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

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

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

#### The key functions of the CEC are to:

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

#### The CEC fulfils these functions by:

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



The Hon Reba Meagher MP Minister for Health Governor Macquarie Tower 1 Farrer Place SYDNEY NSW 2000

#### Dear Minister

We have pleasure in submitting the Clinical Excellence Commission's 2006/07 Annual Report.

The report complies with the requirements for annual reporting under the Accounts and Audit Determination for public health organisations and the 2006/07 Directions for Health Service Annual Reporting.

Yours sincerely

Professor Bruce Barraclough AO Chairman Professor Clifford Hughes AO Chief Executive Officer

# Table of Contents

HIGHLIGHTS/ACHIEVEMENTS	4	Equal employment opportunity
CHAIRMAN'S REPORT	5	Ethnic Affairs Priority Statement
CHIEF EXECUTIVE OFFICER'S REPORT	6	Occupational health & safety
PROFILE, PURPOSE AND GOALS	9	Conference presentations
CEC Board	9	Official overseas travel by CEC staff
Board sub-committee:		Research
Audit and Risk Management	14	Teaching and training initiatives
Board sub-committee: Finance	14	OUR COMMUNITY
Board sub-committee: Research	15	Citizens Engagement Advisory Counc
Board sub-committee:		Sponsorship
Citizens Engagement Advisory Council	16	Freedom of Information (FOI) report
Clinical Council	17	
Organisational chart	18	FINANCIAL REPORTS
Alliance with State Health Plan's		Executive Summary
strategic directions	19	Independent Audit Report
Corporate governance statement	20	Certification of Financial Statement
PERFORMANCE	22	Financial Statements
Strategic plan 2005–2008	22	Special Purpose Service Entity
Clinical programs and projects	24	Independent Audit Report
Clinical Leadership Program	32	Special Purpose Service Entity Certification of Financial Statement
Quality education	37	Special Purpose Service Entity
Quality Systems Assessment (QSA)	38	Financial Statements
Special committees	39	GLOSSARY
Special reviews	41	ABBREVIATIONS
OUR PEOPLE	42	INDEX
Staff profile	42	
Executive reports	42	

# Highlights/ Achievements

#### **Publications**

Release of first annual IIMS report for 2005/06 data in December 2006.

#### Reviews

- Involvement in NSW Legislative Council Inquiry regarding health complaints handling.
- Inaccurate reporting of pathology and cytology specimens.
- Implantation procedures for permanent pacemakers and related devices.
- Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents in NSW.
- New position of Manager, Special Reviews appointed January 2007.

#### **Partnerships**

- Citizens Engagement Advisory Council formally established.
- Shared quality and safety reporting function with NSW Department of Health.
- Locum postings of Area Directors of Clinical Governance to the CEC.

#### Research

- First Ian O'Rourke PhD Scholar.
- Groundwork for publication of inaugural quality indicator Chartbook.
- Database to support Collaborating Hospitals Audit of Surgical Mortality (CHASM).

#### Education and training

- Clinical Leadership Program.
- Children's Emergency Care Project toolkit.
- Quality Tools refresher courses.
- E-learning modular program for quality improvement.
- Conference and seminar presentations.

#### New project focus areas

- Transfusion Medicine launch of 'Blood Watch'.
- Central Line Associated Bacteraemia in ICU (CLAB).
- Communicating for clinical handover.
- Recognition and management of the deteriorating patient.

#### Strategic planning and development

- Organisational review conducted by external consultant.
- Staff planning day in July 2006 and Board review in March 2007.
- Implementation of new electronic record system for the CEC.

#### Assessment

- Launch of Medication Safety Self Assessment.
- QSA pilots completed and tender awarded for project development stage.

# Chairman's Report

The NSW Clinical Excellence Commission (CEC) has had a most productive year, with an extensive range of activities to address many issues aimed at fulfilling our mission, 'to build confidence in healthcare in NSW by making it demonstrably better and safer for patients and a more rewarding workplace'.

One of the key issues has been to establish a reporting culture. This work started with the collecting, reporting and analysis of sentinel events based on an education program for Root Cause Analysis. Capture of these events continues at the high level we would expect. We have also learnt much from, and in fact are using as a window in to the Health system's problems, the Incident Information Management System (IIMS). Reports are coming in at almost 14,000 per month. The first annual IIMS report highlights some of the issues and the actions taken. This is a 'milestone' in our progress towards openness and the public reporting of problems in the system.

Another vital issue for the CEC was to be able to provide clear and effective messages to the community regarding health related incidents and activities. The bringing together of the Citizens Engagement Advisory Council has been an important start with this activity. All at the CEC are excited by the input of these key people.

The third issue that indicates positive change is the Quality Systems Assessment program of the CEC which focuses on the systems and processes that health services have in place to support, and also to manage risks in relation to, safe and high quality care. This is an important move towards a risk-based approach to management of safety and quality across the system.

In a complex environment such as a modern health system, change for the better only happens if there is effective leadership. The CEC is helping with this with oversubscribed leadership programs for staff at many levels of the system.

Finally, I wish to record that the Board recognises and values the great commitment and effectiveness of the CEC staff under the very effective leadership of CEO, Professor Clifford Hughes.

Professor Bruce Barraclough AO

**Board Chairman** 

# Chief Executive Officer's Report

This report marks the halfway point in the first Five Year (2003-08) Strategic Plan for the Clinical Excellence Commission (CEC). At any point in a journey, there is a number of ways in which we can look at our progress.

The first is to stop and reflect on just how far we have come. The second is to ask the questions 'are we on the right track?' and 'have we come far enough?'. The third is to look to the future and plan the remainder of the journey. Of course, each of these is important, but only part of the necessary self-awareness.

I hope that, as you read through and consider the various programs, projects and campaigns highlighted in this volume, you will catch our vision for the safety and quality of public healthcare delivery in NSW.

#### WORKING IN PARTNERSHIP

One of the hallmarks of this year is the ongoing development of partnerships throughout the health system.

First and foremost, we have sought to develop stronger links with all clinicians across the state. With 110,000 staff, this is no easy task. It requires a balance between travel and 'hard work back at the office' and it also requires a capacity to listen to, as well as work

with, all sectors of the public system in our complex and geographicallychallenging state.

Our relationship with the workforce has been enhanced by the Directors of Clinical Governance, their units and the patient safety managers in each of the Area Health Services (AHS). These ties have been strengthened by participation in their monthly meetings, by regular workshops at the CEC and by visits with them in the field.

We remain committed to our partnership with the Quality and Safety Branch (QSB) of NSW Health. While CEC's reporting lines and responsibilities directly to the Minister are clear, it is equally clear that, without close cooperation with the QSB, implementation of our many joint strategies will be ineffectual.

There are a number of exemplars of this cooperation. Perhaps the most significant is just beginning to be rolled out across the system and that is the Open Disclosure program.

The QSB initially asked CEC to be part of the evaluation of the NSW sites involved in the national program. It soon became clear it was imperative that this program be implemented across the whole of the state. The CEC was asked to take part in the education

program and together we have planned a series of workshops for high-level Open Disclosure, prepared an electronic learning package and made DVDs and other resources available across the system. That preliminary work has now finished and the first of the workshops is underway.

Another area of cooperation has been around the Incident Information Management System (IIMS) program. While we have been delighted with the steadily increasing amount of reporting from clinicians across the state, there were concerns about the capacity to cope with such a workload and to answer specific questions from clinicians with widely diverse needs. The QSB has involved the CEC in many discussions around these requirements and, in particular, the need to report both publicly and to Area Health Services.

The QSB also involved the CEC as they sought to develop quality and safety performance indicators for each AHS. These indicators reflect the patient experience as they proceed through the public hospital portion of their journey of health.

In return, we at the CEC endeavour to engage the QSB in each project and program of the CEC to ensure regular interchange of information and awareness.

We also enjoy close partnerships with Area Health Service Chief Executives and our involvement in NSW Health's Senior Executive Advisory Board. This provides an opportunity for the CEC to hear the concerns of each Area and also to present monthly progress reports on each of our activities.

To further strengthen these ties, I meet regularly with the Director-General and with the Deputy Director-General for Health System Performance, both to be informed and also to inform them of the issues that we have identified.

The last 12 months have seen us strengthening our research involvement with partnerships with The Sax Institute and the development of two important collaborative programs.

The first is the Hospital Alliance for Research Collaboration (HARC) that brings together clinicians, researchers, academics and system managers to apply the principles of pure research to clinical endeavours.

The second is the CHeReL (Centre for Health Record Linkage) project designed to bring together the enormous volume of information contained in various datasets across NSW Health, rather than the previous tedious attempts to build new databases, extract piecemeal information and have multiple time-consuming approaches to ethics committees to approve release of the data.

We have also been particularly pleased with the partnerships developed between the CEC and the various craft groups that make up the Greater Metropolitan Clinical Taskforce (GMCT). The increasing number and detailed clinical focus of each of these groups within GMCT has been a great encouragement to the CEC as we target specific issues. Not the least of these has been the Towards A Safer Culture (TASC) program that focused on the management of acute coronary syndromes, and the Stroke Network as they focused on the development of stroke units and guidelines.

We were delighted to see the appointment of Professor Peter Castaldi AO to lead GMCT. The downside of that decision, of course, was that Professor Castaldi resigned from our Clinical Council but our relationship with GMCT has only been strengthened by this move.

The Clinical Council itself is a partnership providing a key link with clinicians of all types across the state. There is a general consensus that we need to strengthen this partnership by providing more regular meetings of Council and by ensuring even closer links between members of the Council and the Clinical Governance Unit Directors at an Area level.

Plans for the Citizens Engagement Advisory Council (CEAC) have been completed and Major General Peter Dunn AO was appointed by the Board to Chair that group. A core group has been appointed and has had its first meeting. I am looking forward to the important contribution of this group whose responsibility it is to bring expertise from the community to bear on each and all of our programs.

We have been pleased with the work of our consultants on the Quality Systems Assessment (QSA) program, KPMG. It is anticipated that the first report on the QSA will be available by the end of June 2008.

Other external partnerships include the many people and firms delivering the Clinical Leadership Program. Both the Statewide and Modular programs are enormously popular, both being over-subscribed. Advertisements for the second round of courses issued in August 2007.

Our partnerships with other agencies in NSW Health have also been a hallmark of this last year. The continuing development of the Falls program, both in the community and in our hospitals, has been made possible by the close working relationships with NSW Health's Chief Medical Officer and her staff.

# Chief Executive Officer's Report (cont.)

All this collaboration has been instrumental in the success of the Hand Hygiene campaign, the Blood Watch program and the implementation of the Children's Emergency Care Guidelines. Each has involved key groups including infection control practitioners, microbiologists, transfusion committees, the Australian Red Cross blood transfusion service and even the finance department within NSW Health, and many others. These have clearly demonstrated that, not only are such projects possible, they are effective in improving safety and quality and in reducing wastage throughout the system.

But there are two key partnerships without which none of this work would be possible. The first, and most important, is the staff with whom I am privileged to serve. Each of the staff, past and present, has contributed enormously to the individual components that make up the CEC. They have also contributed to the success of each other, they have been supportive (even during the periods of constructive critical appraisal!) and I believe that the increasing teamwork of the CEC will be an exemplar for the whole system.

We did not rest on our laurels of previous years. We undertook an extensive review of the CEC, under the direction of Dr Roger Boyd, and have identified areas in which we can improve our teamwork. Each of those areas has been, and will continue to be, addressed.

I would just like to thank the team for their corporate and individual contributions, which have made my task possible and indeed enjoyable.

The final partnership is with the CEC Board, which has exercised its responsibility with clarity, forthrightness and challenge. They have not allowed us (or me!) to escape the hard questions but, at the same time, have provided us with insights, support, enthusiasm and individual resources. We were sorry to lose Adjunct Professor Kathy Baker, Dr Tom Parry and, more recently, Dr Sue Page as each of them has taken on different challenges over the last six months. Their contributions have been recognised and will be significantly missed. We look forward to the appointment of new members shortly.

Personally, I would like to thank each and all of the partners that I have come to rely on over the last 12 months. The challenge ahead of us is enormous. We have travelled a great distance. The scenery around us at present is both pleasing and challenging. But the journey continues. Our task is not simply to look back but to make sure that we are on track to reach the destination that we set ourselves two and a half years ago.

**Clifford F Hughes AO**Clinical Professor
Chief Executive Officer

# Profile, Purpose and Goals





Professor Bruce Barraclough AO is Chair of the Board of the Clinical Excellence Commission. He is president-elect of the International Society for Quality in Healthcare, Medical Director of the Australian Cancer Network, Associate Dean (clinical strategy) of the University of Western Sydney Medical School, a member of the National Breast Cancer Centre Board and the NSW Healthcare Advisory Council. He was President of the Royal Australasian College of Surgeons (1998-2001), Professor/Director of Cancer Services, Northern Sydney Health and the University of Sydney, (2000-2005) and Chair of the Australian Council for Safety & Quality in Healthcare (2000-2005).

Board Chair since: 1 February 2005 Appointment expires: 31 January 2010



**Professor Clifford Hughes AO** 

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

Board member since: 1 February 2005 Appointment expires: 4 January 2010

The Clinical Excellence
Commission (CEC) was launched
on 24 August 2004, as part of
the NSW Patient Safety and
Clinical Quality Program, and as
an evolution of the Institute for
Clinical Excellence.

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

## Profile, Purpose and Goals (cont.)



#### Dr Alan Amodeo

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

Board member since: 1 February 2005 Appointment expires: 31 January 2009



**Adjunct Professor Kathy Baker** 

Adjunct Professor Kathy Baker retired from the position of Chief Nursing Officer, NSW Health in April 2006, after a career of 42 years across public, private and community sectors. Her experience includes leading service integration processes for public and community hospitals and Area Health Service mergers. Kathy is a Fellow of The College of Nursing and took up a position on that Board in October 2006.

Board member since: 1 February 2005 Appointment expired: 31 January 2007



**Dr Graham Beaumont** 

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

Board member since: 1 February 2005 Appointment expires: 31 January 2008





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

Board member since: 1 February 2005 Appointment expires: 31 January 2010



**Professor Phillip Harris** 

Professor Phillip Harris is the Clinical Director of Sydney South West Area Health Service, Cardiovascular Services – Eastern Zone, the former 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 and Heart Research Institute, Past President of the Cardiac Society of Australia and New Zealand and National Heart Foundation of Australia (NSW Division).

Board member since: 1 February 2005 Appointment expires: 31 January 2009



Associate Professor Brian McCaughan

Associate Professor Brian 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 held a number of positions with the Royal Australasian College of Surgeons, culminating in Chairmanship of the NSW State Committee from 1992 to 1994. Professor McCaughan was a member of the NSW Ministerial Advisory Committee on Quality in Healthcare. He was appointed to the NSW Health Council, and served as president of the NSW Medical Board from October 1999 until December 2004. He is Chair of the Sustainable Access Health Priority Taskforce and a member of the Healthcare Advisory Council for NSW Health. He was recently appointed as an external member of the Cabinet sub-committee overseeing the NSW State Plan.

Board member since: 1 February 2005 Appointment expires: 31 January 2009

## Profile, Purpose and Goals (cont.)





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

Board member since: 1 February 2005 Appointment expires: 31 January 2010



Dr Sue Page

Dr Sue Page is immediate past president of the Rural Doctors Association; senior lecturer and director of education at the Northern Rivers University Department of Rural Health; Chair of the North Coast Area Healthcare Advisory Council; a Board member of the Northern Rivers Division of General Practice and a rural GP VMO at Ballina District Hospital and St Vincent's Hospital in Lismore. She 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, and NSW Healthcare Advisory Committee and a Commonwealth appointee to the Australian Medical Workforce Advisory Committee.

Board member since: 1 February 2005 Resigned effective: 8 June 2007



Dr Tom Parry AM

Dr Tom Parry AM is currently Chair of the First State Super Trustee Corporation and Principal Adviser, Regulatory, with Macquarie Bank's Investment Banking Funds Group. He was the foundation Executive Chairman of the Independent Pricing and Regulatory Tribunal of New South Wales and the foundation commissioner of the NSW Natural Resources Commission. Between 2001-2004, he was a member of the Board of the South Eastern Sydney Area Health Service.

