improvement activity which is focusing on increasing the capacity to provide exercise stress testing.

Development of the TASC Online System

The demand for timely and accurate clinical information within the public health system to support improved health outcomes is increasingly being recognised. The TASC Online System was developed by the Information Management Directorate of the Enterprise Information Technology Branch in 2003.

The TASC Online System is being used to simplify the process of recording clinical information, record data pertaining to patient care, monitor variances and provide feedback to clinicians on their compliance with clinical pathway documentation.

Benefits and key features of the centralised database and reporting system include:

- Linkage between NSW Department of Health administrative and clinical data
- Reports allow comparisons at different levels between State, AHS and hospitals and benchmarking against participating hospitals
- Review of data to identify specific areas for clinical practice improvement

A Steering Group was established in June 2004 to progress the extension of the TASC Online system. Representatives from the NSW Department of Health,

Area Health Services, Greater Metropolitan Clinical Taskforce, Royal Australasian College of Physicians and ICE are scheduled to meet for the first time in July 2004.

The group has resolved to prepare a project plan to scope the future capacity of the TASC Online system within NSW Health. This plan once complete will make recommendations to NSW Health, the ICE and Greater Metropolitan Clinical Taskforce regarding the broader state-wide implementation of the TASC Online system.

A seeding grant of $1,000 has been allocated to four Area Health Services to help with the establishment of a consumer support group. There are consumer representatives on the local ACS and stroke teams in the majority of hospitals participating in the TASC project.

A survey of 445 TASC clinicians prior to the implementation of the clinical pathways showed very strong support for the multidisciplinary approach, with most respondents strongly agreeing with the following statements:

- Multidisciplinary based care is an effective process for care delivery (94 per cent)
- Team-based care plays an important role in my current clinical activities (91 per cent)
- The use of clinical guidelines improves the quality of health care for patients (88 per cent).

Site visits were conducted by members of the State TASC Steering Committee to the participating organisations between mid June - August 2003 and February - June 2004.

The visits provide an opportunity to:

- Meet with the clinicians who are involved in the implementation of TASC
- To review the utilisation of the TASC Online System and the use of the local data
- Highlight successes, opportunities and progress of implementation
- Facilitate clinical leadership of clinical practice improvement
- Discuss sustainability

Anticipated Outcomes:

- ACS and stroke patients will be assessed, diagnosed and treated according to the best available evidence;
- Reduction in adverse incidents; and
- A continuous quality improvement model that's not for just one hospital or condition.

National Medication Safety Breakthrough Collaborative

Key Team Members:

- Dr Jenny Bartlett
  Project Director, Chief Clinical Advisor, Department of Human Services Victoria
- Mr Lee Martin
  Collaborative Director
- Ms Mary Mitchelhill
  Collaborative Co-ordinator NSW
- Ms Kim Moyes
  Collaborative Co-ordinator Queensland
- Ms Fiona Dickson
  Collaborative Co-ordinator Victoria
- Ms Ruth Smith
  Collaborative Co-ordinator Victoria
- Mr Julian Murphy
  Communications Co-ordinator
- Ms Kath Jury
  Events Co-ordinator
- Ms Anna Toscano
  Operational Logistics Co-ordinator
- 10 Steering Committee members
- 31 Planning Group members
- 100 Participating health service teams across Australia

Project Aims

The National Medication Safety Breakthrough Collaborative (NMSBC) is an innovative program aimed at improving medication systems for patients accessing a wide variety of Australia's health services.

NMSBC aims to achieve a national improvement in medication safety by reducing patient harm, associated with medication use by 50 per cent among clients of participating health care teams from throughout Australia and developing a national network and system to sustain and transfer the improvements in medication safety to other health services across Australia following the completion of the collaborative.

The NMSBC is an initiative of the Australian Council for Safety and Quality in Health Care (ACS&QHC). Making medications systems safer is a strategic goal for ACS&QHC and the NMSBC was established to develop and drive improvements in medication safety for patients across Australia.

The NMSBC aims will be achieved through:

- Teamwork
- Sharing
- Improvement
- Communication
- Implementation
- Plan, Do, Study, Act

Governance

The following diagram outlines the governance, management and delegation structure.

Key achievements:

The NMSBC has had a range of key achievements. The collaborative began in September 2003 with 47 participating teams in wave one. A second wave of 53 participating teams commenced in February 2004 resulting in 100 project teams participating nationwide.

To increase expertise in clinical care, academia, risk management and quality improvement processes among healthcare professionals; Health Care Experts Workshops were held in July 2003 for wave one and in January 2004 for wave two. The major focus of the workshops was further development of the change packages.

A Front Line Staff workshop was held in June 2003 with staff such as bedside nurses, ward pharmacists and junior medical staff identifying the specific areas of concern from their perspectives.

To date two consumer panels have been held to identify the issues in medication safety, which particularly pertain to engaging patients and consumers, as well as issues of specific concern for those groups.

Key Achievements Wave One:

- State Information Sessions were held in Melbourne, Sydney and Brisbane, with the aim of achieving the following objectives;
  - To raise awareness and understanding of the NMSBC methodology.
  - To facilitate a forum for questions and clarification prior to the submission of applications.
- One-day orientation session for participating teams, held in Melbourne with 250 delegates.
- Learning session one, a day meeting with 275 delegates from project teams.
- Learning session two, a day meeting with 250 delegates from project teams.
- Learning session three, a day meeting with 208 delegates

Wave 2

- State Information Sessions were conducted in Melbourne, Sydney and Brisbane.
  - Video linkage was available and copies of the video were sent to 96 additional organisations.
- One-day state based orientation sessions for wave two teams totalling 220 delegates across NSW, Victoria, Western Australia and Queensland.
- Learning session one, a two-day meeting with 240 delegates from project teams.
- Learning session two, a two-day meeting with 235 delegates.

Across Collaborative

- Site visits and teleconference calls with the health service teams, Planning Group members and the state based collaborative co-ordinators, to discuss progress, ask questions and resolve any problems or issues. Teams reporting monthly via the NMSBC website.
- Enhancement of the NMSBC website to include more detailed data entry.
- Hosted a total of four topic specific teleconference calls chaired by experts in each field with 25 hospital project teams participating.
- Development of consolidated change package CD-Rom containing wave one and wave two change packages, communication tools and additional tools developed by the NMSBC teams.
- Establishment of a range of communication tools to enhance, gain acceptance and support the NMSBC program. The strategy enhances communication channels that have been developed with health teams across Australia.
- Development of consumer tools, which included
  - Flash cards,
  - Key rings and
  - Question cards.

- NMSBC Newsletter Produced in May 2004 and included articles on teams "good news" stories, hot topic calls and information on the National Medication Chart, website improvements, forthcoming learning sessions and profiles of Planning group Members.

Anticipated outcome:

- Decrease medication related harm by 50 per cent nationally on completion of the collaborative.
- Increase the health service networks across Australia to maintain the sharing of improvement strategies.
- Increase reporting for potential and actual medication related harm.
- Spreading the learning from the National Medication Safety Breakthrough Collaborative.
- Introduce improvement strategies and tools across Australia that will improve medication safety.
- Produce and distribute a formal record of the collaborative.
- Produce and distribute a best practice guide and handbook of the collaborative.

Children's Emergency Care Project

Key Team Members

Dr Michael Hession
Lead Clinician

Ms Marilyn Cruickshank
Project Manager

Project Aim:

The NSW Health System provides an excellent standard of healthcare for children and is a world leader in many aspects of paediatric care. However, we can improve the safety and quality of healthcare for children by decreasing the incidence of preventable adverse events. Implementation of evidence-based guidelines is one method of preventing adverse events by improving standards of clinical practice.

Working Groups established through the Paediatric Networks have developed a number of Clinical Practice Guidelines for the acute care of children including management of infants and children with fever, bronchiolitis, asthma, sore ear, meningitis, head injury, sore throat, seizures and abdominal pain.

The Children's Emergency Care Project is an articulated three-stage project for implementation of the Guidelines in NSW emergency departments and Multi-purpose services. The project is in the first year of implementation in which Pilot Sites have been recruited to develop practical implementation tools and strategies that facilitate compliance with the guidelines.

Methodology

The project will encourage further development of a "community of practice" in children's emergency care through strategies to encourage communication and collaboration across disciplines. While the initial phase of the project will focus on implementation of the Guidelines it is anticipated that information gained during the project about paediatric service provision will be utilised in planning services in the future.

A Steering Committee has been convened to oversee the project with representatives from ICE, NSW Health, Emergency Department Clinical Implementation Group (EDCIG), Association for the Welfare of Children in Hospital, Statewide Paediatric Services Advisory Committee and Rural Doctors Network. The project management team consists of a project manager, an emergency department physician providing clinical leadership and project support from the ICE team.

