



CLINICAL
EXCELLENCE
COMMISSION

ANNUAL
REPORT
2005–2006

The Clinical Excellence Commission
is located at two premises:

Level 3, 65 Martin Place
Sydney NSW 2000

Sydney Hospital
Level 1, Administration Building
8 Macquarie Street
Sydney NSW 2000

Postal address
GPO Box 1614
Sydney NSW 2001

Tel 61 2 9382 7600
Fax 61 2 9382 7615
www.cec.health.nsw.gov.au
ABN 79 172 068 820

Business hours: 8.30am to 5.00pm

This report can be downloaded
from www.cec.health.nsw.gov.au



CLINICAL
EXCELLENCE
COMMISSION

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

Dear Minister

We have pleasure in submitting the Clinical Excellence Commission's 2005–2006 Annual Report.

The report complies with the requirements for annual reporting under the Accounts and Audit Determination for public health organisations and the 2005–2006 Directions for Health Service Annual Reporting.

Yours sincerely

Professor Bruce Barraclough AO
Chairman

Professor Clifford Hughes AO
Chief Executive Officer

TABLE OF CONTENTS

FOREWORD	3	OUR PEOPLE	42
CHAIRMAN'S REPORT	4	Staff profile	42
CHIEF EXECUTIVE OFFICER'S REPORT	5	Executive reports	42
HIGHLIGHTS	8	Equal employment opportunity	43
ORGANISATIONAL PROFILE	9	Occupational health and safety	43
CEC Board	9	Teaching and training initiatives	43
Board sub-committee: Audit and Risk Management	14	Research	44
Board sub-committee: Finance	14	Conference presentations	44
Board sub-committee: Research	15	Official overseas travel by CEC staff	45
Clinical Council	16	OUR COMMUNITY	46
Organisational chart	17	FREEDOM OF INFORMATION (FOI) REPORT	47
Purpose and goals	18	FINANCIAL REPORTS	49
Functions	18	Executive summary	50
Corporate governance statement	18	Independent audit report	51
2005–2006 PERFORMANCE	20	Certification of financial statements	53
Strategic Plan 2005–2008	20	Financial statements	54
Clinical leadership	22	Special Purpose Entity Independent audit report	79
Information management initiatives	23	Special Purpose Entity Certification of financial statement	81
Patient safety and incident management	24	Special Purpose Entity Financial statements	82
Programs and projects	26	INDEX	92
Quality Systems Assessment (QSA)	37		
Research	38		
Special committees	39		
Special Reviews	41		



FOREWORD

This is the second annual report for the Clinical Excellence Commission (CEC), following its launch on 24 August 2004.

Last year's report highlighted the strategic directions of the new organisation, and achievements made in the program areas of chronic care, safety improvement, cardiovascular care, children's emergency care, medication safety and surgical mortality. The report also paid tribute to Dr Ian O'Rourke, founding CEO of the Institute for Clinical Excellence, from which the CEC has evolved.

The following pages demonstrate that the year has been a busy and productive one for the CEC. Programs in safety, children's emergency care, cardiovascular care and medication safety have been further developed, and new programs in other clinically important areas, such as hand hygiene, falls prevention, transfusion medicine, safer systems, venous thromboembolism, clinical leadership

and communication have been initiated. The year has also seen new opportunities emerge via consultation with the newly amalgamated area health services, knowledge management and web-based communications.

A significant development over the year has been the establishment and recruitment of the executive team. As the operational arm of the organisation, members of the executive work collaboratively with the Board to progress key result areas in the organisation's strategic plan. This has seen internal corporate governance structures strengthened, as well as a number of initiatives developed with external partners via special reviews, committees and planning workshops. Further details and achievements of these initiatives are outlined in the Performance section of this report.

CHAIRMAN'S REPORT

In the past year we have moved from the exciting 'start up' phase to one of measured progress with a smoothly running, professional organisation. This annual report is a record of significant achievement in establishing programs to support clinicians in giving the very best care to the people of NSW.

The most exciting area of progress is the knowledge gained about just where the health system can be improved from the voluntary reporting by staff across NSW of 125,000 incidents, including clinical and organisational problems and near misses. This is a world class reporting effort and demolishes the often quoted perception that the health system hides its mistakes. We are putting programs in place to address the key vulnerabilities that have been identified, including falls, infections and medication problems.

In the coming year we will introduce, among other things, a comprehensive Clinical Leadership education program that will help in addressing some of the other key issues identified, including improvement of communication and teamwork.

Board meetings have been times of exciting discussion with all members contributing their extensive knowledge to help solve the complex problems with which we are faced in the NSW health system.

On behalf of the Board, I wish to record our thanks to Cliff Hughes for his leadership as CEO, and to our staff for their extraordinary commitment and enthusiasm.

In a very short timeframe we are, in my view, successfully delivering on our Mission to "Build confidence in healthcare in NSW by making it demonstrably better and safer and a more rewarding workplace".



Professor Bruce Barraclough AO
Chairman

CHIEF EXECUTIVE OFFICER'S REPORT

As I write this report in early September, the Clinical Excellence Commission is enjoying a week of celebrations. A few birthdays amongst the staff and the Board but, more notably, the second anniversary of the day on which the then Minister, Morris lemma, announced the formation of the CEC.

Then again, our four Directors commenced work in the CEC just one year ago this month.

It has been well said that the first day of one's life is the most traumatic (well, so far!) and there is no doubt that the gestation of the CEC has been dramatic, exciting and, in many senses, life changing.

Since our early days, we continue to be watched and protected by our diverse and talented Board. Under the chairmanship of Professor Bruce Barraclough AO, they have provided wise counsel, enthusiasm and direction for all the projects that we have undertaken. Under their direction, our Strategic Plan has matured into a three-year blueprint for the future and provides clear guidance for each of our portfolios.

To complete our round of anniversaries, October marks the end of 12 months' occupation of our

new premises in the Reserve Bank of Australia building. The benefit of this modern space with modern communication facilities linking us across Macquarie Street into the health system network has been a boon. We were fortunate to be seeking space at just the right time and, under the guidance of the Deputy CEO, Dr George Bearham, we were able to strike a very cost-effective deal and provide adequate space for our growing staff, which at that time numbered 25.

We have made significant advances in each of the key reporting areas identified by the Board. Among these, adverse events reporting is paramount. Under the direction of our Manager, Patient Safety, Ms Sarah Michael, the Incident Information Management System (IIMS) program is now receiving over 10,000 reports a month and we are providing six-monthly feedback to the Area Chief Executives and Directors of Clinical Governance.

We are currently developing a query reporting tool with NSW Health and the vendors to enable rapid drill down of large cubes of data within each area health service. We have also released publicly, preliminary details on the analysis of 88,000 clinical events reported voluntarily by the staff of

CHIEF EXECUTIVE OFFICER'S REPORT (CONT.)

NSW Health over the last 12 months. This is a truly spectacular achievement on a volume unparalleled in Australia. This data has identified issues, driven policy, resulted in changes to practice and guided our priority decision-making.

In January 2006, in conjunction with the NSW Department of Health, we released a second adverse events report detailing some 429 Severity Assessment Code 1 events (the most severe).

At our foundation, Mr Lemma gave clear directions to the CEC, one of which was to establish a Quality Systems Assessment program to review quality and safety resources and programs in place throughout NSW Health. Under the direction of Ms Bernie Harrison, Director of QSA, the first of three levels of this program has been tested in three area health services. The results of these tests have been pleasing and tenders have now been received for the remaining two levels, namely institution/clinical stream level, and clinical unit/departmental level. This program is an annual self-lodgement of evidence of systems in place combined with a program of strategic review of identified areas of concern.

