



CLINICAL
EXCELLENCE
COMMISSION

ANNUAL
REPORT
2004/2005



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CLINICAL
EXCELLENCE
COMMISSION

The Hon John Hatzistergos MP
Minister for Health
Level 31
Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

Dear Minister,

We have pleasure in submitting the Clinical Excellence Commission 2004/2005 Annual Report.

The Report complies with the requirements for annual reporting under the Accounts and Audit Determination for public health organisations and the 2004/05 Directions for Health Service Annual Reporting.

Yours sincerely

Professor Bruce Barraclough AO
Chairman

Professor Clifford Hughes AO
Chief Executive Officer

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FOREWORD

Last year's Annual Report foreshadowed the formation of the Clinical Excellence Commission (CEC), replacing the former Institute for Clinical Excellence (ICE). The CEC was launched by the Minister for Health, the Hon Morris Iemma¹ MP on 24 August 2004. In launching the Commission, the Minister paid tribute to the work of ICE's founding Chief Executive Office, the late Dr Ian O'Rourke who passed away on 16 August 2004. Just weeks prior to his death, Dr O'Rourke was actively involved in developing the framework for the transition to the new organisation. The CEC will build on the work of ICE and the legacy of Dr O'Rourke under the leadership of Professor Clifford Hughes AO, who was appointed Chief Executive Officer in January 2005.

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 establishment of the CEC resulted from the strengthening of 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.

The CEC forms part of the NSW Patient Safety and Clinical Quality Program. Its core purpose, as set down in the NSW Clinical Excellence Commission Directions Statement published by the Department of Health, is "to identify issues of a systemic nature that affect patient safety and clinical quality in the NSW health system and develop and advise upon implementation strategies to address these issues. It will therefore acquire and share information as well as provide advice and implementation assistance to other agencies in the discharge of this responsibility."

The Directions Statement also lists a guiding set of principles, which are embodied in the NSW Patient Safety and Clinical Quality Program. These are:

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

The CEC is putting in place the strongest support system it can for healthcare workers and their patients.

¹ The Hon Morris Iemma MP was the Minister for Health during the reporting period.

CHAIRMAN'S REPORT



The transition from the very successful Institute for Clinical Excellence to a new, vibrant and functioning Clinical Excellence Commission has been achieved with surprising ease, even though the NSW health system has been undergoing many changes associated with the amalgamation of the area health services, a new Premier and a new Health Minister. This transition process was very efficiently handled by ICE staff and in particular, Acting CEO, Dr George Bearham who put in an exemplary performance in keeping the team together and completing and progressing continuing projects from ICE.

We have been privileged to have Professor Clifford Hughes accept the Chief Executive Officer's role. Since January 2005 he has worked tirelessly to set the new commission on a solid foundation. He brings with him all the necessary skills and great knowledge of contacts within the health system. Excellent, high level individuals have been appointed to supplement the small, continuing cadre of ICE staff as the role of the CEC is expanded.

A new Board has settled into its role and is providing knowledge and enthusiastic governance. The Board and CEO will have expert advice from a Clinical Council chaired by Professors Mary Chiarella and Peter Castaldi. To deliver the expanded role of CEC which is addressed in detail in this report and in our strategic plan, is an exciting prospect for all concerned. The Board and staff and our colleagues and stakeholders in the health system are committed to working together to deliver significant health system improvement to the benefit of the people of New South Wales.

Professor Bruce Barraclough AO
Chairman

CHIEF EXECUTIVE OFFICER'S REPORT



A year ago, the Clinical Excellence Commission was but a new name for an established institute. Now, at the end of the reporting period, we have not only a new name but a new Board, a Strategic Plan, new staff, a Clinical Council, a new CEO, a new look and, shortly, a new home!

The CEC (pronounced 'See-E-See' and definitely not 'Keck'!) is privileged to have a diverse and talented Board. Some members of the Board of the former Institute for Clinical Excellence, Dr Graham Beaumont, Major General Peter Dunn and Professor Phil Harris have been joined by Assoc. Professor Brian McCaughan, Dr Alan Amodeo, Mrs Elizabeth Rummery, Dr Sue Page, Associate Professor Kathy Baker, Mr Noel O'Brien, and Professor Tom Parry and, under the continued chairmanship of Professor Bruce Barraclough AO, have begun the task of oversight and advice.

We have not completely lost the experience of other former ICE Board Members and I have been encouraged by the support and advice of Professor John Dwyer AM and Dr Diana Horvath AM, past Board Members and also by the continued support offered by such people as Professor John Overton AM, Professor Tim Cartmill AO and Dr Tom Hugh.

The first task for the Board was to participate in a planning day from which we have developed the Strategic Plan and our Key Result Areas for the next three years. This has guided the staff development plans and led to the

essential pillars of our organisation – Clinical Practice Improvement Projects, Quality System Assessment, Information Management, Organisation Development and Education, and Corporate Services. Each of these pillars will be essential in supporting and guiding improvements in safety and quality as we seek to ensure that our mission statement is achieved.

ICE provided a strong foundation for the establishment of the CEC and I would like to acknowledge the leadership and support of Dr George Bearham, Ms Rhonda Topp and Ms Barbara Dundas during the change over and in assisting my orientation to the work of the CEC and I am delighted to be part of such a great team.

There have been staffing changes over the year. We farewelled Dr Rohan Hammett, Director Healthcare Improvement Projects in February. Rohan played a key role in the Patient Flow and Safety Collaborative. Some staff on secondment have been appointed permanently to the CEC whilst some of our Project Officers, having completed their tasks, have moved on to newer challenges and I look forward to their continued engagement with the CEC.

In September 2005, our second tier appointments will commence at the CEC and I expect that the volume of work will rapidly escalate. Ms Margaret Coffey (Organisation Development and Education) and Ms Rhonda Topp

CHIEF EXECUTIVE OFFICER'S REPORT

CONTINUED

(Corporate Services) will be joined by Mr André Jenkins (Information Management), Ms Bernie Harrison (Quality Systems Assessment) and Dr Annette Pantle (Clinical Practice Improvement Projects).

The expansion in role for the CEC has seen us outgrow our space in Sydney Hospital. We have been fortunate, to locate additional space directly across Macquarie Street from our current offices. We will be retaining the existing office in Sydney Hospital and, with the aid of modern communication technology, will be able to link directly in to the health networks from this new site. We expect this move will be completed by mid-October 2005.

One of the key strengths of the CEC will be its ability to develop partnerships with many parts of the NSW health system. In particular, we are pleased to be able to liaise with the newly appointed Clinical Governance Directors in each of the eleven Public Health Organisations (eight Area Health Services, The Children's Hospital at Westmead, Justice Health and the NSW Ambulance Service). These units, with their Directors and Patient Safety Officers, will be a key partnership in our renewed clinical focus on safety and quality.

A number of the CEC projects are now finished and these include Chronic Care, Medication Safety and the Patient Flow and Safety Collaborative along with the Towards a Safer Culture Project (now the

Towards a Safer Culture Program). I refer you to the individual reports on projects further on in this annual report. In particular, the Chronic Care Collaborative and Towards a Safer Culture (TASC) have been extraordinarily useful in identifying issues, outlining potential solutions and implementing change across the system.

The CEC has also been involved in launching several publications. The CEC was actively involved in the first report on incident management in the NSW public health system 2003–2004 with the Minister for Health, in January 2005. Despite dramatic headlines, the text of articles and comments from the community has indicated that comprehensive surveillance of the system is considered to be an essential ingredient of any safety agenda. This publication has recognised the first three key elements of the NSW Patient Safety and Clinical Quality Program i.e. openness about failure, emphasis on learning, and an obligation to act. The CEC is working with NSW Health in the preparation of the second report.

It is worth noting that the NSW report included many adverse events not included in reports from other jurisdictions. In those areas as agreed by the Australian Council for Safety and Quality in healthcare for national collection, the performance in NSW was very similar to other reporting states.

In May 2005 the CEC was also privileged to have the Minister for Health launch the toolkit entitled "Improving Patient Access to Acute Care Services". This concise, detailed volume and its accompanying CD is a wealth of information for clinicians wishing to improve not only access but the quality and safety of clinical programs. The first print run was "sold out" almost immediately and the second has just been completed.

Information underpins any serious attempts at system change. The CEC has, in conjunction with NSW Health, purchased the operating licences for the Australian Incident Monitoring System software and this is being rolled out across NSW Health as part of the Incident Information Management System (IIMS). All 108,000 employees of NSW Health will be able to report any incident online. The Severity Assessment Code system is used to assign severity and, therefore, priority of action around these events.

The CEC, whilst not involved in day-to-day management of the system, will have unfiltered access to all de-identified reports and it is our hope to be able to offer online, secure reports back to those clinicians who need to utilise this information and implement change both locally and globally. Notifications to the IIMS are now averaging approximately 10,000 per month and are likely to increase in the short term as staff become more familiar with the system.

The work of the CEC, however, cannot exist in isolation. There are two key components of our organisational strategy that are just being developed. The first of these has been the appointment of a Clinical Council co-chaired by Professor Mary Chiarella and Professor Peter Castaldi. The role of the Clinical Council is to contribute to the development and delivery of the Commission's programs and advise the Board on strategies to achieve clinician participation.

We are embarking on a strategy to develop an effective Community Council to ensure that, at all times, our work remains patient focused. At the same time, we are seeking links to other areas of healthcare such as aged care, chronic care, mental health and general practice, not to mention the private sector. Each of these groups has expressed enthusiasm for working with us in partnership and I look forward to these challenges.

Also within our charter is the responsibility to investigate systems issues within NSW Health. Whilst clearly important, the boundary between individual practice and system variations is often blurred and complex.

Nevertheless, the CEC has satisfactorily completed a number of enquiries and reviews during the year. Whilst we do not expect this to be a major component of our work, we look forward to working with staff to identify areas in which system change can be made quickly and securely to continue the basic tenant of continuous quality improvement.

This report details many of the activities of the staff of the CEC. Whilst it, by its very nature looks back, I hope you will see the forward vision of the CEC, its Board and all our staff.

However, mission, vision and indeed activity alone is not enough. We need to have skilled and coordinated leadership. The CEC is privileged to have had a close working relationship over the reporting period with the then Minister for Health The Hon Morris Iemma MP. His vision in conceptualizing the CEC, ensuring its budget and charter and his continued support have been much appreciated.

The CEC has also been privileged to enjoy close working relationships with the Director General, Ms Robyn Kruk and her Deputy Directors General. Our regular communications ensure that our focus is secured and our work relevant in the overall context of the NSW Patient Safety and Clinical Quality Program.

Our close links with each of the Public Health Organisations (PHOs) has also been exciting and I look forward to continuing my visits to each of them and, in particular, meeting with the staff at the clinical "coalface" and identifying the issues that concern them. It is the clinicians who drive the system and the clinicians who interface first of all with patients. It is only by working with clinicians that we can expect to maximise the opportunity for effective change.

The coming years are likely to be a period of great change and I look forward to the challenges that this will bring as we advance the agenda for improvements in patient safety and quality.



Professor Clifford Hughes AO
Chief Executive Officer

VALE



DR IAN O'ROURKE
MBBS MS (SYD UNI) FRACS FRCS (ENG)
1943–2004

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 (ICE) from its inception in November 2001 until his death in August 2004.

On joining ICE Dr O'Rourke was charged with making healthcare safer and better for people in NSW. He achieved great results at the Institute for Clinical Excellence and his commitment and leadership enabled the development of activities and programs that have been implemented across the health system. Dr O'Rourke made many of these achievements while fighting the very severe effects of lung cancer.

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. 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 had an extraordinarily varied, interesting and productive clinical and academic life. His 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.

Ian 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 Ian 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 Danila Dilba, Port Keats, Galiwinku and Gove Hospital.

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".

Ian 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 MEMBER PROFILES



PROFESSOR BRUCE BARRACROUGH AO

Professor Barracrough is Chairman of the Clinical Excellence Commission (CEC) and continues in this position from the Board of the Institute for Clinical Excellence (ICE). He is Chair of the Australian Council for Safety and Quality in healthcare and past President of the Royal Australasian College of Surgeons. Professor Barracrough is an elected Member of the Executive Board and Treasurer of the International Society for Quality in healthcare; and Professor and Director of Cancer Services, Northern Sydney Area Health Service.



DR ALAN AMODEO

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



ASSOC. PROFESSOR KATHY BAKER

Assoc. Professor Baker is the Chief Nursing Officer of New South Wales Health and has a Masters Degree in Educational Administration. Professor Baker has held many Education and Community Health positions including Adjunct Professor, Faculty of Nursing, University of Technology Sydney and Director of Integrated Health Care Services and Area Director of Nursing, Northern Sydney Health.



DR GRAHAM BEAUMONT

Dr Beaumont, who continues from the Board of ICE, retired from Qantas in 2003 where he held several management and training captain positions with the Flight Operations Department. He was responsible for the initial development and implementation of human factors training programs for Qantas aircrew and his doctoral research concerned the human factors involved in the management of dynamic real time operations scenarios. He is a member of the Committee of Management of the Australian Aviation Psychology Association, and a member of the External Advisory Committee, School of Management, University of Western Sydney.

BOARD MEMBER PROFILES

CONTINUED



MAJOR GENERAL PETER DUNN AO

Major General Dunn, who continues from the Board of ICE, is Commissioner of the ACT Emergency Services Authority that was established as a result of recommendations made following the disastrous fires in Canberra in 2003. During his time in the Australian Army he was instrumental in achieving significant changes in the Australian Defence Forces (ADF) including relocation of staff, restructure of defence budget and merging the entire logistics function of the ADF.



PROFESSOR PHILLIP HARRIS

Professor Harris is Head of the Department of Cardiology at Royal Prince Alfred Hospital, Chair of the Patient Care Committee and Chair of the Clinical Training Committee. He is Clinical Professor of Medicine at the University of Sydney, 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).