Key Achievements for the year

The project commenced in March 2004. In response to the excellent uptake by emergency departments, 50 hospitals were recruited as Pilot Sites. This represents one-third of Emergency Departments in NSW. Almost two-thirds of the pilot sites are from rural and regional areas. Phase One of the project involves the implementation of four of the Clinical Practice Guidelines. Five regional orientation meetings were held to initiate the project. The orientation sessions addressed approaches to auditing medical records, project planning, toolkit development, change management strategies, implementation of guidelines and reporting processes. The pilot teams were encouraged to begin their project planning in relation to implementing the guidelines. Retrospective medical record audits were completed by each of the pilot site teams.

Ongoing teleconferences were organised for Pilot Sites to report their progress and to establish communication with the Project Management Team. Site visits by the Project Management Team are undertaken to support the pilot site teams in the implementation of the guidelines. This will be supplemented by two workshops at which the sites will report on their experiences with implementing the four guidelines to date.

A major part of the project is the development of practical tools to facilitate implementation of the guidelines. The formation of a listserve for the

project has been instrumental in the dispersal of flowcharts and algorithms between the pilot site teams.

The Toolkit Development Group, facilitated by the Project Management Team will synthesise a draft Toolkit which will include change strategies, tools and checklists sourced from the literature, existing handbooks, best practice sites and through consultation with the Steering Committee and interested Emergency Departments Physicians. Information in the guidelines will be synthesised into these change strategy tools.

Anticipated Final Outcome

At the time of the report the Children's Emergency Care Program is in the initial stage of phase one. The second phase will involve the implementation of the remaining Clinical Practice Guidelines and the development of practical tools to facilitate their implementation. During year two of the project an Education and Implementation Package will be developed by the Project Management Team. This package is likely to include the Final Toolkits developed during the piloting, a multidisciplinary education program with a dedicated Junior Medical Officer component. It will be in a variety of formats such as video case studies, laminated checklists, posters and a CD Rom will be developed in addition to the other education and implementation toolkit items.

After completion of the Toolkit there will be a road show to all Area Health Services to showcase the Education Package, implementation tools and strategies. Clinical leads from successful pilot sites will also be asked to present their work during the road shows and provide expert opinion and guidance to local participants. Participants at these sessions should include those staff who would be critical to, or have an interest in, implementation of the guidelines at the facility, hospital or emergency department level. This might include Directors of Emergency Departments, Emergency Department Nurse Unit Managers, Triage Nurses, Head of Division of Medicine, Paediatricians and Health Service Managers.

Participants in the road shows will be provided with copies of the guidelines and the education and implementation Package. They will also have the opportunity to workshop and develop an action plan for implementation of the guidelines in their local facility.

NSW Chronic Care Collaborative

Key Team Members:

- Prof Ron Penny
  Collaborative Co-Chair, Senior Clinical Advisor and Chair Chronic Care Program NSW Health
- Assoc Prof Trish Davidson
  Collaborative Co-Chair; Western Sydney AHS and University of Western Sydney
- Dr Simon Willcock
  Collaborative Co-Chair; School of Medicine, University of Sydney
- Dr Ian O'Rourke
  CEO, ICE
- Ms Catherine Katz
  Director, Inter-Government and Funding Strategies Branch, NSW Health
- Ms Kym Scanlon
  Associate Director, Chronic Care Unit, NSW Health
- Dr Rohan Hammett
  Director of Healthcare Improvement Projects, ICE
- Ms Dianne Kelleher
  Collaborative Director (to June 2004)
- Ms Lorraine McEvilly
  Collaborative Director (from June 2004)
- Ms Melanie McKinnon
  Collaborative Coordinator
- Ms Barbara Lay
  Project Officer
- 30 planning group members

Teams

Area Health Service	Area/Sector	Disease focus
Central Coast Area Health Service	Area-wide	COPD
Justice Health Service	Area-wide	COPD
Central Sydney Area Health Service	Area-wide	COPD
Far West Area Health Service	Broken Hill Health Service	Both
Greater Murray Area Health Service	Griffith	HF
Hunter Area Health Service	Area-wide	Both
Illawarra Area Health Service	Northern Illawarra	Both
Illawarra Area Health Service	Shoalhaven	Both
Macquarie Area Health Service	Area-wide	COPD
Mid North Coast Area Health Service	Area-wide	Both
Mid Western Area Health Service	Parkes, Peak Hill, Forbes, Condobolin and Orange	Both
New England Area Health Service	Bingara	COPD
New England Area Health Service	Gunnedah	HF
Northern Rivers Area Health Service	Lismore Base Hospital	Both
Northern Sydney Area Health Service	Lower North Shore	Both
Southern Area Health Service	Eurobodalla Division	Both
Southern Area Health Service	Southern Slopes Division	Both
South Eastern Sydney Area Health Service	St George	COPD
South Eastern Sydney Area Health Service	St George	HF
South Western Sydney Area Health Service	Macarthur	HF
Wentworth Area Health Service	Area-wide	Both
Western Sydney Area Health Service	Area-wide	HF

Background:

NSW Chronic Care Collaborative is a joint initiative of the Institute for Clinical Excellence and NSW Health.

The Collaborative draws on the successes of the NSW Chronic Care Program which seeks to:

- Improve the quality of life for people with chronic illness
- Improve the quality of life of their carers and families
- Decrease avoidable and unplanned admissions to hospital.

There are 22 teams participating in the Collaborative, representing each Area Health Service from across NSW excluding the Children's Hospital at Westmead. Teams are made up of a mix of clinical and management staff from hospital and community health services, including a GP representative, consumer and carer representatives and an Executive Sponsor. The Director General NSW Health Robyn Kruk, is the overall Executive Sponsor for the Collaborative.

Project Aim:

The Collaborative focuses on improving the care and outcomes of patients with Heart Failure (HF) and/or Chronic Obstructive Pulmonary Disease (COPD).

Improvements are made through increasing the number of people who have had a clearly defined set of diagnostic and management interventions, which are based on the Clinical Service Framework standards for HF and COPD. An optional aim focuses on increasing the number of people with HF and/or COPD with whom advance care directives are discussed. Teams have elected to focus on HF only, COPD only or both conditions.

Methodology:

The Collaborative uses adapted Breakthrough Series Collaborative methodology and is the third Collaborative to have been run by ICE.

The Collaborative Management Team supports the teams over the course of the Collaborative via site visits, teleconferences, the Collaborative listserve and website. This ensures the support of metropolitan, rural and regional teams alike. Ten members from each AHS team are funded to participate in five Collaborative events (an Orientation Session and four Learning Sessions) where they report on and share interventions tested, successes and barriers.

Between the Orientation Session and Learning Session One teams carry out preliminary diagnostic work and following each Learning Session there is an action period where teams undertake a series of Plan Do Study Act cycles to test change and measure the results. Teams report their progress against changes tested on a monthly basis to the Collaborative Management Team.

Key Achievements:

Teams from Area Health Services across NSW have worked collaboratively since February 2004 to improve the care and outcomes of patients with COPD and HF.

An Orientation Session and three Learning Sessions have been held, providing over 200 participants at each event with the opportunity to network and share information and resources regarding the best practice of patients with COPD and HF. In addition, through the Learning Sessions participants have been equipped with the skills required to implement and sustain improvements in clinical practice.

Specific achievements to date include:

- Engagement of Area Health Service Executives and Clinical Leaders through site visits - Nov to Feb 2004
- Diagnostic work carried out by teams, including consumer focus groups - Feb to April 2004
- Site visits and process mapping sessions to facilitate diagnostic work with each team - Feb to April 2004

- Support to teams during Action Periods One and Two (April to August 2004) through site visits, topic specific teleconferences and team teleconferences
- All teams are trialing interventions, measuring and reporting progress
- June 2004 - Improvements demonstrated for each component of the diagnostic and management bundles
- June 2004 - 81per cent of teams demonstrating improvements from baseline
- Improvements demonstrated in both COPD and HF, by both rural and metropolitan teams
- Between Learning Session One and Learning Session Two feedback from participants indicated increased levels of confidence in both individual and a team's ability to plan and implement clinical practice improvement
- Targeted funding provided by NSW Health to facilitate:
  - Area Health Service participation - funding for travel and accommodation for 10 participants per rural AHS
  - GP involvement - $6,000 provided to each AHS to facilitate GP involvement
  - Uptake of spirometry -
    - $15,000 provided to each AHS for purchase of spirometers; and
    - Spirometry training held for 36 participants prior to Learning Session Three
  - Uptake of self-management -
    - Training sessions in the Flinders self-management model held prior to Learning Sessions Two and Three; over 80 participants trained.

Evaluation:

A formal evaluation of the Collaborative will be completed by March 2005. The evaluation will focus on:

- Collaborative teams' success in achieving Collaborative aims
- The role of the Collaborative in improving participants' ability to plan, implement and achieve health care improvement
- Impact of the Collaborative on communication and co-operation between services within an Area Health Service
- Impact of the Collaborative on patient outcomes across the NSW Health System

In addition, the evaluation will identify the most successful interventions and key factors contributing to team success.