The Information Management portfolio, under the directorship of Mr André Jenkins, has developed a stocktake of quality and safety resources available to all staff across the system. A Chartbook of safety indicators is also in the early stages of development and, when complete, will provide another measure of the effectiveness of our quality and safety systems.

The database serving the Special Committee Investigating Deaths Under Anaesthesia has been extensively upgraded and the CEC remains in dialogue with the Royal Australasian College of Surgeons regarding a comprehensive audit of surgical mortality (CHASM – Collaborating Hospitals Audit of Surgical Mortality), which will provide two levels of case review for all deaths associated with surgery in NSW.

The Clinical Practice Improvement portfolio, under the direction of Dr Annette Pantle, has also been busy and is in the process of completing a toolkit on the implementation of 12 key children's emergency care guidelines and roll-out of the statewide Hand Hygiene program, with appointment of a Hand Hygiene Project Officer in each Area.

The Falls program has seen the establishment of a Falls Coordinator appointed to all area health services. The CEC is also collaborating with a number of national quality and safety programs, including medication safety, the Safer Systems – Saving Lives program, the Towards A Safer Culture program and a program on venous thromboembolism.

Organisational Development and Education, under the directorship of Ms Margaret Coffey, has defined a clinical leadership training program. This program is undergoing extensive review by clinicians throughout the system before the detailed curriculum is implemented. It is anticipated that this program will commence early in 2007 and seek to train approximately 30 doctors and 160 nurses and allied health professionals around a framework of leadership capabilities and dimensions.

The CEC itself has been actively involved in organisational development with strategic planning a regular feature on our program. In-house educational programs and workshops supplement our extensive partnerships with other organisations such as the Greater Metropolitan Clinical Taskforce, stroke networks, Northern Centre for Healthcare Improvement, Directors of Clinical Governance, Patient Safety Managers and others.

The Board has recognised the importance of an effective community involvement. In May, it adopted the principle of a Citizens Engagement & Advisory Council. This council will be appointed on merit and seeks to bring relevant expertise from the community to bear on the matters of healthcare delivery, safety and quality. Such expertise will include aspects such as experience in service clubs, journalism, adult education, local government, communication skills and risk management. This important council will be in place to complement and work in partnership with the Clinical Council.

The Clinical Council has provided a great opportunity for communication to healthcare professionals throughout NSW and they, in turn, have provided extremely valuable feedback on each of our projects and programs, providing us with robust and entertaining discussions on our programs every three months. The committees are ably chaired by Professor Peter Castaldi AO and Professor Mary Chiarella.

The CEC has been asked to undertake a number of special reviews. The recommendations of the Meningococcal Review completed 12 months ago have been reviewed with each of the relevant area health services by the Deputy CEO and the CEO. It was pleasing to note that all

recommendations had either been completed or were in the process of completion by each of the area health services in question.

Reviews are currently underway regarding communication around Lookback incidents following variations in pathology reporting in South Eastern Sydney and Illawarra Area Health Service and Hunter New England Area Health Service.

A review of pacemakers is also under development.

All of these programs, I believe, demonstrate the enthusiasm and competency of all our staff who tirelessly give much more than is expected of them. It is pleasing to be in the office early in the morning and to see people arrive before their allotted hour with a smile and depart, often quite late, but content in the knowledge of a job well done.

But the staff are only as good as the partnerships that they are developing with area health services, with the Quality and Safety Branch at the NSW Department of Health, with Area Directors of Clinical Governance and, indeed, with Directors of Clinical Operations, Patient Safety Managers and many other officers throughout the health system that make this task enjoyable.

It is not without its controversy, it is not without its challenge and it is certainly not without its rewards. I am grateful for the opportunity to work with the staff, to work with the clinicians across the state and to see, slowly but surely, the development of systems that will ensure a continued emphasis on patient safety, clinical quality and on the people who resource the system that provides healthcare to 6.7 million residents of this state.



Clifford F Hughes AO
Clinical Professor
Chief Executive Officer

CEC HIGHLIGHTS DURING 2005–2006

Publications

- 2nd Report on Adverse Events, released October 2005, in collaboration with the NSW Department of Health.
- Launch of Patient Access to Acute Care Services Toolkit.

Reviews

- Special review commenced, regarding the safety and quality of care of patients implanted with permanent pacemakers and related devices.
- Special review commenced, regarding communication around lookback incidents following variations in pathology reporting.

Strategic planning

- Statewide patient safety planning workshop.
- Internal strategic planning workshops.

Quality Systems Assessment (QSA)

- Development and piloting of an area health service level QSA tool.

Educational

- Education for Quality Improvement, including:
 - needs analysis process (rural and metro)
 - workshops on quality (statistical) tools: one metro and four rural locations
 - master class on presentation and facilitation skills
 - investigation of feasibility of modular online learning packages on quality improvement/clinical practice improvement methodology to support area health service clinical governance units.

- Root Cause Analysis (RCA) train-the-trainer sessions.

- Development of an education and implementation toolkit for care of children in emergency departments.

Research

- Establishment of the Ian O'Rourke Scholarship to fund doctoral research in patient safety and quality improvement in indigenous health.
- Hospitals Alliance Research Collaborative (HARC) with The Sax Institute.

Clinical Practice Improvement

- Progressing of programs in cardiovascular care, children's emergency care and medication safety.
- Initiation of new programs in hand hygiene, falls prevention, transfusion medicine, communication and venous thromboembolism.

Information Management

- Detailed analysis of Incident Information Management System (IIMS) data.
- Progress on development of a statewide database for cardiac surgery (with GMCT).
- Foundation membership of Health Record Linkage Unit.

Partnerships

- First meeting of the CEC Clinical Council.
- Collaborative links with Area health services, Department of Health, Greater Metropolitan Clinical Taskforce.
- Foundation laid for Citizens Engagement & Advisory Council.

ORGANISATIONAL PROFILE

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

The CEC is a board-governed statutory health corporation established under the Health Services Act 1987, with the Chief Executive Officer reporting directly to the NSW Minister for Health.

CEC BOARD

BOARD MEMBER PROFILES



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



Professor Cliff Hughes AO is the Chief Executive Officer of the Clinical Excellence Commission. He was previously Head of the Department of Cardiothoracic Surgery at Royal Prince Alfred Hospital, Sydney. He was a foundation member of the Australian Council for Safety and Quality in Health Care, Chairman of the Therapeutic Device Evaluation Committee (Australian Government) and Founding Chairman of the NSW Special Committee Investigating Deaths Associated with Surgery. He was a Councillor, Senior Examiner and Divisional Chairman (Cardiothoracic) for the Royal Australasian College of Surgeons.

ORGANISATIONAL PROFILE (CONT.)

BOARD MEMBER PROFILES CONTINUED



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



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 associated with public and community hospitals and area health service mergers. She has also held corporate and Director of Operation type positions in major public hospitals and area health services. Kathy is a Fellow of The College of Nursing and took up a position on that Board in October 2006. She holds the position of Adjunct Professor at the University of Technology, Sydney and the University of Western Sydney and has recently been appointed Visiting Professor at the University of Technology Sydney.



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 Qantas 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. Currently, 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.



Major General Peter Dunn AO, 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. During his time in the Australian Army he held numerous senior leadership positions and was instrumental in restructuring the strategic Defence personnel organisation. He has also worked in the fields of acquisition, logistics and information systems. He is currently consulting in the fields of emergency management and change management.



Professor Phillip Harris is head of the Department of Cardiology at Royal Prince Alfred Hospital, chair of the Patient Care Committee and chair of the Clinical Training Committee. He is Clinical Professor of Medicine at the University of Sydney, member of the Board of the National Heart Foundation of Australia and Heart Research Institute, and past president of the National Heart Foundation of Australia (NSW Division) and the Cardiac Society of Australia and New Zealand.