ASSOC. PROFESSOR BRIAN MCCAUGHAN

Assoc. Professor McCaughan is a cardiothoracic surgeon and his major clinical interest is the management of lung cancer. He is a Clinical Associate Professor at the University of Sydney and has held a number of positions with the Royal Australasian College of Surgeons culminating in the Chairmanship of the NSW State Committee from 1992 to 1994. Professor McCaughan is a member of the Ministerial Advisory Committee on Quality in healthcare. He was appointed to the newly formed NSW Health Council, and served as the President of the New South Wales Medical Board from October 1999 until December 2004.



MR NOEL O'BRIEN

Mr O'Brien was Chairperson of the New England Area Health Service from 2000–2004, Chairperson of the New England Area Health Service Audit Committee from 1998–2000 and Chairperson of the Strategic Planning Committee. He was Chairperson of New South Wales Association of Mining Related Council from 1999–2004. Mr. O'Brien has been a Councillor of Gunnedah Shire from 1991–2004 and has served two terms as Mayor. He is participating in the community consultation process co-chaired by the Rt. Hon Ian Sinclair and Wendy McCarthy AO. He is on the Board of Directors of Westpac Rescue Helicopter Service, Hunter/New England/North West and a member of the Audit Committee.



DR SUE PAGE

Dr Page is President of the Rural Doctors Association Australia and Immediate Past President, Rural Doctors Association (NSW). Dr. Page has been a ministerial appointee to several committees including NSW Mental Health Sentinel Events Review Committee, NSW Expert Advisory Group on Drugs and Alcohol, NSW Rural Health Taskforce, Expert Advisory Committee for Paracetamol Use, General Practice Advisory Committee 2002/03 and a Commonwealth appointee to Australian Medical Workforce Advisory Committee and Medical Indemnity Policy Review Panel 2003. Dr Page is Director of Education, Northern Rivers University Department of Rural Health and a senior lecturer at the University of Sydney.



DR TOM PARRY

Dr Parry is currently the foundation Commissioner of the NSW Natural Resources Commission, Chairman of First State Super Trustee Corporation and Chairman of Macquarie Community Partnerships Funds Management Business of Macquarie Bank. He was the foundation Executive Chairman of the Independent Pricing and Regulatory Tribunal of New South Wales. Between 2001–2004 Professor Parry was a member of the Board of South Eastern Sydney Area Health Service.



MRS M. E. (LIZ) RUMMERY AM

Mrs Rummery retired from legal practice after 30 years specialising in Property and Commercial Law. Mrs. Rummery was Co-chair of the Rural Health Implementation Group (NSW Government's Action Plan for Health) and is now Co-chair of NSW Rural Taskforce as well as being a member of several NSW Advisory Groups including,

Rural Cardiology Clinical Advisory Group, Rural Oncology Clinical Advisory Group, Rural Trauma/Critical Care Advisory Group, Rural Renal Clinical Advisory Group, advisory Board of Centre for Rural and Remote Mental Health and is a member of the State Clinical Council (NSW Government's Action Plan for Health). She is Deputy Chancellor, Southern Cross University Council and Chair of the Audit Committee and Commercial Activities Committee and a member of the Finance Committee.



PROFESSOR CLIFF HUGHES AO

Professor Hughes is the Chief Executive Officer of the Clinical Excellence Commission. Previously Professor Hughes was Head of the Department of Cardiothoracic Surgery at Royal Prince Alfred Hospital. In 1997 he commenced the cardiac unit at Liverpool Hospital as a co-operative venture between Central Sydney Area Health Service and South Western Sydney Area Health Service, the first such "joint venture" of its type in New South Wales. Professor Hughes was the Foundation Chairman of the New South Wales Special Committee Investigating Deaths Associated With Surgery and is a member of the Australian Council for Safety and Quality in healthcare.

BOARD MEMBER MEETING ATTENDANCE

	ICE BOARD		CLINICAL EXCELLENCE COMMISSION INTERIM BOARD			
	(from 1.7.04 to 17.8.04)		(from 18.8.04 to 31.1.05)			
Directors Meetings	13.7.04	10.8.04	14.9.04	12.10.04	9.11.04	14.12.04
Prof B Barraclough AO	x	x	x		x	x
Dr G Beaumont	x	x		x	x	x
Prof M Chiarella ¹	x					
Prof P Davidson	x		x	x		x
Maj Gen P Dunn AO	x	x	x	x	x	x
Prof J Dwyer AO		x	x	x	x	x
Prof P. Harris	x		x	x	x	
Dr D Horvath AO ²		x				
Prof C Hughes						x

	CLINICAL EXCELLENCE COMMISSION BOARD				
	(from 1.2.05)				
Directors Meetings	8.2.05	8.3.05	12.4.05	10.5.05	14.6.05
Prof B Barraclough AO	x	x	x	x	x
Dr A Amodeo	x	x	x	x	x
Assoc. Prof K Baker				x	x
Dr G Beaumont	x	x	x	x	x
Maj Gen P Dunn AO	x	x	x	x	x
Prof P Harris	x	x	x	x	x
Prof C Hughes	x	x	x	x	x
Assoc. Prof B McCaughan		x	x	x	x
Mr N O'Brien	x	x	x	x	x
Dr S Page	x		x	x	x
Prof T Parry	x	x		x	
Mrs M E Rummery	x	x	x	x	x

¹ Resigned on 14 July 2005² Resigned on 27 January 2005

CLINICAL COUNCIL

The governance structure for the CEC provides for a Clinical Council. This comprises medical, nursing and allied health staff and managers who will contribute to the development and delivery of the Commission's programs and advise the Board on strategies to achieve comprehensive clinician participation.

Professors Mary Chiarella and Peter Castaldi have been appointed Co-chairs. One Co-chair is a member of the Board ex officio. The members of the Clinical Council were appointed in April 2005 and an Orientation Day was held in August 2005.

CLINICAL COUNCIL MEMBERSHIP

Professor Peter Castaldi AO

(Co-chair)

Professor Emeritus University of Sydney, Consultant Emeritus, Sydney West Area Health Service

Professor Mary Chiarella

(Co-chair)

Professor of Clinical Practice Development and Policy Research, Centre for Health Services Management, University of Technology, Sydney

Assoc. Professor Michael Besser AM

Clinical Director of Neurosciences, Sydney South West Area Health Service

Ms Patricia Bradd

Speech Pathology Manager, Northern Illawarra Speech Pathology Services, Area Advisor in Speech Pathology, National President, Speech Pathology Australia

Dr Sue Crosdale

Executive Medical Director Health

Albury-Wodonga, Greater Southern Area Health Service

Professor Patricia (Trish) Davidson

Paediatric Surgeon, Area Director of Kaleidoscope, Hunter Children's Health Services, Professor within the Faculty of Health, University of Newcastle

Mr Anthony Dombkins

Director of Nursing, Dubbo Base Hospital, Acting General Manager and Director of Medical Services, Dubbo Base Hospital

Professor Creswell Eastman AM

Former Director of The Institute of Clinical Pathology and Medical Research (ICP&MR), Chairman of the Division of Laboratory Medicine, Westmead Hospital, Director, Sydney West Area Pathology Services

Assoc. Professor Brad Frankum

Director of Complex and Primary Care, Sydney South West Area Health Service, Acting Director of Immunology, Liverpool Health Service, Director of Medicine, Macarthur Health Service

Ms Julie Gawthorne

Clinical Nurse Consultant, Emergency and Trauma Services, St Vincent's Hospital

Dr Rohan Hammett

Consultant Gastroenterologist, Royal North Shore Hospital, Director Clinical Practice Improvement Unit, Northern Sydney Central Coast Health

Ms Linda Justin

Clinical Practice Improvement Coordinator, The Children's Hospital at Westmead

Dr Andrew Keegan

Consultant Gastroenterologist/Hepatologist, Nepean

Hospital, Head of Clinical Gastroenterology, Nepean Hospital

Dr Michael McGlynn

Surgeon and Clinical Director, Medical, Sydney Children's Hospital, Randwick

Dr Sandy Middleton

Professor of Nursing, Australian Catholic University

Dr Garry Nieuwkamp

Director Emergency Department, Wyong Hospital, Member of the NSW faculty, Australasian College for Emergency Medicine

Ms Melanie Pittard

Clinical Systems Strategy Unit, Information & Business Solutions Branch, NSW Department of Health

Dr Valerie Poxon

Manager Clinical Governance Unit, Liverpool Health Service

Dr Anthony Schembri

Area Clinical Director, Allied Health & Clinical Support, Sydney South West Area Health Service

Dr James Telfer

Chairman of the Section of Psychiatry, Royal North Shore Hospital, Director of Psychiatric Services, Emergency Department, Royal North Shore Hospital

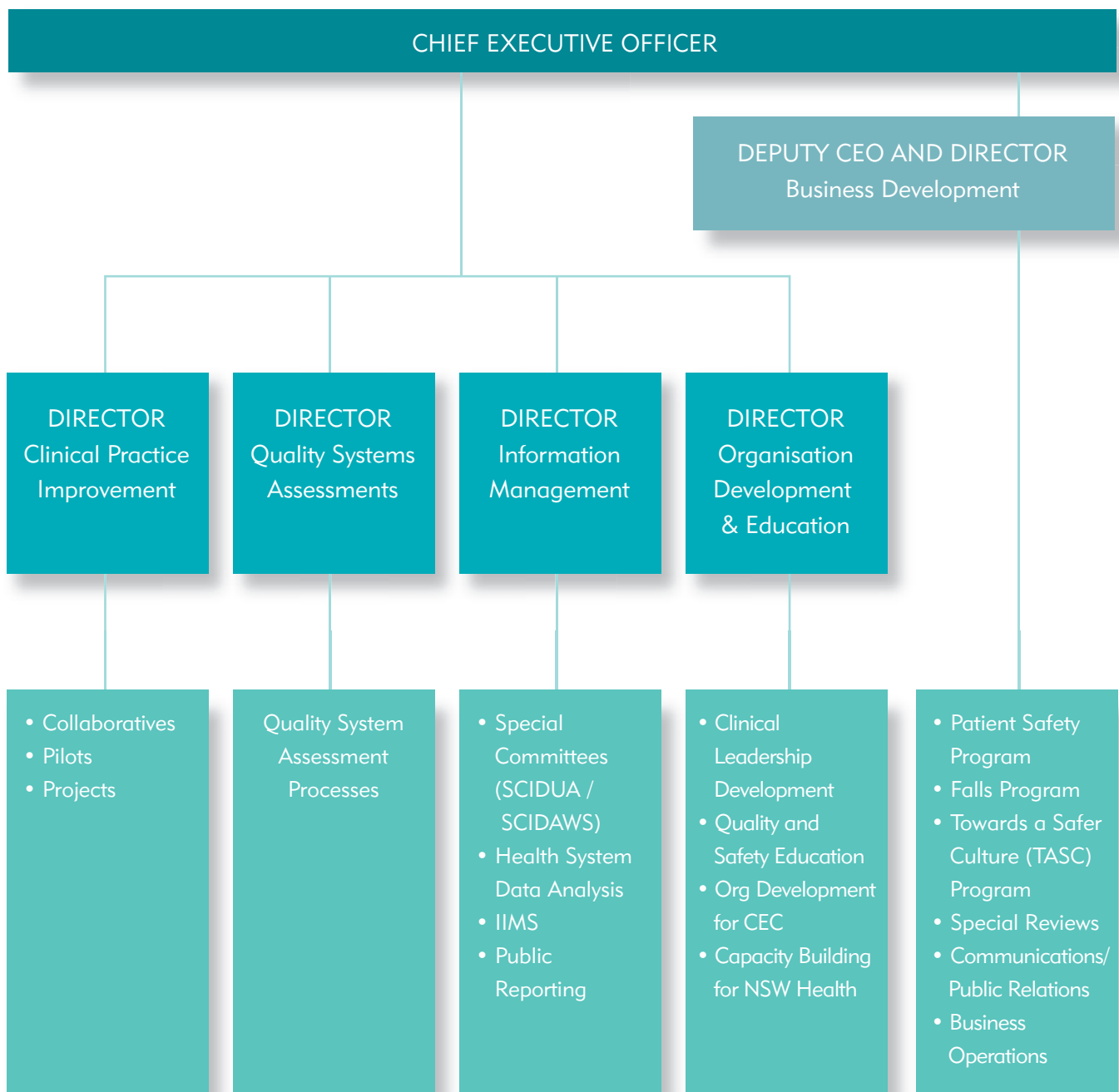
Ms Penny Thornton

Pharmacy Services Manager, The Children's Hospital at Westmead

Ms Catriona Wilson

Area Quality Manager, Northern Rivers Area Health Service

ORGANISATIONAL STRUCTURE



PURPOSE AND FUNCTIONS

The purpose and functions of the Clinical Excellence Commission are outlined in the NSW Clinical Excellence Commission's Directions Statement published in August 2004.

The CEC is a statutory health corporation established under the Health Services Act to:

- promote and support improvement in clinical quality and safety in public and private health services
- monitor clinical quality and safety processes and performance of public health organisations and to report to the Minister thereon
- identify, develop and disseminate information about safe practices in healthcare on a state-wide basis, including (but not limited to):
 - i) developing, providing and promoting training and education programs
 - ii) identifying priorities for and promoting the conduct of research about better practices in healthcare
- consult broadly with health professionals and members of the community in performing its functions
- provide advice to the Minister for Health and Director-General of Health on issues arising out of its functions.

In order to fulfil these functions, the Commission will:

- provide advice to the Minister and the Department on the status of safety and quality of healthcare in the NSW health system
- notify the Department of any system-wide safety concerns it identifies with NSW health services that require immediate action
- conduct quality system assessments of PHOs¹ and, utilising available information, evidence, expert analysis and evaluation, recommend improvements to the NSW health system
- work with PHOs, where appropriate, to facilitate implementation of quality improvements
- provide a source of expert advice and assistance to PHOs, private healthcare organisations and other interested parties
- develop and promote a state-wide approach to improving the safety and quality of health services in NSW
- engage doctors, nurses, allied health professionals, administrators and the community in the development of this state-wide approach to safety and quality improvement

- lead a state-wide program for the transfer of knowledge essential for improving safety and quality, through the identification and development of training and education strategies as well as clinical tools that can be widely applied
- lead the development and system-wide dissemination of evidence-based guidelines for improving safety and clinical quality
- focus on system issues for improvement across NSW. Any matters relating to the conduct of individuals will be dealt with in accordance with the existing policy and procedures of the PHO.