Anticipated Outcomes:

Increase in the proportion of patients with COPD and HF receiving evidence-based diagnosis and management, leading to improvements in patient care and outcomes.

The NSW Chronic Care Program will facilitate the sustainability of improvements made within the Collaborative.

It is anticipated these improvements will ultimately reduce hospital admissions and readmissions for people with these chronic conditions. It is also anticipated that the processes established for enhanced management of people with heart failure and COPD will be transferable for managing other chronic conditions, also impacting on hospital admissions and readmissions.

Safety Improvement Program

Key Team Members:

- Dr Ian O'Rourke
  CEO, ICE
- Ms Maureen Robinson
  Director, Quality & Safety Branch, NSW Health
- Dr Paul Douglas
  Program Director, Safety Improvement Program (SIP), Director Population Health and Service Improvement, Hunter Area Health Service
- Ms Sarah Michael
  SIP Program Manager, Senior Analyst, Quality and Clinical Policy Branch, NSW Health
- Ms Annika Sander
  SIP Project Officer
- Prof Tim Cartmill
  SIP Faculty Member
- Dr Tom Hugh
  SIP Faculty Member
- Assoc Prof John Overton
  SIP Faculty Member
- Ms Jan Stow
  SIP Faculty Member

Project Aim:

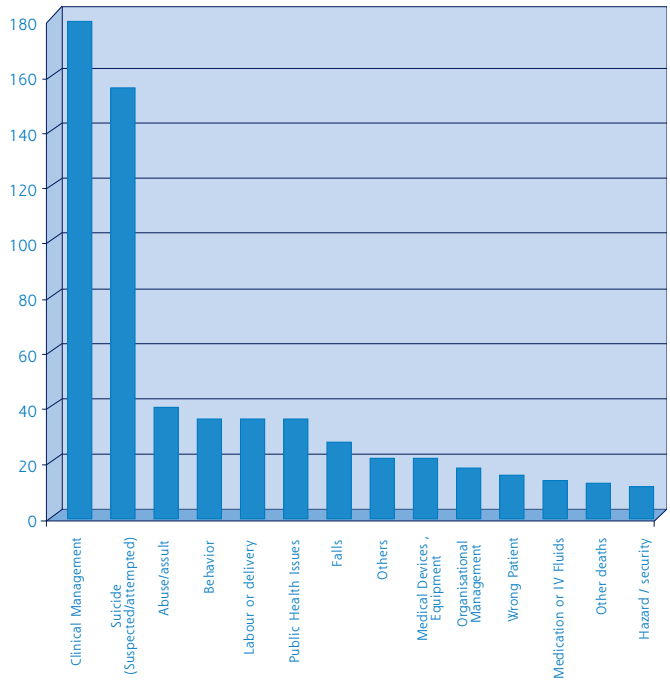
The Safety Improvement Program was developed to introduce a standardised system-wide approach to improving the safety of health care provided in NSW. The Safety Improvement Program has been progressively implemented in all Area Health Services in NSW over the past 18 months. One of the fundamental objectives of the program is to reduce harm to patients through the identification and rectification of system vulnerabilities. The program focuses on the management of all incidents and involves identifying, reporting, monitoring, investigating, analysing and acting appropriately on incidents that occur in the health system. All of these components are integral to improving the safety and quality of care. With exposure to over 2,500 people, outcomes from the incidents reported and Root Cause Analyses received, there is early evidence that significant system improvements are already occurring in NSW.

Key Achievements:

- Training for 20 health services completed on schedule
- In 2003, all Area Health Services were provided with resources, education and training and practical examples on how to undertake detailed investigation or Root Cause Analysis (RCA) of serious incidents. Specifically, the program included:
  - How to identify incidents
  - How to use the severity assessment code to apply a risk rating to incidents
  - How to use the RCA method for investigation of major incidents
  - How to develop appropriate actions and recommendations and feed back to the system
- Over 2000 people attended the two-and-a-half day program
- Over 1000 people attended information seminars on the program
  - Attendees included Board members, Area CEOs and Executives, senior managers and clinicians, and consumers
- In mid 2003, the DOH introduced the Reportable Incident Brief (RIB) process and endorsed the use of the Severity Assessment Code (SAC) to improve incident management at the State level
  - The RIB is a means of notification and management of serious adverse events at a State level
  - The SAC is a method by which an employee or manager can stratify the risk associated with an incident so as to determine who needs to know about it and what further definitive action is required, based on the severity or consequence of the incident and the probability or likelihood of recurrence.

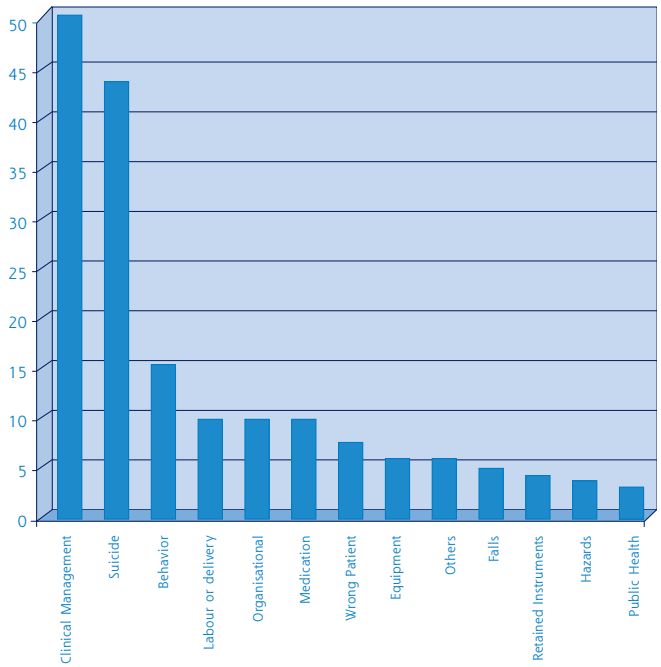
- The following outlines the key steps in incident management:
  - An incident is identified and reported to a manager
  - The incident is prioritised using the SAC
  - All incidents rating a SAC of 1 or 2 are reported to the Area CEO
  - If the incident is given a SAC of 1, it must be reported to the NSW Department of Health within 24-hours and an RCA of the incident commenced within five days
  - If the incident is rated at either 2, 3 or 4 on the SAC matrix but it is likely to attract external attention, it must also be reported to the NSW Department of Health;
  - Other incidents may be reported to the NSW Department of Health at the discretion of the CEO
  - A report of the results of the RCA must be forwarded to the NSW Department of Health within 50 days of the incident occurring
  - Analysis of all incidents and identification of opportunities for improvement are undertaken at the unit, facility, area and State levels
  - These reports and recommendations are analysed and managed at the State level for possible policy development and fed back to the system as lessons learned so as to avoid similar incidents occurring in other Area Health Services
- The nature of reporting is changing
  - In 2000, prior to the Safety Improvement Project (SIP), 5per cent of reportable incidents received in the Department related to clinical management - excluding suicides.
  - In 2004, 35per cent of reportable incidents, excluding suicides, are related to clinical management.
  - Of the RIB's received 37per cent are SAC 1 incidents and over 40per cent have had RCA's completed.
  - The graph below outlines the classification of SAC 1 incidents received since May 2003.

Classification SAC 1 RIB's since May 2003



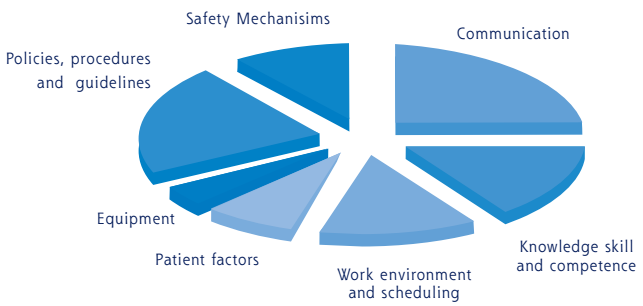
- Over 250 Root Cause Analysis reports have been received. Graph 2 outlines the classification of incidents from which RCA's have been received.

Classification of RCA's received



- Following receipt of the RCA's, a manual analysis has been undertaken to identify the major causal and contributing factors. These are described in Graph 3.

Causal factors, RCA's received total



- Analysis of the RIB's and the RCA's has identified a number of system wide improvements that have occurred at the state level.
- These have involved the development of new and revised policies and procedures, alerts to the system, publication of safety advocates on specific issues, liaison with manufacturers regarding equipment design and draft development of state-wide reporting mechanisms back to the system. Specifically, these have included:
  - Safety advocates on medication and IV safety including Potassium Chloride alerts, bed rail safety, breast feeding, falls prevention and infusion pumps
  - Advice on various types of equipment including self inflating resuscitation bags, staple guns and retained instruments
  - Discussion with manufacturers regarding rapid infusers and visceral retractors
  - Policy development on accountable items and correct site, correct side and correct patient surgery.
- Follow-up visits to 80 per cent of the AHS have been undertaken to assess the overall uptake of the program, the issues identified and how AHSs are progressing in moving forwards. The feedback/evaluation has highlighted the following strengths and weaknesses:
  - All areas are very pleased with how the system is working
  - The program is seen as one of the most important steps for change management and cultural change introduced to the AHS
  - The program has generally added value to the AHS by identifying system vulnerabilities
  - Many compliments have been made about the training
  - Generally, the executive of the AHS's believe that they are hearing about many more significant adverse events than they were previously

- A high proportion of incidents result in changes in policy and procedures and more education and training rather than other corrective actions.