Associate Professor Brian McCaughan is a cardiothoracic surgeon whose 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 the chairmanship of the NSW State Committee from 1992 to 1994. Professor McCaughan was a member of the Ministerial Advisory Committee on Quality in Health Care. He was appointed to the NSW Health Council, and served as president of the New South Wales Medical Board from October 1999 until December 2004. He is currently Chair of the Sustainable Access Health Priority Taskforce and a member of the Health Care Advisory Council for NSW Health.

ORGANISATIONAL PROFILE (CONT.)

BOARD MEMBER PROFILES CONTINUED



Mr Noel O'Brien OAM was Chair of the New England Area Health Service from 2000 to 2004, Chair of the New England Area Health Service Audit Committee from 1998 to 2000 and Chair of its strategic planning committee. He was Chair of the NSW Association of Mining Related Council from 1999 to 2004. Mr O'Brien was councillor of Gunnedah Shire from 1991 to 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 the managing director of a mining industry training company.



Dr Sue Page is immediate past president of the Rural Doctors Association and is senior lecturer and director of education at the Northern Rivers University Department of Rural Health. Recently appointed as chair of the North Coast Area Health Care Advisory Council, she is on the board of Northern Rivers Division of General Practice and is a rural GP VMO at Ballina District Hospital and St Vincent's Hospital in Lismore. Dr Page has been a ministerial appointee to several committees including the NSW Mental Health Sentinel Events Review Committee, the NSW Expert Advisory Group on Drugs and Alcohol, the NSW Rural Health Taskforce, and the NSW Health Care Advisory Committee; and a Commonwealth appointee to the Australian Medical Workforce Advisory Committee, the 4th Pharmacy Agreement Professional Programs and Services Advisory Committee, and the 2003 and 2005 Medical Indemnity Policy Review Panels.



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 and 2004, Dr Parry was a member of the Board of the South Eastern Sydney Area Health Service.



Mrs M. E. (Liz) Rummery AM retired from legal practice after 30 years specialising in property and commercial law. Mrs Rummery was co-chair of the Rural Health Implementation Group (NSW Government's Action Plan for Health) and is now co-chair of the NSW Rural Taskforce as well as being a member of several NSW Health clinical advisory groups, including rural cardiology, rural oncology, rural trauma/critical care, rural renal, the Centre for Rural and Remote Mental Health, and the NSW Clinical Council (NSW Government's Action Plan for Health). She is deputy chancellor of the Southern Cross University Council, Chair of the Audit Committee and Commercial Activities Committee, and a member of the CEC Finance Committee.

Table 1: Board member meeting attendance

The Board meets on a bi-monthly basis. An extra meeting was held in May 2006.	9 Aug 05	11 Oct 05	13 Dec 05	14 Feb 06	11 Apr 06	9 May 06	13 Jun 06
Professor B Barraclough	x	x	x	x	x	x	x
Dr A Amodeo		x	x	x	x	x	
A/Professor K Baker	x		x		x		x
Dr G Beaumont	x	x	x		x	x	
Major General P Dunn	x	x	x	x	x	x	
Professor P Harris	x	x	x	x		x	x
Professor C Hughes	x	x	x	x	x	x	x
A/Professor B McCaughan		x	x		x	x	x
Mr N O'Brien		x	x	x	x	x	
Dr S Page	x	x	x	x	x	x	x
Dr T Parry		x			x		x
Mrs M E Rummery	x	x		x	x		x

ORGANISATIONAL PROFILE (CONT.)

BOARD SUB-COMMITTEE: AUDIT AND RISK MANAGEMENT

This committee was previously called the Audit Committee. It was renamed in 2005 to reflect a broader risk management role.

Membership

- Mr Noel O'Brien (Chair), Board member
- Major General Peter Dunn, Board member
- Mrs Liz Rummery, Board member
- Professor Clifford Hughes, CEO

In attendance

- Dr George Bearham, Deputy CEO
- Ms Rhonda Topp, Director of Corporate Services
- Mr Martin Lee, Director of Internal Audit, SESIAHS
- Representatives from NSW Audit Office
- Miss Barbara Dundas, Manager, Board Support

The Committee meets quarterly.

Objective

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

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.
- Ensuring the independence of the internal auditing function from management.
- Coordination with the External Audit Plan.

External Audit

- Review of the proposed audit strategy.
- Review of external audit reports, performance and fees.
- Review of the financial statement preparation process.
- Review of management's responsiveness to the external auditor's findings.

Audit and Risk Management Committee meetings during 2005–2006

13 September	13 December
14 March	11 July

BOARD SUB-COMMITTEE: FINANCE

Membership

- Dr Alan Amodeo (Chair), Board member
- Mr Noel O'Brien, Board member
- Dr Graham Beaumont, Board member
- Professor Clifford Hughes, CEO

In attendance

- Dr George Bearham, Deputy CEO
- Ms Rhonda Topp, Director of Corporate Services
- Mr Nick Didnal, Finance Officer
- Miss Barbara Dundas, Manager, Board Support

The committee meets monthly except January.

Objective

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

Functions

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

1. Forward estimates and plans

- Financial planning and policy.
- Annual budget for capital, operating receipts and payments and cash flow.

2. Financial management

- Income and expenditure budgets.
- Balance sheet budgets.
- Cash flow budgets.
- Accounting standards, instructions and determinations of the Board.
- Financial delegations.

3. Performance reporting

- Activity budgets, efficiency targets, benchmarks and best practice.

4. Other Board committees

- Liaise with the Audit and Risk Management 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 2005–2006

12 July	9 August
13 September	11 October
14 November	13 December
14 February	14 March
11 April	9 May
13 June	

BOARD SUB-COMMITTEE: RESEARCH

Membership

- Professor Phillip Harris (Chair), Board member
- Mr Noel O'Brien, Board member
- Professor Clifford Hughes, CEO

In attendance

- Dr George Bearham, Deputy CEO
- Miss Barbara Dundas, Manager, Board Support

The committee meets on a quarterly basis.

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 2005–2006

7 November	14 February
9 May	

ORGANISATIONAL PROFILE (CONT.)

CLINICAL COUNCIL

The Clinical Council comprises medical, nursing and allied health staff and managers from the NSW health system, who contribute to the development and delivery of the CEC's programs and advise the Board on strategies to achieve comprehensive clinician participation. It acts as a sounding-board and advocate on CEC matters. Members were appointed in April 2005.

Membership

**Professor Peter Castaldi AO
(Co-chair)**

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

Professor Mary Chiarella (Co-chair)

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

Associate Professor

Michael Besser AM

Clinical Director of Neurosciences, Eastern Zone, Sydney South West Area Health Service

Ms Patricia Bradd

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

Dr Sue Crosdale

Executive Medical Director Health, Albury-Wodonga, Greater Southern Area Health Service.

Professor Patricia (Trish) Davidson

Paediatric Surgeon; Area Director of Kaleidoscope, Hunter Children's

Health Services; Professor, Faculty of Health, University of Newcastle.

Mr Anthony Dombkins

Service Director, Primary Health Care, Justice Health

Professor Creswell Eastman AM

Former Director of the Institute of Clinical Pathology and Medical Research; Chairman of the Division of Laboratory Medicine at Westmead Hospital; Director of Sydney West Area Pathology Services.

Professor Brad Frankum

Professor of Clinical Education, University of Western Sydney; Clinical Dean, Macarthur Clinical School, Campbelltown Hospital; Director of Complex Care and General Practice, Western Zone Sydney South West Area Health Service.