¹ Public Health Organisations

STRATEGIC PLAN

THE CURRENT POSITION

The CEC is well placed to build its future role based on the strong platform provided by the achievements of ICE, particularly in relation to project outcomes and proven methodologies, established partnerships and information and knowledge about improving safety and quality.

However, the CEC faces some challenges, not the least of which is strengthening its compliance role while building on the collaborative approaches and partnerships established by ICE. There is a danger that the compliance role may threaten future collaboration.

Despite the CEC's reputation with stakeholders who were aware of its work, there is a need for broader recognition of the CEC's profile at all levels, including clinicians, consumers and decision makers.

Finally, while the ICE projects achieved significant local outcomes, there is now a need to roll out these improvement activities across other areas and to facilitate sustained, system level interventions across the NSW health system.

STATEMENT OF STRATEGIC INTENT

Mission

The mission of the Clinical Excellence Commission is to build confidence in healthcare in NSW by making it

demonstrably better and safer for patients and a more rewarding workplace.

Vision

The CEC will be the publicly respected voice providing the people of NSW with assurance of improvement in the safety and quality of healthcare.

Desired Outcomes for 2008

By 2008, the CEC will have delivered the following specific outcomes:

- Evidence of improvement in relation to specific targets can be demonstrated
- CEC reports are widely used by decision makers and the community to shape healthcare improvement
- Self-assessment using the CEC quality systems assessment framework is in place in all NSW Public Health Organisations (PHOs)¹
- Decision makers at all levels are using robust data to identify and implement improvements
- NSW Health has a cohort of clinical leaders skilled in the leadership of quality improvement initiatives and
- There is evidence that the workforce is engaged with the principles and practices of a safe culture.

Broad Measures of Performance

As it moves forward, CEC will be able to evaluate its success by high levels of:

Uptake

The extent to which its reports, data and methodologies are used and implemented.

Demand

The extent to which the demand for participation in CEC leadership and clinical improvement programs increases over time.

Satisfaction

The level of perceived satisfaction and respect for the CEC and its services by clinical leaders and key decision makers in NSW and elsewhere.

Influence

The extent to which CEC's influence extends across the continuum of care and it is a primary point of reference on healthcare improvement.

Stakeholders

In planning for 2008, the CEC must take account of the interests and needs of its key stakeholders:

The Minister(s)

The NSW Minister for Health is the CEC's sole shareholder and expects the CEC to address issues of access in addition to issues of safety and quality in healthcare in NSW. The CEC will need to provide assistance in solving problems in the health system and pro-actively manage issues.

¹ The term Public Health Organisation (PHO) in this document includes Area Health Services; The Children's Hospital, Westmead; Justice Health; the Ambulance Service of NSW; and affiliated health organisations.

Consumers

Patients and their families expect that the CEC will evaluate the quality and safety of the system with honesty, fairness and transparency. The CEC will not only identify areas for improvement but will facilitate system wide solutions.

Clinical Leaders

Clinicians expect the CEC to demonstrate that its requirements and programs are not yet another imposition on their workload, but will help them to help their patients and help them to acquire additional resources and tools to do their work.

Health Decision Makers including Area Health Service Chief Executives

The Chief Executives of the eight Area Health Services expect the CEC to assist with achieving better outcomes in relation to appropriateness, effectiveness and accessibility. They will be expecting economic benefits to be delivered by the quality agenda.

Clinical Governance Units (CGUs)

The CGUs will be the CEC's primary interface with Area Health Services and expect the CEC to assist them in undertaking their role and in achieving results for patients.

Values

The CEC places a significant emphasis on four key values which underpin and guide its strategic direction and actions. These values are:

Effectiveness

The CEC will be recognised for its capacity to make a difference in healthcare by improving the safety and quality of healthcare in NSW. To achieve this, the CEC will need to focus on achieving results.

Courage

The work of the CEC will necessitate courage to report truthfully, to address difficult issues and to take decisive action.

Integrity

The actions of the CEC will be characterised by the integrity of its approach: its agenda and priorities will be clear, its methods and processes will be practical and it will follow through on its commitments.

Honesty

The CEC will be honest in its dealings with stakeholders and will demonstrate that it is trustworthy. It will ensure that its actions are based on sound evidence, its processes are transparent and accountable, and it will be open in its communication with stakeholders.

Distinctive role and Contribution

The CEC has been established to be a catalyst for change and improvement in healthcare service delivery in NSW. It is uniquely placed to do this as a result of its:

- Focus on both health system processes and engagement with the community
- Independence and honesty enabling it to identify the best way forward, based on evidence
- Authority arising from its mandate and linkages to governance of the health system
- Capacity to apply an integrated and disciplined approach to coordination within the health system
- Experience and a knowledge base in relation to clinical quality improvement and system change
- Ability to challenge the status quo.

KEY DRIVERS AND IMPERATIVES

Workforce

- Health workforce shortages and changing work expectations and participation rates are placing increased pressure on the system and this will increase expectations on the CEC to provide solutions to these issues.
- Related workforce issues are the changing skills mix and career expectations of staff, which will have implications for the CEC's initiatives. In particular there are significant shifts in expectations about working conditions and work practices that will require new approaches.

STRATEGIC PLAN

CONTINUED

Consumers

- Socio-demographic changes in the patient population are resulting in significant pressures on the delivery of healthcare, particularly in relation to population relocation and ageing.
- Widespread use of electronic sources of healthcare information has created a better informed and more articulate consumer population which expects the healthcare system to operate at an optimal level in terms of safety and quality; which wants to have confidence in that system; and which expects open disclosure practices to be practised across all health disciplines when there is an adverse event.

Resources

- These pressures will impact on resource allocation and models of healthcare. They will require a focus on the management of chronic disease in ambulatory/community care settings, multi-disciplinary care, and an increased focus on primary/preventative care.
- Finally, the current national discourse on Commonwealth/State arrangements for funding healthcare needs to be monitored on an ongoing basis.

From this analysis the following strategic imperatives emerge as key to the CEC's success in achieving its mission in the next three years:

- Strengthen the CEC's profile and influence

- Build skills and capacity within the CEC and across the health system, including leadership capacity
- Develop and implement targets based on available data
- Build partnerships with stakeholders
- Get some 'runs on the board', including the first CEC annual report on NSW Health System Safety and Quality.

STRATEGIC DIRECTIONS/KEY RESULT AREAS: 2005–2008

1. Provide assurance through credible public reporting

The CEC will provide annual public reports on safety and quality and on adverse events in NSW healthcare. The reporting will identify areas to address and, over time, demonstrate improvements.

2. Facilitate the uptake of clinical improvement programs

Clinical Governance Units will be a critical link in the overall system of improvement. They will work in partnership with the CEC and clinicians to implement improvement programs and methodologies.

3. Implement a system of quality assessments

The CEC will ensure that Public Health Organisations have the capacity to self-assess against processes, indicators and targets established by the CEC, whose

role is to provide an assurance that the self-assessment process is in place.

4. Develop and manage information and reporting systems

A robust and integrated information base regarding key areas of risk that are of public interest is critical to provide the basis for improvement. Working in partnership with the CEC, clinicians will have feedback reporting systems that support clinical improvement initiatives.

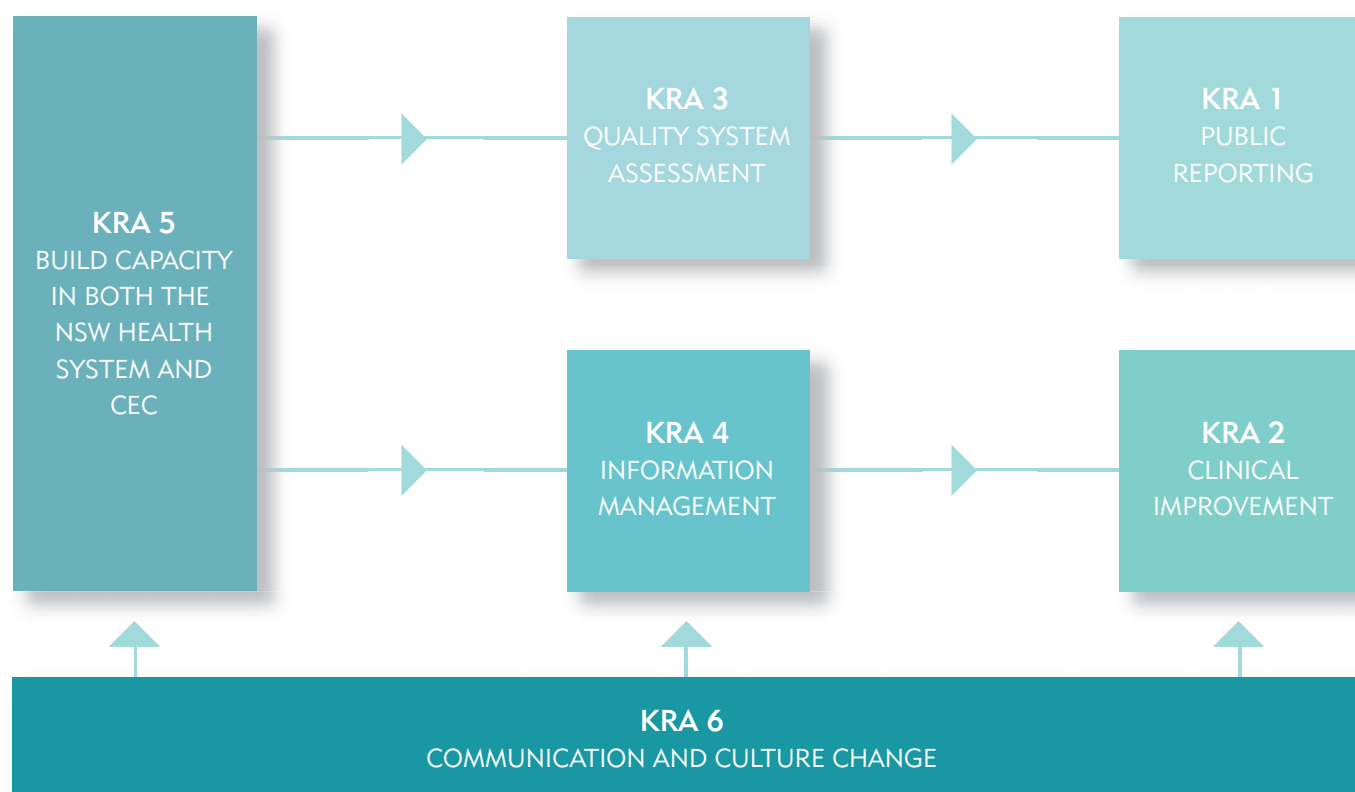
5. Build leadership capacity

The CEC will ensure that effective professional development opportunities in safety and quality leadership are available and utilised. In addition, the CEC will be a high performing organisation, demonstrating excellence in its own management and business practices.

6. Influence culture through communication and advocacy

The capacity of the CEC to communicate the need for change, influence, uptake and advocate publicly and with decision makers will be critical to its success.