Key Issues:

- It is recognised that the system in not currently capturing all incidents, including SAC 1s, and mechanisms are being put in place to address this.
- There is a gap between recommendations and the implementation of actions and this is being addressed by the Areas.
- The process is seen as resource intensive (time taken to do RCA's) however, it is recognised as being a beneficial exercise.
- TRUST in the system is seen as the key factor for ongoing success and sustainability

The Future:

Over the coming five years the NSW Government will invest $55 million in the NSW Safety and Clinical Quality Program. The Program will build on the sound platform established by the SIP. The key objective is to rebuild confidence and trust in the health system so that patients continue to receive the highest quality of care knowing that appropriate structures are in place to monitor and manage safety and quality issues as they arise.

Patient Flow and Safety Collaborative

Key Team Members:

- Professor Mary Chiarella
  Collaborative Co-Chair, Chief Nursing Officer NSW
- Dr Patrick Cregan
  Collaborative Co-Chair, Head of Division of Surgery Wentworth Area Health Service
- Dr Rohan Hammett
  Healthcare Improvement Projects Director
- Ms Louise Kershaw
  Collaborative Director
- Ms Lorraine McEvilly
  Collaborative Co-ordinator
- 19 planning group members

Participating hospitals

Albury	Lithgow	RPAH
Auburn	Liverpool	St George
Bathurst	Manning Base	Sutherland
Broken Hill	Moree	Sydney Hospital
Calvary	Narrabri	Tamworth
Campbelltown	Nepean	Tweed
Canterbury	Orange	Wagga Wagga
Coffs Harbour	Port Macquarie	Westmead
Concord	PoW	Wollongong
Dubbo	Queanbeyan	Wyong
Hornsby	RNSH	

Project Aim:

The Patient Flow and Safety Collaborative aimed to improve access to acute hospitals for patients throughout NSW and reduce the rates of significant adverse events through fostering a safety culture.

Specific Collaborative aims included:

- Decrease delays in access to Operating Theatres for Emergency Surgery cases;
- Reduce delays and blockages in the discharge process;
- Increase timeliness of diagnostic services (pathology, radiology, echocardiography etc);
- Decrease delays in access to specialist consultation; and
- Reduce the incidence of pressure ulcers and falls.

Methodology:

The Breakthrough Series Collaborative methodology was utilised to engage truly multidisciplinary teams from around NSW to tackle these issues. Breakthrough Collaborative is a method that:

- Has been tested around the world and is effective in achieving rapid and sustainable improvements in outcomes for patients;
- Relies on spread and adaptation of existing best practice to multiple sites in order to accomplish a common aim; and
- Engages multi-disciplinary teams and creates partnerships between managers and clinicians.

A Collaborative produces improvement by harnessing the collective wisdom of participants, an advisory panel of experts and a literature review, to develop strategies to aid implementation of evidence-based best practice.

ICE has adapted traditional Breakthrough Series Collaborative methodology initially developed by the Institute of Healthcare Improvement. These modifications included pre-collaborative site visits or videoconferences, extensive diagnostic work by the

teams, aim specific teleconferences with a guest expert, targeted sessions for project co-ordinators and executive sponsors, a special rural sites session, and, an extensive post-collaborative phase with strategies designed to help spread the lessons learned.

All teams were encouraged to analyse the processes that were currently operating in their own organisations by following patients as they made their journey through the hospital, mapping existing processes of care delivery, and utilising targeted data analysis to inform clinical teams about key blockages in their current systems. Teams were coached in change management methodology and supported as they developed, trialed and implemented their own solutions to local problems. Examples of best practice and learnings from teams who had successfully tackled specific issues were disseminated throughout NSW via quarterly meetings of all the collaborating teams, a dedicated website, teleconferences and regular listserve email postings.

Key Achievements for the year:

In total 36 teams from hospitals around NSW worked collaboratively over a 12-month period (March 2003 to March 2004) to improve processes of care for emergency and elective surgical patients and complex medical patients.

One Orientation Session and four Learning Sessions were held over the course of the Collaborative. Learning Sessions are the major integrative events of the Collaborative and attendance at each of the four Learning Sessions was in excess of 210 participants. At each Learning Session, teams reported on their activities, methods used and results achieved. This sharing provided a powerful social support and encouragement to make further changes.

They shared models of best practice and established new networks of information exchange across the State. Participants were trained in the skills of clinical practice improvement, change management, teamwork, leadership and process redesign. The engagement and capacity building that occurred within Area Health Services in developing a workforce capable of continuously improving their standards of care is difficult to overestimate.

Expert Panel	
Orientation Session	
Learning Session 1 with participation in the two-day meeting of 211 delegates from 36 teams and the Planning Group	June 2003
Site visits and 23 Process mapping workshops	May 2003-May 2004
Teams Teleconferences	June 2003
Topic specific Teleconferences with 41 teams participating	July 2003
Collaborative Planning Group Training Day	August 5 2003
Evaluation Workshop (UNSW, ICE Team)	August 8 2003
Rural Issues Workshop attended by over 70 participants from the nine rural AHS participating in the Collaborative	August 14 2003
Learning Session Two with participation from 220 participants	August 15 2003
Collaborative Planning Group Training Day	August 2003
Learning Session 3	November 7 2003
Quality and Culture Change within the Health System - Workshop with John Ovretvreit	February 6 and February 9 2004
Learning Session 4	March 5 2004
Improving Access Workshop	
Improving Patient Flow - Master Classes	May 5 and August 2 2004

Outcomes:

There have been tangible results in multiple sites and these include:

- reductions in time to rehabilitation beds;
- reduction in time to emergency surgery for patients with fractured hips;
- reduction in access block in the emergency departments;
- reduction in number of hospital initiated delays to elective surgery;
- improved weekend discharge rates;
- reduction in time to specialist consultation;
- improved times to access pathology and radiology results;
- one major regional hospital has seen such an improvement in flow that it went from having no available beds, to initially nine empty beds in winter and has now been able to reallocate the resources from a medical ward to a medical assessment unit to better meet patient's clinical needs; and
- most participating hospitals have seen a significant reduction in pressure ulcers and patient falls.

Results demonstrate that 90 per cent of teams achieved at least modest improvement in process measures (e.g. completion of Estimated Day of Discharge; increased completion of risk screens completed), 63 per cent achieved sustained improvement in outcome measures (e.g. reduced time to Operating Theatre for patients with fractured neck of femur; increased weekend discharge rates) and developed plans for spread and 16 per cent demonstrated sustained improvement for 3 months or longer.

All of the teams that worked to improve patient safety implemented significant changes to existing clinical practice. Of the total 100 per cent - 78 per cent of teams achieved significant improvement in process measures (such as improving the proportion of patients receiving risk screening for pressure ulcers and falls on admission to hospital) and 63 per cent achieved significant improvement in measures that were directly related to outcomes for patient care (such as the number of pressure ulcers or falls occurring in a particular hospital).

Eight teams implemented changes to reduce the rate of falls among patients. The average reduction in falls across eight sites was 56 per cent. Six out of the eight sites achieved sustained reduction in falls by implementation of a raft of safety initiatives.

The University of NSW has undertaken a preliminary external evaluation of the effects of the Collaborative. This analysis compared data from NSW hospitals that participated in the Collaborative with hospitals in NSW that did not participate in the Collaborative. Evaluation of waiting list data showed a significant decrease in the number of hospital initiated waiting list delays in those hospitals participating in the Collaborative who were focusing on surgical aims ($p=0.021$). That means fewer patients being inconvenienced by last minute delays to their elective surgery. Similarly, hospitals that participated had statistically significant improvements in their four hour and eight hour access times through their emergency departments compared to hospitals that did not participate.

In a survey of Collaborative participants (120 respondents) 91 per cent were confident that patients had benefited from changes made in the Collaborative. All participants found the Collaborative experience of value. As a tool for facilitating change - 70 per cent of participants cited that the Collaborative improved communication and 75 per cent of participants cited that the Collaborative had increased their ability to facilitate change within their workplace. As a tool for sustaining improvements in access and safety - 88 per cent of participants cited that they intended to continue their work on flow and safety. 97 per cent of respondents thought that the Collaborative increased their knowledge on how to improve patient safety. In all, 65 per cent of respondents said the Collaborative increased work satisfaction.