Board member since: 1 February 2005 Resigned effective: 5 April 2007



Mrs M. E. (Liz) Rummery, AM

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

Board member since: 1 February 2005 Appointment expires: 31 August 2008

Table 1: Board Member Meeting Attendance 2006/07

The Board meets on a bi-monthly basis

Directors	8 Aug 2006	10 Oct 2006	12 Dec 2006	13 Feb 2007	10 Apr 2007	12 Jun 2007
B Barraclough	✓	✓	✓	✓	✓	✓
A Amodeo	✓	✓	✓	✓	✓	✓
K Baker		✓		Retire	d 31.1.07	
G Beaumont	✓	✓	✓	✓	✓	✓
P Dunn		✓		✓	✓	✓
P Harris	✓	✓	✓	✓	✓	✓
C Hughes	✓	✓	✓	✓	✓	✓
B McCaughan	✓	✓	✓	✓		✓
N O'Brien	✓	✓	✓	✓		✓
S Page	✓		✓	✓	✓	Resigned 8.6.07
T Parry		✓		Resign	ed 5.4.07	
M E Rummery	✓	✓	✓	✓		✓

### Profile, Purpose and Goals (cont.)

### **BOARD SUB-COMMITTEE:** AUDIT AND RISK MANAGEMENT

#### Membership

- Mr Noel O'Brien OAM (Chair)
- Major General Peter Dunn AO
- Mrs Liz Rummery AM
- Professor Clifford Hughes AO

#### In attendance

- Deputy CEO, CEC
- Director of Corporate Services, CEC
- Director of Internal Audit, SESIAHS
- Representatives from NSW **Audit Office**
- Manager, Board Support, CEC

The committee meets quarterly.

#### Objective

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

#### **Functions**

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

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

Activities of the Audit and Risk Management Committee include:

#### Internal Audit

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

#### **External Audit**

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

#### Audit & Risk Management Committee Meetings during 2006/07

11 July	13 March
12 September	31 May
12 December	

#### **BOARD SUB-COMMITTEE: FINANCE**

#### Membership

- Dr Alan Amodeo (Chair)
- Mr Noel O'Brien OAM
- Dr Graham Beaumont
- Professor Clifford Hughes AO

#### CEC staff in attendance

- Deputy CEO
- **Director of Corporate Services**
- Finance Officer
- Manager, Board Support

The committee meets monthly, excluding January.

#### Objective

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

#### **Functions**

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

- Forward Estimates and Plans
- Financial planning and policy
- Annual budget for capital, operating receipts and payments and cash flow
- Financial Management
- Income and expenditure budgets
- Balance sheet budgets
- Cash flow budgets
- Accounting standards, instructions and determinations of the Board
- Financial delegations
- Performance Reporting
- Activity budgets, efficiency targets, benchmarks and best practice
- Other Board Committees
- Liaise with Audit Committee with respect to accounting controls, risk management issues and insurance generally.

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

### Finance Committee Meetings during 2006/07

11 July	13 February
8 August	13 March
12 September	10 April
10 October	8 May
12 December	12 June

### BOARD SUB-COMMITTEE: RESEARCH

#### Membership

- Professor Phillip Harris (Chair)
- Mr Noel O'Brien OAM
- Dr Graham Beaumont
- Professor Clifford Hughes AO

#### CEC staff in attendance

- Deputy CEO
- Manager, Board Support

The committee meets quarterly.

#### Objective

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

#### **Functions**

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

### Research Committee Meetings during 2006/07

8 August	10 April	
31 October		
13 December		

## Profile, Purpose and Goals (cont.)

#### **BOARD SUB-COMMITTEE:** CITIZENS ENGAGEMENT **ADVISORY COUNCIL**

#### Membership

- Major General Peter Dunn AO (Chair)
- Mr Gary Cox
- Professor Clifford Hughes AO
- Mr Jimmy Little AO
- Ms Julie McCrossin
- Mr David Hirsch

#### In attendance

- Mr Don Palmer, Jimmy Little Foundation
- Deputy CEO, CEC
- Manager, Board Support, CEC

#### Objective

The Citizens Engagement Advisory Council (CEAC) is an exciting new initiative for the CEC, inspired in 2005 and refined throughout 2006.

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

#### **Functions**

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

- Advise the Board on strategic approaches to developing a shared understanding with the community around issues of safety and quality of health services
- Advise the Board on best practice/ proven methods for facilitating a meaningful dialogue with the community around the CEC's plans, initiatives and programs
- On behalf of the Board, oversee the development and implementation of a public education campaign to inform the community about aspects impacting on the quality and safety of healthcare in NSW. This includes addressing the matters recommended by the Legislative Council General Purpose Standing Committee No. 2
- Consult with, and where necessary co-opt the services of, those having skills and experience in areas such as safety, community engagement, adult education, media, public relations, marketing and largescale public sector planning and consultation, to help progress the CEAC's objectives

- Advise the Board on how to shift the debate on safety and quality of healthcare from one which is single issue or agenda driven, to one that is more systems focussed
- Determine and help implement key quality and safety messages for the CEAC to promote and develop in the community on behalf of the CEC
- Assist the Board in building capacity and community development around issues that span the dimensions of quality (safety, access, effectiveness, efficiency, appropriateness, consumer participation).

The CEAC was formalised in May 2007. It complements the Clinical Council in fostering two-way communication between the CEC and its community, and helps the CEC meet its strategic objective of consulting and engaging with healthcare providers and the community.

#### **CLINICAL COUNCIL**

#### Membership

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

Professor Peter Castaldi AO\* (co-Chair) Professor Mary Chiarella (co-Chair) Dr Austin Curtin (co-Chair) A/Professor Michael Besser AM\* Ms Patricia Bradd Dr Sue Crosdale Professor Patricia Davidson Mr Anthony Dombkins Professor Creswell Eastman AM A/Professor Brad Frankum Ms Julie Gawthorne Dr Rohan Hammett Ms Linda Justin Dr Andrew Keegan Dr Michael McGlynn Dr Sandy Middleton Ms Melanie Pittard\*

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

Dr Valerie Poxon\*

Mr Anthony Schembri

Dr Gabriel Shannon Dr Jim Telfer Ms Penny Thornton Ms Catriona Wilson

#### Description

The Clinical Council was established in April 2005. It comprises medical, nursing, allied health and management staff who work within the public or private health sectors of NSW. Members contribute to the development and delivery of the CEC's programs and advise the Board on strategies to achieve comprehensive clinician participation.

The Clinical Council is co-Chaired by Professor Mary Chiarella and Dr Austin Curtin. Professor Chiarella is a former NSW Health Chief Nurse and current Professor of Clinical Practice Development and Policy Research at the Centre for Health Services Management at the University of Technology, Sydney. Dr Curtin, a surgeon from Lismore, is Chair of the NSW Institute of Rural Clinical Services, Teaching sub-dean of the North Clinical School (Lismore) and a member of the NSW Rural Health Priority Taskforce.

#### **Activities**

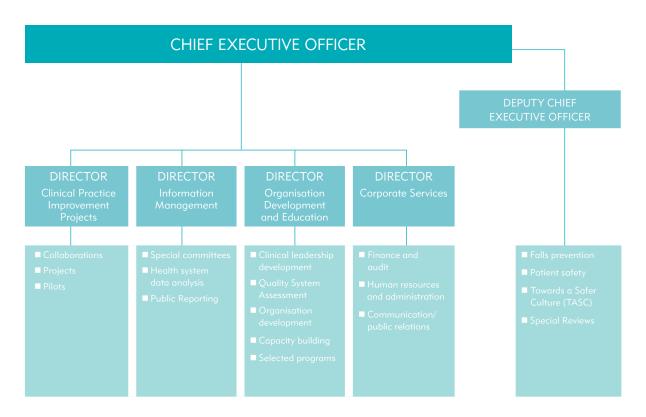
The council met face-to-face on three occasions over the past year, with the large group being split into two smaller groups for the majority of the meetings to allow for maximum interaction. Meetings have dual purposes, in providing potential for clinicians to learn more about the work of CEC to assist their role in dissemination of information around NSW, and also valuable feedback from the clinical areas on the uptake and efficacy of CEC programs. In addition to the faceto-face meetings, members participated in a discussion forum using a secure website available for the use of staff working in the New South Wales human services sector (HSNET).

Through a process of natural attrition within the health sector, a number of vacancies have arisen on the council. A formal advertisement for expressions of interest for membership of council was placed in July 2007.

## Profile, Purpose and Goals (cont.)

#### ORGANISATIONAL CHART

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



#### Principal Directors and Titles

#### Chief Executive Officer

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

#### **Deputy Chief Executive Officer**

Dr George Bearham, MBBS, MHP, FRACMA (until January 2007)

Dr Peter Kennedy, MBBS, FRACP (from February 2007)

Development and Education directorate in February 2007.

#### **Director Clinical Practice** Improvement Projects

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

#### **Director Corporate Services**

Rhonda Topp, BAppSci (OT), BHA, MCom

#### **Director Information Management**

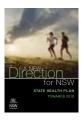
André Jenkins, BA (Hons)

#### **Director Organisational Development & Education**

Bernie Harrison, RN, RM, MPH (Hons), Grad.Cert.Med.Ed. (From February 2007\*) Margaret Coffey, BA, Dip Ed, A Mus A, M Lib (Management)

(To February 2007)

<sup>\*</sup> Previously the Director of Quality Systems Assessment within the CEC. The Quality Systems Assessment directorate was incorporated into the Organisational



### ALLIANCE WITH STATE HEALTH PLAN'S STRATEGIC DIRECTIONS

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

- Make prevention everybody's business
- Hand Hygiene Program
- NSW Falls Program
- Blood Watch Program
- Medication Safety collaborative
- Safer Systems Saving Lives collaborative
- Central Line Associated
   Bacteraemia collaborative
- Review of incident management data
- 'Management of the Deteriorating Patient' interest group.
- 2. Create better experiences for people using health services
- Implementation of Clinical Leadership Program across NSW
- Development of the Citizens
   Engagement Advisory Council (CEAC)
- Fostering of partnerships via the CEC Clinical Council

- Review of incident management data and investigations
- Communicating for Clinical Care focus area
- Communication at Clinical Handover focus area
- Participation in statewide Incident Information Management System project.
- Strengthen primary healthcare and continuing care in the community
- Development of the Citizens Engagement Advisory Council (CEAC)
- Clinical Leadership program across NSW
- Partnerships with primary healthcare providers and managers.
- 4. Build regional and other partnerships for health
- Development of the Citizens Engagement Advisory Council (CEAC)
- Clinical Leadership program provided across NSW
- Locum positions within CEC for area
   Directors of Clinical Governance
- Visits by CEC staff to health services across NSW
- Shared quality and safety reporting function with Department of Health
- Partnerships with key stakeholders within and outside health sector.

- Make smart choices about the costs and benefits of health services
- Quality Systems Assessment (QSA) program
- Partnership with Department of Health regarding quality and safety data
- Participation in statewide
   Incident Information Management
   System project
- Release of incident management data and recommendations to the system.
- 6. Build a sustainable health workforce
- Clinical Leadership Program across NSW
- Recruitment of skilled workers to key positions within the CEC
- Inservices and training opportunities available to all CEC staff.
- 7. Be ready for new risks and opportunities
- Review of internal risk management framework and strategy
- Participation in statewide
  Incident Information Management
  System project
  Partnership with Department
  of Health regarding quality and
  safety data.

## Profile, Purpose and Goals (cont.)

#### CORPORATE GOVERNANCE **STATEMENT**

This statement sets out the main corporate governance practices in operation throughout the 2006/07 financial year.

#### The CEC Board

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

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

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

Board membership consists of a Chair, ten other non-executive members, the Chief Executive Officer. One of the co-Chairs of the Clinical Council is an ex-officio member of the Board.

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

- Setting strategic direction
- Ensuring compliance with statutory requirements
- Monitoring organisational performance

- Monitoring the quality of health services
- Board appraisal
- Community consultation
- Professional development.

The Board identifies each Board member, noting the:

- i) Qualifications, specific skills and experience they bring to the Board
- ii) Term of appointment of Board members
- iii) Frequency of Board meetings and members' attendance at meetings.

#### Resources Available to the Board

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

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

#### Strategic Direction

The Board has in place processes for the effective planning, delivery and monitoring of programs and projects to improve the safety and quality of healthcare in NSW. These include the setting of a strategic direction for the organisation and providing independent leadership on patient safety and quality. The Board held a performance review on 13 March 2007, and a strategic planning day with staff on 17 July 2006. An external consultant was engaged to undertake a review of executive operations and portfolios during 2006. Recommendations from the review are currently being implemented.

#### Code of Ethical Behaviour

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

#### Risk Management

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

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

A risk management policy and framework, incorporating a Risk Register, is in place. This was reviewed in 2007, with mechanisms put in place for routine review of risk and activity via the Board's Audit and Risk Management Committee.

#### Committee Structure

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

#### Performance Appraisal

The Board has processes in place to:

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

A review of the Board's operations and members' contributions was undertaken as part of a planning and review day in March 2007.

### Performance

#### **PERFORMANCE**

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

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

#### CEC STRATEGIC PLAN 2005-2008

#### KEY RESULT AREAS AND **GOALS TO ACHIEVE BY 2008**

#### **STRATEGIES 2005-2008**

#### ACHIEVEMENTS DURING 2006-2007

#### 1. Public reporting

Report publicly to the Minister and the community on quality and safety in NSW Health.

- 1.1 Develop and deliver an annual public report on adverse events.
- 1.2 Develop and deliver an annual public report on quality system improvements.
- 1.3 Engage the community in an informed discussion around the quality and safety of healthcare.
- 1.1 First annual report of incident (IIMS) data issued December 2006 in collaboration with DoH 3rd incident report, with media release by Minister for Health.
- 1.2 Chartbook of safety and quality indicator
- 1.3 Citizens Engagement Advisory Council formally developed.

#### 2. Quality systems assessment

Implement a Quality System Assessment (QSA) program across NSW Health, including identification of assessment criteria that allow measurement, benchmarking and trending over time.

- 2.1 Develop the methodology for the QSA
- 2.2 Conduct pilot QSA in two health services (one metro, one rural), then roll-out to all health services
- 2.3 Complete baseline measures based on NSW Department of Health assessment criteria across the system.
- 2.1 QSA methodology in place by July 2006.
- 2.2 QSA pilots completed and activity statements
- 2.3 Staged roll-out of QSA program due to start with Area Health Services September/ October 2007.

#### 3. Information management

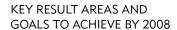
Develop, in partnership with clinicians, feedback reporting systems that support clinical improvement.

- 3.1 Develop and implement an Information Management Strategic Plan to support the work of the CEC.
- 3.2 Work with the Department of Health to implement an incident and adverse event reporting system across NSW Health.
- 3.3 Develop and implement effective information and reporting system for deaths associated with surgery and anaesthesia.
- 3.1 Information Management Strategic Plan developed.
- 3.2 Shared quality and safety reporting function with Department of Health established early 2007.
- 3.3 Surgical mortality database established; committees continue to meet, with secretariat services provided by the CEC.

#### 4.Clinical improvement

Assist health services to implement effective clinical improvement programs in partnership with clinicians.

- 4.1 Assist health services to undertake quality improvement projects.
- 4.2 Enhance professional skills within health services to implement effective improvement programs and methodologies.
- 4.3 Conduct statewide quality and safety initiatives.
- 4.1 Existing programs developed. New programs launched in transfusion medicine; central line associated bacteraemia; communication. Clinical Practice Improvement (CPI) workshops conducted via Clinical Leadership program.
- 4.2 Collaborative initiatives with area clinical governance units and Department of Health; Clinical Leadership Program launched 2007.
- 4.3 Statewide programs in place in hand hygiene, falls, medication safety, transfusion medicine; statewide train-the-trainer sessions for root cause analysis.



#### **STRATEGIES 2005-2008**

#### ACHIEVEMENTS DURING 2006-2007

#### 5. Capacity building

Provide clinical leaders and the Clinical Excellence Commission with skills and tools to effectively lead quality and safety improvement.

- 5.1 Develop and implement clinical leadership development and education programs.
- 5.2 Identify the specific role of the CEC in the knowledge management framework under development.
- 5.3 Support rural health services by identifying and developing individual CEC-health service initiatives.
- 5.4 Develop capacity within the CEC to undertake special reviews.
- 5.1 statewide Clinical Leadership Program launched in 2007, with over 200 participants in the two modules; second cohort to commence late 2007.
- 5.2 Continued participation in statewide knowledge management committees.
- 5.3 Rural outreach options explored in collaboration with rural Area Health Services during 2006–07.
- 5.4 Manager Special Reviews appointed January 2007; reviews undertaken regarding pacemakers and 'Lookback' procedures.