CEC BUSINESS MODEL CORE FUNCTIONS & KEY RESULT AREAS

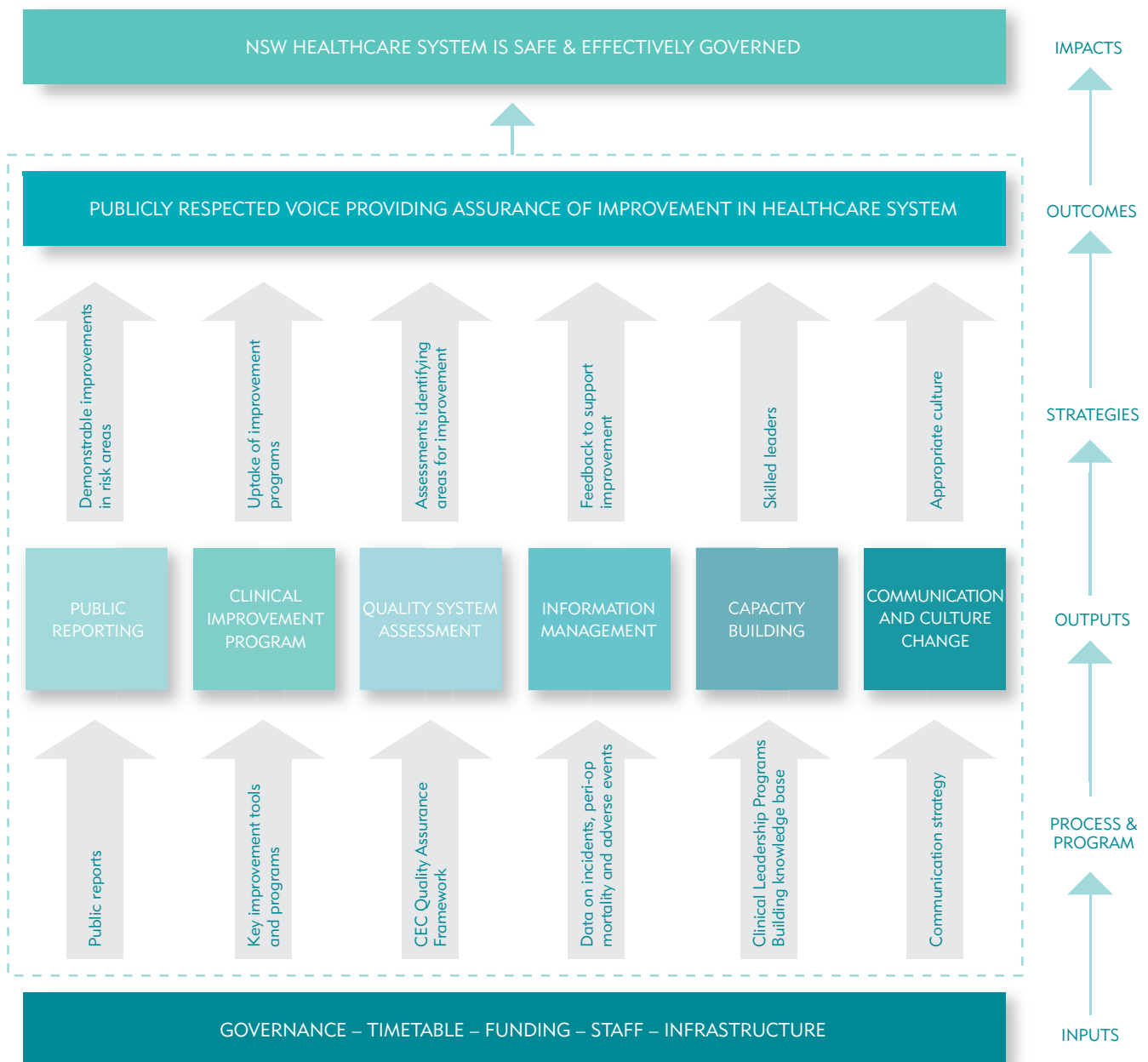


CEC IMPLEMENTATION PLAN 2005–2008

Key Result Areas	Goals for 2008 (outcome oriented objectives)	Strategies 2005–08	Performance Indicators for 2008
1 PUBLIC REPORTING	Report publicly to the Minister and the community on quality and safety in NSW Health	1.1 Develop and deliver an annual Public Report on adverse events 1.2 Develop and deliver an annual Public Report on quality system improvements	Published reports are recognised and sought as valuable information and are cited by decision-makers and the media
2 CLINICAL IMPROVEMENT	Assist Clinical Governance Units (CGUs) to implement effective clinical improvement programs in partnership with clinicians	2.1 Assist CGUs in undertaking quality improvement projects 2.2 Enhance professional skills within CGUs to implement effective improvement programs and methodologies	Clinical improvement programs are established in both rural and metropolitan area health services
3 QUALITY SYSTEM ASSESSMENT	Implement a Quality System Assessment (QSA) program across NSW, including identification of assessment criteria that allow themselves to be measured, benchmarked and trended over time	3.1 Identify methodology and external provider to undertake the QSA program 3.2 Conduct a Pilot QSA of a Public Health Organisation (PHO) within NSW 3.3 Review Pilot and determine whether external provider should be contracted to undertake QSA on remaining PHOs 3.2 Determine an ongoing assessment framework for the QSA program in partnership with the Department of Health following Year 1 of the QSA program, including process and outcomes measures	Pilot QSA of a PHO conducted QSA program implemented with all PHOs undergoing assessments on an annual basis Identification of process and outcomes indicators that reflect PHO performance
4 INFORMATION MANAGEMENT	Build a robust and integrated information base regarding peri-operative mortality and reporting for use by decision makers	4.1 Work with the Department of Health and PHOs to implement an incident and adverse event reporting system across NSW Health 4.2 Develop, in partnership with clinicians, feedback reporting systems that support clinical improvement 4.3 Develop and implement an effective reporting system for deaths associated with surgery	Complete two pilot projects for reporting surgical mortality, one each in Sydney West and the Hunter New England Area Health Services by the end of 2005 and roll them out to other Area Health Services by June 2006

Key Result Areas	Goals for 2008 (outcome oriented objectives)	Strategies 2005–08	Performance Indicators for 2008
5 CAPACITY BUILDING	Provide clinical leaders and the CEC with skills and tools to effectively lead quality improvement	NSW health system: 5.1 Develop and implement a clinical leadership development program CEC: 5.2 Build the capacity of CEC staff to lead quality improvement through professional development 5.3 Design and build the CEC as an organisation characterised by excellence in governance (including risk management; knowledge management partnerships; effective business practices and relationship management) 5.4 Develop capacity within the CEC to respond to emerging crises and referred issues	Investment in clinical leadership is significant and demand for the CEC leadership programs exceeds supply
6 COMMUNICATION AND CULTURE CHANGE	Influence current and future decision makers, at all levels of health, to apply improvement programs and methodologies	6.1 Develop and implement a communication strategy that builds the profile of the CEC and inspires confidence in its work 6.2 Provide the Minister, the community, the CEC Board, the CEC Clinical Council, decision makers and the NSW Health community with key safety and quality messages and evidence based information with a practical application 6.3 Work with PHOs in effective uptake and implementation of workplace cultural change relating to clinical improvement strategies	The CEC is influential and regarded as a primary point of reference on issues of clinical improvement

CEC STRATEGY LOGIC DIAGRAM



CORPORATE GOVERNANCE STATEMENT

CORPORATE GOVERNANCE STATEMENTS FOR THE NSW CLINICAL EXCELLENCE COMMISSION

The Board is responsible for the corporate governance practices of the NSW Clinical Excellence Commission (CEC). This statement sets out the main corporate governance practices in operation throughout the financial year, except where indicated.

THE CLINICAL EXCELLENCE COMMISSION BOARD

The Board carries out all its functions, responsibilities and obligations in accordance with the Health Services Act of 1997.

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

Board membership consists of a Chair, ten other non-executive members, the Chief Executive Officer, ex officio and one of the Co-chairs of the Clinical Council.

The Board has in place practices that ensure that the primary governing responsibilities of the Board are fulfilled in relation to:

- setting strategic direction
- ensuring compliance with statutory requirements

- monitoring organisational performance
- monitoring the quality of health services
- Board appraisal
- community consultation
- professional development

RESOURCES AVAILABLE TO THE BOARD

The Board and its members has available to it various sources of independent advice. This includes advice of the External Auditor (the Auditor General or the nominee of that office), the Internal Auditor who is free to give advice direct to the Board, and professional advice.

The engagement of independent professional advice to the Board shall be subject to the approval of the Board or of a committee of the Board.

STRATEGIC DIRECTION

The Board has in place processes for the effective planning and delivery of programs and projects to improve the safety and quality of healthcare in NSW. This process includes setting of a strategic direction for the organisation and providing independent leadership in relation to patient safety and quality.

CODE OF ETHICAL BEHAVIOUR

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

The Board has also adopted the SESAHS Code of Conduct and will develop a CEC Code of Conduct following receipt of the state-wide Code of Conduct guidelines that are currently in development.

RISK MANAGEMENT

The Board is responsible for supervising and monitoring risk management by the NSW Clinical Excellence Commission, including the CEC's system of internal controls. The Board has mechanisms for monitoring the operations and financial performance of the CEC.

The Board receives and considers all reports of the CEC's External and Internal Auditors and, through the Audit Committee, ensures that audit recommendations are implemented.

A risk management plan for the CEC is under development.

CORPORATE GOVERNANCE STATEMENT

CONTINUED

COMMITTEE STRUCTURE

The Board meets at regular intervals and has in place mechanisms for the conduct of special meetings. The Board has a committee structure in place to enhance its corporate governance role. These committees meet regularly.

AUDIT COMMITTEE

The Board has established an Audit Committee. The Committee is chaired by Mr Noel O'Brien and consists of the following Board members, Major General Peter Dunn AO, Mrs Mary Elizabeth Rummery AM, and Professor Clifford Hughes AO (Chief Executive Officer).

The Audit Committee meets four times per year. The Terms of Reference for the Audit Committee are:

OBJECTIVE

The role of the Audit Committee is to assist the Board in carrying out its corporate governance responsibilities in relation to the financial reporting, internal control, risk management, compliance with laws, regulations, ethics and the internal and external audit functions of the Clinical Excellence Commission.

FUNCTIONS

The Audit Committee assists the Board in carrying out its responsibilities as they relate to the Commission's:

1. Financial and other reporting
2. Risk management
3. Internal control
4. Compliance with laws, regulations and ethics.

THE AUDIT COMMITTEE HAS A RESPONSIBILITY FOR THE FOLLOWING ACTIVITIES:

Internal Audit

- Review and approval of the Internal Audit Charter
- Concurrence with the service agreement with provider for the provision of Internal Audit function
- Review and approval of audit plans and budgets
- Review of audit results
- Suggestions for audit topics
- Support for communication with Internal Auditors
- Ensure the independence of the internal auditing function from management
- Coordination with the External Audit Plan

External Audit

- Review of the proposed audit strategy
- Review all External Audit reports
- Review the financial statement preparation process
- Review External Audit performance and fee
- Review management's responsiveness to the External Auditors findings

INTERNAL CONTROL AND RISK MANAGEMENT

Ensure:

- The reliability and accuracy of information
- Compliance with applicable laws, policies, plans, procedures, contracts and delegation of authority
- The safeguarding of assets
- The economical and efficient use of resources
- The effective accomplishment of established goals and objectives for operation of programs

FINANCE COMMITTEE

The Board has established a Finance Committee. This committee is chaired by Dr Alan Amodeo and consists of the following Board Members, Mr Noel O'Brien, Dr Graham Beaumont, and Professor Clifford Hughes AO (Chief Executive Officer). The Finance Committee meets bi-monthly except January.

The Terms of Reference for the Finance Committee are:

OBJECTIVE

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

FUNCTIONS

The Finance Committee shall bring to the attention of the Board matters of accountability, control, audit and advice relating to:

1. Forward Estimates and Plans

- financial planning and policy
- the annual budget for capital, operating receipts and payments and cash flow

2. Financial Management

- income and expenditure budgets
- balance sheet budgets
- cash flow budgets
- accounting standards, instructions and determinations of the Board
- financial delegations

3. Performance Reporting

- activity budgets, efficiency targets, benchmarks and best practice

4. Other Board Committees

- liaise with Audit Committee with respect to accounting controls, risk management issues and insurance generally

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

PERFORMANCE APPRAISAL

The Board will ensure that there are processes in place to:

- monitor progress of the matters contained within the Performance Agreement between the Board and the Director-General of the NSW Department of Health
- regularly review the performance of the Board through a process of Board self appraisal.



REVIEW OF PROJECTS

CHRONIC CARE COLLABORATIVE

KEY TEAM MEMBERS

Professor Ron Penny – Co-Chair Chronic Care Collaborative, Senior Clinical Advisor and Chair Chronic Care Program NSW Health

Assoc. Professor Trish Davidson – Collaborative Co-Chair, Western Sydney Area Health Service and University of Western Sydney

Dr Simon Willcock – Collaborative Co-Chair; School of Medicine, University of Sydney

Ms Catherine Katz – Director, Inter-Government and Funding Strategies Branch, NSW Department of Health

Ms Kym Scanlon – Associate Director, Chronic Care Unit, NSW Department of Health

Dr Rohan Hammett – former Director of Healthcare Improvement Projects, Clinical Excellence Commission

Ms Lorraine Acheson – Collaborative Director

Ms Melanie McKinnon – Collaborative Coordinator

Ms Barbara Lay – Project Officer

Plus 30 Planning Group Members

BACKGROUND

The increasing incidence of chronic disease is a challenge facing health services nationally and internationally. By 2020 it is anticipated that 80% of the disease burden in Australia will be attributable to chronic disease. NSW Chronic Care Collaborative was established as a joint initiative of the Clinical Excellence Commission (CEC) and NSW Department of Health aimed at improving care and outcomes for people with chronic disease.

The Collaborative drew 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.

Twenty two multidisciplinary teams from across NSW participated in the Collaborative between February and November 2004. Teams included clinicians and managers from hospital and community health services, including General Practitioners, consumer and carer representatives and an Executive Sponsor. The Director General NSW Department of Health Ms Robyn Kruk, was the overall Executive Sponsor for the Collaborative.

PROJECT AIMS

The Collaborative focused on improving diagnosis and management of people with Chronic Obstructive Pulmonary Disease (COPD) and/or heart failure. Improvements were made by increasing the number of people who had a clearly defined set of diagnostic and management interventions. The interventions were drawn from the NSW Clinical Service Framework standards for COPD and heart failure and packaged into diagnostic and management bundles for teams to implement (see Table 1).

TABLE 1

Diagnostic and Management Bundles for NSW Chronic Care Collaborative

Diagnostic bundle	clinical assessment, spirometry, echocardiography
Management bundle	baseline investigations, smoking cessation, medications, referral to rehabilitation, self-management support, vaccinations, after hours point of contact, GP review, advance care directives

An optional Collaborative aim focused on increasing the number of people with COPD and/or heart failure with whom advance care directives are discussed.

Teams elected to focus on COPD only, heart failure only or both conditions.

CHRONIC CARE COLLABORATIVE

CONTINUED

METHODOLOGY

The Collaborative used adapted Breakthrough Series Collaborative methodology to facilitate the uptake of best practice.

The Collaborative Management Team at CEC supported the teams over the course of the Collaborative via site visits, teleconferences, the Collaborative listserve and website. This ensured the support of metropolitan, rural and regional teams alike. Ten members from each AHS team were funded to participate in five Collaborative events (an Orientation Session and four Learning Sessions) where they reported on and shared information about interventions tested and successes; and barriers encountered. In addition, a state-wide Chronic Care Forum was held at the conclusion of the Collaborative to which a broader audience of healthcare professionals working in the field of chronic disease was invited.

Between the Orientation Session and Learning Session One, teams carried out preliminary diagnostic work. Following each Learning Session there was an action period when teams undertook a series of small scale improvement cycles to test changes and measure the results. Teams reported their progress against changes tested on a monthly basis to the Collaborative Management Team. This allowed teams to monitor progress and to tailor interventions to specific components of the diagnostic and management bundles.

OUTCOMES

An independent evaluation of the Collaborative was completed by the Centre for Health Services Research at Westmead Hospital in April 2005. The evaluation demonstrated that the Collaborative was successful in improving the skills of team members to introduce clinical practice improvements and consequently improved the care of people with COPD and heart failure. In addition a review of consumer involvement in the Collaborative demonstrated the importance of consumer participation and the need to develop strategies to ensure meaningful engagement.