Teams were requested to submit reports monthly and a summary report at the completion of the program. The final team reports detailing individual team results and key interventions were collated and sent to AHS CEOs and participating Hospital General Managers. Approximately 100 further copies were emailed or posted out to hospitals on request. A promotional brochure showcasing some of the great results from the Collaborative was distributed to over 500 clinicians, managers and policy makers.

Anticipated Final Outcome:

There is strong evidence that most hospitals are continuing the work commenced during the Collaborative. Illawarra Area Health Service conducted a one-day workshop on reducing pressure ulcers and falls on June 29, 2004. South Eastern Sydney Area Health Service has established a network of teams in all its hospitals who are working on projects to improve aspects of patient flow with strong support from the area quality unit.

A practical Toolkit for use in public hospitals "Improving Patient Access to Acute Care Services" that incorporates key strategies and lessons learned from the Collaborative is nearing completion. It will cover all aspects of managing patient flow and be designed for use by clinical teams, hospital clinical and executive management. It will include step-by-step instructions to assist hospitals to diagnose problems inhibiting efficient patient flow and an implementation strategy for key interventions to improve flow. High impact strategies that assist hospital sites to achieve targets set by NSW Health will be included in the Flow Tool Kit.

The first Improving Patient Flow Master Class was held in May 2004 and was enthusiastically received. A second Master Class is being held in August 2004 and was booked out within one week of its announcement. These Master Classes aim to provide staff who are implementing changes to improve access to services with the skills and knowledge required for redesigning processes in their hospitals.

It is hoped that the lessons learnt by those hospitals that participated in the Patient Flow and Safety Collaborative can be passed on to the rest of the NSW Health system. ICE aims to make information available to the health system about what has already been shown to work to improve patient flow and safety.

Institute
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SPECIAL COMMITTEES

Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)

Special Committee Investigating Deaths Associated with Surgery (SCIDAWS)

Chairmen

Dr Chris Borton
Special Committee Investigating Deaths Under Anaesthetic

Professor Cliff Hughes
Special Committee Investigating Deaths Associated with Surgery

Background:

The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) and the Special Committee Investigating Deaths Associated with Surgery (SCIDAWS) were established to review deaths associated with anaesthetic and surgical practice respectively, and to make recommendations to the Minister for Health on the prevention of morbidity and mortality associated with anaesthesia and surgery in NSW. The Special Committee Investigating Deaths Under Anaesthesia was established in 1960 and the Special Committee Investigating Deaths Associated with Surgery was established in 1994. The committees are established under the Health Administration Act 1982 and have qualified privilege.

Current Situation:

In 2002 the Department of Health commissioned a project to develop an effective model to review morbidity and mortality in NSW in relation to anaesthesia and surgery, and to identify the most efficient and appropriate operational strategy and information system to support the model. The Morey Report 2003 on this project made a number of recommendations concerning the operation of the SCIDUA and SCIDAWS. One of the recommendations was that the committees become part of ICE to provide support and links with other quality and safety initiatives and this commenced in January 2004 with the transfer of funding for the secretariat from the Department of Health to ICE. ICE is now working with the committees to implement the Report's other recommendations.

Key Achievements:

Some of the operational changes recommended in the Morey Report that have been implemented include:

Development and installation of an upgraded database for the SCIDUA, which has automated many of the labour intensive clerical duties associated with obtaining the information required for the case review.

The SCIDUA has also put in place a process for triaging cases. This helps to ensure that only those cases most likely to have anaesthetic factors associated with the death are reviewed by the full committee.

Access to the National Coronial Information System has been approved by the Monash University National Centre for Coronial Information Research Committee. This will provide electronic access to data and full text reports produced by the Coroner and will facilitate the trend analysis of surgically related deaths. Initial development of specifications for reports to improve identification of cases and trend data for analysis is under way. This should significantly increase the percentage of total cases classified or reviewed by the Committees.

A draft communication strategy has been prepared and a plan for its implementation is to be developed.

Existing models of surgical mortality reviews have been assessed and planning has commenced to pilot a case review study using the West Australian Audit of Surgical Mortality (WAASM) model. Negotiations with the WAASM secretariat for the SCIDAWS to utilise the WAASM database and data collection forms are in progress.

The Future:

The model proposed in the Morey Report involves the continuation of SCIDUA and SCIDAWS, with greater emphasis on the provision of timely aggregate information and recommendations, for both actions that could be taken to prevent morbidity and mortality and areas of concern that may require further review.

Institute
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FINANCIALS REPORTS

GPO BOX 12
SYDNEY NSW 2001

INDEPENDENT AUDIT REPORT

INSTITUTE FOR CLINICAL EXCELLENCE

To Members of the New South Wales Parliament

Audit Opinion Pursuant to the *Public Finance and Audit Act 1983*

In my opinion, the financial report of the Institute for Clinical Excellence:

(a) presents fairly the Institute for Clinical Excellence's financial position as at 30 June 2004 and its financial performance and cash flows for the year ended on that date, in accordance with applicable Accounting Standards and other mandatory professional reporting requirements in Australia, and

(b) complies with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act).

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

The Board's Role

The financial report is the responsibility of the members of the Board of the Institute for Clinical Excellence. It consists of the statement of financial position, the statement of financial performance, the statement of cash flows and the accompanying notes.

The Auditor's Role and the Audit Scope

As required by the PF&A Act, I carried out an independent audit to enable me to express an opinion on the financial report. My audit provides *reasonable assurance* to Members of the New South Wales Parliament that the financial report is free of *material* misstatement.

My audit accorded with Australian Auditing and Assurance Standards and statutory requirements, and I:

- evaluated the accounting policies and significant accounting estimates used by the Board in preparing the financial report,
- examined a sample of the evidence that supports the amounts and other disclosures in the financial report.

An audit does *not* guarantee that every amount and disclosure in the financial report is error free. The terms 'reasonable assurance' and 'material' recognise that an audit does not examine all evidence and transactions. However, the audit procedures used should identify errors or omissions significant enough to adversely affect decisions made by users of the financial report or indicate that the Board members had not fulfilled their reporting obligations.

My opinions do *not* provide assurance:

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

Audit Independence

The Audit Office complies with all applicable independence requirements of Australian professional ethical pronouncements. The PF&A Act further promotes independence by:

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

P.K. Brown

P.K Brown FCA
Director of Audit

SYDNEY
20 October 2004

Certificate of financial statement

The attached financial statements of the Institute for Clinical Excellence for the year ended 30 June 2004;

1. have been prepared in accordance with the requirements of applicable Australian Accounting Standards, other authoritative pronouncements of the Australian Accounting Standards Board (AASB), UIG Consensus Views, the requirements of the Public Finance and Audit Act, 1983 and its regulations, the Health Services Act 1997 and its regulations, the Accounts and Audit Determination and the Accounting manual for Area Health Services and Public Hospitals. Where there are inconsistencies between the above requirements, the legislative provisions have prevailed. Statements of Accounting Concepts are used as guidance in the absence of applicable Accounting Standards and other mandatory professional legislative requirements;

2. present fairly the financial position and transactions of the Institute for Clinical Excellence; and

3. have no circumstances that would render any particulars in the financial statements to be misleading or inaccurate.

Professor Bruce Barraclough	***Dr George Bearham***	***Rhonda Topp***
Chairman	*Acting Chief Executive Officer*	*Director Business Operations*

Institute for Clinical Excellence
Statement of Financial Performance for the Year Ended 30 June 2004

	Notes	Actual 2004 $000	Budget 2004 $000	Actual 2003 $000
Expenses				
Operating Expenses				
Employee Related	3	1,145	1,193	643
Goods and Services	4	2,044	2,043	1,657
Maintenance	5	17	17	33
Depreciation and Amortisation	2(l), 6	2	3	2
Total Expenses		**3,208**	**3,256**	**2,335**
Revenues				
Sale of Goods and Services	7	66	-	1
Investment Income	8	13	-	21
Grants and Contributions	9	59	-	-
Other Revenue	10	20	-	-
Total Revenues		**158**	**-**	**22**
NET COST OF SERVICES	19	**3,050**	**3,256**	**2,313**
Government Contributions				
NSW Health Department Recurrent Allocations	2(d)	3,255	3,255	1,865
Acceptance by the Crown Entity of Employee Superannuation Benefits	2(a)	68	-	-
Total Government Contributions		**3,323**	**3,255**	**1,865**
RESULT FOR THE YEAR FROM ORDINARY ACTIVITIES	16	**273**	**(1)**	**(448)**
TOTAL CHANGES IN EQUITY OTHER THAN THOSE RESULTING FROM TRANSACTIONS WITH OWNERS AS OWNERS	16	**273**	**(1)**	**(448)**

The accompanying notes form part of these Financial Statements

Institute for Clinical Excellence
Statement of Financial Position as at 30 June 2004