#### 6. Organisational development

Design and build the Clinical Excellence Commission as an organisation characterised by excellence in governance.

- 6.1 Strengthen the CEC's governance arrangements, particularly in relation to project management, communication and budget planning.
- 6.2 Develop and implement robust risk management practices.
- 6.3 Invest in the CEC's people.
- 6.4 Develop strong partnerships.
- 6.1 Strategic planning session with staff held 17 July 2006.
- 6.2 Risk management framework reviewed and incorporated into Audit and Risk Management committee schedule.
- 6.3 Range of professional development and education programs offered throughout the year, as outlined in teaching and training section of report.
- 6.4 CEC continues to develop partnerships with stakeholders, such as Department of Health, Area Health Services, GMCT and the community.

### 7. Communication and culture change

Influence current and future decision makers, at all levels of NSW Health, to apply improvement programs and methodologies.

- 7.1 Develop and implement a communication strategy with health services that provides the Minister, the CEC Board, CEC Clinical Council, decision makers and the NSW health system with key safety and quality messages and evidence-based information.
- 7.2 Work with Area Health Services in effective uptake and implementation of workplace cultural change relating to clinical improvement strategies.
- 7.1 Communications officer in place; website reviewed; Citizens Engagement Advisory Council (CEAC) formally developed to assist with providing clear and effective community messages regarding healthrelated incidents and activities.
- 7.2 Continued liaison with Area Health Services via Clinical Council, directors of clinical governance, and via staff working on CEC projects.

# Performance (cont.)



#### **CLINICAL PROGRAMS** AND PROJECTS

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

#### Aligns with CEC key result areas:

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

#### Aligns with State Health Plan objectives:

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

#### Description

International studies demonstrate compliance with evidence based care processes may lead to reduced mortality, morbidity and ICU length of stay. Experience from the Safer Systems Saving Lives (SSSL) project highlighted the importance for future related projects to conduct monthly data collection on process indicators (eg central venous catheter care components such as hand hygiene, barrier precautions) to inform project strategies and monitor ongoing improvement. In addition, regular review of outcome indicators (reduction in CLAB) should also be conducted during the project period. To support ongoing monitoring and sustainability, data

collection needs to be incorporated into existing systems and work practices.

Key objectives of the project are to:

- Develop/adapt NSW Health guideline/s for the insertion and management of Central Lines in ICU in NSW
- Use a modified collaborative methodology to implement the guideline in all intensive care units in NSW
- Develop and facilitate simple data collection systems to monitor project outcomes that use existing data collections wherever possible and do not create additional burden for clinicians
- Achieve measurable reduction in CLAB in ICU in NSW. Specifically, establish baseline measures, achieve 20% reduction in CLABS in ICU patients by January 2008 (and enable reduction by 80% in CLABS in ICU patients by January 2010)
- Develop systems and processes to support sustainable reduction in CLAB in ICU.

#### Key achievements

■ The project commenced on 1 March 2007 with the formation of an expert group of clinicians to develop the consensus quideline and agree on data collection definitions and processes

- The project was formally launched on 4 June 2007 with an orientation workshop for ICU clinicians from around the state attended by more than 130 participants
- All 36 intensive care units in NSW are participating in the project as well as the Canberra Hospital
- Intensive care units in private hospitals will also be invited to participate
- Data collection has been established via a Teleform system allowing direct transmission to the CEC where data collation and analysis will be undertaken on behalf of teams
- A Working Policy for the Safe Insertion of Central Venous Catheters (CVCs) in NSW intensive care units has been developed by the expert group in consultation with the NSW Department of Health and distributed to all teams for implementation.

#### **Future directions**

The first post implementation learning session will be conducted on 2 November 2007.

# Clean hands save lives

#### Aligns with CEC key result greas:

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

#### Aligns with State Health Plan objectives:

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

#### Description

Hand decontamination has been shown to prevent the spread of infectious agents in clinical settings for over 150 years. In NSW, a system of mandatory surveillance of multi-resistant organisms (MRO) infection and colonisation within the public hospital system has been available since 2003. Recently published results show that methicillinresistant Staphylococcus aureus (MRSA) is endemic in many hospitals and vancomycin-resistant enterococci (VRE), multi-resistant Acinetobacter baumanii (MRAB), other multiresistant gram negative bacteria (MR GNB) and vancomycin intermediate Staphylococcus aureus (VISA) occur sporadically in some, but not all, hospitals.

The Clean Hands Save Lives campaign was launched on 27 March 2006, with the aim of reducing MROs by improving hand hygiene compliance in NSW health facilities. The campaign was conducted as a joint initiative of the CEC and NSW Department of Health.

Combining campaign methodologies from Pittet and Larson, *Clean Hands Save Lives* has used a multi-modal approach to improve staff compliance and usage of alcohol-based hand rubs and to reduce MRO infections.

#### Campaign strategies

- Project officers were appointed in each Area Health Service (AHS) to co-ordinate the campaign locally
- Dissemination of campaign collateral was linked to key messages, based on the World Health Organization's 'Talking Walls' strategy
- Introduction of alcohol-based hand rubs at point of patient care within each facility to assist busy staff to decontaminate their hands before and after patient contact
- Measuring alcohol-based hand rub product usage and distribution throughout NSW facilities
- Monitoring adherence and providing staff with feedback on their performance
- Standardised data collection tools assisted staff to evaluate local implementation of the campaign, and provide de-identified data for statewide aggregation and analysis.

#### Key achievements

- Improved hand hygiene compliance across all professional groups in NSW health facilities
- Improvement in availability of alcohol-based hand rubs in patient care areas and confidence of staff in using them

- Staff reported increased understanding and knowledge of hand hygiene, reflected in observed hand hygiene compliance
- An improved understanding of patient and visitor involvement in this aspect of healthcare while patients and visitors strongly encourage involvement and knowledge of activities affecting patient care, they reported preference for 'passive involvement', rather than confronting staff directly about hand hygiene
- MRO data collected through the Infection Control Quality Monitoring Indicator Program during the campaign period showed a reduction of MRO infections, particularly MRSA.

#### **Future directions**

- The CEC has launched a new program to reduce bacteraemia associated with the insertion of central venous catheters. Hand hygiene is a key component of this initiative
- Hand hygiene is also a key component of planned initiatives to reduce surgical site infections as part of wider work on healthcare associated infections, in partnership with the NSW Department of Health
- Ongoing audit of hand hygiene compliance and alcohol hand rub placement and usage are required to maintain the gains made in this campaign.

### Performance (cont.)

#### COMMUNICATING FOR **CLINICAL CARE**

#### Aligns with CEC key result areas:

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

#### Aligns with State Health Plan objectives:

- 1. Make prevention everybody's business
- 2. Create better experiences for people using health services
- 6. Build a sustainable workforce

#### Description

- Communication failures have been identified as a significant factor in adverse patient outcomes in the Walker Report 2004, and from trend analysis of the statewide Incident Information Management System (IIMS)
- The CEC Directions Statement reflects these concerns and cites education in communication as part of the capacity building role of the CEC

■ The Communicating for Clinical Care (CFCC) Project is a direct response to these issues and aims to improve communication practices/ processes in frontline patient healthcare delivery across the NSW health system by the introduction of education tools in communication.

#### Key achievements

- Education tools (trigger DVDs) developed by two Area Health Services, depicting effective and ineffective communication practices in a clinical setting (1-3 minute scenarios), were identified for use in Area Health Services
- The CFCC Project tested the DVDs across a selection of health service facilities, in different clinical settings and with different healthcare groups from October to December 2006.
- Results showed the tools are effective when used with a local multi-disciplinary team

- The trigger scenarios are effective in raising communication issues and identifying barriers to effective communication
- The tools assist health service staff to identify local improvements and to develop alternative strategies for improved patient safety and clinical quality.

#### **Future directions**

The CEC has funded the development of four e-newsletters by NSW hospital staff, to be trialled in late 2007 utilising 'CARE' (Collaboration, Acceptance, Reflection, and Empathy) messages.

### NSW FALLS PREVENTION PROGRAM

#### Aligns with CEC key result areas:

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

#### Aligns with State Health Plan objectives:

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

The NSW Falls Prevention Program leader and project officer provide statewide co-ordination and support to Area Health Services. Each Area Health Service has appointed an Area Falls Co-ordinator to manage the implementation of an Area falls prevention plan.



CEC Falls Program project officer (Ingrid Hutchinson) and program leader (Lorraine Lovitt)



Bronwyn Kuzmiuk, Gaye Sykes, Dianne Dennis, Orinda Jones, Professor Clifford Hughes, Dr Denise Robinson, Jan Hughes, Christine Quinn, Lyn Cohen, Josephine Mortimer

#### Key focus areas include:

#### Community

- Early identification of falls risk factors and referral to suitable programs by GPs, NSW Ambulance, community health teams and community service providers
- Forming links with other agencies to build a network of exercise programs (community and homebased) with a focus on strength, flexibility and balance training.

#### Hospital

 Implementation of the Australian Safety Quality Council's falls bestpractice guidelines (2005).

#### **Residential Care**

Establish networks to support education, management and the implementation of the Australian Safety and Quality Council's falls best-practice guidelines (2005).

#### 2007 key initiatives

 CEC April Falls Day: Showcase of key falls initiatives being implemented in the hospital and community sector in Area Health Services demonstrating what is

- working in falls prevention: How they got staff on board/involved; challenges faced; achievements: future plans.
- Rural Telehealth Project: Interactive education sessions supporting implementation best-practice guidelines (2005). This pilot was run at two sites in each of the four rural Area Health Services in May and June 2007.
- Valley Community Health Centre.
  An evidence-based program which indicates that multi-disciplinary approaches encompassing comprehensive identification of falls risks, assessment and targeted intervention can reduce falls and falls injury rates. This model has been described and can be found on the ARCHI website: http://www.archi.net.au/elibrary/build/moc/falls\_prevention
- NSW Falls Injury Prevention Network Meeting June 4 2007 UNSW – an update on falls research and evidence and a showcase of falls initiatives being undertaken across the State.

### Performance (cont.)

#### PERFORMANCE INDICATORS AND MEDICATION SAFETY (PIMS)

#### Aligns with CEC key result areas:

- 3. Information management
- 4. Clinical improvement

#### Aligns with State Health Plan objectives:

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

#### Description

The CEC has collaborated with the NSW Therapeutic Advisory Group (TAG) to improve medication safety, by way of the Performance Indicators and Medication Safety (PIMS) project. The project, which started in 2005, aims to improve medication safety and the quality use of medicines in NSW by the implementation of two Medication Safety Self-Assessment (MSSA) tools, and the revision of indicators for drug use in Australian hospitals.

The project has been developed in two phases:

- 1 The adaptation of the Institute for Safe Medicines Practice (ISMP) tools: the MSSA for Australian hospitals and the Medication Safety Self Assessment for Antithrombotic Therapy in Australian Hospitals (MSSA - AT).
- 2 Revision of the drug use indicators.

#### Key achievements

#### Phase 1

- After extensive field testing, the tools were finalised and launched for implementation in NSW in February 2007
- The CEC and NSW TAG, in collaboration with the Canadian Institute for Safe Medicine Practices (ISMP), have developed a webbased version of the MSSA tool. This enables real-time online reporting, comparison of data for a hospital between two reporting periods, comparison of de-identified data between hospitals with similar demographics, and comparison with aggregate data

The Australian Council on Healthcare Standards (ACHS) has included a medication safety standard in its updated accreditation standards (EQuIP 4), with reference to the MSSA tools, aiming to encourage usage and uptake of the self-assessment tools

#### Phase 2

 A final indicator set has been selected by extensive consultation and field testing.

#### **Future directions**

- Implementation and launch of the Indicators for Drug Use in Australian Hospitals will happen in late 2007
- The MSSA-AT database will be complete and available to be used in late 2007
- Data from the MSSA undertaken in NSW will be analysed and reported back to Area Health Services in April 2008.

Recommendations for future State level medication safety initiatives will be based on this data.



#### SAFER SYSTEMS SAVING LIVES (SSSL)

#### Aligns with CEC key result areas:

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

#### Aligns with State Health Plan objectives:

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

#### Description

The Safer Systems Saving Lives (SSSL) project was based on the Institute for Healthcare Improvement's 100,000 Lives campaign in the USA, which sought to reduce harm to patients in hospitals by the implementation of six key clinical interventions.

The SSSL project aimed to demonstrate the impact of those six key interventions, when applied consistently and comprehensively in the Australian healthcare setting.

The interventions, which are evidencebased and known to improve outcomes and prevent harm to patients, include:

- Prevention of ventilator associated complications
- Prevention of central venous catheter related blood stream infections

- Prevention of surgical site infections
- Implementation of rapid response systems
- Prevention of adverse drug events
- Improved care for patients with acute myocardial infarction.

Each intervention is represented by a 'bundle of care' components. The care bundle is based on the 'all or nothing concept' – that while each component is important, if all its elements are used, its impact is increased. For example, bundle items for the surgical site infection intervention include:

- day of surgery admission
- appropriate use of prophylactic antibiotics
- appropriate hair removal
- compliance with local surgical wound dressing protocol.

#### Achievements

SSSL was a 12-month project (February 2006 – February 2007), and involved 39 teams across five states from both public and private sector hospitals. Ten NSW teams from both rural and metropolitan hospitals were funded to participate in the project. They were:

- Coffs Harbour Base Hospital
- Gosford Hospital
- Hornsby Ku-ring-gai District Hospital
- Lismore Base Hospital

- Liverpool Hospital
- Prince of Wales Private Hospital
- Royal North Shore Hospital
- St Vincent's Hospital, Sydney
- The Tweed Hospital
- The Children's Hospital at Westmead.

Organisational leadership was provided by the Department of Human Services in Victoria on behalf of the Australian Commission on Safety and Quality in Healthcare. A project co-ordinator, based at the Clinical Excellence Commission, provided project leadership in NSW.

#### **Future directions**

In recognition of the potential of SSSL for widespread clinical practice improvement, the CEC undertook an external evaluation of the NSW project to inform the rollout of SSSL interventions in NSW beyond the conclusion of the project. This has resulted in a statewide initiative, in partnership with the NSW Department of Health, involving all intensive care units in the state to reduce central line associated bacteraemia (CLAB-ICU Project).

### Performance (cont.)



#### TRANSFUSION MEDICINE

#### Aligns with CEC key result areas:

- 3. Information management
- 4. Clinical improvement

#### Aligns with State Health Plan objectives:

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

#### Description

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

Key performance targets include the establishment of clinical governance structures such as transfusion committees; developing and implementing education strategies to inform and support changes in clinical practice, consistent quality reporting of adverse events through existing systems such as the Incident Information Management System (IIMS), improving the appropriateness of transfusion

of fresh products, and developing an accurate costing model of direct and indirect costs of transfusion medicine.

Within each Area Health Service, a CEC-funded position of transfusion project officer/CNC, together with the appointed clinical lead, support area and local initiatives to sustain transfusion best practice.

#### Key achievements

- Establishment of transfusion committees in all Area Health Services
- An audit of red cell usage completed by each Area Health Service, with information reported to transfusion committees
- A review of NSW IIMS blood, or blood product incidents reported between July 2005 June 2006 has been completed and reported to NSW Health and the National **Blood Authority**
- Dissemination of marketing collateral including Blood Myths poster series
- A data linkage project which linked pathology, blood bank and Health Information Exchange (HIE) data for the first time, to assist Area Health Services to understand local blood utilisation levels

- Completion of market research into the transfusion prescribing behaviours of senior clinicians in NSW, to inform a communications and direct marketing strategy
- Pilot and evaluation of the South Australian Department of Health e-learning course by graduate medical program students in two NSW teaching hospitals.

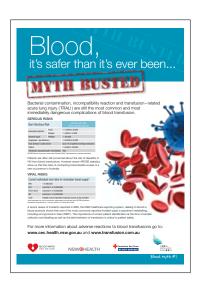
#### **Future directions**

- Direct marketing and communication to clinicians regarding appropriate transfusion and blood management
- Statewide roll-out of e-learning program to meet Australian Council on Healthcare Standards (ACHS)'s accreditation standards
- Blood Watch Congress to be held in Sydney in March 2008
- Development and dissemination of NSW Health endorsed Consumer Guide to Blood Transfusions Brochure.