KEY ACHIEVEMENTS INCLUDE:

- Approximately 300 clinicians and managers from acute and community health services across NSW actively engaged in improving care and outcomes for people with chronic disease
- Estimated 16,000 inpatient bed days saved through decreased hospital admissions of people with COPD
- Estimated 9,000 inpatient bed days saved through decreased hospital admissions of people with heart failure
- Significant improvements in diagnosis and management of people with COPD and heart failure, including increased referral to rehabilitation for people with COPD and increased dose titration for people with heart failure

- Improved understanding for clinicians and managers in principles of chronic care management
- Increased ability of clinicians and managers to implement clinical practice improvements for people with chronic disease
- Enhanced communication and team work across health services
- Empowering patients to become active partners in the management of their chronic disease through training in self-management techniques
- Catalogue of resources to support health services in improving care for people with chronic disease.

FUTURE DIRECTIONS

The NSW Chronic Care Collaborative has demonstrated what can be achieved when diverse groups come together to achieve a common aim – to improve the diagnosis and management of people with COPD and heart failure. The achievements made within the Collaborative will continue to be built upon by a range of initiatives led by NSW Health Chronic Care Unit.

CHILDREN'S EMERGENCY CARE PROJECT

PROGRAM MEMBERS

The members of the project management team are Ms Marilyn Cruickshank, Project Leader, Dr Michael Hession, Lead Clinician and Ms Fiona Ferguson, Project Officer (from January 2005).

The Children's Emergency Care Project (CECP) is a joint initiative between the Clinical Excellence Commission (CEC), NSW Health and the NSW Child Health Networks (Greater Eastern and Southern, Western and Northern). 53 hospitals from across NSW have participated in the Project. The aim of the Project is to promote safety and quality of services for children presenting to emergency departments in NSW, through the implementation of Clinical Practice Guidelines for the most common presentations. The CECP is implementing a model that integrates the methodologies of clinical practice improvement and evidence based practice to enable clinicians to embed best practice for children and their families in NSW Emergency Departments.

PROJECT AIMS

The aims of the CECP are to:

- make healthcare safer and better for children and their families in NSW emergency departments
- promote confidence in local services
- promote appropriate referral of children to higher level of service

- promote safety and quality of service and consistency of management for mobile and junior staff through the implementation of twelve clinical practice guidelines.

METHODOLOGY

The project uses a modified collaborative methodology. The project is being conducted in four phases which include the implementation of the clinical practice guidelines: Recognition of a Sick Child, Fever, Asthma, Gastroenteritis, Bacterial Meningitis, Croup, Head Injury, Bronchiolitis, Acute Abdominal Pain, Seizures, Sore Throat, and Otitis Media in pilot sites. The final phase involves roll out of the guidelines to the rest of the NSW Emergency Departments.

A steering group advises the CECP with representation from key stakeholders and clinicians. Local multidisciplinary teams and a local executive sponsor support pilot sites. Each multidisciplinary team includes senior administrators, medical and nursing staff representing the emergency department, and in some cases paediatricians and paediatric nurses. The majority of pilot sites have had access to a paediatric Clinical Nurse Consultant (CNC) supported by one of the Child Health Networks. Although the role of the CNCs differs in some respects, each has the implementation of the Clinical Practice Guidelines as a component of their work. The CNCs have played an integral part in the implementation process as members of the pilot site teams through to

coordinating teams on an area-wide basis. Most, if not all, the CNCs have already begun the roll out to non-pilot sites within their area.

Local teams seek guidance from the CECP Management Team, and the Child Health Networks through the CNCs, on clinical issues such as risk stratification, application of clinical guidelines and medical record audits.

The project has used ten steps for inducing change: Local adaptation and development of pathways and resources at a local level; education to promote awareness and stimulate interest; audit of medical records to create understanding and develop insight; opinion leaders and clinical champions to develop positive attitude to change; PDSA cycles to change practice and confirm the value of changes; audit and feedback to integrate new practice into routine, embed new practice; and educating parents through the use of parent information sheets.

Three workshops and one learning session have been provided for pilot site team members. The workshops for the pilot site teams focused on the collaborative nature of the project in sharing resources, developing implementation strategies and the provision of localised tools to accompany the guidelines. The aims were to facilitate networking opportunities for the pilot site team members, to share project outcomes and achievements, to provide educational content on clinical practice

CHILDREN'S EMERGENCY CARE PROJECT

CONTINUED

improvement models, to inform teams of successful strategies in implementing the guidelines and overcoming barriers to discuss models for sustainability and ongoing improvement and to motivate teams through the celebration of successes and the sharing of ideas.

The program included an update of the project, expert speakers on paediatrics and quality and clinical practice improvement, round table reports by the project teams and workshops around implementation themes. Participating team members have rated these activities as highly beneficial. The sessions catered for both medical and nursing staff.

KEY ACHIEVEMENTS FOR THE YEAR

Implementation of Phase One guidelines (fever, asthma, gastroenteritis and recognition of the sick child) has been accomplished in most of the pilot sites. Phase Two guidelines (bacterial meningitis, head injury, croup and bronchiolitis) are currently being implemented.

IMPROVEMENT IN AUDIT RESULTS

Baseline and post implementation audits of medical records have been undertaken as part of the implementation process in all pilot sites. Results of the post implementation audits for phase one guidelines have demonstrated improvement in the following:

Asthma

Statistically significant improvement in the management of children with moderate asthma (correct Salbutamol and correct assessment); improvement in the number of children discharged from the emergency department with asthma plans.

Gastroenteritis

Statistically significant improvement in documentation of severity, information given at discharge, trial of fluids offered to children with mild and moderate dehydration, correct intravenous fluids and a significant decrease in representations especially among children provided with discharge information.

Fever

Statistically significant improvement in children under the age of three presenting with fever having a urinalysis, temperature measured per axilla, blood culture taken and antibiotics given if WCC above $15 \times 10^9/L$.

CONFERENCE PAPER PRESENTATIONS

Presentations were undertaken by CECP team and pilot site representatives at the following conferences:

Marilyn Cruickshank

- Invited speaker: Clinical Pathways Conference, Sydney, 15 February 2005
- Keynote speaker: Women's and Children's Hospitals Australasia Conference 11 May 2005

Helen Stevens

- Invited speaker: Children's Hospitals Australasia and the Paediatrics and Child Health Division the Royal Australasian College of Physicians, Sydney Children's Hospital, 9 February 2005
- Keynote speaker: Women's and Children's Hospitals Australasia Conference 10, 11 and 12 May 2005

ANTICIPATED OUTCOME OF THE CHILDREN'S EMERGENCY CARE PROJECT

Work is underway on an education and implementation package (toolkit) that will have two major aims:

- to facilitate the roll out of the clinical practice guidelines to non-pilot sites; and
- to provide sustainability amongst pilot sites.

The toolkit will contain strategies developed by the pilot sites for implementation of guidelines, and a suite of tools that will complement the guidelines.

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 Coordinator NSW

Ms Kim Moyes – Collaborative Coordinator Queensland

Ms Fiona Dickson – Collaborative Coordinator Victoria

Ms Ruth Smith – Collaborative Coordinator Victoria

Mr Julian Murphy – Communications Coordinator

Ms Kath Jury – Events Coordinator

Ms Anna Toscano – Operational Logistics Coordinator

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 safety for patients accessing a wide variety of Australia's health services.

The Institute for Clinical Excellence (ICE) participated in the National Medication Safety Breakthrough Collaborative (NMSBC) as the key contact point and support in NSW. ICE contributed to the development of project materials as a member of the Steering Committee, and employed a state-based Collaborative Coordinator to liaise with state-based participating teams through conference calls, site visits, Orientation / Pre work Sessions, Learning Sessions and through web based interactions. ICE and later the Clinical Excellence Commission assisted with state-wide communication and at a local level built on existing links to ensure alignment between state-based medication safety initiatives and the NMSBC.

NMSBC aimed to achieve a national improvement in medication safety by reducing patient harm, associated with medication use by 50 per cent among clients of participating healthcare 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 were achieved through:

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

GOVERNANCE

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



NATIONAL MEDICATION SAFETY BREAKTHROUGH COLLABORATIVE

CONTINUED

KEY ACHIEVEMENTS

The NMSBC has had a range of key achievements. The collaborative began in September 2003 with 47 participating teams in Wave One completing the collaborative in September 2004. A second wave of 53 participating teams commenced in February 2004 completing the collaborative in December 2004. This resulted in 100 project teams participating nationwide.

KEY ACHIEVEMENTS WAVE ONE

- Teams worked to improve the processes associated with medication utilisation in the areas of prescribing, administration, dispensing and documentation and consumer information focussing on high-risk medications that result in medication incidents such as anticoagulants, antibiotics, corticosteroids, cancer chemotherapy and medications acting on the central nervous system.
- 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 1, a day meeting with 275 delegates from project teams.
- Learning Session 2, a day meeting with 250 delegates from project teams.
- Learning session 3, a day meeting with 253 delegates from project teams.
- Learning Session 4, a day meeting with 234 delegates from project teams.

KEY ACHIEVEMENTS WAVE TWO

- Teams focused on improving the systems interface where patients move between the hospital or healthcare setting and the community. Emphasis was given to the admission and discharge process, generic prescribing and administration issues, adherence issues, and high-risk medications as listed for Wave One.
- 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 1, a two-day meeting with 240 delegates from project teams.
- Learning Session 2, a two-day meeting with 235 delegates from project teams.
- Learning Session 3, a one-day meeting with 266 delegates from project teams.
- Learning Session 4, a one-day meeting with 272 delegates from project teams.

KEY ACHIEVEMENTS ACROSS THE COLLABORATIVE

- Site visits and teleconference calls with the health service teams, Planning Group Member and the state-based Collaborative Coordinators, to discuss progress, ask questions and resolve any problems or issues. Teams reported monthly via the NMSBC website.
- 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. These tools have been made available on the NMSBC website.

- Development of CD-ROM packages to include a Sustainability Toolkit, Consumer Improvement Toolkit, and Zero Tolerance Program Improvement Toolkit. These toolkits have been made available on the NMSBC website.
- 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 include:
 - Flash cards,
 - Key rings, and
 - Question cards.
- NMSBC Newsletters produced throughout the collaborative included articles on teams "good news" stories, hot topic calls and information on the National Inpatient Medication Chart, website improvements, forthcoming learning sessions and profiles of Planning Group Members.
- Produced and distributed 'strategy and innovation' improvement guides to highlight specific team stories and achievements.
- Enhanced the NMSBC website to provide public access to the site, and enable contribution to discussion pages and access to collaborative resources, specific documents and tools, and links to websites relating to medication safety. The website will be hosted and supported for public access and continued team use until June 2007 to promote networking nationally and sharing of information.
- Produced and distributed a publication suite to include three booklets: The Project Chronicle, Team Showcase and Improvement Toolkit. The Publication Suite is available on a CD-ROM and accessible to the public via website downloads.
- Showcase Event, a one-day event to launch the Publication Suite, bring teams together to identify and develop future medication safety support networks and feature the medication safety initiatives of the NMSBC participants and develop future medication safety support networks. 280 delegates attended the Showcase Event.
- The NMSBC was felt to have assisted the organisations approach to safety and quality.
- Introduced improvement strategies and tools across Australia that will improve medication safety; these strategies have been taken on by some State Health Departments and medication safety groups for advancing medication safety improvements.
- Medication safety is no longer a pharmacy-based initiative but has full multidisciplinary involvement.
- Medication safety has been incorporated into hospital governance structures and organisational strategic plans.
- Nationally, the NMSBC teams have led the way as the pilot sites for the National Inpatient Medication Chart.
- NMSBC team achievements have been recognised through commendations from the Australian Council on Healthcare Standards (ACHS) accreditation board and as a finalist in the Baxter Quality Health Care Awards and winner of the Baxter 2004 NSW Health Awards.

OUTCOMES

- Increased networking between the health services across Australia to maintain the sharing of improvement strategies and spread the learning of the NMSBC.
- Increased reporting for potential and actual medication related harm has been beneficial in raising awareness and working towards a culture of reporting and open disclosure.

NATIONAL MEDICATION SAFETY BREAKTHROUGH COLLABORATIVE

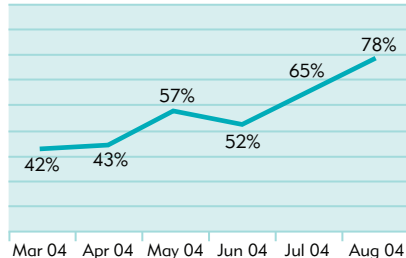
CONTINUED

WAVE ONE RESULTS

Wave One NMSBC teams focused on improving the generic processes of medication safety in the acute care setting – prescribing, administration, dispensing and documentation – and safety issues associated with high-risk drugs. A selection of improvements can be seen in the following graphs.

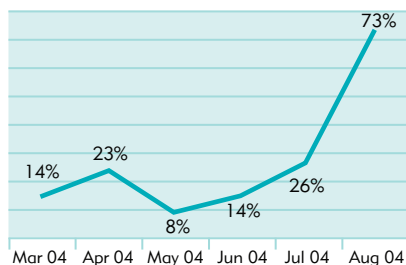
% of accurate, complete and legible medication charts

(Aggregate results – top 7 hospital teams)



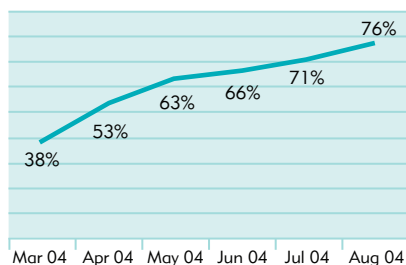
% of Pharmacy interventions

(Results for one leading hospital)



% of patients who have a medical history including ADR documented within 24 hours of admission

(Aggregate results – top 4 hospital teams)

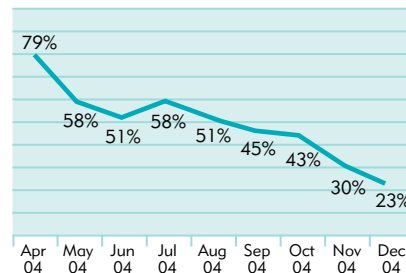


WAVE TWO RESULTS

Wave Two NMSBC teams focused on improving the medication safety during the admission and discharge process and on the community-based safety issues of patient adherence to medication regimes and of the high-risk drug groups. A selection of improvements can be seen in the following graphs.