	Notes	Actual 2004 $000	Budget 2004 $000	Actual 2003 $000
ASSETS				
Current Assets				
Cash	11	582	582	387
Receivables	12	1	1	-
Total Current Assets		**583**	**583**	**387**
Non-Current Assets				
Plant and Equipment	13	37	37	39
Total Non-Current Assets		**37**	**37**	**39**
Total Assets		**620**	**620**	**426**
LIABILITIES				
Current Liabilities				
Payables	14	219	416	286
Provisions	15	65	100	55
Other		-	20	-
Total Current Liabilities		**284**	**536**	**341**
Non-Current Liabilities				
Provisions	15	11	33	33
Total Non-Current Liabilities		**11**	**33**	**33**
Total Liabilities		**295**	**569**	**374**
Net Assets		**325**	**51**	**52**
EQUITY				
Accumulated Funds	16	325	51	52
Total Equity		**325**	**51**	**52**

The accompanying notes form part of these Financial Statements

Institute for Clinical Excellence
Statement of Cash Flows for the Year Ended 30 June 2004

	Notes	Actual 2004 $000	Budget 2004 $000	Actual 2003 $000
CASH FLOWS FROM OPERATING ACTIVITIES	2(o)			
Payments				
Employee Related		(1,089)	(1,148)	(589)
Maintenance		(17)	(17)	(33)
Other		(2,111)	(1,913)	(1,549)
Total Payments		**(3,217)**	**(3,078)**	**(2,171)**
Receipts				
Sale of Goods and Services		46	-	1
Investment Income		13	-	21
Grants		59	-	-
Other		39	19	-
Total Receipts		**157**	**19**	**22**
Cash Flows From Government				
NSW Health Department Recurrent Allocations		3,255	3,255	1,865
Net Cash Flows from Government		**3,255**	**3,255**	**1,865**
NET CASH FLOWS FROM OPERATING ACTIVITIES	19	**195**	**196**	**(284)**
CASH FLOWS FROM INVESTING ACTIVITIES				
Purchases of Plant and Equipment		-	(1)	(41)
NET CASH FLOWS FROM INVESTING ACTIVITIES		**-**	**(1)**	**(41)**
NET INCREASE / (DECREASE) IN CASH		**195**	**195**	**(325)**
Opening Cash and Cash Equivalents		387	387	712
CLOSING CASH AND CASH EQUIVALENTS	11	**582**	**582**	**387**

The accompanying notes form part of these Financial Statements

Institute for Clinical Excellence
Notes To and Forming Part of the Financial Statements
For the Period Ended 30 June 2004

1. The Institute for Clinical Excellence Reporting Entity

The Institute for Clinical Excellence 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 mission of the Institute for Clinical Excellence is to change health care across New South Wales to make it safer and better for patients. The Institute for Clinical Excellence will work collaboratively on high priority clinical projects across multiple sites being orientated solely on improved patient outcomes; drive implementation of Clinical Practice Improvement and champion the lessons learned across the system; provide education and training to support the implementation of improvement projects; support targeted health services research.

The Institute for Clinical Excellence is a controlled entity of the Department of Health, and is consolidated as part of the NSW Total State Sector Accounts.

2. Summary of Significant Accounting Policies

The Institute for Clinical Excellence's Financial Statements are a general purpose financial report which has been prepared on an accruals basis and in accordance with applicable Australian Accounting Standards, other authoritative pronouncements of the Australian Accounting Standards Board (AASB), Urgent Issues Group (UIG) Consensus Views and 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.

Where there are inconsistencies between the above requirements, the legislative provisions have prevailed. In the absence of a specific Accounting Standard, other authoritative pronouncements of the AASB or UIG Consensus View, the hierarchy of other pronouncements as outlined in AAS6 "Accounting Policies" is considered. Statements of Accounting Concepts are used as guidance in the absence of applicable Accounting Standards, other mandatory professional requirements and legislative requirements.

Except for certain investments, land and buildings, plant and equipment and infrastructure systems, which are recorded at valuation, the financial statements 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.

Other significant accounting policies used in the preparation of these Financial Statements are as follows:

a) Employee Benefits and Other Provisions

1. Salaries and Wages, Annual Leave, Sick Leave and On Costs (including non-monetary benefits).

Liabilities for wages and salaries, annual leave, vesting sick leave and related on-costs are recognised and measured in respect of employees' services up to the reporting date at nominal amounts expected to be paid when the liabilities are settled.

Employee leave entitlements are dissected between the "Current" and "Non Current" components on the basis of anticipated payments for the next 12 months.

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 (FBT), which are consequential to employment, are recognised as liabilities and expenses where the employee benefits to which they relate have been recognised.

2. Long Service Leave.

Long Service Leave is measured on a shorthand basis at an escalated rate of 1.6% above the salary rates immediately payable at June 30 2004 for all employees with five or more years of service. The Government Actuary considers that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

Employee leave entitlements are dissected between the "Current" and "Non Current" components on the basis of anticipated payments for the next twelve months.

3. Superannuation.

The Institute for Clinical Excellence's liability for superannuation is assumed by the Crown Entity. The Institute for Clinical Excellence 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 Superannuation Benefits".

The superannuation expense for the financial year is determined by using the formulae specified by the NSW Health Department. 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

Institute for Clinical Excellence
Notes To and Forming Part of the Financial Statements
For the Period Ended 30 June 2004

Superannuation Scheme) the expense is calculated as a multiple of the employees' superannuation contributions.

4. Other Provisions

Other provisions exist when the Institute for Clinical Excellence has a present legal, equitable or constructive obligation to make a future sacrifice of economic benefits to other entities as a result of past transactions or other past events. These provisions are recognised when it is probable that a future sacrifice of economic benefits will be required and the amount can be reliably measured.

b) Insurance

The Institute for Clinical Excellence'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) Borrowing Costs

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

d) Revenue Recognition

Revenue is recognised when the Institute for Clinical Excellence has control of the good or right to receive, it is probable that the economic benefits will flow to the Institute for Clinical Excellence and the amounts of revenue can be measured reliably. Additional comments regarding the accounting policies for the recognition of revenue are discussed below.

Sale of Goods and Services

Revenue from the sale of goods and services comprises revenue from the provision of products or services, i.e. user charges. User charges are recognised as revenue when the Institute for Clinical Excellence obtains control of the assets that result from them.

Investment Income

Interest revenue is recognised as it accrues. Rent revenue is recognised in accordance with AAS17 "Accounting for Leases". Dividend revenue is recognised when the Institute for Clinical Excellence's right to receive payment is established.

Debt Forgiveness

In accordance with the provisions of Australian Accounting Standard AAS23, debts are accounted for as extinguished when and only when settlement occurs through repayment or replacement by another liability or the debt is subject to a legal defeasance.

Grants and Contributions

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

NSW Health Department Allocations

Payments are made by the NSW Health Department on the basis of the allocation for the Institute for Clinical Excellence as adjusted for approved supplementations mostly for salary agreements, and approved enhancement projects. This allocation is included in the Statement of Financial Performance before arriving at the "Result for the Year from Ordinary Activities" on the basis that the allocation is earned in return for the services provided on behalf of the Department. Allocations are normally recognised upon the receipt of Cash.

e) Goods and Services Tax (GST)

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

f) Receivables

Receivables are recognised and carried at cost, based on the original invoice amount less a provision for any uncollectable debts. An estimate for doubtful debts is made when collection of the full amount is no longer probable. Bad debts are written off as incurred.

Institute for Clinical Excellence
Notes To and Forming Part of the Financial Statements
For the Period Ended 30 June 2004

g) Acquisition of Assets

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by the Institute for Clinical Excellence. Cost is determined as the fair value of the assets given as consideration plus the costs incidental to the acquisition.
Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition except for assets transferred as a result of an administrative restructure.
Fair value means the amount for which an asset could be exchanged between a knowledgeable, willing buyer and a knowledgeable, willing seller in an arm's length transaction.
Where settlement of any part of cash consideration is deferred, the amounts payable in the future are discounted to their present value at the acquisition date. The discount rate used is the incremental borrowing rate, being the rate at which similar borrowing could be obtained.

h) Plant and Equipment

Individual items of plant and equipment costing $5,000 and above are capitalised.

i) Depreciation

Depreciation is provided for on a straight line basis for all depreciable assets to write off the depreciable amount of each asset as it is consumed over its useful life to the Institute for Clinical Excellence. Thus, the depreciation rates for some assets may vary from the standard depreciation rates (shown below).

Standard depreciation rates for major asset categories are as follows:

Computer Equipment	20.0%
Computer Software	20.0%
Infrastructure Systems	2.5%
Office Equipment	10.0%
Plant and Machinery	10.0%
Furniture, Fittings and Furnishings	5.0%

j) Revaluation of Physical Non-Current Assets

Non-specialised generalised assets with short useful lives are measured at depreciated historical cost, as a surrogate for fair value. As such these assets are not revalued.

k) Maintenance and Repairs

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

l) 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 inception of the lease. 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 Financial Performance in the periods in which they are incurred.

m) Financial Instruments

Financial instruments give rise to positions that are a financial asset of either the Institute for Clinical Excellence or its counterpart and a financial liability (or equity instrument) of the other party. For the Institute for Clinical Excellence these include cash at bank, receivables, other financial assets, payables and interest bearing liabilities.
In accordance with Australian Accounting Standard AAS33, "Presentation and Disclosure of Financial Instruments", information is disclosed in Note 23 in respect of the credit risk and interest rate risk of financial instruments. All such amounts are carried in the accounts at net fair value.
The specific accounting policy in respect of each class of such financial instrument is stated hereunder.