#### Blood Watch 'myth buster' posters











### Performance (cont.)

#### TOWARDS A SAFER CULTURE (TASC)

#### Aligns with CEC key result areas:

- 3. Information management
- 4. Clinical improvement

#### Aligns with State Health Plan objectives:

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

#### Description

TASC is one of the CEC's longestrunning programs, dating back to a pilot in 2000. By late 2005, 35 hospitals in seven of the eight Area Health Services had joined the project, aided by development of the TASC Online System.

The TASC program aims to develop a sustainable quality system to:

- improve the translation of guideline recommendations into clinical practice
- improve the management of patients who present with acute coronary syndromes or stroke and ensure that these patients receive evidence-based treatment and secondary prevention.

The CEC acknowledges, with thanks, the significant contribution of Cate Ferry as Program Manager for TASC from its inception. Cate left the CEC in April 2007 for another position.

#### Key achievements

- Completion of successful User Acceptance Testing of requested alterations to the TASC Online System, which enhance the stroke data upload from participating facilities
- Participation in rural stroke forums held at Cooma, Tamworth, Nowra, Orange, Wagga Wagga, Lismore, Dubbo, Broken Hill, Coffs Harbour, Port Macquarie and Ballina, attended by over 750 clinicians
- Development and exploration of options to expand the TASC program to support the collection of clinical information and routine reporting for additional clinical areas/networks.

#### **Future directions**

■ The TASC program will be incorporated into the Patient Safety directorate, with future directions to be explored with the director.

#### CLINICAL LEADERSHIP PROGRAM

#### Aligns with CEC key result areas:

- 5. Capacity Building
- 6. Organisational development

#### Aligns with State Health Plan objectives:

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

#### Description

The CEC Clinical Leadership Program has funding for two years, and is aimed at enhancing the capacity of clinicians to be agents of sustainable system improvement and patient safety.

An effective clinical leader will:

- Demonstrate a high level of technical mastery
- Build the capability of the clinical team
- Advocate for patient safety and integrate system improvement into clinical care
- Have insights into his or her own leadership style and its impact on others

- Work effectively with a range of clinicians and managers
- Use consensus development and vision to set, align and achieve goals
- Resolve conflict and balance demands within the larger health environment
- Provide skills and tools to be more effective advocates for the safety and quality initiatives.

The program content aims to build a cohort of effective clinical leaders who progressively become the 'critical mass' needed for patient-centred system change.

The Clinical Leadership Program is offered in two modes: The statewide program is multi-disciplinary, delivered in five modules by local Area facilitators. The Modular program is delivered as five intensive modules, designed to build on each other as participants enhance their skills throughout the program.

#### Key achievements

#### Modular program

- The modular program started in February 2007 with 31 health service participants from eight AHS and Justice Health – 27 senior Medical Staff and 4 senior executives
- Clinical leaders play a pivotal role in the patient safety and clinical quality environment. They need to have their full potential harnessed to ensure that the health system works better and more safely for staff, patients and their families
- To achieve this, participants are undertaking a clinical service challenge aimed at enhancing their knowledge and skills relating to patient safety and clinical quality systems. The challenge will serve to equip them as advocates for patient safety while integrating health system improvement into their everyday clinical care.

#### Statewide Program

- The Statewide program started in February 2007, with 180 participants and 19 groups
- Local facilitators oversee delivery of the program within the public health organisation. The intention is that the programs be adopted and continued at a local level when the Statewide program ends at the end of 2008
- A statewide co-ordinator oversees the program and supports the facilitators via skills training, information sharing and coaching.

#### **Future directions**

A second cohort of participants will be selected for the next cycle of the program to commence in October/November 2007.



Statewide Clinical Leadership Program – facilitators' workshop, February 2007

Back Row (L-R): Annette Solman; Mary Lambell; Richard Tewson; Raichel Green; Michelle Eason; Rachelle Ellem; Kane Wyborn; Margot Tugwell; Jacqui Blackshaw; Jane Conway; Christine Lee; Paul Crowe; Louise Van Baarle; Claire Nabke-Hatton Front Row (L-R): Karen Patterson; Nicole Dixon; Loretta Martin; Ketty Rivas; Jacqui Cross; Jenelle Langham; Amanda Baker Absent: Rebekkah Middleton

### Performance (cont.)

#### INFORMATION MANAGEMENT INITIATIVES

#### Aligns with CEC key result areas:

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

#### Aligns with State Health Plan objectives:

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

#### Chartbook

As part of our goal to provide assurance through credible public reporting, the CEC is progressing the development of a Chartbook, to be released annually.

The aims of the Chartbook are to:

- Provide a tool for measuring and reporting safety and quality in the NSW health system at a state and Area Health Service level
- Provide a key resource for driving change within the NSW health system

- Provide a simple overview of the state of knowledge of the safety and quality of healthcare services in NSW for use by the public and non-specialist audiences
- Provide relevant information in tabular and graphical formats with interpretive text that interprets the findings, for Area Health Services and clinical governance units
- Report on outcomes of key initiatives of the CEC and NSW Health that address safety and quality issues.

#### **Key Achievements**

A Chartbook Advisory Group (CAG) was convened in 2006, comprising leaders from NSW Department of Health, Area Health Services and the CEC. The group is tasked with:

- Providing advice on identification of NSW safety and quality indicators
- Providing advice on the framework and structure for the Chartbook
- Reviewing candidate measures for priority action areas
- Advising on data collection procedures.

#### **Future Directions**

- Produce the inaugural Chartbook, which has been drafted and reviewed by clinical experts in a number of disciplines
- Commence work on producing indicators for the 2008 Chartbook.

#### Health Record Linkage

The Centre for Health Record Linkage (CHeReL) is a new collaborative venture established by NSW Health and the Cancer Institute NSW, with key partners including the CEC, University of Sydney, University of New South Wales, University of Newcastle, ACT Health and The Sax Institute.

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

The routine availability of linked data will provide the CEC with significantly enhanced capacity to report on deaths associated with surgery and anaesthesia. It will also support significantly enhanced output from the Incident Information Management System (IIMS) by linkage to outcomes data which has been previously unavailable.

Additionally, several other programs and projects at the CEC (eg. Safer Systems Saving Lives; medication safety; and transfusion medicine) stand to benefit from being in a position to ascertain post-discharge outcomes (particularly deaths).

### PATIENT SAFETY AND INCIDENT MANAGEMENT

#### Aligns with CEC key result areas:

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

#### Aligns with State Health Plan objectives:

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

#### Description

The CEC's Patient Safety Program is aligned with the NSW Patient Safety and Clinical Quality Program (PSCQP), which seeks to deliver a simple, standardised, system-wide approach to improving the safety of healthcare across the NSW health system. Analysis of statewide clinical incident data from the Incident Information Management System (IIMS) is an integral part of the program.

#### Key achievements

- The CEC released its first annual report of IIMS data in December 2006, for the 2005/06 financial year, comprising 125,000 notifications, of which around 70 per cent (88,000) were clinical in nature. The analysis was disseminated throughout the health system, followed by a report for the July-December 2006 period showing similar trends. Further reports will be released on a bi-annual basis in collaboration with the NSW Department of Health
- A major focus this year has been the establishment of a shared reporting function with the NSW Department of Health. It aims to foster collaboration and consistency in analysis and the reporting of quality and safety data. Outcomes have included streamlined processing of requests for data, a workshop for Area IIMS co-ordinators, and a suite of pre-defined reports

- IIMS data used to help inform on other issues that may be causing concern within the health system. Reports using IIMS data have been prepared for special interest clinical groups, to help identify and inform issues for guidance related to clinical safety
- Other achievements include contributing to system enhancements for IIMS reporting and on-going training for Root Cause Analysis presentation skills.

#### Future directions

- Preparations are on-going in partnership with NSW Health to improve IIMS functionality with the introduction of a new reporting tool
- The Patient Safety Program will be strengthened as part of an internal organisational review
- The CEC will continue to work with NSW Health and Area Health Services and use data to decide priorities for the development of future projects to improve patient safety.

# Performance (cont.)

Figure 1: NSW Trend IIMS Notifications 2006/07

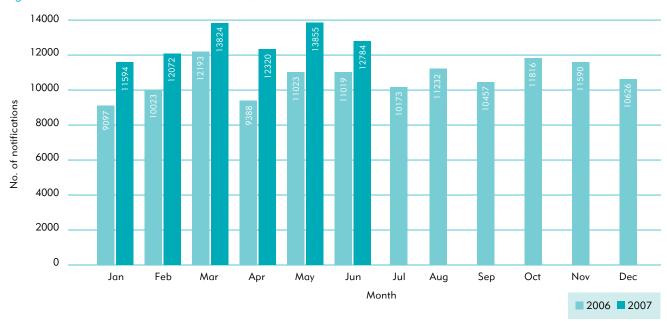
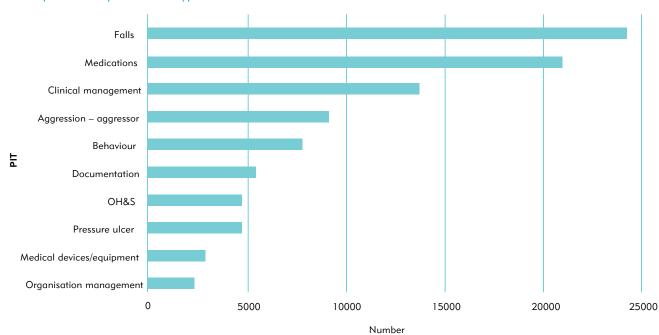


Figure 2: Top Ten Principal Incident Types – Clinical Incidents



#### **QUALITY EDUCATION**

#### Aligns with CEC key result areas:

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

#### Aligns with State Health Plan objectives:

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

#### Description

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

#### Key achievements

The CEC held workshops in clinical practice improvement (CPI) to address the need for Clinical Leadership Program participants to learn about health service improvement. Additional health service staff were nominated to attend the workshops by their clinical governance unit.

- The workshops were held in three metropolitan and four rural locations between April and June 2007
- Audiences included NSW Health Quality Improvement staff, Patient Safety staff, medical and nursing clinicians and managers and allied health staff
- A total of 235 health service staff attended the workshops
- A CPI workshop at the CEC for CEC and the NSW Department of Health staff attracted 20 people.

#### **Future directions**

- The CEC has selected, through tender process, an online learning company to develop a modular education program for health service improvement. The program will be developed in collaboration with the NSW Department of Health to ensure synergy with health service improvement education programs, and a consistent and standardised approach to statewide online learning programs
- The Clinical Practice Improvement workshop will be revised for continued delivery in 2007–2008.

### Performance (cont.)

#### **QUALITY SYSTEMS ASSESSMENT**

#### Aligns with CEC key result areas:

- 2. Quality Systems Assessment
- 6. Organisational development

#### Aligns with State Health Plan objectives:

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

#### Description

The Quality System Assessment (QSA) program is a new initiative for the NSW health system and an integral and innovative component of the NSW Patient Safety and Clinical Quality Program. The QSA has been specifically developed for the eight Area Health Services (AHS), the Ambulance Service of NSW, Justice Health and The Children's Hospital at Westmead.

The QSA will review annually the systems and processes health services have in place to support safety and quality of clinical care, and to manage risks widely acknowledged to impact significantly on patient safety and quality of care. The initial assessment in 2007–2008 will involve a baseline measure of patient safety and clinical quality activities in the NSW system.

Reflecting the complexity of the NSW health system, the QSA program will comprise three levels of organisational focus. Each is an accountability point in the system and is responsible for the governance of patient safety and quality system. The three levels are:

- Area health services
- Facilities and/or clinical streams
- Clinical units.

The QSA program has four components:

- Completion of a self-assessment survey at the three levels of the organisation
- Verification of the activity statements. This will occur in one of three ways: comparison of activity statements from each level to confirm operational dependencies and linkages: a 'desk-top' review of cited documentation and an external audit process to verify a sample of the activity statements
- Feedback will be provided to participating organisations on their own performance and will be 'benchmarked' against the NSW health system in general
- Development of improvement plans will be expected at each level of the organisation. These should respond to the issues highlighted in the self-assessment process. The improvement plan will be subject to review in subsequent QSA assessments.

#### Key achievements

- Finalisation of the QSA methodology and framework
- Comprehensive literature review undertaken to identify developments in the assessment of quality, safety and risk management systems, both within and outside the health system
- Development of the QSA web page on the CEC website
- Completion of statewide stakeholder consultations workshops in NSW. Workshops in metropolitan and rural areas, with separate consultations for Justice Health and the Ambulance Service of NSW. Nine workshops were held, involving over 300 participants
- Successful piloting of the three organisational levels of the activity statements in Area Health Services, Ambulance Service of NSW and Justice Health.

#### **Future directions**

- Handover of final deliverables. by contractor for QSA program development project
- A staged roll-out of the QSA program is planned to start with AHSs and the hospital system in September/October 2007, and with Justice Health and the Ambulance Service of NSW in February 2008.

#### SPECIAL COMMITTEES

#### Aligns with CEC key result areas:

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

#### Aligns with State Health Plan objectives:

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

# SPECIAL COMMITTEE INVESTIGATING DEATHS ASSOCIATED WITH SURGERY (SCIDAWS)

The Special Committee Investigating Deaths Associated with Surgery was established on 26 May 1994 under section 20 (4) of the Health Administration Act 1982 and has authority under section 23 (7) of the same Act.

In 2006, the Minister for Health approved the following expanded functions for the committee to enable it to oversee a systematic audit of surgical mortality in NSW, based on the successful Scottish and Western Australian models. In NSW this audit will be known as the Collaborating Hospitals' Audit of Surgical Mortality (CHASM).

The revised functions of the committee are:

- To undertake, oversee and coordinate a systematic audit of surgical mortality in NSW using peer review processes
- To review deaths associated with surgical care, identify potentially preventable factors associated with these cases and provide confidential feedback to the surgeons involved
- To contribute surgical expertise to the preparation, analysis and interpretation of reports derived from de-identified aggregate data and make recommendations for appropriate action
- To promote the systematic clinical review of deaths associated with surgical care, including voluntary compliance with the Special Committee's review processes among surgeons and their professional organisations.

#### **Key Achievements**

Nominations for membership were received from the NSW State Committee of the Royal Australasian College of Surgeons, university departments of surgery, surgical craft groups and Area Health Services

- Membership has been approved by Cabinet and duly appointed by the Minister for Health
- Sydney West and Hunter New England Area Health Services are piloting the CHASM process which will be progressively rolled out across the State
- Engagement of key stakeholders and personnel
- A step-by-step guide to the CHASM audit process has been prepared by CEC in consultation with key stakeholders
- A background information pack has been developed and presented to surgeons in pilot Area Health Services
- Specific NSW software has been commissioned and is under development
- Practical support for the CHASM implementation is being provided through a CEC funded part-time Clinical Audit Manager based in each participating Area Health Service. The overall purpose of this position is to facilitate surgeon participation in the program and the exact duties may vary between AHSs.

### Performance (cont.)

#### SPECIAL COMMITTEES (CONT.)

#### SPECIAL COMMITTEE INVESTIGATING DEATHS UNDER ANAESTHESIA (SCIDUA)

SCIDUA was convened in 1961 to provide 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, has authority under section 23, and reports to the Minister for Health.

#### **Key Achievements**

- The CEC is pleased to report that the operational efficiency of the committee has been maintained this year, despite the increased workload resulting from the adoption in 2006 of the national classification scheme for anaesthesia-related deaths
- The secretariat has undertaken a formal audit, to best practice standards, of the completeness and accuracy of the SCIDUA records on deaths from 2000-2005

- The next report will contain descriptive data on anaesthesiarelated deaths in similar format to that of the national reports prepared by the Australian and New Zealand College of Anaesthetists and published triennially
- In addition the CEC has worked with the Department of Health and SCIDUA to determine the most appropriate option for preservation of its archive. The process has been agreed, is progressing smoothly and will be completed later this year. This is approximately six months ahead of the anticipated timescale.

#### SCIDUA membership is drawn from

- Australian & New Zealand College of Anaesthetists
- Australian Society of Anaesthetists
- 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 College of Pathologists of Australasia.