Ms Julie Gawthorne

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

Dr Rohan Hammett

Consultant Gastroenterologist, Royal North Shore Hospital; Principal Medical Adviser, Therapeutic Goods Administration.

Ms Linda Justin

Program Manager, Knowledge Management, Clinical Services Redesign Program, Health System Performance Improvement Branch, NSW Department of Health

Dr Andrew Keegan

Consultant Gastroenterologist/Hepatologist at Nepean Hospital; Deputy Director of Gastroenterology and Hepatology, Western Cluster, Sydney West Area Health Service.

Dr Michael McGlynn

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

Professor Sandy Middleton

School of Nursing (NSW), Australian Catholic University.

Dr Garry Nieuwkamp

Director of Emergency Department, Wyong Hospital; member of NSW faculty of the Australasian College for Emergency Medicine.

Ms Melanie Pittard

Acting Manager, CIAP, Knowledge Management Unit, NSW Health Technology.

Dr Valerie Poxon

Project Manager, Clinical Cancer Registry, Sydney South West Area Health Service.

Mr Anthony Schembri

Clinical Director, Allied Health and Clinical Support (Western Zone), Sydney South West Area Health Service.

Dr James Telfer

Chairman of Section of Psychiatry at Royal North Shore Hospital; Director of Psychiatric Services, Emergency Department, Royal North Shore Hospital.

Ms Penny Thornton

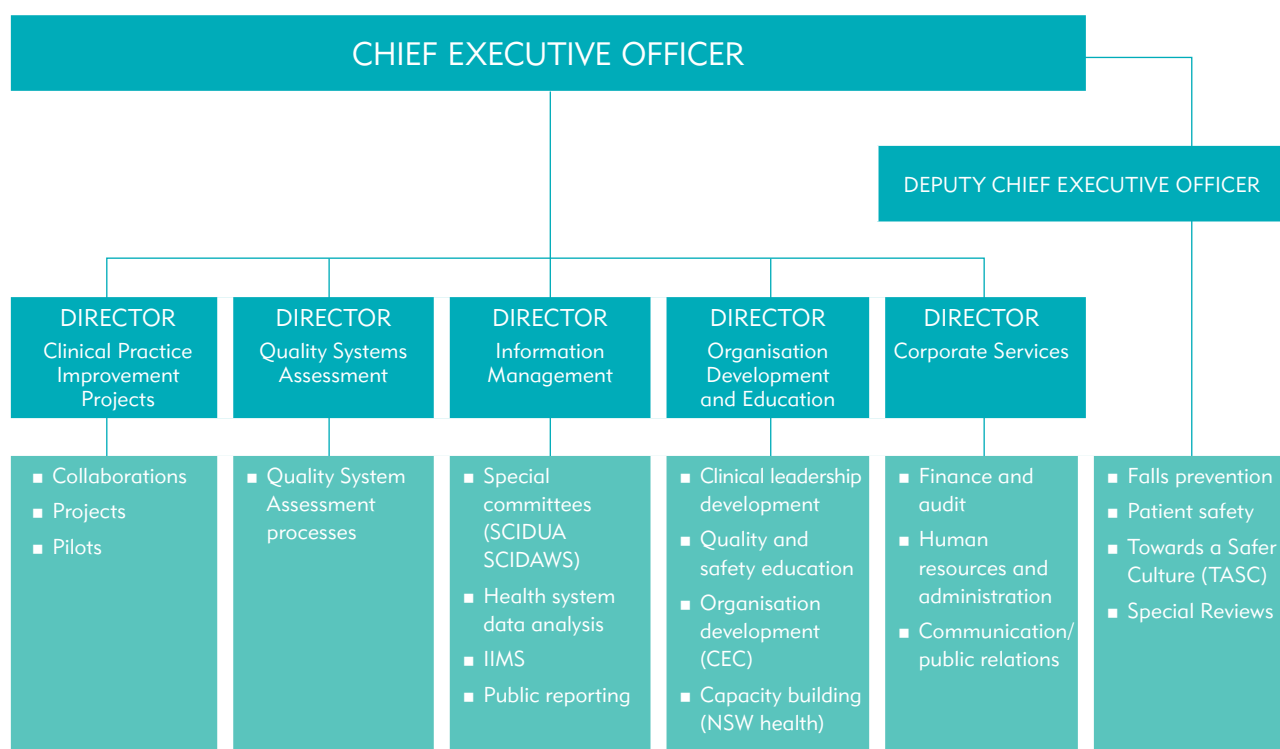
Pharmacy Services Manager, Children's Hospital at Westmead.

Ms Catriona Wilson

Area Quality Manager, North Coast Area Health Service

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

Director Clinical Practice Improvement Projects

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

Director Corporate Services

Ms Rhonda Topp, BAppSci (OT), BHA, MCom

Director Information Management

Mr André Jenkins, BA (Hons)

Director Organisational Development and Education

Ms Margaret Coffey, BA, Dip Ed, A Mus A, M Lib (Management).

Director Quality System Assessment

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

ORGANISATIONAL PROFILE (CONT.)

PURPOSE AND GOALS

The Clinical Excellence Commission (CEC) has been established 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.

FUNCTIONS

The key functions of the CEC, as outlined in the Clinical Excellence Commission's Directions Statement published in August 2004, are to:

- promote and support improvement in clinical quality and safety in public and private health services
- monitor clinical quality and safety processes and performance of public health organisations, and to report to the Minister thereon
- identify, develop and disseminate information about safe practices in healthcare on a statewide basis, including (but not limited to):
 - i. developing, providing and promoting training and education programs
 - ii. identifying priorities for and promoting the conduct of research about better practices in healthcare

- consult broadly with health professionals and members of the community in performing its functions
- provide advice to the Minister for Health and Director-General of Health on issues arising out of its functions.

The CEC fulfils these functions by:

- providing advice to the Minister for Health and the Department of Health on the status of the safety and quality of healthcare in the NSW health system
- notifying the Department of any system-wide safety concerns it identifies with NSW health services that require immediate action
- conducting quality system assessments of public health organisations (PHOs) and, utilising available information, evidence, expert analysis and evaluation, to recommend improvements to the NSW health system
- working with PHOs to facilitate implementation of quality improvements
- providing a source of expert advice and assistance to PHOs, private healthcare organisations and other interested parties
- developing and promoting a statewide approach to improving the safety and quality of health services in NSW
- engaging doctors, nurses, allied health professionals, administrators and the community in developing a statewide approach to safety and quality improvement

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

CORPORATE GOVERNANCE STATEMENT

This statement sets out the main corporate governance practices in operation for the Clinical Excellence Commission (CEC) throughout the 2005–2006 financial year.

THE CEC BOARD

The Board is responsible for the corporate governance practices of the CEC.

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

The Board is committed to better practices contained in the Corporate Governance and Accountability Compendium in Health Better Practice Reference Guide, issued jointly by the

Health Services Association NSW and the NSW Department of Health.

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

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

- setting strategic direction
- ensuring compliance with statutory requirements
- monitoring performance of the organisation
- monitoring the quality of services provided
- board appraisal
- community consultation
- professional development
- ensuring ethical practice.

The Board identifies each Board member, noting:

- the qualifications, specific skills and experience they bring to the Board
- their term of appointment to the Board
- the 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 free to give advice direct to the Board, and professional advice.

The engagement of independent professional advice is 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. This includes the setting of a strategic direction for the organisation and providing independent leadership in relation to patient safety and quality.

In March 2006, the Board held a strategic planning workshop with the executive team and an external facilitator, to review core directions and elements of its Strategic Plan 2005–2008, and to provide guidance as to the direction and priorities for the organisation in 2006–2007.

CODE OF ETHICAL BEHAVIOUR

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

For CEC staff, the NSW Department of Health Code of Conduct has been adopted.