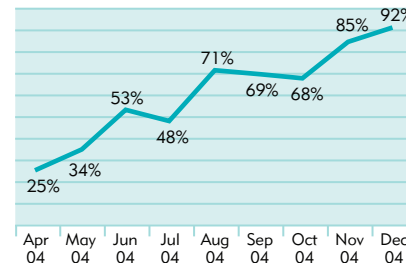
% of patients who experience medication related harm during the discharge process

(Aggregate results – top 15 hospital teams)



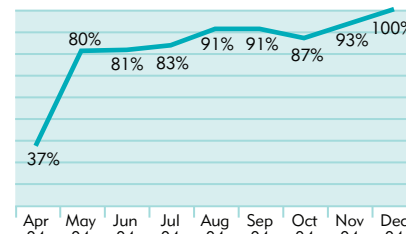
% of patients whose relevant medicines information is communicated to their community health provider in a timely fashion

(Aggregate results – top 8 hospital teams)



% of patients/carers who are informed of how their discharge medicines and schedules are different from medicines they were admitted on

(Aggregate results – top 7 hospital teams)



SAFETY IMPROVEMENT PROGRAM

KEY TEAM MEMBERS

The late Dr Ian O'Rourke – CEO, Institute for Clinical Excellence (to August 2004)

Professor Cliff Hughes – CEO, Clinical Excellence Commission (from January 2005)

Ms Maureen Robinson – Past Director, Quality and Safety Branch, NSW Health

Dr Paul Douglas – Director Population Health and Planning, Northern Sydney Central Coast Area Health Service

Ms Sarah Michael – Manager Patient Safety, CEC

Ms Annika Sander – Project Officer

Dr Tim Cartmill – SIP faculty member

Dr Tom Hugh – SIP faculty member

Dr John Overton – SIP faculty member

PROGRAM AIMS

There is a growing body of international and Australian knowledge that has contributed to the evolving concept of quality improvement in healthcare. Central to this approach is an acknowledgement that very few errors are due to a lack of care or commitment from healthcare professionals or the result of the action of one individual. In most cases, potentially harmful incidents occur as part of a chain of events.

The Safety Improvement Program (SIP) was developed in 2002 to introduce a simple, standardised system-wide approach to improving the safety of healthcare provided in NSW. The Safety Improvement Program has been progressively implemented in all area health services in NSW over the past three years.

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 all incidents that occur in the health system. All of these components are integral to improving the safety and quality of care provided.

Following the provision of training to over 2500 people, a train the trainer program has been developed to ensure that sustainability is achieved through the delivery of targeted education and training at the local Area Health Service level.

The Safety Improvement Program is now a component of a broader health strategy – The NSW Patient Safety and Clinical Quality Program. This new program builds on previous policies, frameworks and strategies already in operation within the NSW health system to create what is potentially one of the greatest ever systemic improvements to clinical quality and safety.

Central to the success of the NSW Patient Safety and Clinical Quality Program's success is ensuring:

- A culture of safety that encourages reporting
- A system that facilitates the classification and investigation of incidents
- Structures and processes that increase accountability so that problems are rectified and quality improvements can be made

The NSW Patient Safety and Clinical Quality Program has five key components:

1. An electronic Incident Information Management System (IIMS) to facilitate the reporting and recording of incidents.
2. A framework that assists in managing incidents and identifying risks so that steps are swiftly taken to prevent the incident occurring again.
3. Clinical Governance Units in each area health service to oversee the management of patient safety at a local level.

SAFETY IMPROVEMENT PROGRAM

CONTINUED

4. A Quality Systems Assessment Program, conducted by an external agency, to assess quality and safety systems within all public health organisations and determine whether everything is in place and working well.
5. A Clinical Excellence Commission (CEC) to promote and support better clinical quality and advise the Minister for Health on where broad reaching quality improvements can be made.

ACHIEVEMENTS

Following on from the training achievements in 2003–04, a further five centralised training programs were provided in 2004–05 taking the total exposure of the program to over 4000 managers, clinicians and general staff – representing close to 4% of the total health staff in NSW.

This training focused on four key components:

1. Rationale for the process and an introduction to the concepts of human factors.
2. How to prioritise incidents and near misses using the Severity Assessment Code (SAC).
3. A step by step overview of the Root Cause Analysis (RCA) process using practical examples.
4. Closing the loop through the development of appropriate actions and recommendations.

In recognition of the need to ensure sustainability and delivery of the program, the CEC worked with the Cognitive Institute to decentralise the training through the development of a train-the-trainer program. The overall strategy of the model was to train trainers in presentation skills and to equip them to run the RCA training program at the local level. The program included lectures and didactic explanation of skills, however the major focus was on providing time to practice skills where effective feedback was maximised. It was during these rehearsal times that the bulk of learning took place.

In April 2005, a total of 60 participants attended one of three, three day training courses. Significant progress in presentation capabilities and individual confidence was made among almost all

participants. Since the introduction of the train-the-trainer model, local training courses have been delivered or scheduled in each area health service.

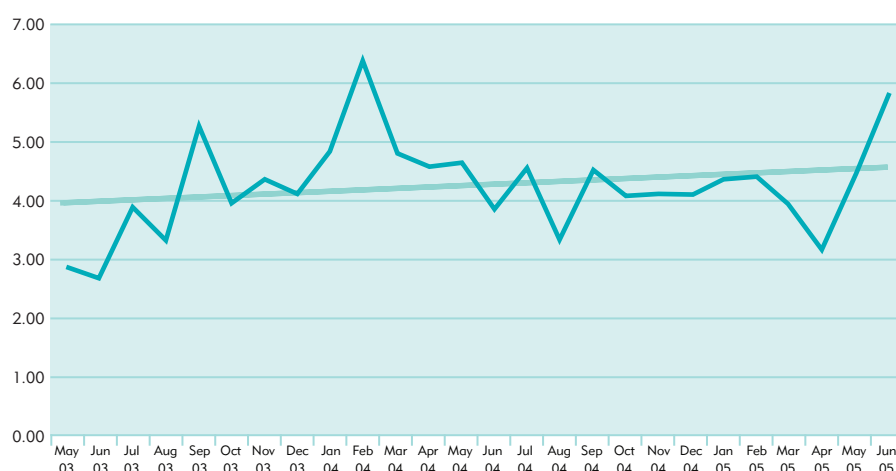
CAPTURING INFORMATION

The NSW Department of Health introduced the Reportable Incident Brief (RIB) in 2003 to improve incident management at the State level. The RIB has ensured the timely and responsive management of issues and serious adverse events.

In the first two years of reporting via the RIB process over 3,000 reportable incidents were received. Of these, 35% were a serious adverse event or SAC 1. Compared to the reporting system in place prior to the introduction of the RIB, there has been a 30% increase in the

FIGURE 1

SAC 1 Reportable Incident Briefs per 10,000 patient admissions
May 03 – Jun 05



reporting of incidents related to clinical care. Following this steep jump, reporting has continued to rise progressively. Figure 1 shows the monthly trends in reporting of SAC 1 notifications, expressed as a rate per 10,000 inpatient separations, between May 2003 and June 2005 (the first 2 full years of reporting).

In November 2004 the electronic Incident Information Management System (IIMS) was introduced in all Area Health Services. The system records all healthcare incidents, including those that resulted in, or had the potential to result in a serious adverse event.

The IIMS captures incidents under four categories:

- Clinical
- Complaints
- Property security and hazards
- Staff, visitors and contractors

The IIMS will assist managers to deal with incidents in their areas, record the results of reviews and investigations of incidents and provide reports on all incidents recorded in the system in a timely manner.

There are 100,000 potential users of the IIMS system, that includes all NSW health system employees and contractors. A comprehensive training and education program has been developed using 'e-learning modules', a CD-ROM, DVD and video to ensure all

potential users have consistent training in the use of the IIMS. Full deployment across the whole of NSW was completed in May 2005.

EVALUATION

In 2004 the Quality and Safety Branch and the Clinical Excellence Commission engaged the Centre for Clinical Governance Research in Health from the University of NSW to undertake an evaluation of the Safety Improvement Program. The four key components of the evaluation focused on:

- the training program on safety improvement techniques and approaches
- generating and managing information about incidents
- conducting RCA's on serious clinical incidents and
- making recommendations and actioning these recommendations as appropriate.

The final report indicated that the program has been a major patient safety initiative and has made considerable gains in addressing patient safety within NSW. The evaluation reports with confidence that the SIP training met the needs of over 2,500 policymakers, clinicians and managers across the NSW health system. This cohort was exposed to principles, practices, skills and tools designed to improve patient safety.

The evaluation identified a convincing case for more effective reporting of incidents however noted that significant progress has been made in this area with the introduction of the Incident Information Management System.

With Root Cause Analysis now the accepted method to review serious clinical incidents (SAC 1), the report stated that the initiatives represent a considerable step forward in creating systems change and improving cultural perspectives on safety.

THE FUTURE

The CEC has established a Patient Safety Unit responsible for the analysis of state-wide clinical incident data to identify trends and recommend preventative action to reduce the likelihood of adverse events, increase patient safety and improve clinical quality within the NSW health system. The unit will work closely with the other key directorates within the CEC.

TOWARDS A SAFER CULTURE (TASC) PROJECT

KEY TEAM MEMBERS

Ms Cate Ferry – TASC Project Manager

Assoc. Professor Drew Fitzpatrick – TASC Clinical Director

Professor Chris Levi – Clinical Leader – Stroke

Mr Paul Long – Royal Australasian College of Physicians

Ms Celia Mahoney – Administrative Officer

PROJECT AIMS

The Toward a Safer Culture Project (TASC) is a joint initiative of the NSW Clinical Excellence Commission (CEC) and the Royal Australasian College of Physicians (RACP).

The TASC Project aims to develop a sustainable quality system to better translate guideline recommendations into clinical practice. TASC 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 Project 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

In Phase 1 (Nov 2000 to Nov 2002), 4 hospitals participated: John Hunter and Nepean Hospitals in NSW, Townsville Hospital in Queensland and Frankston Hospital in Victoria. In Phase 2 (February 2003 – present), 30 hospitals in 7 Area Health Services across NSW are participating.

The project is coordinated by a steering group and supported by local multidisciplinary teams. Each multidisciplinary team includes senior administrators, medical, nursing, allied health staff and consumers from the emergency department, cardiology and neurology.

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 practice (EBP) to enable clinicians to embed best practice routinely in clinical care. TASC is about implementing the evidence that 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.

The TASC Management Team has provided support for teams over the course of the TASC Project via site visits, teleconferences and the TASC listserve. Two Learning Sessions were held in 2004. At each Learning Session, teams report on their activities, progress and share successes and barriers.

KEY ACHIEVEMENTS

There are 30 participating hospitals across seven Area Health Services in NSW.

Clinical pathways for ACS and stroke have been developed and are in use in the participating hospitals. The pathways facilitate risk stratification to guide subsequent management and replace the handwritten medical record notes.

The demand for timely and accurate clinical information within the public health system to support improved health outcomes is increasingly being recognised. A key component of the TASC Project for sustaining clinical practice improvement efforts includes embedding measurement into daily clinical work.

The TASC Online System, developed in 2003, 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, area health services and hospitals and benchmarking against participating hospitals
- Review of data to identify specific areas for clinical practice improvement

3,076 stroke patients and 3,284 ACS patients have been recorded in the TASC Online System from 1 July 2004 to 30 June 2005. Measurement of the stroke classification and level of severity using the Scandinavian Stroke Scale (SSS) are available in 1,237 cases. Application of the SSS identified the following levels of severity for stroke patients: 65% mild, 28% moderate and 7% severe. Discharge outcomes were assessed using a Modified Rankin Score. In 1,125 cases 61% of patients had a favourable outcome with a Modified Rankin Score being between 0-2 on discharge. (0 indicating no symptoms at all, 2 indicating a slight disability, patient unable to carry out all previous activities, but able to look after own affairs without assistance).

Swallowing assessments have been conducted within the first 24 hours of admission at the participating hospitals in 66% of stroke patients. The rate of aspiration pneumonia at these hospitals from July 2004 – June 2005 has decreased from 6% to 5%.

Results demonstrate that 77% of ACS patients presenting to emergency departments of hospitals participating in the TASC Project were allocated an appropriate triage of Category 1 or Category 2, as recommended by the guidelines.

The rates of delivery of aspirin and beta-blockers in participating hospitals for ACS patients have increased. Patients receiving aspirin at discharge has increased from 87% in 2003 to 89% in 2004. Patients receiving beta-blockers at discharge has increased from 85% in 2003 to 90% in 2004.

To enhance the efficient but safe management of intermediate risk patients a number of hospitals have increased the availability of exercise stress testing services. This has led to a reduction in the number of inappropriate cardiac discharges from hospital. Readmission rates within 28 days from July 2004 to June 2005 were 8.7% (2003/04 11%) for ACS readmissions within 28 days and 1.4% (2003/04 2.2%) for ACS representations to the emergency department within 48 hours.

TOWARDS A SAFER CULTURE (TASC) PROJECT

CONTINUED

CONFERENCE PRESENTATIONS

- *Improving the quality of care* – The Towards a Safer Culture Project 2nd Australian Conference on Safety & Quality in Health Care Canberra, August 2004.
- *Translating Evidence into Clinical Practice* – The Towards a Safer Culture Project, 10th European Forum on Quality Improvement in Health Care London, April 2005.
- *Implementation of a multicentre stroke unit clinical support and outcome measurements system in NSW, Australia* – the TASC Stroke Project, European Stroke Meeting Italy, May 2005.

EVALUATION

A formal evaluation of the TASC Project will be completed by November 2005. The evaluation will identify the impact of the TASC Project on specific processes and outcomes for ACS and stroke patients. The evaluation will compare data from NSW hospitals that participated in the TASC Project with hospitals in NSW that did not participate in the TASC Project.

ANTICIPATED OUTCOMES

- ACS and stroke patients will be assessed, diagnosed and treated according to the best available evidence
- Standardised care for Acute Coronary Syndromes and stroke patients in the emergency departments of participating hospitals
- Reduction in adverse incidents

FUTURE SCOPE

The achievements of TASC will now be further developed in a three-year program. The vision is for the TASC Project to move from a project to be given recognition as the NSW TASC Program, which will deliver an integrated clinical support system to NSW public hospitals to improve the management and clinical outcomes of patients presenting for assessment, diagnosis and treatment for a number of important clinical conditions.