#### **SPECIAL REVIEWS**

#### Aligns with CEC key result areas:

- 1. Public reporting
- 3. Information management
- 4. Clinical improvement
- 5. Capacity building

#### Aligns with State Health Plan objectives:

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

The Director General of NSW Health may, from time to time, require the CEC to conduct reviews on his or her behalf about the quality and safety of healthcare, with the specific nature of the review determined by the Director-General.

The purpose of these reviews is to bring about improvements in clinical quality and patient safety within NSW. The CEC does not investigate matters of individual performance, nor does it deal with individual patient incidents or complaints.

Recognising the importance of this function to the NSW health service, the CEC has established a full-time position of Manager, Special Reviews. Alex Warner started in this position in January 2007.

Special reviews undertaken by the CEC over the year in review are as follows:

- Review of communication with affected patients and the public by two Area Health Services concerning inaccurate reporting on pathology and cytology specimens. Report completed September 2006
- Review of implantation procedures for permanent pacemakers and related devices.

#### Report in progress

 Review of Attention Deficit
 Hyperactivity Disorder in children and adolescents.

Review in progress.

### Our People

#### STAFF PROFILE

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

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

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

Dr George Bearham, Deputy CEO, took 12 months leave from January 2007. Dr Peter Kennedy now fills this position.

The number of full time equivalent staff at the CEC at 30 June 2007 was 29.63, comprising 25.63 CEC appointed staff (3.84 of these medical), 3.00FTE agency staff and 1.00FTE contractor.

#### Full-Time Equivalent Staff at 30 June:

06/07	29.63
05/06	23.76
04/05	13.70

#### **EXECUTIVE REPORTS**

Professor Clifford F Hughes AO **Health Service:** 

Clinical Excellence Commission Period in Position:

18 January 2005 to 30 June 2007

#### Strategic Initiatives

- Midterm review of organisational strategic plan and key result areas
- Development of additional strategies in key portfolios of Quality Systems Assessment, Clinical Practice Improvement Projects, Information Management and Organisation Development and Education
- Provide statewide leadership, support and guidance for clinical practice improvement projects including hand hygiene; falls; medication safety; communication; transfusion medicine; venous thromboembolism
- Provide statewide train-the-trainer sessions in root cause analysis
- Appointment of designated clinical leadership staff
- Launch of statewide Clinical Leadership Program
- Publication of first year of IIMS statewide data in December 2006
- Publication of Third report on Adverse Events in the NSW public health system, in collaboration with NSW Department of Health
- Preparation for annual CEC Chartbook containing NSW safety and quality indicators

- Completion of piloting of Area Health Service level assessment tool as part of Quality Systems Assessment
- Developed with external contractor criteria and assessment tools for three levels (Area Health Service; clinical stream/division; clinical unit) for Quality Systems Assessment
- Knowledge management initiative, 'Stocktake' of data collections published December 2006 and introduction of HSNet discussion boards as a knowledge sharing tool
- Establishment of the Citizens **Engagement & Advisory Council to** progress community engagement around the quality and safety of healthcare
- Collaborating Hospitals Audit of Surgical Mortality (CHASM) program initiated, with two Area Health Services selected as pilot sites
- Appointment of Manager, Special Reviews to manage special reviews in the areas of pacemakers and attention deficit disorder (ADHD) in children and adolescents in NSW
- Appointment of the inaugural lan O'Rourke PhD Scholar who will conduct research into Improving Health Outcomes for Indigenous Australians at high cardiovascular risk through strategies to reduce systems barriers to quality care.

#### Management Accountabilities

- Plans underway to open the first CEC rural campus with the relocation of the Program Leader, NSW Falls Program to Coffs Harbour Hospital in North Coast Area Health Service
- Ongoing management of CEC projects in collaboration with executive staff
- Appointment of Deputy Chief Executive Officer
- All statutory and financial reporting requirements completed
- Development and implementation of corporate risk register
- Code of conduct and performance development policies finalised and implemented.

### EQUAL EMPLOYMENT OPPORTUNITY

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

### ETHNIC AFFAIRS PRIORITY STATEMENT

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

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

- Respect and make provision for the expression of culture, language and religion by staff and constituents
- Provide full opportunity for staff and constituents to utilise and participate in relevant CEC activities and programs
- Recognise the linguistic and cultural assets in the population of New South Wales as a valuable resource, and promote this resource where possible
- Consider in its service planning and development activities, strategies to incorporate and draw on the experience and wisdom of its diverse and multicultural population
- Not limit or withhold provision of its services to any individuals or organisation on the basis of linguistic, religious, racial or ethnic background

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

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

These strategies will be further developed over the next reporting period, with a view to identifying additional strategies and opportunities.

### OCCUPATIONAL HEALTH & SAFETY

At 30 June 2007, the CEC had not received any workers compensation claims and there were no reported incidents. This is consistent with the two previous reporting periods.

### Our People (cont.)

#### **CONFERENCE PRESENTATIONS**

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

#### Professor Clifford Hughes AO

Chief Executive Officer

- 'The passion for excellence An exploration of system improvements'. ACHSE & RACMA Joint Congress, Hobart, 3 August 2006
- 'Using IT to improve the reporting and management of adverse events'. Centre of Research Excellence Seminar, Melbourne, 7 August 2006
- 'Integrated governance in Australian healthcare: 'Walking the talk' - the role of the CEC in NSW'. Clinical Governance Australia Summit, Sydney, 17 October 2006
- 'Winning down under!' NSW Health Expo, Sydney, 20 October 2006
- 'Children's Emergency Care Project'. International Society of Quality conference, London, 22-25 October 2006
- 'Collaborating hospitals' audit of surgical mortality in NSW'. Royal Australian College of Surgeons NSW state committee, Sydney, 6 February 2007
- 'My patients are different! The flaw in the human genome project'. 16th Annual NSW Health Informatics Conference, Sydney, 30 March 2007

- 'A change for leadership or leadership for change? Breaking down the barriers of resistance in changing culture and behaviour'. Baptist Care Australia Conference, Sydney, 31 May 2007
- 'A bifocal vision of safety'. ACHSE Conference, Adelaide, 15 June 2007.

#### Dr George Bearham

Deputy CEO, 2006

'Role of the CEC'. Medico-legal symposium, Sydney, October 2006.

#### Lorraine Lovitt

Program Leader. Falls Prevention Program

- Residential Aged Care Association conference, 27 July 2006
- Book Launch: 'Staying Power' by Lindy Clemson, 7 August 2006
- TASC Stroke Workshop, Broken Hill, 16 August 2006
- NSW Community Options State Conference, 5 September 2006
- TASC Stroke forum Coffs Harbour, 12 September 2006
- Australian Injury Prevention Network, 27 September 2006
- Australian Falls Conference, 7 November 2006
- Port Macquarie Health Promotion Active Over 50's Forum, 19 February 2007
- Trade Display: Aged Care Expo 10-11 May 2007

- Sydney South West Area Health Service Allied Health forum, 29 May 2007
- NSW Falls Injury Prevention Meeting, University of NSW, 4 June 2007
- Aged and Community Services Association State Conference, 6 June 2007
- Falls Forum, Queensland Department of Health, 7 June 2007.

#### **Dr Annette Pantle**

**Director Clinical Practice** Improvement Projects

- 'Coughs and Harbouring Colds: What's coming through the door?' **NSW Infection Control Association** Conference, 28 July 2006
- 'From understanding to improvement – it's child play: The Children's Emergency Care Project', Australian Patient Safety Foundation Conference, 11 October 2006
- 'The Children's Emergency Care Project', NSW Institute of Medical **Education and Training:** Pre-Vocational Committee for Training, 24 October 2006
- 'Guideline implementation: The experience of the NSW Children's Emergency Care Project'. Cancer Institute of NSW Chemotherapy Accreditation Forum, 14 February 2007
- 'Strategies for implementing safety and quality projects: an overview.' University of Technology, Sydney, 11 May 2007

'Translating evidence into practice: The Children's Emergency Care Project'. Collaborations for Translating Evidence Into Practice workshop, 22 June 2007.

#### OFFICIAL OVERSEAS TRAVEL BY CEC STAFF

#### Professor Clifford Hughes AO Chief Executive Officer

 23rd annual conference of International Society for Quality in Healthcare London, 22–25 October 2006.

#### Dr Annette Pantle

**Director Clinical Practice Improvement** 

 International Forum on Quality and Safety in Healthcare\*
 Barcelona, 18–20 April 2007.

### **Dr George Bearham**Deputy CEO

Attendance at Clinical Practice Improvement course with Intermountain Healthcare\* Salt Lake City, USA, 2006.

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

#### **RESEARCH**

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

### Ian O'Rourke Scholarship in Patient Safety

The inaugural Ian O'Rourke Scholarship in Patient Safety was awarded to Dr David Peiris in November 2006. Dr Peiris is conducting his PhD research through the George Institute for International Health and is enrolled in the School of Public Health at the University of Sydney. David Peiris' research program is entitled Improving health outcomes for Indigenous Australians at high cardiovascular risk through strategies to reduce systems barriers to quality care.

When he was working at Elcho Island in the Northern Territory, Dr Peiris met Dr Ian O'Rourke who became a significant mentor. David's work experience has made him acutely aware of significant deficiencies in access to, and quality of tertiary hospital services for indigenous people and he is committed to improving the health of Aboriginal Australians. It is a commitment he shared with Ian O'Rourke.



Kate O'Rourke, Ian O'Rourke's daughter, Trish O'Rourke, Ian O'Rourke's wife, David Peiris, Ian O'Rourke Scholar, Bruce Barraclough, Chairman of CEC.

#### Improving patient flow in the Sydney and Sydney Eye Hospital Ophthalmology Outpatient Department

This project was led by Dr George Bearham as part of a Clinical Practice Improvement project, in collaboration with a project team from the Sydney Hospital and Sydney Eye Hospital ophthalmology outpatient department. Its goal was to reduce waiting times, overbooking and delays in seeing medical officers in three glaucoma clinics. Data was collected and analysed, and interventions identified in collaboration with project team members and relevant clinicians. Interim identified solutions included re-convening a local outpatients committee and revising booking procedures, with longer-term suggestions including a larger-scale clinical redesign project.

#### Membership of Advisory Board

The CEC is a member of the international Advisory Board. CEC staff attended the 2007 annual meeting for hospital executives forum in Sydney on 30 May, where the topic was 'Transforming the acute care enterprise: staff engagement, clinical efficiency and the hospital of the future'. Advisory Board staff also delivered a workshop for the Clinical Leadership Program (modular), entitled 'Finding True North'.

### Our People (cont.)

#### **TEACHING AND** TRAINING INITIATIVES

Professional development for CEC staff is fundamental to building knowledge and keeping them aware of updates and initiatives in the field of safety and quality and other organisational capabilities. The CEC has therefore created a development program to provide regular professional development opportunities and a forum for sharing information and knowledge.

The CEC has presented internal professional development courses and workshops since February 2006, including presentations/workshops by CEC staff, staff from the Area Health Services showcasing initiatives, and external consultants. Topic areas have included:

- CIAP training
- Writing briefs
- Presentation skills
- Myers Briggs Type Indicator (MBTI) workshop
- Open disclosure
- Clinical Practice Improvement workshop
- Updates of CEC projects
- Advisory Board Company international meeting.

A journal club established in early 2006 offers a professional development forum for CEC staff to promote discussion around key quality and safety topics, with reference to the literature and to enhance skills in critical review.

Two meetings were held during the past year.

Staff also benefited from attendance at a range of local, national and international conferences relating to quality and safety. Those marked with an asterisk indicate conferences in which CEC staff presented:

- Stroke conference, Sydney, July 2006\*
- Chronic care forum, Sydney, July 2006
- 'Coughs and harbouring colds what's come through the door?', **NSW Infection Control Association** Conference, Coffs Harbour, July 2006\*
- Lean methodology Masterclass, Sydney, July 2006
- Raising the bar for quality -4th Australasian Conference on Safety and Quality in Healthcare, Melbourne, July 2006\*
- ACHSE and RACMA 2006 joint national congress, Hobart, August 2006
- The role of IT in improving patient safety – Centre for Research Excellence, Melbourne, August 2006\*
- 'Improving medication safety: sharing the lessons learned', Sydney, September 2006
- Clinical Governance Australia 2006, Sydney, October 2006\*
- 'Using evidence: using guidelines' symposium - National Institute

- of Clinical Studies, Melbourne, October 2006\*
- Medico-legal symposium, Sydney, October 2006\*
- 23rd annual International Society for Quality in Healthcare, London, October 2006
- Evolving System Safety 2006 7th international symposium of the Australia Aviation Psychology Association (CEC stall), Sydney, November 2006
- 3rd Australasian Redesigning Healthcare Summit: 'Making patient journeys work', Sydney, February 2007
- Leadership, the critical success factors - Masterclass, Sydney, February 2007
- International forum on quality and safety in healthcare, Barcelona, April 2007
- The Expert Witness and Expert Evidence Workshop, Sydney, April 2007\*
- Transfusion update 2007, Adelaide, May 2007\*.

Dr George Bearham, deputy CEO, completed the Brent James Clinical Practice Improvement course with Intermountain Healthcare in the United States in the latter half of 2006. As part of the course, he undertook a clinical practice improvement project with a team from the Sydney and Sydney Eye Hospital's Ophthalmology Outpatient Department, focusing on improving patient flow.

### Our Community

#### CITIZENS ENGAGEMENT ADVISORY COUNCIL

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

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

The model complements existing links the CEC has with the statewide **Healthcare Advisory Council**, which is attended by the Chairman of the CEC Board and which provides a valuable link between the CEC and Area Healthcare Advisory Councils.

#### **SPONSORSHIP**

The CEC provided sponsorship and hosted an information stand at the 'Evolving System Safety 2006 – 7th International Symposium of the Australia Aviation Psychology Association', held in Sydney 9–12 November 2006.

### FREEDOM OF INFORMATION (FOI) REPORT

The CEC did not receive any applications under the FOI Act for the period 1 July 2006 to 30 June 2007. This is consistent with the two previous reporting periods.

# FINANCIAL REPORTS

### **Executive Summary**

For the year ended 30 June 2007

The audited financial statements presented for the Clinical Excellence Commission for the 2006–2007 financial year provide for a Net Cost of Services budget of \$7.888 million, against which the audited actuals of \$5.856 million represents a variation of \$2.032 million or 26%.

Activity has increased during this financial year and has resulted in higher expenditure than in previous years. However, the actual result was better than budget expectations due mainly to lower than expected projected costs throughout the year. This was mainly due to several new projects commencing in the latter part of this financial year. These projects will continue on into the next financial year and will have a significant impact on expenditure in 2007–2008. The result also reflects a higher than expected actual revenue which has contributed to a lower Net Cost of Services result in comparison to the previous financial year.

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

Comparisons of actual performance with the preceding 12 months is provided in the following table:

	2005–2006 \$000	2006–2007 \$000	Comparison \$000	Movement %
EXPENSES EXCLUDING LOSSES	4000	4000	4000	~
Employee Related	3,060	3,917	857	28
Other Operating Expenses	1,645	2,257	612	37
Depreciation and Amortisation	32	90	58	100+
Grants and Subsidies	1,438	157	-1,281	89
Total Expenses	6,175	6,421	246	4
Sale of Goods and Services	146	36	-110	75
Investment Income	27	34	7	26
Grants and Contributions	0	495	495	100
Other Revenue	3	0	-3	100
Total Revenue	176	565	389	100+
Net Cost of Services	5,999	5,856	-143	2

### Independent Audit Report

For the year ended 30 June 2007



GPO BOX 12 Sydney NSW 2001

#### INDEPENDENT AUDITOR'S REPORT

#### CLINICAL EXCELLENCE COMMISSION AND ITS CONTROLLED ENTITY

#### To Members of the New South Wales Parliament

I have audited the accompanying financial report of the Clinical Excellence Commission (the Commission) and the Commission and its controlled entity (the consolidated entity), which comprises the balance sheet as at 30 June 2007, and the operating statement, statement of recognised income and expense, cash flow statement, and a summary of significant accounting policies and other explanatory notes. The consolidated entity comprises the Commission and the entities it controlled at the year's end or from time to time during the financial year.