RISK MANAGEMENT

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

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

A risk management policy and framework, incorporating a Risk Register, is in place in the organisation.

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, finance and research. These sub-committees meet on a regular basis throughout the year, with Terms of Reference and membership detailed in the previous section of this report.

PERFORMANCE APPRAISAL

The Board has ensured that there are processes in place to review its performance regularly through a process of self-appraisal.

A review of the Board's operations and members' contributions was undertaken as part of a Board planning and review day on 22 March 2006.

2005–2006 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 Board reviewed progress and set future priorities against the KRAs at a Board planning and review day in March 2006.

The KRAs, associated goals, strategies and achievements during the year are outlined in the following table, followed by profiles of significant activities.

CEC STRATEGIC PLAN 2005–2008

KEY RESULT AREAS AND GOALS TO ACHIEVE BY 2008	STRATEGIES 2005–2008	ACHIEVEMENTS DURING 2005–2006
1. PUBLIC REPORTING Report publicly to the Minister and the community on quality and safety in NSW Health.	i. Develop and deliver an annual public report on adverse events. ii. Develop and deliver an annual public report on quality system improvements. iii. Engage the community in an informed discussion around the quality and safety of healthcare.	i. Second report on incident management in the NSW public health system 2004–2005, published in collaboration with NSW Department of Health; first 12 months of IIMS data to be presented at national conference on quality and safety in August (on CEC website). ii. Committee convened to progress CEC Chartbook containing safety and quality indicator data. iii. Model developed to progress community engagement: Citizens Engagement and Advisory Council.
2. QUALITY SYSTEMS ASSESSMENT Implement a Quality System Assessment (QSA) program across NSW Health, including identification of assessment criteria re measurement, benchmarking and trends.	i. Develop the methodology for the QSA program. ii. Conduct pilot QSA in two area health services (one metro, one rural), then roll-out to all health services. iii. Complete baseline measures based on NSW Department of Health assessment criteria across the system.	i. Framework and draft activity statement developed following literature review. ii. Three area health service sites (two metro, one rural) selected to commence QSA pilot in July 2006. iii. QSA framework and measures being refined during 2006–2007.
3. INFORMATION MANAGEMENT Develop, in partnership with clinicians, feedback reporting systems that support clinical improvement.	i. Develop and implement an Information Management Strategic Plan to support the work of the CEC. ii. Work with the Department of Health to implement an incident and adverse event reporting system across NSW Health. iii. Develop and implement effective information and reporting system for deaths associated with surgery and anaesthesia.	i. Information Management Strategic Plan in development. ii. Incident information management system (IIMS) in place across NSW health system, with version 3.5 going live 9 March 2006. iii. Surgical mortality database under development; committees reviewing deaths associated with surgery and deaths under anaesthesia continue to meet with secretariat services provided by the CEC.

KEY RESULT AREAS AND GOALS TO ACHIEVE BY 2008	STRATEGIES 2005–2008	ACHIEVEMENTS DURING 2005–2006
4. CLINICAL IMPROVEMENT Assist Health Services to implement effective clinical improvement programs in partnership with clinicians.	i. Assist health services to undertake quality improvement projects. ii. Enhance professional skills within health services to implement effective improvement programs and methodologies. iii. Conduct statewide quality and safety initiatives.	i. Variety of clinical practice improvement programs in place, with CEC providing statewide leadership, support and guidance. Projects include children's emergency care, hand hygiene, falls, medication safety, communication, transfusion medicine and venous thromboembolism (see following sections). ii. Links with area directors of clinical governance are in place; options to work collaboratively with clinical governance units are being explored. iii. Statewide programs in place (e.g. hand hygiene, falls, transfusion medicine), Statewide train-the-trainer sessions provided in root cause analysis, tailored statewide quality and safety initiatives are being explored for rollout 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.	i. Develop and implement clinical leadership development and education programs. ii. Identify the specific role of the CEC in the Knowledge Management framework under development. iii. Support rural health services through identifying and developing individual CEC-health service initiatives. iv. Develop capacity within the CEC to undertake special reviews.	i. Designated clinical leadership staff in place at CEC; leadership and education programs in development. ii. Knowledge management workshop held for CEC staff in March 2006; CEC participates in statewide knowledge management committees. iii. Rural outreach options being explored in collaboration with rural area health services. iv. Variety of special reviews undertaken (see following sections).
6. ORGANISATIONAL DEVELOPMENT Design and build the Clinical Excellence Commission as an organisation characterised by excellence in governance.	i. Strengthen the CEC's governance arrangements, particularly in relation to project management, communication and budget planning. ii. Develop and implement robust risk management practices. iii. Invest in the CEC's people. iv. Develop strong partnerships.	i. Strategic planning session held 22 March 2006; staff planning session scheduled for 17 July 2006. ii. Risk management policy and framework developed, including risk matrix and register. iii. Professional development and education and performance development programs in place; variety of inservice sessions held. iv. CEC continues to develop partnerships with stakeholders, such as area health services, Greater Metropolitan Clinical Taskforce, other jurisdictions 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.	i. Develop and implement a communication strategy with health services that provides the Minister, the CEC Board, CEC Clinical Council, decision makers and NSW Health system with key safety and quality messages and evidence-based information. ii. Work with area health services in the effective uptake and implementation of workplace cultural change relating to clinical improvement strategies.	i. Communications officer appointed; communications strategy to be developed during 2006–2007. ii. CEC works with area health services via Clinical Council, directors of clinical governance meetings, and via staff working on CEC projects. iii. Model for Citizens Engagement and Advisory Council developed which will be progressed late 2006.

2005–2006 PERFORMANCE (CONT.)

CLINICAL LEADERSHIP

Aligns with Key Result Areas:

- 5. Capacity building
- 6. Organisational development

The Clinical Leadership Program is a CEC initiative to enhance the capacity of clinicians to be agents of sustainable system improvement and patient safety.

Clinical Leadership occurs at all levels of patient care and refers to the process of leading and influencing activities within a team, unit, stream or network to improve the delivery of safe clinical care.

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 their 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, and
- resolve conflict and balance demands within the larger Health environment.

Following broad consultation, 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 program will be offered to all health services within NSW Health, including Ambulance Service, Justice Health and the Children's Hospital Westmead, and will commence in February 2007.



INFORMATION MANAGEMENT INITIATIVES

Aligns with Key Result Areas:

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

CHARTBOOK

As part of the CEC's 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 March 2006, with members comprising leaders from NSW Department of Health, area health services and the CEC. The group is required to:

- 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, and
- advising on data collection procedures.

Future directions

- Production of the inaugural Chartbook is due early 2007.
- Active consideration is being given to future reporting methods, including possible electronic reporting via the internet, and potential development of a minimum data set for quality and safety.

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 factors related to deaths associated with surgical and anaesthetic mortality, as well as supporting 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 (e.g. Safer Systems – Saving Lives, medication safety, and transfusion medicine) stand to benefit from being in a position to ascertain post-discharge outcomes (particularly deaths).

STOCKTAKE OF DATA COLLECTIONS

The Stocktake of Data Collections is designed to provide a concise summary of key data collections and publications relating to safety and quality.

The Stocktake will be posted on the CEC website, with provision for feedback and a notification system for potential inclusions to facilitate the continued currency and relevancy of the tool. A limited number of copies will be printed, with a web version updated more routinely.

It is envisaged the collection will be available from early 2007.

2005–2006 PERFORMANCE (CONT.)