SPECIAL COMMITTEES

THE SPECIAL COMMITTEE INVESTIGATING DEATHS ASSOCIATED WITH SURGERY (SCIDAWS)

Chairman

Professor Cliff Hughes AO
(to January 2005)

Chairman

Professor Hugh Carmalt
(from January 2005)

BACKGROUND

The Special Committee Investigating Deaths Associated With Surgery was established in 1994 under the Health Administration Act 1982 to review deaths associated with surgical practice in New South Wales.

It was envisaged that the Special Committee would receive information on individual deaths that occurred within 30 days of a surgical procedure from two sources, the Coroner and individual surgeons on a voluntary basis. It has become apparent that this mechanism for referrals has resulted in inconsistent reporting of relevant deaths for consideration by the Committee, to the extent that it has not been possible to produce meaningful aggregate data. Prior to its transfer to the Clinical Excellence Commission, the Committee had also operated in isolation from other relevant State and Federal quality improvement programmes.

RECENT DEVELOPMENTS IN SURGICAL AUDIT

The Committee has enthusiastically welcomed the opportunity to transfer its activities to the Clinical Excellence

Commission and to benefit from increased resourcing of its secretariat. The aim is to substantially improve the number of surgeons participating in systematic audits of surgical mortality in New South Wales. The Committee has assessed existing models of surgical audit and has recommended adoption of the model developed by the Scottish Audit of Surgical Mortality.

The successful Scottish model of surgical mortality audit has been adapted for use in Australia by the Western Australian Audit of Surgical Mortality (WAASM). Originally WAASM was established by:

- the WA Safety and Quality of Surgical Care Project, a collaborative project of the Royal Australasian College of Surgeons (WA Branch)
- the Centre for Health Services Research within the School of Population Health (University of Western Australia)
- the WA Department of Health.

Since January 2005 WAASM has been managed by the Royal Australasian College of Surgeons, with the intention of facilitating the College Council's commitment to develop a bi-national surgical mortality audit programme across Australia and New Zealand.

Within New South Wales, the recently re-configured Area Health Services are undertaking mortality audits as part of their Patient Safety and Clinical Quality Programs.

THE FUTURE

The potential exists within NSW for both significant omission and duplication of effort and resources with respect to auditing surgical mortality. There is a clear and pressing need to rationalise these activities in order to streamline the process, minimize confusion and maximize efficiency. Therefore the Clinical Excellence Commission is working in close collaboration with the NSW State Committee of the Royal Australasian College of Surgeons, SCIDAWS and the NSW Area Health Services to develop an agreed, sustainable mechanism that will fulfil the needs of all stakeholders.

MEMBERSHIP

The Royal Australasian College of Surgeons

Special Committee Investigating Deaths Under Anaesthesia

The Royal College of Pathologists of Australia

The NSW Health Department

Departments of Surgery of the University of Sydney, New South Wales and Newcastle

Professional associations concerned with each of the various surgical sub-specialties.

THE SPECIAL COMMITTEE INVESTIGATING DEATHS UNDER ANAESTHESIA (SCIDUA)

Chairman

Dr Christopher L Borton

BACKGROUND

The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) was originally convened in 1961 to make an expert clinical assessment of the cause of deaths occurring during or shortly after the administration of anaesthesia. The Committee was re-established under the Health Administration Act 1982 and has privilege. The Committee reports to the Minister for Health and makes recommendations for the prevention of morbidity and mortality associated with anaesthesia in NSW.

Specifically the Special Committee investigates deaths that are reportable to the Coroner under Section 12B(1) (e) of the NSW Coroners Act and similar deaths from Tasmania. The NSW Special Committee is the longest established body of its kind and is a world leader in studies of this nature.

Further information and procedures relevant to the statutory obligation of hospitals and doctors to report deaths are contained in the NSW Health Policy Directive Coroners' Cases and Amendments to Coroners Act 1980 (Document number PD2005_352).

CURRENT SITUATION

The year 2004/05 has marked a major milestone for the Special Committee in terms of its operational efficiency since

its transfer to the Clinical Excellence Commission. A very considerable backlog of cases had accrued over several years with the result that feedback from the Special Committee to referring clinicians was often significantly and undesirably delayed. The Committee is pleased to report that the backlog was cleared in November 2004.

Currently, the investigation of new cases commences on receipt of the notification with feedback to the referring anaesthetist usually occurring within a few months.

For the first time in many years, the Committee's secretariat has been sufficiently resourced to enable the collation of aggregate information within a clinically meaningful timeframe.

This year the Committee has reported to the NSW Minister for Health on its caseload for the calendar years 2000–2003 inclusive, identified areas of concern that may require further review and formulated recommendations for preventive actions. In addition, aggregate data from Tasmanian and NSW cases for the years 2000–2002 inclusive has been submitted to the national audit of anaesthesia-related mortality. This audit is collated and edited by the Australian and New Zealand College of Anaesthetists and published in a series of triennial reports.

THE FUTURE

The secretariat for the Special Committee Investigating Deaths Under Anaesthesia will physically relocate from Royal Prince Alfred Hospital to the Clinical Excellence Commission in October 2005. At this time the Committee's administrative support will be strengthened and its data management systems upgraded.

MEMBERSHIP

Australian & New Zealand College of Anaesthetists

Australian Society of Anaesthetists

Royal Australian & NZ College of Obstetricians & Gynaecologists

Departments of Anaesthesia at the University of Newcastle, University of Sydney

Department of Surgery at the University of Sydney, University of NSW

The Special Committee Investigating Deaths Associated with Surgery

Royal Australian & N Z College of Obstetricians & Gynaecologists

Royal College of Pathologists of Australasia

OUR PEOPLE

STAFF PROFILE

Full time equivalent staff as at 30 June is:

2002/03	8
2003/04	14
2004/05	13.7

EXECUTIVE REPORT

Name: Clifford F Hughes AO

Health Service: Clinical Excellence Commission

Period in Position: 18 January 2005 to 30 June 2005

Strategic Initiatives

- Establishment of Board structure and programme.
- Development, education and establishment of Clinical Council.
- Development of organisational Strategic Plan and Key Result Areas 2005–2008.
- Development of strategies and the key portfolios of Quality Systems Assessment, Clinical Practice Improvement Projects, Information Management and Organisation Development and Education.
- Development of strategies with the Quality and Safety Branch, NSW Health for Clinical Governance Units and the Directors.

- Development and implementation of strategies and policies around the use of Incident Information Management System data.
- Provided advice on the compilation and release of the 1st Report on Adverse Events in NSW.
- Development of a Strategic Plan for conversion of the Special Committee Investigating Deaths Associated With Surgery program into Collaborating Hospitals Audit of Surgical Mortality on an Area by Area basis.

Management Accountabilities

- Development of organisational structure for the CEC including development of position statements for second tier positions.
- Identified and negotiated additional accommodation to enable expansion of CEC.
- Met budget.
- Ongoing management of the following CEC projects:
 - Chronic Care Collaborative.
 - Improving Patient Access to Acute Care Services.
 - Children's Emergency Care.
 - NSW component of National Medication Safety Breakthrough Collaborative.
 - Towards A Safer Culture.

- Development of reporting mechanisms to the Board and to the Director-General, NSW Health.
- Initiated partnerships with NSW Therapeutic Advisory Group, The Sax Institute and Cancer Institute NSW.
- Observed all statutory and financial reporting requirements.

EQUAL EMPLOYMENT OPPORTUNITY

The CEC has a Service Level Agreement with South Eastern Sydney Illawarra Area Health Service for Human Resources services, among other corporate services. CEC applies the Area's EEO strategies regarding recruitment and is developing a targeted Professional Development Program to ensure that the skills and experience of CEC staff are enhanced during their periods of secondment or employment with the organisation.

OCCUPATIONAL HEALTH & SAFETY

As at 30 June 2005, CEC had not experienced any workers' compensation claims. There were also no reported incidents, as opposed to claims, for the period.

OFFICIAL OVERSEAS TRAVEL

OVERSEAS VISITS BY CLINICAL EXCELLENCE COMMISSION STAFF

Dr George P Bearham

Acting Chief Executive Officer

21st ISQa International Conference on
Quality in Healthcare, including
International Indicators Summit.

18–22 October 2004

Ms Cate Ferry

Project Leader, TASC Program

10th European Forum on Quality
Improvement in Health Care, London,
United Kingdom

13–15 April 2005

Ms Marilyn Cruickshank

Project Leader, Children's Emergency
Care Project

Women's & Children's Hospitals of
Australasia, Christchurch, New Zealand

10–12 May, 2005

Dr Rohan Hammett

Director Healthcare
Improvement Projects

10th European Forum on Quality
Improvement in Health Care, London,
United Kingdom

13–15 April 2005

All visits funded from the General fund.

FREEDOM OF INFORMATION (FOI) REPORT

The Clinical Excellence Commission did not receive any applications under the FOI Act for the period 1 July 2004 to 30 June 2005.



FINANCIAL
REPORTS
2004/2005

EXECUTIVE SUMMARY

The audited financial statements presented for the Clinical Excellence Commission for the 2004/05 financial year provides for a Net Cost of Services budget of \$5.459 million, against which the audited actuals of \$3.037 million represents a variation of \$2.422 million or 56%.

The reported variation can be attributed to:

- The actual result was better than budget expectations due mainly to lower than expected costs throughout the year. The result also reflects higher than expected grants revenue.
- Due to the favourable net cost of service position, the actual deficit for 2004/2005 period was lower than budget expectations.

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

Comparisons of actual performance with the preceeding twelve months is provided in the following table.

	2003/04 \$000	2004/05 \$000	Movement \$000 %	
Employee Related Expenses	1,145	1,606	461	40
Visiting Medical Officers				
Goods & Services	2,044	1,523	-521	25
Maintenance	17	28	11	64
Depreciation & Amortisation	2	3	1	50
Grants & Subsidies				
Borrowing Costs				
Payments to Affiliated Health Organisations				
Other Expenses				
Total Expenses	3,208	3,160	-48	1.5
Sale of Goods & Services	66	6	-60	90
Investment Income	13	17	4	31
Grants & Contributions	59	100	41	69
Other Revenue	20	0	-20	100
Total Revenues	158	123	-35	22
Gain/Loss on Disposal of Non Current Assets				
Net Cost of Services	3,050	3,037	-13	0.4

INDEPENDENT AUDIT REPORT



GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDIT REPORT CLINICAL EXCELLENCE COMMISSION

To Members of the New South Wales Parliament

Audit Opinion

In my opinion, the financial report of the Clinical Excellence Commission:

- (a) presents fairly the Clinical Excellence Commission's financial position as at 30 June 2005 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 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 Board of the Clinical Excellence Commission. 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 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, and
- 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 had not fulfilled their reporting obligations.

INDEPENDENT AUDIT REPORT

CONTINUED

My opinion does *not* provide assurance:

- about the future viability of the Clinical Excellence Commission
- that the Clinical Excellence Commission 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 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, FCPA
Director, Financial Audit Services

SYDNEY
7 October 2005

CERTIFICATION OF FINANCIAL STATEMENTS

The attached financial statements of the Clinical Excellence Commission for the year ended 30 June 2005:

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 Clinical Excellence Commission; and
3. have no circumstances that would render any particulars in the financial statements to be misleading or inaccurate.



Professor Bruce Barraclough, AO
Chairman



Professor Clifford Hughes, AO
Chief Executive Officer



Rhonda Topp
Director, Business Operations

STATEMENT OF FINANCIAL PERFORMANCE

FOR THE YEAR ENDED 30 JUNE 2005

	Notes	Actual 2005 \$000	Budget 2005 \$000	Actual 2004 \$000
Expenses				
Operating Expenses				
Employee Related	3	1,606	1,385	1,145
Goods and Services	4	1,523	3,574	2,044
Maintenance	5	28	500	17
Depreciation and Amortisation	2(i), 6	3	–	2
Total Expenses		3,160	5,459	3,208
Revenues				
Sale of Goods and Services	7	6	–	66
Investment Income	8	17	–	13
Grants and Contributions	9	100	–	59
Other Revenue	10	–	–	20
Total Revenues		123	–	158
NET COST OF SERVICES	20	3,037	5,459	3,050
Government Contributions				
NSW Health Department Recurrent Allocations	2(d)	2,580	2,580	3,255
Acceptance by the Crown Entity of Employee Superannuation Benefits	2(a)	97	95	68
Total Government Contributions		2,677	2,675	3,323
RESULT FOR THE YEAR FROM ORDINARY ACTIVITIES	17	(360)	(2,784)	273
TOTAL CHANGES IN EQUITY OTHER THAN THOSE RESULTING FROM TRANSACTIONS WITH OWNERS AS OWNERS	17	(360)	(2,784)	273

The accompanying notes form part of these Financial Statements

STATEMENT OF FINANCIAL POSITION

FOR THE YEAR ENDED 30 JUNE 2005

	Notes	Actual 2005 \$000	Budget 2005 \$000	Actual 2004 \$000
ASSETS				
Current Assets				
Cash	11	447	(2,202)	582
Receivables	12	–	1	1
Other	14	1	–	–
Total Current Assets		448	(2,201)	583
Non-Current Assets				
Plant and Equipment	13	68	37	37
Total Non-Current Assets		68	37	37
Total Assets		516	(2,164)	620
LIABILITIES				
Current Liabilities				
Payables	15	324	220	219
Provisions	16	108	65	65
Total Current Liabilities		432	285	284
Non-Current Liabilities				
Provisions	16	119	11	11
Total Non-Current Liabilities		119	11	11
Total Liabilities		551	296	295
Net Assets/(Liabilities)		(35)	(2,460)	325
EQUITY				
Accumulated Funds	17	(35)	(2,460)	325
Total Equity		(35)	(2,460)	325

The accompanying notes form part of these Financial Statements

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 30 JUNE 2005

	Notes	Actual 2005 \$000	Budget 2005 \$000	Actual 2004 \$000
CASH FLOWS FROM OPERATING ACTIVITIES				
Payments				
Employee Related		(1,358)	(1,290)	(1,089)
Maintenance		(28)	(28)	(17)
Other		(1,419)	(4,046)	(2,111)
Total Payments		(2,805)	(5,364)	(3,217)
Receipts				
Sale of Goods and Services		6	–	46
Investment Income		17	–	13
Grants		100	–	59
Other		1	–	39
Total Receipts		124	–	157
Cash Flows From Government				
NSW Health Department Recurrent Allocations		2,580	2,580	3,255
Net Cash Flows from Government		2,580	(2,784)	3,255
NET CASH FLOWS FROM OPERATING ACTIVITIES	20	(101)	(2,784)	195
CASH FLOWS FROM INVESTING ACTIVITIES				
Purchases of Plant and Equipment		(34)	(1)	–
NET CASH FLOWS FROM INVESTING ACTIVITIES		(34)	(1)	–
NET INCREASE / (DECREASE) IN CASH		(135)	(2,785)	195
Opening Cash and Cash Equivalents		582	583	387
CLOSING CASH AND CASH EQUIVALENTS	11	447	(2,202)	582

The accompanying notes form part of these Financial Statements

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2005

1. THE CLINICAL EXCELLENCE COMMISSION REPORTING ENTITY

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

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

The Clinical Excellence Commission 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 Clinical Excellence Commission'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 twelve 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 covered by the master policy for South Eastern Sydney and Illawarra Area Health Service.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2005

2. Long Service Leave.

Long Service Leave is measured on a shorthand basis at an escalated rate of 3.42% above the salary rates immediately payable at June 30 2005 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 Clinical Excellence Commission's liability for superannuation is assumed by the Crown Entity. The Clinical Excellence Commission accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of Employee 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 Superannuation Scheme) the expense is calculated as a multiple of the employees' superannuation contributions.