#### Auditor's Opinion

In my opinion, the financial report:

- presents fairly in all material respects, the financial position of the Commission and the
  consolidated entity as at 30 June 2007, and of their financial performance and their cash flows
  for the year then ended in accordance with Australian Accounting Standards (including the
  Australian Accounting Interpretations)
- is in accordance with section 45E of the Public Finance and Audit Act 1983 (the PF&A Act) and the Public Finance and Audit Regulation 2005

#### The Chief Executive's Responsibility for the Financial Report

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

#### Auditor's Responsibility

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

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

### Independent Audit Report (cont.)

For the year ended 30 June 2007

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

My opinion does not provide assurance:

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

#### Independence

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

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

Jack Kheir BEc, FCPA Director, Financial Audit Services

22 November 2007 SYDNEY

### Certification of Financial Statement Parent/Consolidated

For the year ended 30 June 2007

#### Certification of Parent/Consolidated Financial Statements For the Period Ended 30 June 2007

The attached financial statements of the Clinical Excellence Commission for the year ended 30 June 2007:

- Have been prepared in accordance with the requirements of applicable Australian Accounting Standards which include Australian equivalents to International Financial Reporting Standards (AEIFRS), the requirements of the *Public Finance and Audit Act 1983* and its regulations, the Health Services Act 1997 and its regulations, the Accounts and Audit Determination and the Accounting Manual for Area Health Services and Public Hospitals;
- Present fairly the financial position and transactions of the Clinical Excellence Commission;

Demachen Clife idention ( The

Have no circumstances which would render any particulars in the financial statements to be

Professor Bruce Barraclough, AO Professor Clifford Hughes, AO Chief Executive Officer

21 November 2007 21 November 2007 Mr André Jenkins A/Director, Corporate Services

21 November 2007

# **Operating Statement**

For the year ended 30 June 2007

			PARENT		CONSOLIDATION		
	Notes	Actual 2007 \$000	Budget 2007 \$000	Actual 2006 \$000	Actual 2007 \$000	Budget 2007 \$000	Actual 2006 \$000
EXPENSES EXCLUDING LOSSES							
Operating Expenses							
Employee Related	3	0	1,573	2,167	3,917	1,573	3,060
Personnel Services	4	3,917	0	893	0	0	0
Other Operating Expenses	5	2,257	6,315	1,645	2,257	6,315	1,645
Depreciation and Amortisation	2(h), 6	90	0	32	90	0	32
Grants and Subsidies	7	157	0	1,438	157	0	1,438
Total Expenses excluding losses		6,421	7,888	6,175	6,421	7,888	6,175
RETAINED REVENUE							
Sale of Goods and Services	8	36	0	146	36	0	146
Investment Income	9	34	0	27	34	0	27
Grants and Contributions	10	550	0	16	495	0	0
Other Revenue	11	0	0	3	0	0	3
Total Retained Revenue		620	0	192	565	0	176
Net Cost of Services	21	5,801	7,888	5,983	5,856	7,888	5,999
GOVERNMENT CONTRIBUTIONS							
NSW Health Department							
Recurrent Allocations	2(d)	7,870	7,870	7,436	7,870	7,870	7,436
Acceptance by the Crown Entity of employee benefits	2(a)(ii)	0	58	40	55	58	56
Total Government Contributions		7,870	7,928	7,476	7,925	7,928	7,492
RESULT FOR THE YEAR		2,069	40	1,493	2,069	40	1,493

The accompanying notes form part of these Financial Statements.

# Statement of Recognised Income and Expense

For the year ended 30 June 2007

		PARENT			CONSOLIDATION		
	Notes	Actual 2007 \$000	Budget 2007 \$000	Actual 2006 \$000	Actual 2007 \$000	Budget 2007 \$000	Actual 2006 \$000
TOTAL INCOME AND EXPENSE RECOGNISED DIRECTLY IN EQUITY		0	0	0	0	0	0
Result for the Year	18	2,069	40	1,493	2,069	40	1,493
TOTAL INCOME AND EXPENSE							
RECOGNISED FOR THE YEAR		2,069	40	1,493	2,069	40	1,493

The accompanying notes form part of these Financial Statements.

### **Balance Sheet**

As at 30 June 2007

		PARENT			CON	ISOLIDATIO	N
	Notes	Actual 2007 \$000	Budget 2007 \$000	Actual 2006 \$000	Actual 2007 \$000	Budget 2007 \$000	Actual 2006 \$000
ASSETS							
Current Assets							
Cash and Cash Equivalents	12	438	133	133	438	133	133
Receivables	13	1,101	691	665	1,101	691	665
Total Current Assets		1,539	824	798	1,539	824	798
NON-CURRENT ASSETS							
Plant and Equipment	14	699	676	676	699	676	676
Intangible Assets	15	2,323	708	708	2,323	708	708
Total Non-Current Assets		3,022	1,384	1,384	3,022	1,384	1,384
Total Assets		4,561	2,208	2,182	4,561	2,208	2,182
LIABILITIES							
Current Liabilities							
Payables	16	331	116	90	371	116	90
Provisions	17	637	243	595	597	243	595
Total Current Liabilities		968	359	685	968	359	685
Non-Current Liabilities							
Provisions	17	66	7	39	66	7	39
Other	17	0	344	0	0	344	0
Total Non-Current Liabilities		66	351	39	66	351	39
Total Liabilities		1,034	710	724	1,034	710	724
Net Assets		3,527	1,498	1,458	3,527	1,498	1,458
11017133013		3,321	1,770	1,750	3,321	1,770	1,730
EQUITY							
Accumulated Funds	18	3,527	1,498	1,458	3,527	1,498	1,458
Total Equity		3,527	1,498	1,458	3,527	1,498	1,458

The accompanying notes form part of these Financial Statements.

### Cash flow statement

For the year ended 30 June 2007

					COI	<b>ISOLIDATI</b>	UN
		Actual	Budget	Actual	Actual	Budget	Actual
	Masaa	2007	2007	2006	2007	2007 \$000	2006 \$000
CASH FLOWS FROM OPERATING ACTIVITIES	Notes	\$000	\$000	\$000	\$000	\$000	\$000
Payments							
Employee Related		0	(1,515)	(1,716)	(3,873)	(1,515)	(2,597)
Other Operating Expenses		(5,849)	(6,315)	(2,765)	(1,976)	(6,315)	(1,884)
Grants and Subsidies		(157)	0	(1,438)	(1,770)	0,010)	(1,438)
Total Payments		(6,006)	(7,830)	(5,919)	(6,006)	(7,830)	(5,919)
		(-//	( //	(-7 7	(-,,	( ) /	(-7 7
Receipts							
Sale of Goods and Services		(360)	0	(513)	(360)	0	(513)
Interest Received		34	0	27	34	0	27
Grants and Contributions		495			495		
Other		0	0	3	0	0	3
Total Receipts		169	0	(483)	169	0	(483)
Cash Flows From Government							
NSW Health Department Recurrent Allocations		7,870	7,870	7,436	7,870	7,870	7,436
Net cash flows from Government		7,870	7,870	7,436	7,870	7,870	7,436
Net cash flows from operating activities	21	2,033	40	1,034	2,033	40	1,034
CASH FLOWS FROM INVESTING ACTIVITIES							
Purchases of Land and Buildings, Plant and Equipment							
Infrastructure Systems and Intangible Assets		(1,728)	0	(1,348)	(1,728)	0	(1,348)
Net cash flows from investing activities		(1,728)	0	(1,348)	(1,728)	0	(1,348)
The case have been alreading determined		(.,,, ==,		(.,,	(.,. = 0)		(.,0 .0,
CASH FLOWS FROM FINANCING ACTIVITIES							
Proceeds from Borrowings and Advances		0	0	0	0	0	0
Net cash flows from financing activities		0	0	0	0	0	0
Net increase / (decrease) in cash		305	40	(314)	305	40	(314)
Opening Cash and Cash Equivalents		133	133	447	133	133	447
CLOSING CASH AND CASH EQUIVALENTS	12	438	173	133	438	173	133

The accompanying notes form part of these Financial Statements.

For the year ended 30 June 2007

#### 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.

With effect from 17 March 2006 fundamental changes to the employment arrangements of the Clinical Excellence Commission were made through amendment to the Public Sector Employment and Management Act 2002 and other Acts including the Health Services Act 1997. The status of the previous employees of the Clinical Excellence Commission changed from that date. They are now employees of the Government of New South Wales in the service of the Crown rather than employees of the Clinical Excellence Commission. Employees of the Government are employed in Divisions of the Government Service. In accordance with Accounting Standards these Divisions are regarded as special purpose entities that must be consolidated with the financial report of the Clinical Excellence Commission. This is because the Division was established to provide personnel services to enable the Clinical Excellence Commission to exercise its functions.

As a consequence the values in the annual financial statements presented herein consist of the Clinical Excellence Commission (as the parent entity), the financial report of the special purpose entity Division and the consolidated financial report for the economic entity. Notes have been extended to

capture both the Parent and Consolidated values with Notes 3, 4, 10, 17 and 22 being especially relevant. In the process of preparing the consolidated financial statements for the economic entity consisting of the controlling and controlled entities, all inter-entity transactions and balances have been eliminated.

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

These financial statements have been authorised for issue by the Chief Executive Officer on 21 November 2007.

#### 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The Clinical Excellence Commission's Financial Statements are a general purpose financial report which has been prepared in accordance with applicable Australian Accounting Standards, (which include Australian equivalents to International Financial Reporting Standards (AEIFRS)), 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.

Except for plant and equipment and intangible assets, which are recorded at fair value, 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.

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

The parent and consolidated financial statements and notes comply with Australian Accounting Standards which include AEIFRS.

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

AASB-2007.04, Amendments to Australians Accounting Standards arising from ED151 and other amendments, has application for accounting periods commencing on or after 1 July 2007. The standard is not being early adopted in 2006/07 and the new options available in the standard will not be applied.

AASB123, Borrowing Costs, has application in reporting years beginning on or after 1 January 2009. The Standard, which requires capitalisation of Borrowing Costs has not been adopted in 2006/07 nor is adoption expected prior to 2009/10.

AASB101, Presentation of Financial Statements, has reduced the disclosure requirements for various reporting entities. However, in not-for-profit entities such as the Clinical Excellence Commission, there is no change required.

AASB7 Financial Instruments: Disclosures, locates all disclosure requirements for financial instruments within the one standard. The Standard has application for annual reporting period beginning on or after 1 January 2007. The Standard will not be early adopted and has no differential impact.

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

#### a) Employee Benefits and Other Provisions

### i) Salaries and Wages, Current Annual Leave, Sick Leave and On-costs (including non-monetary benefits).

At the consolidated level of reporting liabilities for salaries and wages, (including non monetary benefits) annual leave, and paid sick leave that fall wholly within 12 months of the reporting date are recognised and measured in respect of employees' services up to the reporting date at undiscounted amount based on the amount expected to be paid when the liabilities are settled. All Annual Leave employee benefits are reported as "Current" as there is an unconditional right to payment. Current liabilities are then further classified as "Short Term" or "Long Term" based on past trends and known resignations and retirements. Anticipated payments to be made in the next 12 months are reported as "Short Term". On-costs of 21.7% are applied to the value of leave payable at 30 June 2007 inclusive of the 4% award increase

payable from 1 July 2007, such on-costs being consistent with actuarial assessments.

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

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

Consequential to the legislative changes of 17 March 2006 no salary costs or provisions are recognised by the Parent Health Service beyond that date.

#### ii) Long Service Leave and Superannuation Benefits

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

Long Service Leave provisions are measured on a short hand basis at an escalated rate of 8.1% inclusive of the 4% payable from 1 July 2007 for all employees with five or more years of service. Actuarial assessment has found that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

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

For the year ended 30 June 2007

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

Consequential to the legislative changes of 17 March 2006 no salary costs or provisions are recognised by the Parent entity beyond that date.

#### iii) Other Provisions

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

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

#### b) Insurance

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

#### c) Finance Costs

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

#### d) Income Recognition

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

#### Sale of Goods and Services

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

#### **Investment Income**

Interest revenue is recognised using the effective interest method as set out in AASB 139, "Financial Instruments: Recognition and Measurement". Rental revenue is recognised in accordance with AASB 117 "Leases" on a straight line basis over the lease term.

#### **Debt Forgiveness**

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

#### **Grants and Contributions**

Grants and Contributions are generally recognised as revenues when the Clinical Excellence Commission obtains control over the assets comprising the contributions. Control over contributions is normally obtained upon the receipt of cash. The Clinical Excellence Commission, as a not-forprofit entity has applied the requirements in AASB 1004 'Contributions' regarding contributions of assets (including grants) and forgiveness of liabilities. There are no differences in the recognition requirements between the new AASB 1004 and the previous AASB 1004. However, the new AASB 1004 may be amended by proposals in Exposure Draft ED 125 Financial Reporting by Local Governments and ED 147 Revenue from Non-Exchange Transactions (including Taxes and Transfers). If the ED 125 and ED 147 approach is applied, revenue and/or expense recognition will not occur until either the Clinical Excellence Commission supplies the related goods and services (where grants are in-substance agreements for the provision of goods and services) or until conditions are satisfied. ED 125 and ED 147 may therefore delay revenue recognition compared with AASB 1004, where grants are recognised when controlled. However, at this stage, the timing and dollar impact of these amendments is uncertain.

#### **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 Operating Statement before arriving at the "Result for the Year" 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) Acquisition of Assets

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

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

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

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

#### g) Plant and Equipment

Individual items of property, plant & equipment are capitalised where their cost is \$10,000 or above. Prior to 1 July 2006 assets were recognised based on a value of \$5,000 or above.

#### h) Depreciation

Depreciation is provided for on a straight line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life to the Clinical Excellence Commission. Depreciation rates are subsequently varied where changes occur in the assessment of the remaining useful life of the asset reported.

Standard depreciation rates for major asset categories are as follows:

Computer Equipment	20.0%
Office Equipment	10.0%
Plant and Machinery	10.0%
Furniture, Fittings and Furnishings	5.0%

#### i) 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.

#### j) Impairment of Property, Plant and Equipment

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

For the year ended 30 June 2007

#### k) Intangible Assets

The Clinical Excellence Commission recognises intangible assets only if it is probable that future economic benefits will flow to the Health Service and the cost of the asset can be measured reliably. Intangible assets are measured initially at cost. Where an asset is acquired at no or nominal cost, the cost is its fair value as at the date of acquisition. All research costs are expensed. Development costs are capitalised only when certain criteria are met. The useful lives of intangible assets are assessed to be finite. Intangible assets are subsequently measured at fair value only if there is an active market. As there is no active market for the Clinical Excellence Commission's intangible assets, the assets are carried at cost less any accumulated amortisation. The Clinical Excellence Commissions's intangible assets are amortised using the straight line method over a period of 20 years. In general, intangible assets are tested for impairment where an indicator of impairment exists. However, as a not-for-profit entity the Clinical Excellence Commission is effectively exempted from impairment testing (see Note 2[j]).

#### I) 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.

#### m) Leased Assets

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

Where a non-current asset is acquired by means of a finance lease, the asset is recognised at its fair value at the 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 Operating Statement in the periods in which they are incurred.

#### n) Other Financial Assets

Financial assets are initially recognised at fair value plus, in the case of financial assets not at fair value through profit or loss, transaction costs.

#### o) Financial Instruments

Financial instruments give rise to positions that are a financial asset of either the Clinical Excellence Commission or its counter party 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 AASB 139, "Financial Instruments: Recognition and Measurement" disclosure of the carrying amounts for each of the AASB 139 categories of financial instruments is disclosed in Note 25. The specific accounting policy in respect of each class of such financial instruments is stated hereunder.

Classes of instruments recorded and their terms and conditions measured in accordance with AASB 139 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 5.0% as compared with 5.5% in the previous year.

#### 2. Receivables

Accounting Policies

Receivables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of

discounting is immaterial. An allowance for impairment of receivables is established when there is objective evidence that the Clinical Excellence Commission will not be able to collect all amounts due. The amount of the allowance is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. Bad debts are written off as incurred

#### Terms and Conditions

Accounts are generally 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. Trade and Other Payables

#### Accounting Policies

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

#### 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.

#### p) Budgeted Amounts

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

#### q) Programs/Activities of the Clinical Excellence Commission

The Clinical Excellence Commission operates under a single program of the DOH (this can be found in the Budget Papers) and has been confirmed with DOH that this program relates to CEC operations.

#### Teaching and Research

Program Objective(s)

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 New South Wales.