PATIENT SAFETY AND INCIDENT MANAGEMENT

Aligns with Key Result Areas:

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

Description

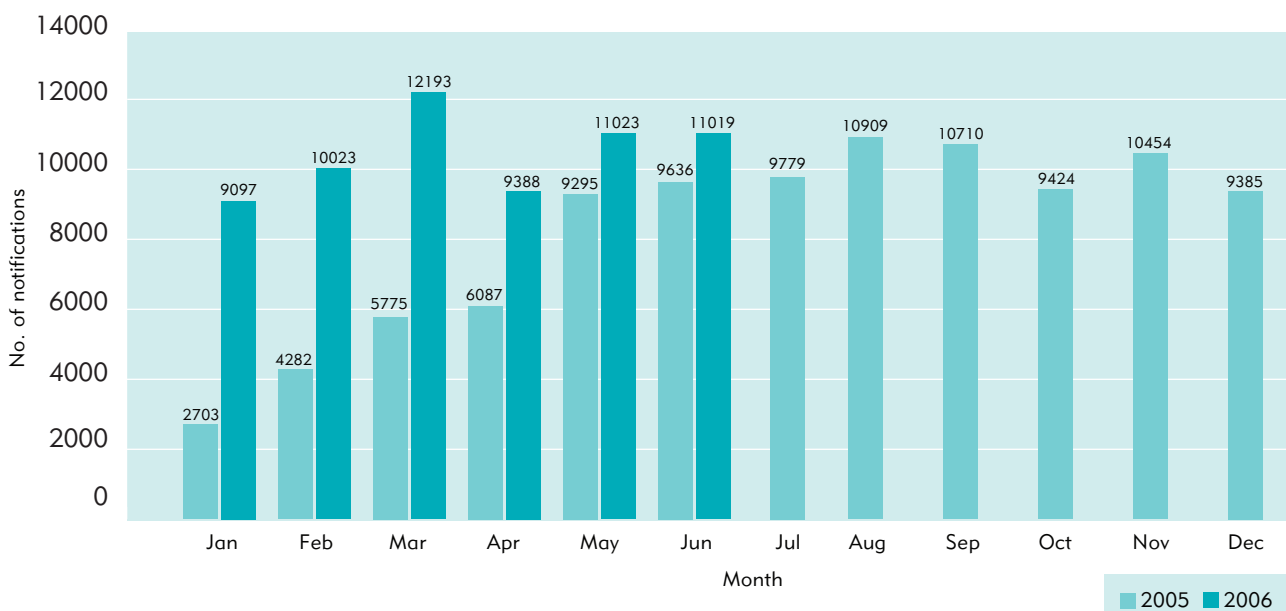
The CEC continues to work with the NSW health system to help reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety. Central to this approach is an acknowledgement that very few errors are due to a lack of care or commitment from healthcare professionals or result from the action of an individual, but that they result, in most cases, when breakdowns occur across a number of defences.

NSW remains the only state to publicly report both serious adverse events and incidents resulting in minimal or no harm, with data frequently cited by other providers and publications.

Key Achievements

The CEC has analysed over 88,000 reports of clinical adverse events and near-misses notified by healthcare staff across all area health services in NSW through the Incident Information Management System (IIMS). This is the first time a jurisdiction in Australia has had access to data of this scale to provide an insight into the quality and safety of healthcare. While the data represents voluntary notifications made to the system and therefore does not represent all incidents occurring within the health system, it is anticipated that over time, as clinicians and managers become more familiar with the capacity and value of the data, notifications will increase and provide a better understanding of safety issues within the system.

Figure 1: NSW trend IIMS notifications 2005–2006



The data show that from January 2005 to June 2006 there was a 12% increase in overall notifications to the IIMS system but the rate of notifications for serious adverse events did not statistically change. Statewide initiatives that the CEC is undertaking to address falls, medication errors and clinical management, which comprise the highest number of IIMS notifications, are outlined elsewhere in this report.

In June 2006, the CEC convened a patient safety workshop to determine current, medium and longer-term strategic priorities for patient safety. Key outcomes of the workshop relating to governance and strategic direction have been incorporated into the CEC's workplan for 2006–2007.

To ensure sustainability and delivery of the root cause analysis (RCA) training program, the CEC commissioned the Cognitive Institute to provide a train-the-trainer program to a further 40 participants in 2006. The training focused on presentation skills with an emphasis on training at the local level, skills practice and feedback.

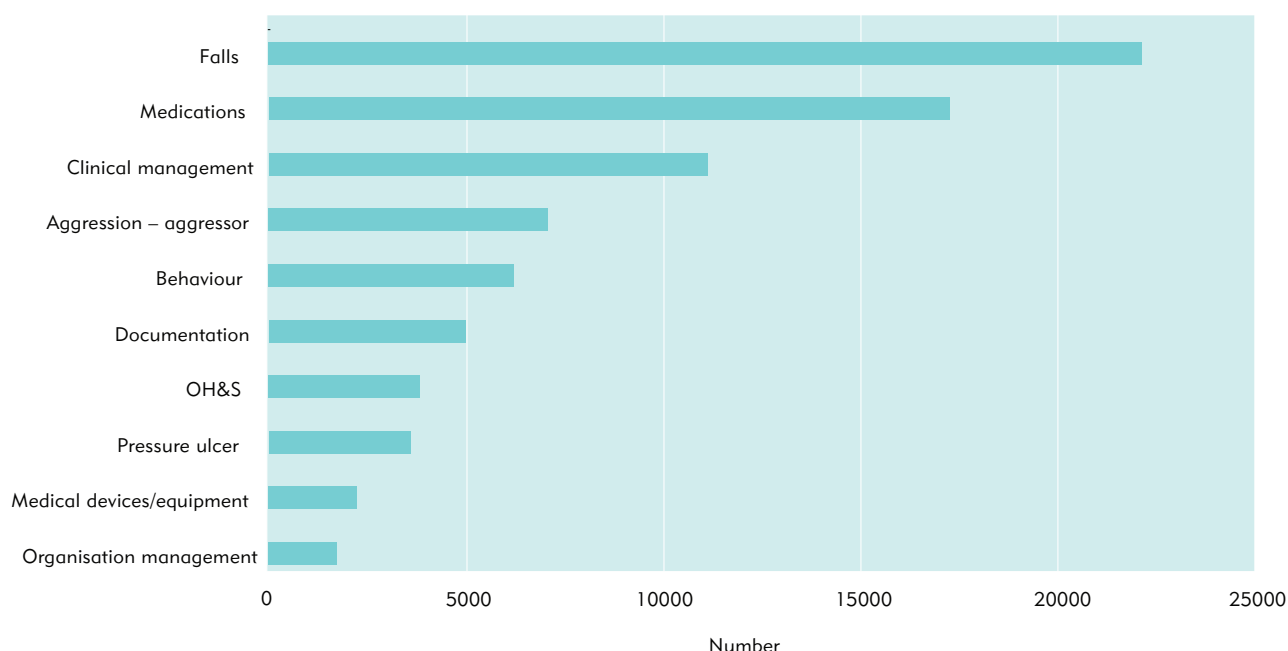
Future directions

The CEC will continue to analyse IIMS data to identify trends and recommend actions to reduce the likelihood of adverse events, increase patient safety and improve clinical quality within the NSW health system, and to ensure that lessons are learnt from an event or series of events so as to avoid further similar occurrences.

Further training resources to support incident management are under development, including an introduction to incident management for unit level managers and an enhanced skills program for people leading or facilitating RCAs.

Figure 2: Principal types of clinical incidents

Clinical incidents (Clinical form n = 88,335) Principal incident types top 10 July 2005 – June 2006



2005–2006 PERFORMANCE (CONT.)

PROGRAMS AND PROJECTS

CHILDREN'S EMERGENCY CARE PROJECT

Aligns with Key Result Areas:

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

Description

The Children's Emergency Care Project (CECP), initiated in 2004, has been a joint initiative of the CEC, NSW Department of Health and NSW child health networks.