Institute for Clinical Excellence
Notes To and Forming Part of the Financial Statements
For the Period Ended 30 June 2004

Classes of instruments recorded at cost and their terms and conditions at balance date are as follows:

1. Cash
Accounting Policies - Cash is carried at nominal values reconcilable to monies on hand and independent bank statements.
Terms and Conditions - Monies on deposit attract an effective interest rate of approximately 4.5% (4.2% in 2002/2003).

2. Receivables
Accounting Policies - Receivables are recognised and carried at cost, based on the original invoice amount less a provision for any uncollectable debts. An estimate for doubtful debts is made when collection of the full amount is no longer probable. Bad debts are written off as incurred. No interest is earned on trade debtors.
Terms and Conditions - Accounts are issued on 30 day terms.

3. Investments
Accounting Policies – Interest on Investments, held on Current Account with South Eastern Sydney Area Health Service, is recognised as it accrues.
There are no classes of instruments that are recorded at other than cost or market valuation.
All financial instruments including revenue, expenses and other cash flows arising from instruments are recognised on an accrual basis.

4. Payables
Accounting Policies - Payables are recognised for amounts to be paid in the future for goods and services received, whether or not billed to the Institute for Clinical Excellence.
Terms and Conditions - Trade liabilities are settled within any terms specified where possible, subject to available funds. If no terms are specified, payment is made by the end of the month following the month in which the invoice is received.

n) Payables

These amounts represent liabilities for goods and services provided to the Institute for Clinical Excellence, and other amounts, including interest. Interest is accrued over the period it becomes due. Creditors are paid by South Eastern Sydney Area Health Service and balances outstanding at year end are reported as Intra Health Creditors.

o) Budgeted Amounts

The budgeted amounts are drawn from the budgets as formulated at the beginning of the financial year and with any adjustments for the effect of additional supplementation provided. Details of the budget are contained in note 21 on budget review. The budget amounts exclude GST.

p) Programs

The Institute for Clinical Excellence has only one program (refer to note 22). Accordingly a program statement is not required.

Institute for Clinical Excellence
Notes To and Forming Part of the Financial Statements
For the Period Ended 30 June 2004

q) Comparitive Figures

The 2003 financial report included amounts for the period 5th December 2001 to 30th June 2002, and for the year ended 30th June 2003. The 2003 comparitive figures included in the 2004 financial report represent transactions for the year 1st July 2002 to 30th June 2003.

	2004 $000	2003 $000
3. Employee Related Expenses		
Employee related expenses comprise the following:		
Salaries and Wages	977	576
Long Service Leave [see note 2(a)]	41	7
Annual Leave [see note 2(a)]	64	33
Nursing Agency Payments	1	3
Other Agency Payments	-	17
Salary Packaging	(6)	-
Workers' Compensation Insurance	-	7
Superannuation [see note 2(a)]	68	-
	1,145	643

Salaries and Wages include $79,000 in 2003/2004 and $60,033 in 2002/2003, paid to members of the Institute for Clinical Excellence Board, consistent with the statutory determination by the Minister for Health, which provided remuneration effective from 1 July 2001.

The payments have been made within the following bands:

$ range	Number paid
$0 to $15,000	5
$15,000 to $30,000	1

Fees/other benefits paid to the Institute for Clinical Excellence Board members, excluding payments made in the nature of normal employee salary or payments made in accordance with conditions applied to Visiting Medical Officers in general, is nil.

	2004 $000	2003 $000
4. Goods and Services		
(a) Expenses on goods and services comprise the following:		
Computer Related Expenses	116	24
Domestic Charges	5	5
Food Supplies	47	10
Fuel, Light and Power	1	1
General Expenses [see note 4(b)]	1,075	1,310
Postage	3	1
Printing and Stationery	70	49
Rental of Premises	30	27
Rates and Charges	1	-
Staff Related Costs	267	157
Telephone	21	6
Travelling - Domestic	400	65
Travelling - Overseas	7	1
Water Rates	1	1
	2,044	1,657

Institute for Clinical Excellence
Notes To and Forming Part of the Financial Statements
For the Period Ended 30 June 2004

	2004 $000	2003 $000
4. Goods and Services (continued)		
(b) General expenses include:		
Advertising	2	2
Audio Visual Supplies	9	15
Books and Magazines	1	-
Consultancies	15	62
Courier and Freight	-	1
Auditor's Remuneration - Audit of financial reports	12	5
Legal Expenses	18	18
Licence Fees	6	2
Membership/Professional Fees	-	6
Motor Vehicle Expenses	2	1
Motor Vehicle Operating Leases	4	-
Other Operating Lease Expense	7	4
Project Payments		
Blood Transfusion	50	395
CPI Evaluation	127	34
New Generation of Health Leaders	-	100
Safety Improvement	-	99
Safety Improvement Program Software	433	-
Towards a Safer Culture	86	447
Research ICE effectiveness	120	-
Erromed Review	27	-
Chronic Care	9	-
Services Provided by South East Health	45	40
Special Functions	41	58
Other	61	21
	1,075	**1,310**
5. Maintenance		
Repairs and Routine Maintenance	2	1
Renovations and Additional Works	-	6
Replacements and Additional Equipment less than $5,000	15	26
	17	**33**
6. Depreciation and Amortisation		
Depreciation - Plant and Equipment	2	2
	2	**2**
7. Sale of Goods and Services		
Sale of Goods and Services comprise the following:		
Conference and Training Receipts	19	1
Other	47	-
	66	**1**
8. Investment Income		
Interest	13	21
	13	**21**

Institute for Clinical Excellence
Notes To and Forming Part of the Financial Statements
For the Period Ended 30 June 2004

	2004 $000	2003 $000
9. Grants and Contributions		
Commonwealth Grants	9	-
Grants from DOH	50	-
	59	-
10. Other Revenue		
Other Income	20	-
	20	-
11. Current Assets – Cash		
Cash at Bank	582	387
	582	387
Cash assets recognised in the Statement of Financial Position are reconciled to cash at the end of the financial year; as shown in the Statement of Cash Flows as follows:		
Cash (per Statement of Financial Position)	582	387
Closing Cash and Cash Equivalents (per Statement of Cash Flows)	582	387
12. Receivables		
Current		
Other Debtors	1	-
	1	-
13. Plant and Equipment		
Plant and Equipment		
At Fair Value	41	41
Less Accumulated Depreciation	4	2
	37	39
Total Plant and Equipment at Net Book Value	37	39

	Plant and Equipment $000	Total $000
Balance 1 July, 2003	41	41
Balance at 30 June, 2004	41	41
Depreciation		
Balance 1 July, 2003	2	2
Charge for the year [see note 2(k)]	2	2
Balance at 30 June, 2004	4	4
Carrying Amount at 30 June, 2004	37	37

Institute for Clinical Excellence
Notes To and Forming Part of the Financial Statements
For the Period Ended 30 June 2004

	2004 $000	2003 $000
14. Payables		
Current		
Creditors	4	-
Other Creditors		
- Intra Health	210	281
- Other	5	5
	219	**286**
15. Provisions		
Current		
Employee Annual Leave	50	40
Employee Long Service Leave	15	15
Total Current Provisions	**65**	**55**
Non Current		
Employee Annual Leave	7	7
Employee Long Service Leave	4	26
Total Non Current Provisions	**11**	**33**
Aggregate Employee Benefits and Related On-costs		
Current	65	55
Non Current	11	33
Total Provisions	**76**	**88**

16. Equity

	Accumulated Funds		Total Equity	
	2004 $000	2003 $000	2004 $000	2003 $000
Balance at the beginning of the financial year	52	500	52	500
Result for the year	273	(448)	273	(448)
Balance at the end of the financial year	**325**	**52**	**325**	**52**

Institute for Clinical Excellence
Notes To and Forming Part of the Financial Statements
For the Period Ended 30 June 2004

	2004 $000	2003 $000
17. Commitments for Expenditure		
Expenditure Commitments		
Aggregate other expenditure committed at balance date and not provided for in the accounts:		
Not later than one year	1,223	301
Between one and five years	867	410
Total Expenditure Commitments	**2,090**	**711**

These commitments are not recognised in the financial statements as liabilities.
The Institute for Clinical Excellence has an operating lease for office accommodation $2,429 per month with no fixed term

18. Contingent Liabilities

There are no contingent liabilities.