	PARENT		CONSOLIDATION		
	2007 \$000	2006 \$000	2007 \$000	2006 \$000	
3. EMPLOYEE RELATED					
Employee related expenses comprise the following:					
Salaries and Wages	0	1,724	3,234	2,434	
Superannuation [see note 2(a)] – defined benefit plans	0	40	55	56	
Superannuation [see note 2(a)] – defined contributions	0	130	187	183	
Long Service Leave [see note 2(a)]	0	65	90	92	
Annual Leave [see note 2(a)]	0	187	281	265	
Sick Leave and Other Leave	0	21	58	30	
Workers Compensation Insurance	0	0	12	0	
	0	2,167	3,917	3,060	
4. PERSONNEL SERVICES					
Personnel Services comprise the purchase of the following:					
Salaries and Wages	3,234	710	0	0	
Superannuation [see note 2(a)] – defined benefit plans	55	16	0	0	
Superannuation [see note 2(a)] – defined contributions	187	53	0	0	
Long Service Leave [see note 2(a)]	90	27	0	0	
Annual Leave [see note 2(a)]	281	78	0	0	
Sick Leave and Other Leave	58	9	0	0	
Workers Compensation Insurance	12	0	0	0	
	3,917	893	0	0	

	PARENT		CONSOL	IDATION
	2007 \$000	2006 \$000	2007 \$000	2006 \$000
5. OTHER OPERATING EXPENSES				
Domestic Supplies and Services	5	6	5	6
Food Supplies	17	8	17	8
Fuel, Light and Power	1	1	1	1
General Expenses (See (b) below)	1,009	773	1,009	773
Information Management Expenses	147	61	147	61
Insurance	1	2	1	2
Maintenance Contracts	4	0	4	0
New/Replacement Equipment under \$10,000	64	84	64	84
Repairs	2	1	2	1
Other	1	3	1	3
Postal and Telephone Costs	36	21	36	21
Printing and Stationery	178	241	178	241
Rates and Charges	1	1	1	1
Rental	244	182	244	182
Special Service Departments	18	61	18	61
Staff Related Costs	201	95	201	95
Travel Related Costs	328	105	328	105
	2,257	1,645	2,257	1,645

	PARENT		CONSOLIDA	TION
	2007 \$000	2006 \$000	2007 \$000	2006 \$000
a) General Expenses include				
Advertising	11	4	11	4
Audio Visual	2	0	2	0
Books, Magazines and Journals	16	6	16	6
Consultancies	298	154	298	154
Courier and Freight	1	2	1	2
Auditor's Remuneration – Audit of financial reports	18	15	18	15
Legal Services	107	15	107	15
Membership/Professional Fees	127	1	127	1
Other Operating Lease Expense – minimum lease payments	1	6	1	6
Translator Services	1	0	1	0
Project Payments				
Transfusion Medicine Improvement Program	2	0	2	0
Clinical Council	2	0	2	0
CEC Administration and Program Development	21	91	21	91
Clinical Practice Improvement Projects	7	0	7	0
Emergency Care for Children	0	55	0	55
Information Management	22	0	22	0
Quality System Assessment	154	2	154	2
Safety Improvement Program	1	0	1	0
Short Term Projects	84	16	84	16
Special Committee Investigating Death under Anaesthetic	0	197	0	197
Clinical Leadership Program	117	0	117	0
Safer System Savings Lives	0	154	0	154
Other	17	55	17	55
	1,009	773	1,009	773
b) Maintenance				
Reconciliation Total Maintenance				
Maintenance (non employee Maintenance expense –				
contracted labour and other related ), included in Note 5	71	88	71	88
Total maintenance expenses included in Notes 3, 4 and 5	71	88	71	88

	PARENT		CONSOLIDATION	
	2007 \$000	2006 \$000	2007 \$000	2006 \$000
6. DEPRECIATION AND AMORTISATION				
Depreciation – Plant and Equipment	23	32	23	32
Amortisation – Intangible Assets	67	0	67	0
	90	32	90	32
7. GRANTS AND SUBSIDIES				
Research and Evaluation Program: Safety and Quality	0	240	0	240
Safer System Saving Lives Program	140	298	140	298
Transfusion Medicine Programs	0	900	0	900
Ian O'Rourke Scholarship Fund (University of Sydney)	17	0	17	0
	157	1,438	157	1,438
8. SALE OF GOODS AND SERVICES				
Rendering of Services comprise the following:				
Commercial Activities	32	131	32	131
Services Provided to Non NSW Health Organisations	0	12	0	12
Other	4	3	4	3
	36	146	36	146
9. INVESTMENT INCOME				
Interest	34	27	34	27
	34	27	34	27
10. GRANTS AND CONTRIBUTIONS				
NSW Government grants	495	0	495	0
Personnel Services – Super Annuation Defined Benefits	55	16	0	0
	550	16	495	0

	PARENT		CONSOLIDATION	
	2007 \$000	2006 \$000	2007 \$000	2006 \$000
11. OTHER REVENUE				
Other	0	3	0	3
	0	3	0	3
12. CURRENT ASSETS – CASH AND CASH EQUIVALENTS				
Cash at bank and on hand	438	133	438	133
	438	133	438	133
Cash assets recognised in the Balance Sheet are reconciled to cash at the end of the financial year as shown in the Cash Flow Statement as follows:				
Cash and cash equivalents (per Balance Sheet)	438	133	438	133
Closing Cash and Cash Equivalents (per Cash Flow Statement)	438	133	438	133
13. CURRENT/NON CURRENT RECEIVABLES  Current  (a) Sale of Goods and Services				
Debtors Intra Health	1,040	659	1,040	659
Other Debtors	15	0	15	0
Sub Total	1,055	659	1,055	659
Prepayments	46	6	46	6
Total	1,101	665	1,101	665

	PARENT		CONSOLIDATION	
	2007 \$000	2006 \$000	2007 \$000	2006 \$000
14. PLANT AND EQUIPMENT				
Plant and Equipment				
At Fair Value	754	708	754	708
Less Accumulated depreciation	(55)	(32)	(55)	(32)
Net Carrying Amount	699	676	699	676
Total Plant and Equipment At Net Carrying Amount	699	676	699	676

PARENT AND CONSOLIDATION Plant and Equipment – Reconciliations	Plant and Equipment \$000	Total \$000
2007		
Carrying amount at start of year	676	676
Additions	46	46
Depreciation expense	(23)	(23)
Carrying amount at end of year	699	699
2006		
Carrying amount at start of year	68	68
Additions	640	640
Depreciation expense	(32)	(32)
Carrying amount at end of year	676	676

	PARENT	PARENT		CONSOLIDATION	
	2007 \$000	2006 \$000	2007 \$000	2006 \$000	
15. INTANGIBLE ASSETS					
Software					
Cost (Gross Carrying Amount)	2,390	708	2,390	708	
Less Accumulated Amortisation and Impairment	(67)	0	(67)	0	
Net Carrying Amount	2,323	708	2,323	708	
Total Intangible Assets at Net Carrying Amount	2,323	708	2,323	708	

PARENT AND CONSOLIDATION Intangibles – Reconciliation	Software \$000	Total \$000
2007		
Net Carrying amount at start of year	708	708
Additions (from internal development or acquired separately)	1,682	1,682
Amortisation (recognised in depreciation and amortisation)	(67)	(67)
Net Carrying amount at end of year	2,323	2,323
2006		
Net Carrying amount at start of year	0	0
Additions (from internal development or acquired separately)	708	708
Amortisation (recognised in depreciation and amortisation)	0	0
Net Carrying amount at end of year	708	708

	PARENT	PARENT		TION
	2007 \$000	2006 \$000	2007 \$000	2006 \$000
16. PAYABLES				
Current				
Accrued Salaries and Wages	0	0	40	0
Trade Creditors	326	85	326	85
Other Creditors	5	5	5	5
	331	90	371	90
17. PROVISIONS				
Current Employee benefits and related on-costs				
Employee Annual Leave – Short Term Benefit	0	0	85	75
Employee Annual Leave – Long Term Benefit	0	0	71	200
Employee Long Service Leave – Short Term Benefit	0	0	95	46
Employee Long Service Leave – Long Term Benefit	0	0	346	274
Provision for Personnel Services Liability	637	595	0	0
Total Current Provisions	637	595	597	595
Non Current Employee benefits and related on-costs				
Employee Long Service Leave – Conditional	0	0	66	39
Provision for Personnel Services Liability	66	39	0	0
Total Non Current Provisions	66	39	66	39
Aggregate Employee Benefits and Related On-costs				
Provisions – current	637	595	597	595
Provisions – non-current	66	39	66	39
	703	634	663	634

For the year ended 30 June 2007

	ACCUMULATED FUNDS		TOTAL EQUITY	
	2007 \$000	2006 \$000	2007 \$000	2006 \$000
18. PARENT AND CONSOLIDATION – EQUITY				
Balance at the beginning of the financial reporting period	1,458	(35)	1,458	(35)
Correction of errors		0		0
Restated Opening Balance	1,458	(35)	1,458	(35)
Changes in equity other than transactions with owners as owners				
Result for the year	2,069	1,533	2,069	1,533
Correction of errors	0	(40)	0	(40)
Balance at the end of the financial reporting period	3,527	1,458	3,527	1,458

	PARE	ENT	CONSOL	IDATION
	2007 \$000	2006 \$000	2007 \$000	2006 \$000
19. COMMITMENTS FOR EXPENDITURE				
(a) Capital Commitments				
Aggregate capital expenditure contracted for at balance date but not provided for in the accounts:				
Not later than one year	0	841	0	841
Later than one year and not later than five years	0	841	0	841
Later than five years	0	0	0	0
Total Capital Expenditure Commitments	0	1,682	0	1,682
Prior year capital commitments were for the IIMS software licence.				
(b) Other Expenditure Commitments				
Aggregate other expenditure contracted for at balance date				
but not provided for in the accounts:				
Not later than one year	93	91	93	91
Later than one year and not later than five years	387	383	387	383
Later than five years	43	43	43	43
Total Other Expenditure Commitments	523	517	523	517
Other expenditure commitments reflect service level agreements with SESIAHS.				
(c) Operating Lease Commitments				
Commitments in relation to non-cancellable operating leases				
are payable as follows:				
Not later than one year	206	200	206	200
Later than one year and not later than five years	411	847	411	847
Later than five years	0	232	0	232
Total Operating Lease Commitments	617	1,279	617	1,279

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

### **20. CONTINGENT LIABILITIES**

There are no contingent liabilities.

For the year ended 30 June 2007

	PAREI	PARENT		DATION
	2007 \$000	2006 \$000	2007 \$000	2006 \$000
21. RECONCILIATION OF NET CASH FLOWS FROM				
OPERATING ACTIVITIES TO NET COST OF SERVICES				
Net Cash Flows from Operating Activities	2,033	1,034	2,033	1,034
Depreciation	(90)	(32)	(90)	(32)
Acceptance by the Crown Entity of				
Employee Superannuation Benefits	0	(40)	(55)	(56)
(Increase)/Decrease in Employee Entitlements	(69)	(407)	(29)	(407)
(Increase)/Decrease in Other Debtors (Intra HIth)	396	659	396	659
Increase/(Decrease) in Prepayments	40	5	40	5
Increase/(Decrease) in Income in Advance	0	0	0	0
(Increase)/Decrease in Creditors	(241)	234	(281)	234
(NSW Health Department Recurrent Allocations)	(7,870)	(7,436)	(7,870)	(7,436)
Net Cost of Services	(5,801)	(5,983)	(5,856)	(5,999)

### 22. UNCLAIMED MONEYS - PARENT AND CONSOLIDATION

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

### 23. BUDGET REVIEW - PARENT AND CONSOLIDATION

### **Net Cost of Services**

The actual Net Cost of Services was lower than budget by \$2.03m. This was primarily due to some major projects still in their service delivery stage, which continues to reflect the timing differences between budgeted allocation and actual projected expenditure. Greater than budgeted actual revenue of \$565K represents mainly additional project funding from NSW Health for short term projects. The remainder represents commercial activity revenue from health campaign resource development and dissemination on behalf of NSW Health.

### Result for the Year

The result for the year was higher than budget by \$2.07m due to the favourable Net Cost of Services position.

### Assets and Liabilities

### **Current Assets**

Current Assets were greater than budget by \$0.71m. This was primarily due to higher than budgeted receivables comprising of intra-health debtors. The two Incident Information Systems (IIMS) payments, in addition to the reduction of actual Creditors has resulted in the reduced actual cash balance at the end of the year. The Clinical Excellence Commission has been in a position to negotiate its cash allocation based on its expenditure requirements.

### **Non-Current Assets**

Non-current assets were higher than budget by \$1.64m reflecting the IIMS licence capital payment.

### **Current Liabilities**

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

### **Non-Current Liabilities**

Non-Current Liabilities were higher than budget due to an increase in leave provisions and other.

### Cash Flows

### **Operating Activities**

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

### **Investing Activities**

Actual capital expenditure exceeded budget by \$1.7m which is largely attributable to the Incident Information Systems (IIMS) payments.

### Financing Activities

Financing activities continues to reflect intra-health debtors.

Movements in the level of the NSW Health Department Recurrent Allocation that have occurred since the time of the initial allocation on 28th July 2006 are as follows:

	2007 \$000	2006 \$000
	<b>\$000</b>	<b>\$000</b>
Initial Allocation, 28th July 2006	7,414	7,095
Secretariat Funding/Enhancements	0	4,284
Government Cash Payments	0	(3,718)
Budget Reduction Effected By Treasury	(1)	0
Hand Hygiene Program	0	(605)
Paediatric Clinical Practice Guidelines	0	27
Falls Prevention Program	270	202
Super Guarantee Charge	187	151
Balance as per Operating Statement	7,870	7,436

For the year ended 30 June 2007

### 24. FINANCIAL INSTRUMENTS - PARENT AND CONSOLIDATION

### 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. The Clinical Excellence Commission exposure to interest rate risks and the effective interest rates of financial assets and liabilities, both recognised and unrecognised, at the (consolidated) Balance Sheet date are as follows:

	FLOAT INTERES		NON-INTEREST BEARING		TOTAL CARRYING AMOUNT AS PER THE BALANCE SHEET		AVER/ EFFEC INTEREST	TIVE
	2007 \$000	2006 \$000	2007 \$000	2006 \$000	2007 \$000	2006 \$000	2007 %	2006 %
Financial Assets								
Cash	438	133	0	0	438	133	6.15	5.45
Receivables	0	0	1,101	665	1,101	665		
Total Financial Assets	438	133	1,101	665	1,539	798		
Financial Liabilities								
Payables	0	0	371	90	371	90		
Total Financial Liabilities	0	0	371	90	371	90		

<sup>\*</sup>Average effective interest rate was computed on a semi-annual 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 there under. The Clinical Excellence Commission's maximum exposure to credit risk is represented by the carrying amounts of the financial assets included in the consolidated Balance Sheet.

Credit Risk by classification of counterparty.

	BANKS		OTHER		TOTAL	
	2007 \$000	2006 \$000	2007 \$000	2006 \$000	2007 \$000	2006 \$000
Financial Assets						
Cash	438	133	0	0	438	133
Receivables	0	0	1,101	665	1,101	665
Total Financial Assets	438	133	1,101	665	1,539	798

There is no significant concentration of credit risk.

### c) Derivative Financial Instruments

The Clinical Excellence Commission holds no Derivative Financial Instruments.

### d) After Balance Date Events

There are no events after the balance sheet date that affect these financial statements.

For the year ended 30 June 2007

### 25. PRIOR PERIOD BUSINESS - PARENT AND **CONSOLIDATION**

In 2006/07 the Department of Health determined the need to make allowance for on-costs which need to be paid on the settlement of annual leave liability. This resulted in the application of an on-cost of 21.7% as reported in note 2(a).

The provision of AASB119, Employee Benefits and Treasury's Financial Reporting Code for Budget Dependent General Government Sector agencies, as pre existing in prior years, recognised the need to include such on-costs and therefore the on-costs now recognised have been brought to account as "Prior Period Errors".

The amount corrected against the Opening Balance as 1 July 2005 was Nil, with the 2005/06 Result being increased by \$0.040M. In the Parent financial statements the \$0.040M has been apportioned between Employee Related Expenses (\$0.028M) for the period up to 17 March 2006 and Personal Services (\$0.012M) for the period 17 March 2006 to 30 June 2006.