The aims of the CECP have been to make healthcare in NSW emergency departments safer and better for children and their families; to promote confidence in local services; to promote appropriate referral of children to a higher level of service; and to promote the safety and quality of service and the consistency of management through the implementation of 12 clinical practice guidelines.

Teams from 53 pilot sites, including hospitals and multi-purpose services from all area health services in NSW, used a modified 'collaborative' methodology to reach the goal of implementing the guidelines.

Key achievements

- Practical implementation tools and strategies identified by pilot sites to help integrate the paediatric guidelines into clinical practice.
- Development and dissemination of an education and implementation toolkit throughout emergency departments in NSW, to help implement the guidelines.
- Initiation of an electronic learning package to facilitate and help sustain project gains by promoting utilisation of the guidelines by junior medical officers, locum medical officers and nurses working in emergency departments in NSW Health.
- External evaluation of the project by Consan Consulting, comprising focus groups, surveys and review of the quantitative data, showed improvements in the quality of care for children, clinical practice, and consistency of care; and increases in staff confidence in caring for children, and in parents' awareness of treatment and of the need to follow advice.
- The success of CECP has put paediatrics on the emergency department agenda, improved knowledge of clinicians in change strategies, improved networking and fostered an enhanced spirit of collaboration and teamwork.

Future directions

- Dissemination of the Implementation and Education Toolkit.
- Finalisation and dissemination of the e-learning package
- Sustainability of implementation through the NSW child health networks
- Ongoing program review of clinical practice guidelines by the NSW Department of Health, with updates of e-learning managed accordingly.

Clean hands save lives

Aligns with Key Result Areas:

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

Description

In June 2005, in response to community and health system concerns about multiple antibiotic resistant organisms (MROs), the NSW Minister for Health established the NSW Expert Group on Multi-Resistant Organisms. The need to improve hand hygiene among all healthcare workers was identified as a key issue by the expert group.

The Clean Hands Save Lives campaign aims to reduce the incidence of healthcare associated infections by increasing hand hygiene compliance. The campaign was launched on 27 March 2006 at Royal North Shore Hospital, with similar launches in every area health service across the state at the same time. The campaign includes three key strategies:

- alcohol-based hand rubs placed in easy-to-access locations such as near patient beds and nursing stations
- promotional posters that change every month, via a 'Talking Walls Strategy', and
- user-friendly materials designed to encourage patients to become involved in their own healthcare.

The success of the campaign will be measured by an increase in hand hygiene compliance, a decrease in healthcare associated infections and utilisation of alcohol hand rub.

Key achievements

Overt observations were conducted in February 2006, to measure hand hygiene compliance. Results confirmed previously reported international data for hand hygiene compliance, including a need for system improvements to address factors of low compliance such as staff being too busy, availability of hand hygiene facilities, and generally hand hygiene being considered a low priority.

Campaign resources have been developed and disseminated to area health services including over:

- 180,000 patient and visitor brochures
- 21,000 patient and visitor posters
- 50,000 'It's OK to Ask' badges
- 70,000 campaign posters (Talking Walls – posters changed monthly)
- 7,000 Hand Hygiene Technique posters
- 6,500 Hand Hygiene Champion posters.

Private health facilities have been provided with an opportunity for participation and some have ordered the Clean Hands Save Lives Campaign resources to implement the campaign in their facility.

The Clean Hands Save Lives campaign has been supported by AMA, Nurses' and Midwives Board, NSW Nurses' Association, Royal College of Nursing, and Committee of Presidents of Medical Colleges.

Future directions

The Clean Hands Save Lives Campaign has been in place since March 2006, and will continue until March 2007. Overt observations, staff surveys, and patient and visitor surveys will be conducted throughout the campaign period and results fed back to clinicians and area health services to facilitate further improvement. A detailed final report will be produced at the conclusion of the campaign.

The image displays eight posters arranged in a 2x4 grid, all part of the 'Clean hands save lives' campaign. Each poster has a unique visual theme and text in both English and Swahili.

- Poster 1 (Top Left):** Features a blue water droplet with a handprint shape inside. Text: 'Clean hands save lives. Get with the program!' and 'Kusafiri kwa maji ya safi na afya ni kazi ya kawaida. Lakini kuna watu ambao hawana maji ya safi. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida.' (Clean hands save lives. Get with the program! Water is a basic need for all, and health is a basic need for all. This is a basic need. This is a basic need. This is a basic need.)
- Poster 2 (Top Second):** Features a pair of hands made of many small, colorful dots. Text: 'The most unlikely partners may be carrying the worst germs.' and 'Wakazi wa maji ya safi wanakusudia maji ya kawaida. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida.' (The most unlikely partners may be carrying the worst germs. Residents of clean water are cleaning water. This is a basic need. This is a basic need. This is a basic need.)
- Poster 3 (Top Third):** Features the number '20' made of many small, colorful dots. Text: 'Get a spare 20 seconds to save a life?' and 'Kuna 20 sekunde za maji ya safi ambazo zinakusudia maji ya kawaida. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida.' (Get a spare 20 seconds to save a life? There are 20 seconds of clean water that are cleaning water. This is a basic need. This is a basic need. This is a basic need.)
- Poster 4 (Top Fourth):** Features a clear glass bottle with a handprint shape inside. Text: 'Hand hygiene is a big job. To help, we need a little squirt.' and 'Kusafiri kwa maji ya safi ni kazi ya kawaida. Lakini kuna watu ambao hawana maji ya safi. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida.' (Hand hygiene is a big job. To help, we need a little squirt. Water is a basic need for all, and health is a basic need for all. This is a basic need. This is a basic need. This is a basic need.)
- Poster 5 (Bottom Left):** Features two hands, one purple and one blue, with water droplets between them. Text: 'Before you put your gloves on, and after you take your gloves off, please clean your hands.' and 'Kabla ya kuweka miti ya maji ya safi, na baadaye, wakati wa kutoa miti ya maji ya safi, tafadhali safi miti ya maji ya safi.' (Before you put your gloves on, and after you take your gloves off, please clean your hands. Before you put your gloves on, and after you take your gloves off, please clean your hands.)
- Poster 6 (Bottom Second):** Features a handprint shape made of many small, colorful dots. Text: 'Whenever you use hands in your job, handle some hand cleaner too.' and 'Wakati wa kutumia miti ya maji ya safi, tafadhali safi miti ya maji ya safi. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida.' (Whenever you use hands in your job, handle some hand cleaner too. When you use clean water, please clean your hands. This is a basic need. This is a basic need. This is a basic need.)
- Poster 7 (Bottom Third):** Features a green handprint shape with a green background. Text: 'Patients need our extra assurance that their surroundings are MRSA free. Let's give them a hand.' and 'Wakazi wa maji ya safi wanakusudia maji ya kawaida. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida.' (Patients need our extra assurance that their surroundings are MRSA free. Let's give them a hand. Residents of clean water are cleaning water. This is a basic need. This is a basic need. This is a basic need.)
- Poster 8 (Bottom Fourth):** Features a cluster of blue bubbles. Text: 'Getting into a bubble at work? Well, clean.' and 'Kusafiri kwa maji ya safi ni kazi ya kawaida. Lakini kuna watu ambao hawana maji ya safi. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida. Hii ni kazi ya kawaida.' (Getting into a bubble at work? Well, clean. Water is a basic need for all, and health is a basic need for all. This is a basic need. This is a basic need. This is a basic need.)