19. Reconciliation of Net Cost of Services to Net Cash Flows from Operating Activities

Net Cash Flows from Operating Activities	195	(284)
Depreciation	(2)	(2)
Increase / (Decrease) in Employee Entitlements	12	(54)
Acceptance by the Crown Entity of Superannuation Liability	(68)	-
Increase in Other Debtors	1	-
(Increase) / Decrease in Creditors	67	(108)
NSW Health Department Recurrent Allocations	(3,255)	(1,865)
Net Cost of Services	**(3,050)**	**(2,313)**

20. Unclaimed Monies

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. All money and personal effects of patients which are left in the custody of the Institute for Clinical Excellence by any patient who is discharged or dies in the hospital and which are not claimed by the person lawfully entitled thereto within a period of 12 months, are recognised as the property of the Institute for Clinical Excellence.
All such money and the proceeds of the realisation of any personal effects are lodged to the credit of the Samaritan Fund that is used specifically for the benefit of necessitous patients or necessitous outgoing patients.

Institute for Clinical Excellence
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For the Period Ended 30 June 2004

21. Budget Review

Whereas budgets are allocated to the Institute for Clinical Excellence on an annual basis, the operations of the Institute for Clinical Excellence are more dependent on the availability of specialised resources to meet its objectives. Therefore, there can be a delay between budget allocation and service delivery (i.e. expenditure).

Net Cost of Services
The actual result was better than budget expectations due mainly to grants received from the NSW Department of Health and other revenue.

Result for the Period from Ordinary Activities
The actual surplus for the 2003/04 period was higher than budget expectations due to the favourable net cost of service position and the superannuation benefits accepted by the Crown Entity.

Assets/Liabilities
Current Assets
For the entire period, cash was higher than expected due to the favourable operating result and the need to meet staff leave commitments and pay creditors in the future.

Non Current Assets
No additions were made during the year to plant and equipment.

Current Liabilities
Creditors were reduced significantly due to the improved operating result. Staff leave provisions increased marginally due to a proportion of leave being postponed and carried over into 2004/05.

Non Current Liabilities
The results were slightly over budget. This was mainly due to increased long service leave provisioning. Long service leave was indexed by a factor of 1.6%; based upon actuarial advice, and was included in the budget.

Cash Flows

Operating Activities
The actual result was greater than expected due to improved revenue collection.

Investing Activities
There was no financial activity in investing for the year.

Government Contributions
Movements in the level of the NSW Health Department Recurrent Allocation that have occurred since the time of the initial allocation on 30 September, 2003 are as follows:

	2004 $000	2003 $000
Initial Allocation 30 September, 2003	2,434	2,500
Secretariat Funding	40	-
ICE NSW Chronic Care	779	-
Children's Emergency Care Program	72	-
Patient Safety	(70)	(378)
Best Practice	-	(100)
Towards a Safer Culture	-	(157)
Balance as per Statement of Financial Performance	**3,255**	**1,865**

Institute for Clinical Excellence
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For the Period Ended 30 June 2004

22. Programs/Activities of the Institute for Clinical Excellence

The Institute operates under a single program.

Program 6.1 Teaching and Research

Objective: 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 the people of NSW.

23. Financial Instruments

a) Interest Rate Risk

Interest rate risk is the risk that the value of the financial instrument will fluctuate due to changes in market interest rates. Institute for Clinical Excellence's exposure to interest rate risks and the effective interest rates of financial assets and liabilities, both recognised and unrecognised, at the Statement of Financial Position date, are as follows:

Financial Instruments	Floating interest rate		Non-interest bearing		Total carrying amount as per the Statement of Financial Position		Weighted average effective interest rate*	
	2004 $000	2003 $000	2004 $000	2003 $000	2004 $000	2003 $000	2004 %	2003 %
Financial Assets								
Cash	582	387	-	-	582	387	4.50	4.20
Receivables	-	-	1	-	1			
Total Financial Assets	**582**	**387**	**1**	**-**	**583**	**387**		
Financial Liabilities								
Accounts payable	-	-	219	286	219	286		
Other	-	-	20	-	20	-		
Total Financial Liabilities	**-**	**-**	**239**	**286**	**239**	**286**		

* The weighted average effective interest rate was computed on a monthly and quarterly basis. It is not applicable for non-interest bearing financial instruments.

b) Credit Risk

Credit risk is the risk of financial loss arising from another party to a contract/or financial position failing to discharge a financial obligation thereunder.

The Institute for Clinical Excellence's maximum exposure to credit risk is represented by the carrying amounts of the financial assets included in the statement of financial position.

Credit Risk by classification of counterparty

	Banks		Other		Total	
	2004 $000	2003 $000	2004 $000	2003 $000	2004 $000	2003 $000
Financial Assets						
Cash	582	387	-	-	582	387
Receivables	-	-	1	-	1	
Total Financial Assets	**582**	**387**	**1**	**-**	**583**	**387**

There is no significant concentration of credit risk.

Institute for Clinical Excellence
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c) Net Fair Value
As stated in Note 2(m) all financial instruments are carried at net fair value, the values of which are reported in the statement of financial position.

d) Derivative Financial Instruments
The Institute for Clinical Excellence holds no derivative financial instruments.

24. Post Balance Date Events

The Institute for Clinical Excellence's name change to Clinical ExcellenceCommission was effected on 20th August 2004. This was done in accordance with Amendment No. 154 to the Health Services Act 1997.

25. Transition to Australian equivalents to International Financial Reporting Standards (AIFRS)

(1) Management of Transition

The Institute for Clinical Excellence will apply the Australian Equivalents to International Financial Reporting Standards (AIFRS) from the reporting period beginning 1 July 2005.

South Eastern Sydney Area Health Service will be managing the transition to the new standards for The Institute for Clinical Excellence, by allocating internal resources and/or engaging consultants to analyse the pending standards and Urgent Issues Group Abstracts to identify key areas regarding policies, procedures, systems and financial impacts affected by the transition.

End of Audited Financial Statements

Institute
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APPENDICES

Senior Executive Service (SES) Report

Appendix 1

Chief Executive Officer
Name: Dr Ian O'Rourke
Period in Position: 1.7.03 - 30.6.04
SES Level: 3 Special Medical

Strategic Initiatives

Progression of implementation of Strategic Plan 2002-2005 through:

- Working collaboratively with Area Health Services on high priority clinical projects across multiple sites being orientated solely on improved patient outcomes
- Driving implementation of clinical practice improvement and championing the lessons learned across the system through ICE's projects
- Provide education and training to support the implementation of improvement projects
- Targetted health services research

Management Accountabilities

Major Safety & Quality Projects

- **Safety Improvement Program** (in partnership with NSW Health) Continued and completed the roll out of the Safety Improvement Program (SIP) to all Area Health Services, Children's Hospital at Westmead, NSW Ambulance Service and Justice Health Service. Included training of over 2000 healthcare professionals across NSW in Root Cause Analysis and Human Factors
- **Patient Flow & Safety Collaborative** Used breakthrough collaborative methodology and achieved statistically significant reduction in access block in hospitals participating in the collaborative. Reduction by greater than 50 per cent in pressure ulcers in all sites. Reduction by 50 per cent in falls at all participating sites. Reduction in rehabilitation waiting times.
- **Towards a Safer Culture (TASC)** Continuation of TASC with significant improvements in patient outcomes demonstrated including increased utilisation of life saving medication, decreased length of stay, improved time to diagnosis and decreased readmission rates. Clinical pathways have been written in 12 areas and are now in use in 11 area health services for either chest pain or stroke.
- **NSW Chronic Care Collaborative (funded by NSW Health)** Commencement of Chronic Care Collaborative using breakthrough collaborative methodology to focus on increasing the proportion of people with chronic obstructive pulmonary disease (COPD) and heart failure who have the appropriate range of diagnostic and management interventions drawn from the NSW Clinical Service Frameworks for Heart Failure and Respiratory Disease, published in 2003.
- **Emergency Care for Children** Commencement of implementation of guidelines for 12 most common presentations for emergency care for children in non-paediatric hospitals is being funded and managed by ICE. The guidelines are being implemented through a pilot project of 50 health facilities throughout NSW.
- **National Medication Safety Collaborative** Signing of agreement with Department of Human Services Victoria as member of the consortium to improve medication safety across Australia in a project funded by the National Council for Safety and Quality. The project has commenced and aims to reduce the number of episodes of patient harm relating to medication by 50 per cent by March 2005.

- **Research Into Safety & Quality**
  Signing of four year contract with Centre for Clinical Governance Research, University of NSW to design and execute a program of research, the objective of which is to improve the quality and safety of healthcare in NSW by studying the impact of selected ICE/DoH programs on the safety and quality of healthcare and in particular on actual patient care received.

Executive Support

- Provide executive support and direction to the Board and staff of Institute for Clinical Excellence.

Full-Time Equivalent Staff as at June 30:

Appendix 2

- 2001/02 - 3
- 2002/03 - 8
- 2003/04 - 14

Freedom of Information

Appendix 3

In 2003/04 the Institute for Clinical Excellence received no Freedom of Information applications.

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