4. Other Provisions

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

c) Borrowing Costs

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

d) Revenue Recognition

Revenue is recognised when the Clinical Excellence Commission has control of the good or right to receive, it is probable that the economic benefits will flow to the Clinical Excellence Commission 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.

Investment Income

Interest revenue is recognised as it accrues. Rent revenue is recognised in accordance with AAS17 "Accounting for Leases".

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 Clinical Excellence Commission 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 Clinical Excellence Commission 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 Clinical Excellence Commission is registered as part of the South Eastern Sydney and Illawarra 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 uncollectible 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.

g) Acquisition of Assets

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by the Clinical Excellence Commission. Cost is 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 so as to write off the depreciable amount of each asset as it is consumed over its useful life to the Clinical Excellence Commission. Thus, the depreciation rates for some assets may vary from the standard depreciation rates (shown below).

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2005

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) Other Financial Assets

Other financial assets are generally recognised at cost.

n) Financial Instruments

Financial instruments give rise to positions that are a financial asset of either the Clinical Excellence Commission or its counterpart and a financial liability (or equity instrument) of the other party. For the Clinical Excellence Commission these include cash at bank, receivables, other financial assets and payables.

In accordance with Australian Accounting Standard AAS33, "Presentation and Disclosure of Financial Instruments", information is disclosed in Note 24 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.

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 4.7% (4.5% in 2003/2004).

2. Receivables

Accounting Policies – Receivables are recognised and carried at cost, based on the original invoice amount less a provision for any uncollectible 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 and Illawarra 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 Clinical Excellence Commission.

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.

5. Other

There are no classes of instruments which 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.

o) Payables

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

p) 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 22 on budget review. The budget amounts exclude GST.

q) Programs

The Clinical Excellence Commission has only one program (refer note 23). Accordingly a program statement is not required.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2005

r) Reclassification of Financial Information

For the year ended 30 June 2005, General Expenses Project Payment disclosure has been expanded to provide further detail, as a result of which the amounts for 2003/04 have been reclassified to ensure comparability.

s) Impact of Adopting Australian Equivalents to International Reporting Standards

The Clinical Excellence Commission will apply the Australian Equivalents to International Reporting Standards (AEIFRS) from the reporting period beginning 1 July 2005.

The Clinical Excellence Commission has, by known or reliably estimated information, determined the impacts of the AEIFRS, had they application in the 2004/05 year. The effect on the 2004/05 Statements would have been as follows:

AASB1 "First Time Adoption of AEIFRS" requires retrospective application of the new AEIFRS from 1 July 2004, with limited exceptions. Observance of this requirement in 2004/05 would not necessitate any variation to the opening Statement of Financial Position, nor variations in 2004/05 expenses and revenues.

Annual Leave (Non Current) is presently reported at nominal value. In keeping with the provisions of AASB119, "Employee Benefits" the non-current value of Annual Leave is to be calculated at present value using the same methodology as that applied for the calculation of Long Service Leave (refer Note 2a i). The effect, if applied, on opening and closing balances however, is immaterial.

South Eastern Sydney and Illawarra Area Health Service will be managing the transition to the new standards for The Clinical Excellence Commission, 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.

AASB 120 "Accounting for Government Grants and Disclosure of Government Assistance" requires for-profit entities to recognise grant income over the period necessary to match related costs. This has the effect of delaying revenue recognition and increasing liabilities. Under current AGAAP, grants are normally recognised on receipt. It is possible that AASB 120 may be amended to adopt the approach in AASB 141 "Agriculture" where grants are recognised as revenue when conditions are satisfied. However, at this stage, the timing and dollar impact of these amendments are uncertain.

3. EMPLOYEE RELATED EXPENSES

	2005	2004
	\$000	\$000
Employee related expenses comprise the following:		
Salaries and Wages	1,347	977
Long Service Leave [see note 2(a)]	43	41
Annual Leave [see note 2(a)]	98	64
Nursing Agency Payments	3	1
Other Agency Payments	35	—
Salary Packaging	(17)	(6)
Superannuation [see note 2(a)]	97	68
	1,606	1,145

Salaries and Wages include \$89,000 in 2004/2005 and \$79,000 in 2003/2004, paid to members of the Clinical Excellence Commission 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	8
\$15,000 to \$30,000	1

Fees/other benefits paid to the Clinical Excellence Commission 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.

4. GOODS AND SERVICES

	2005 \$000	2004 \$000
(a) Expenses on goods and services comprise the following:		
Computer Related Expenses	27	116
Domestic Charges	6	5
Food Supplies	4	47
Fuel, Light and Power	1	1
General Expenses [see note 4(b)]	989	1,075
Insurance	1	–
Postage	4	3
Printing and Stationery	93	70
Rental of Premises	31	30
Rates and Charges	–	1
Staff Related Costs	143	267
Telephone	12	21
Travelling – Domestic	194	400
Travelling – Overseas	17	7
Water Rates	1	1
	1,523	2,044

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2005

4. GOODS AND SERVICES CONTINUED

	2005 \$000	2004 \$000
(b) General expenses include:		
Advertising	33	2
Audio Visual Supplies	2	9
Books and Magazines	1	1
Consultancies	56	15
Courier and Freight	1	–
Auditors' Remuneration – Audit of financial reports	13	12
Auditors' Remuneration – Other Services	16	–
Legal Expenses	6	18
Licence Fees	–	6
Membership/Professional Fees	1	–
Motor Vehicle Expenses	1	2
Motor Vehicle Operating Leases	4	4
Other Operating Lease Expense	7	7
Project Payments:		
CEC Administration and Program Development	281	804
Blood Transfusion Project	–	50
Towards a Safer Culture (TASC)	77	87
Safety & Flow Collaborative	2	7
Safety Improvement Program	36	22
Emergency Care for Children	3	–
Chronic Care Collaborative	449	29
	989	1,075

5. MAINTENANCE

Repairs and Routine Maintenance	8	2
Replacements and Additional Equipment less than \$5,000	20	15
	28	17

6. DEPRECIATION AND AMORTISATION

Depreciation – Plant and Equipment	3	2
	3	2

7. SALE OF GOODS AND SERVICES

	2005 \$000	2004 \$000
Sale of Goods and Services comprise the following:		
Conference and Training Receipts	6	19
Other	–	47
	6	66

8. INVESTMENT INCOME

Interest	17	13
	17	13

9. GRANTS AND CONTRIBUTIONS

Commonwealth Grants	30	9
Grants from NSW Health	70	50
	100	59

10. OTHER REVENUE

Other Income	–	20
	–	20

11. CASH

Cash at Bank	447	582
	447	582

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)	447	582
Closing Cash and Cash Equivalents (per Statement of Cash Flows)	447	582

12. RECEIVABLES

Current

Other Debtors	–	1
	–	1

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2005

13. PLANT AND EQUIPMENT

	2005 \$000	2004 \$000
At Fair Value	75	41
Less Accumulated Depreciation	7	4
	68	37
Total Plant and Equipment at Net Book Value	68	37

	Plant and Equipment \$000	Total \$000
Balance 1 July, 2004	41	41
Additions	34	34
Balance at 30 June, 2005	75	75
Depreciation		
Balance 1 July, 2004	4	4
Charge for the year [see note 2(i)]	3	3
Balance at 30 June, 2005	7	7
Carrying Amount at 30 June, 2005	68	68

14. OTHER ASSETS

Current		
Prepayments	1	–
	1	–

15. PAYABLES

Current		
Creditors	211	4
Other Creditors		
Intra Health	108	210
Other	5	5
	324	219

16. PROVISIONS

	2005 \$000	2004 \$000
Current		
Employee Annual Leave	93	50
Employee Long Service Leave	15	15
Total Current Provisions	108	65
Non Current		
Employee Annual Leave	7	7
Employee Long Service Leave	112	4
Total Non Current Provisions	119	11
Aggregate Employee Benefits and Related On-costs		
Current	108	65
Non Current	119	11
Total Provisions	227	76

17. EQUITY

	Accumulated Funds		Total Equity	
	2005 \$000	2004 \$000	2005 \$000	2004 \$000
Balance at the beginning of the financial year	325	52	325	52
Result for the year	(360)	273	(360)	273
Balance at the end of the financial year	(35)	325	(35)	325

18. COMMITMENTS FOR EXPENDITURE

Expenditure Commitments

Aggregate other expenditure committed at balance date and not provided for in the accounts:

Not later than one year	2,170	1,223
Between one and five years	2,991	867
Total Expenditure Commitments	5,161	2,090

These commitments are not recognised in the financial statements as liabilities.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2005

19. CONTINGENT LIABILITIES

There are no contingent liabilities.

20. RECONCILIATION OF NET COST OF SERVICES TO NET CASH FLOWS FROM OPERATING ACTIVITIES

Net Cash Flows from Operating Activities	(101)	195
Depreciation	(3)	(2)
(Increase) / Decrease in Employee Entitlements	(151)	12
Acceptance by the Crown Entity of Superannuation Liability	(97)	(68)
Decrease in Other Debtors	(1)	1
Increase in Prepayments	1	–
(Increase) / Decrease in Creditors	(105)	67
NSW Health Department Recurrent Allocations	(2,580)	(3,225)
Net Cost of Services	(3,037)	(3,050)

21. 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 Clinical Excellence Commission 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 Clinical Excellence Commission.

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.

22. BUDGET REVIEW

Whereas budgets are allocated to the Clinical Excellence Commission on an annual basis, the operations of the Clinical Excellence Commission 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 lower than expected costs incurred throughout the year. The result for the year also reflects higher than expected grants revenue.

Result for the Period from Ordinary Activities

Due to the favourable net cost of service position, the actual deficit for the 2004/2005 period was lower than budget expectations.

Assets/Liabilities

Current Assets

Throughout the period cash was higher than expected due to funds remaining unspent. This is also reflected in an increased Creditor balance at year end.

Non Current Assets

A vehicle was purchased in June 2005.

Current Liabilities

Creditors were higher than expected and this, coupled with the better than expected operating result resulted in a higher than expected cash position. Staff leave provisions rose both as a result of greater staff numbers and increased awards.

Non Current Liabilities

The over budget results, due solely to increased long service leave provisioning, was consequent upon greater staff numbers, increased awards, and the 3.42% actuarially based and advised indexing of long service leave.

Cash Flows*Operating Activities*

The actual result was better than budget expectations. Lower than expected actual expenditure and actual revenue being higher than anticipated, contributed to the better than expected result.

Investing Activities

Vehicle expenditure was higher than budget this financial 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 23rd July 2004 are as follows:

	2005 \$000	2004 \$000
Initial Allocation 23rd July 2004	5,580	2,434
Secretariat Funding	(2,784)	40
CEC NSW Chronic Care	424	779
Children's Emergency Care Program	–	72
Patient Safety	(640)	(70)
Balance as per Statement of Financial Performance	2,580	3,255

23. PROGRAMS/ACTIVITIES OF THE CLINICAL EXCELLENCE COMMISSION

The Clinical Excellence Commission 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.

24. 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. Clinical Excellence Commission'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:

24. FINANCIAL INSTRUMENTS CONTINUED

Financial Instruments	Floating interest rate		Non-interest bearing		Total carrying amount as per the Statement of Financial Position		Weighted average effective interest rate*	
	2005 \$000	2004 \$000	2005 \$000	2004 \$000	2005 \$000	2004 \$000	2005 %	2004 %
Financial Assets								
Cash	447	582	–	–	447	582	4.70	4.50
Receivables	–	–	–	1	–	1		
Other Loans and Deposits	–	–	1	–	1	–		
Total Financial Assets	447	582	1	1	448	583		
Accounts payable	–	–	324	219	324	219		
Other	–	–	–	–	–	–		
Total Financial Liabilities	–	–	324	219	324	219		

* 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 Clinical Excellence Commission'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	
	2005 \$000	2004 \$000	2005 \$000	2004 \$000	2005 \$000	2004 \$000
Cash	447	582	–	–	447	582
Receivables	–	–	–	1	–	1
Other	–	–	1	–	1	–
Total Financial Assets	447	582	1	1	448	583

There is no significant concentration of credit risk.

c) Net Fair Value

As stated in Note 2(n) 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 Clinical Excellence Commission holds no derivative financial instruments.



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