END OF AUDITED FINANCIAL STATEMENTS

# Independent Audit Report Special Purpose Service Entity

For the year ended 30 June 2007



GPO BOX 12 Sydney NSW 2001

### INDEPENDENT AUDITOR'S REPORT

### CLINICAL EXCELLENCE COMMISSION SPECIAL PURPOSE SERVICE ENTITY

To Members of the New South Wales Parliament

I have audited the accompanying financial report of Clinical Excellence Commission Special Purpose Service Entity (the Entity), which comprises the balance sheet as at 30 June 2007, and the income statement, statement of recognised income and expense and cash flow statement for the year then ended, and a summary of significant accounting policies and other explanatory notes.

### Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Entity as of 30 June 2007, and of its financial performance and its cash flows for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 45E of the Public Finance and Audit Act 1983 (the PF&A Act) and the Public Finance and Audit Regulation 2005.

### Chief Executive's Responsibility for the Financial Report

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

### Auditor's Responsibility

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

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

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

# Independent Audit Report (cont.) Special Purpose Service Entity

For the year ended 30 June 2007

My opinion does not provide assurance:

- about the future viability of the Entity, that they have carried out their activities effectively, efficiently and economically, or
- about the effectiveness of their internal controls.

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

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

Jack Kheir BEc, FCPA Director, Financial Audit Services

22 November 2007 SYDNEY

# Certification of Financial Statement Special Purpose Service Entity

For the year ended 30 June 2007

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

The attached financial statements of the Clinical Excellence Commission Special Purpose Service Entity for the year ended 30 June 2007:

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

Professor Bruce Barraclough, AO Professor Clifford Hughes, AO

Chief Executive Officer

A/Director, Corporate Services

21 November 2007

21 November 2007

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21 November 2007

# Income Statement of Clinical Excellence Commission

Special Purpose Service Entity for the year ended 30 June 2007

	2007	2006
	\$000	\$000
INCOME	4000	4000
	2.017	000
Personnel Services	3,917	893
Acceptance by the Crown Entity of Employee Benefits	55	16
Total Income	3,972	909
EXPENSES		
Salaries and Wages	3,234	710
Defined Benefit Superannuation	55	16
Defined Contributions Superannuation	187	53
Long Service Leave	90	27
Annual Leave	281	78
Sick Leave and Other Leave	58	9
Redundancies	0	0
Workers Compensation Insurance	12	0
Grants & Subsidies	55	16
Total Expenses	3,972	909
Result for the Year	0	0

The comparatives for 2006 cover the period 17 March 2006 to 30 June 2006 only. Note 1(c) refers.

# Balance Sheet of Clinical Excellence Commission

Special Purpose Service Entity as at 30 June 2007

		2007	2006
	Notes	\$000	\$000
ASSETS			
Current Assets			
Receivables	2	637	595
Total Current Assets		637	595
Non-Current Assets			
Receivables	2	66	39
Total Non-Current Assets		66	39
Total Assets		703	634
LIABILITIES			
Current Liabilities			
Provisions	3	637	595
Total Current Liabilities		637	595
Non-Current Liabilities			
Provisions	3	66	39
Total Non-Current Liabilities		66	39
Total Liabilities		703	634
Net Assets		0	0
EQUITY			
Accumulated funds		0	0
Total Equity		0	0

# Statement of Recognised Income and Expense of Clinical Excellence Commission

Special Purpose Service Entity for the year ended 30 June 2007

	2007 \$000	2006 \$000
Opening Equity	0	0
Result for the Year	0	0
Closing Equity	0	0

# Cash Flow Statement of Clinical Excellence Commission

Special Purpose Service Entity for the year ended 30 June 2007

	2007 \$000	2006 \$000
Net Cash Flows from Operating Activities	0	0
Net Cash Flows from Investing Activities	0	0
Net Cash Flows from Financing Activities	0	0
Net Increase/(Decrease) in Cash	0	0
Closing Cash and Cash Equivalents	0	0

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

Special Purpose Service Entity for the year ended 30 June 2007

### 1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

### a) The Clinical Excellence Commission Service Special **Purpose Entity**

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

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

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

The financial report was authorised for issue by the Chief Executive Officer on 21 November 2007.

### b) Basis of preparation

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

Generally, the historical cost basis of accounting has been adopted and the financial report does not take into account changing money values or current valuations.

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

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

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

### c) Comparative Information

Comparative information reflects the creation of the Special Purpose Service Entity with effect from 17 March 2006 and covers the period 17 March 2006 to 30 June 2006.

### d) Income

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

### e) Receivables

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

A receivable is measured initially at fair value and subsequently at amortised cost using the effective interest rate method, less any allowance for impairment. A shortterm receivable with no stated interest rate is measured at the original invoice amount where the effect of discounting is immaterial. An invoiced receivable is due for settlement within thirty days of invoicing.

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

### f) Payables

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

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

A short-term payable with no stated interest rate is measured at historical cost if the effect of discounting is immaterial.

### g) Employee benefit provisions and expenses

## i) Salaries and Wages, current Annual Leave, Sick Leave and On-Costs (including non-monetary benefits)

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

All Annual Leave employee benefits are reported as "Current" as there is an unconditional right to payment. Current liabilities are then further classified as "Short Term" and "Long Term" based on past trends and known resignations and retirements. Anticipated payments to be made in the next 12 months are reported as "Short Term".

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

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

### ii) Long Service Leave and Superannuation Benefits

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

Long Service Leave provisions are measured on a short hand basis at an escalated rate of 8.1% inclusive of the 4% payable from 1 July 2007 for all employees with five or more years of service. Actuarial assessment has found that this measurement technique produces results not materially different from the estimate determined by using the present value basis of measurement.

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

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

Consequential to the legislative changes of 17 March 2006 no salary costs or provisions are recognised by the Health Service beyond that date.

Special Purpose Service Entity for the year ended 30 June 2007

### h) Financial Instruments

Financial instruments given rise to positions that are a financial asset of either the Entity or its counter party and a financial liability (or equity instrument) of the other party. For the Entity, these include cash at bank, receivables, other financial assets, payables and borrowings.

In accordance with Australian Accounting Standard AASB 139, "Financial Instruments: Recognition and Measurements" disclosure of the carrying amounts for each of AASB 139 categories of financial instruments is disclosed in Note 5. The specific accounting policy in respect of each class of such financial instrument is stated hereunder. Classes of instruments recorded and their terms and conditions measured in accordance with AASB 139 are as follows:

### Receivables

### Accounting Policies

Receivables are recognised at initially fair value, usually based on the transaction cost or face value. Subsequent measures are at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Short term receivables with no stated interest are measured at the original invoice amount where the effect of discounting is immaterial. An allowance for impairment of receivables is established when there is objective evidence that the entity will not be able to collect all amounts due. The amount of the allowance is the difference between the asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. Bad debts are written off as incurred.

Terms and conditions

Accounts are generally issued on 30 day terms.

### **Payables**

### Accounting Policies

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

### Terms and Conditions

Trade liabilities are settled within terms specified. If no terms are specified, payment is made at the end of the month following the month in which the invoice is received.

	2007	2006
	\$000	\$000
2. RECEIVABLES	4000	****
Current		
Accrued Income – Personnel Services Provided	637	595
Non-Current		
Accrued Income – Personnel Services Provided	66	39
Total Receivables	703	634
3. PROVISIONS		
Current Employee benefits and related on-costs		
Accrued Salaries & Wages	40	0
Employee Annual Leave – Short Term Benefit	85	75
Employee Annual Leave – Long Term Benefit	71	200
Employee Long Service Leave – Short Term Benefit	95	46
Employee Long Service Leave – Long Term Benefit	346	274
Total Current Provisions	637	595
Non-Current Employee benefits and related on-costs		
Employee Long Service Leave – Conditional	66	39
Total Non-Current Provisions	66	39
Aggregate Employee Benefits and Related on-costs		
Provision – Current	637	595
Provision – Non-Current	66	39
Total	703	634
	7.00	30 .

Special Purpose Service Entity for the year ended 30 June 2007

### 4. 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. The Entity's exposure to interest rate risks and the effective interest rates of financial assets and liabilities, both recognised and unrecognised, at the Balance Sheet date are as follows:

	NON-INT BEAR		TOTAL CARRYING AMOUNT AS PER THE BALANCE SHEET		AVERAGE EFFECTIVE INTEREST RATE*	
FINANCIAL INSTRUMENTS	2007 \$000	2006 \$000	2007 \$000	2006 \$000	<b>2007</b> %	2006 %
Financial Assets						
Receivables	703	634	703	634	6.15	5.45
Total Financial Assets	703	634	703	634		

<sup>\*</sup>The average effective interest rate was computed on a semi-annual 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 Entity's maximum exposure to credit risk is represented by the carrying amounts of the financial assets included in the Balance Sheet.

	GOVERNMENTS		BANKS		PATIENTS		OTHER		TOTAL	
	2007	2006	2007	2006	2007	2006	2007	2006	2007	2006
CREDIT RISK BY CLASSIFICATION OF COUNTERPARTY										
Financial Assets										
Receivables	703	634	0	0	0	0	0	0	703	634
Total Financial Assets	703	634	0	0	0	0	0	0	703	634

### c) Net Fair Value

Financial Instruments are carried at cost. The resultant values are reported in the Balance Sheet and are deemed to constitute net fair value.

### d) Derivative Financial Instruments

The Clinical Excellence Commission holds no Derivative Financial Instruments.

### e) After Balance Date Events

There are no events after the balance sheet date the affect these financial statements.

### **5. PRIOR PERIOD BUSINESS**

In 2006/07 the Department of Health determined the need to make allowance for on-costs which need to be paid on the settlement of annual leave liability. This resulted in the application of an on cost of 21.7% as reported in note 2(h).

The provision of AASB119, Employee Benefits and Treasury's Financial Reporting Code for Budget Dependent General Government Sector agencies, as pre existing in 2005/06, recognised the need to include such on-costs and therefore the on-costs now recognised have been brought to account as "Prior Period Errors". However expense and revenue adjustments are fully offsetting and the adjustment had no effect on equity.

**END OF AUDITED FINANCIAL STATEMENTS** 

# Glossary

### Adverse Event

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

### Area Health Service (AHS)

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

### Clinical Excellence Commission (CEC)

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

### Clinical Information Access Program (CIAP)

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

### Clinical Practice Improvement (CPI)

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

### Clinician

A health practitioner or health service provider.

### **Director-General**

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

### IIMS

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

### Incident

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

### Incident Management

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

### Minister

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

### Near Miss

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

### **NSW Department of Health (the Department)**

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

### **Open Disclosure**

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

### **Public Health Organisation (PHO)**

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

### **Quality Systems Assessment (QSA)**

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

### Reportable Incident Brief (RIB)

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

### Root Cause Analysis (RCA)

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

### Severity Assessment Code (SAC)

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

### Statutory (Health) Corporation

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

# **Abbreviations**

**ACHS** The Australian Council of Healthcare Standards

**ARCHI** Australian Resource Centre for Healthcare Innovations

CEAC Citizens Engagement and Advisory Council

CEC Clinical Excellence Commission

CEO Chief Executive Officer CGU Clinical Governance Unit

CFCC Communicating for Clinical Care project

CHASM Collaborating Hospitals' Audit of Surgical Mortality

CheReL Centre for Health Record Linkage

CIAP Clinical Information Access Project (online information resource)

CLAB Central Line Associated Bacteraemia

CLP Clinical Leadership Program CNC Clinical Nurse Consultant CPI Clinical Practice Improvement

DOH Department of Health

EEO **Equal Employment Opportunity** 

FOI Freedom of Information

**GMCT** Greater Metropolitan Clinical Taskforce HARC Hospital Alliance for Research Collaboration

HIE Health Information Exchange

ICU Intensive Care Unit

IIMS Incident Information Management System **ISMP** Institute for Safe Medicine Practices (Canada)

MRO Multi-resistant organisms

**MSSA** Medication Safety Self Assessment **NICS** National Institute of Clinical Studies

NSW **New South Wales** 

OH&S Occupational Health and Safety **QSA Quality Systems Assessment** 

QSB Quality and Safety Branch, NSW Department of Health

**RCA** Root Cause Analysis SAC Severity Assessment Code

**SCIDAWS** Special Committee Investigating Deaths Associated With Surgery SCIDUA Special Committee Investigating Deaths Under Anaesthesia

**SESIAHS** South Eastern Sydney & Illawarra Area Health Service

SSSL Safer Systems, Saving Lives TAG Therapeutic Advisory Group **TASC** Towards a Safer Culture

TESL Training, Education and Study Leave for salaried medical practitioners

# Index

Ethnic Affairs Priority Statement 3, 43

Evidence-based guidelines 1

Falls 7, 19, 22, 26, 27, 42, 43, 44

Freedom of Information 3, 47, 94

Financial statements 3, 50, 54, 55, 56, 57, 58, 60, 62, 65, 68, 70, 72, 74, 76, 77, 78, 82, 83, 84, 85, 86, 88, 90, 91

### G Adverse events 22, 30, 42, 44, 93 Audit 2, 14, 15, 20, 21, 23, 30, 39, 40, 42, 51, 52, 66, 94 Н Best practice 15, 16, 30, 40 Highlights 3, 4, 5 Blood Watch 4, 8, 19, 30, 31 Board 2, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 20, 21, 42, 44, 51, 52, 66 C CLAB project 4, 24, 94 Chairman's report 3, 5 Chief Executive Officer's report 3, 6, 7, 8 Citizens Engagement Advisory Council 3, 4, 5, 7, 16, 19, 22, 23, 48 Clinical Council 8, 17, 18, 20, 21, 24, 67 J, K, L Clinical leadership 4, 8, 20, 22, 23, 33, 34, 37, 42, 45, 66, 94 Leadership 46 Clinical practice improvement 17, 22, 29, 37, 42, 45, 46, 66, 92, 94 Communication 14, 16, 18, 19, 22, 23, 24, 25, 26, 29, 30, M, N 35, 39, 41, 42 Conference presentations 3, 44 Community engagement 16, 21, 42 O Corporate Governance statement 3, 20 Overseas travel 3, 45 D, E Education 1, 3, 4, 5, 6, 12, 13, 16, 18, 23, 26, 27, 30, 37, 42, Patient safety program 35

# Guidelines 1 ,7, 8, 27, 46, 75 H Hand hygiene 8, 19, 22, 24, 25, 42, 75 Highlights 3, 4, 5 I Ian O'Rourke Scholarship 43, 45, 67 Incident management 19, 35, 92 IIMS 4, 5, 6, 22, 27, 31, 34, 35, 43, 73, 75, 93, 95 Independent audit report 3, 51, 52 Information management 5, 7, 19, 20, 22, 27, 28, 31, 33, 35, 36, 40, 42, 43, 43, 45, 66, 67, 95 J, K, L Leadership 46 M, N Medication safety 22, 28, 34, 42, 46 O Overseas travel 3, 45

Performance 1, 3, 6, 7, 14, 15, 19, 20, 21, 22, 24, 25, 26, 28, 29, 30, 31, 32, 36, 38, 40, 41, 43, 51, 93

# Index (cont.)

```
Q
Quality 1, 3, 4, 5, 6, 7, 8, 10, 15, 16, 19, 20, 22, 23, 26, 27,
  28, 30, 32, 33, 34, 35, 37, 38, 41, 42, 44, 45, 46, 58, 92,
  93, 94
Quality Systems Assessment 5, 7, 18, 19, 38, 42, 93, 94
Research 1, 3, 4, 5, 6, 7, 10, 11, 14, 15, 17, 21, 27, 28, 42,
  45, 62, 63, 67, 94
Reviews 4, 18, 23, 41, 42
Risk management 3, 14, 15, 19, 21, 23, 38
Root cause analysis 5, 22, 35, 42
S
Safer Systems, Saving Lives (SSSL) 24, 29, 94
Safety 1, 3, 4, 5, 6, 7, 9, 10, 16, 18, 19, 21, 22, 23, 26, 27,
  28, 29, 32, 33, 34, 35, 36, 37, 38, 39, 41, 42, 43, 44, 45,
  46, 47, 66, 67, 92, 93, 94
Scholarship 43, 45, 47
Sponsorship 47
Staff profile 3, 42
Strategic plan 4, 6, 20, 22, 23, 42
Surgical mortality 4, 22, 39, 42, 44, 94
Т
Teaching and training 23
Towards a Safer Culture (TASC) Project 7, 18, 32, 94
Transfusion medicine 4, 22, 30, 34, 42, 66, 67
W, X, Y, Z
```

Workshops 6, 22, 38, 46

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