COMMUNICATING FOR CLINICAL CARE

Aligns with Key Result Areas:

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

Description

Communication failures have been identified as a significant factor in adverse patient outcomes in reports from the Health Care Complaints Commission, the final report of the Special Commission of Enquiry into Campbelltown and Camden Hospitals 2004 (Walker Report), 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.

Key achievements

- Extensive consultation has taken place with key stakeholders from the NSW health system to scope the project.
- Education tools (trigger DVDs) developed by two area health services, depicting effective and ineffective communication practices in a clinical setting in 1–3 minute scenarios, have been identified.

Future directions

- The CFCC project will test the education tools (DVDs) across a selection of health service facilities, in different clinical settings and with different healthcare groups, commencing in October 2006.
- As part of the CFCC project an e-newsletter developed by NSW hospital staff will be trialled statewide early in 2007, utilising 'CARE' (Collaboration, Acceptance, Reflection, and Empathy) messages.

2005–2006 PERFORMANCE (CONT.)

FALLS PREVENTION

Aligns with Key Result Areas:

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

Description

In July 2004, the NSW Minister for Health announced funding of \$8.5 million over four years, for the implementation of the NSW Falls Policy, with recurrent funding thereafter. The Injury Prevention Policy Branch, NSW Department of Health and the CEC share joint responsibility for the program. A Project Leader based at CEC provides statewide coordination and support to area health services in the implementation of Falls plans.

Development of the program has been driven by a number of factors, including:

- A projected increase in bed day demand for falls injury, with demographic changes including an increasing number of females aged 75+.
- Estimates that each year, one in three people in the community over 65 years of age will have a fall, with 30% requiring medical attention and 10% having multiple falls.
- Estimates that the total lifetime cost of falls in NSW is \$644m (\$333m direct costs; \$311m mortality and morbidity costs), excluding falls in healthcare establishments.

- Costs to NSW Health of falls injuries are nearly double that of road trauma.
- A serious fall frequently becomes the precipitating event into residential care.
- In addition to health service costs, there is the hidden cost of the impact on the lives of older people and their relatives and carers. Fear of falling can be debilitating and lead to severe restrictions in activity and social interaction.
- Falls are the leading cause of injury in hospitals and hospital incidents.

Aims of the program are to:

- reduce falls injury in older people and falls-related admission to hospital.
- implement a range of strategies that work across community, hospital and residential care settings.

Key achievements

- The four year 'Stay on Your Feet' community-based falls prevention program trial at North Coast Area Health Service delivered a 20% reduction in falls-related hospital admissions at a cost benefit ratio of 20.6:1.0.
- Each area health service has appointed an area falls coordinator whose role is to coordinate the implementation of local falls plan across acute, community and residential care sectors.



Area Falls Coordinators – inaugural workshop

Future directions

Community initiatives

- Liaison with other agencies for further development of exercise programs with a focus on balance and strength training.
- Identification and management, by general practitioners, community health teams, community service providers and the Ambulance Service NSW, of people with early falls risk factors.
- Development of local referral process to suitable programs and support.
- Community information promoting benefits of physical activity on independence.

Hospital initiatives

- Identification (screening), assessment and management of people at risk from falls.
- Implementation of best evidence guidelines (Australian Council of Safety and Quality in Healthcare, 2005), distribution of good practice tips to hospital wards and education of hospital staff.
- Showcase of good models of practice.
- Review and analysis of IIMS falls incident data at ward level.

MEDICATION SAFETY

Aligns with Key Result Areas:

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

Description

The CEC is working collaboratively with the NSW Therapeutic Advisory Group (TAG) to improve medication safety through a **Performance Indicators and Medication Safety (PIMS)** Project.

Commencing in 2005, PIMS has the aim of improving medication safety and the quality use of medicines in NSW via two phases:

Phase 1	The adaptation of the Institute for Safe Medicines Practice (ISMP) Medication Safety Self Assessment Tools for use in Australia.
Phase 2	Revision of the Indicators for Drug Use in Australian Hospitals.

Key achievements

Phase 1

- Adaptation and field-testing of the Medication Safety Self Assessment (MSSA) tool is complete.
- The CEC and NSW TAG are collaborating with the Canadian Institute for Safe Medicine Practices (ISMP) to develop and pilot a web based version of the ISMP tool. This web based data collection tool will enable real time online reporting; comparison of data for a hospital between two reporting periods; and comparison of de-identified data between hospitals with similar demographics.
- The Australian Council on Healthcare Standards (ACHS) has included the ISMP tools in the revised accreditation standards due for release in 2007 with the aim of encouraging usage and uptake of the self-assessment tools.

Phase 2

- Extensive consultation has taken place for selection of candidate indicator sets.
- Recruitment of hospitals to field test a candidate indicator set is underway.

Future directions

- Implementation and launch of the tools and database.
- The candidate indicator set field test will be evaluated to assess the ability to collect the indicators and to assess the reliability of the candidate indicator set.
- Implementation and launch of the Indicators for Drug Use in Australian Hospitals will occur once a final indicator set is confirmed.

2005–2006 PERFORMANCE (CONT.)

SAFER SYSTEMS – SAVING LIVES

Aligns with Key Result Areas:

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

Description

The Safer Systems – Saving Lives (SSSL) project is based on the American Institute for Healthcare Improvement (IHI) 100K Lives campaign, which seeks to reduce unnecessary hospital deaths by implementing six best practice interventions as part of a 'care bundle'. The concept is that, while each component is important, there is an increased impact if all elements in a care bundle are used.

The interventions include:

- prevention of ventilator associated complications
- prevention of surgical site infections
- prevention of central line associated bloodstream infection
- implementation of a rapid response system
- prevention of adverse drug events
- improved care for acute myocardial infarction.

SSSL is a national project involving 39 hospitals from the private and public sector, with ten of these from NSW. The organisational lead for the project,

conducted under the auspices of the Australian Commission for Safety and Quality in Health Care, is the Quality and Safety Branch of the Victorian Department of Human Services, with project leads in each state jurisdiction. The CEC provides project leadership in NSW with the project timeline being from March 2006 to March 2007

Key achievements

Teams are using quality improvement methodology to trial and assess the impact of improvement strategies, with baseline data collected in the first month of the project helping to identify gaps in practice and opportunities for improvement. Teams use SSSL audit tools and measurement strategies to report against two key indicators for each intervention: compliance with the care bundle and a clinical outcome specific to the intervention.

There has been a slow but steady increase in the rate of compliance with care bundles for most of the interventions. A decline in the rates of complications associated with each of the six interventions is less apparent, but this is expected to change as compliance rates increase and are sustained.

Most site teams report a high level of cooperation from stakeholders. The project has been an opportunity for staff to review current practice and policy in a way that will ensure patients receive the best possible care. The interventions reflect many

of the attributes that favour adoption and the project has benefited from synergies with other improvement work being undertaken by the CEC and area health services such as the Hand Hygiene Campaign.

Future directions

- National conference in November 2006 to promote networking and sharing of ideas.
- Liaison with key clinical stakeholders during the second half of the project to review outcomes and develop the model for wider implementation.

TRANSFUSION MEDICINE

Aligns with Key Result Areas:

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

Description

The **Transfusion Medicine Improvement Program (TMIP)** was established in March 2006 to coordinate implementation of improvements in transfusion practice across NSW, in line with advice from the NSW Health Blood Products Advisory Committee.

Key areas identified for improvement include:

- appropriate use of blood products
- safety of blood and blood product usage, including adverse events reporting
- standardised transfusion ordering practice
- management of blood product inventory including accurate costing of blood components
- mechanisms for ensuring clinical responsibility for best transfusion practice in area health services
- education of clinical staff in relation to all aspects of transfusion medicine.

Key achievements

- A management committee and working party has been established.
- Allocation of \$100,000 to each Area Health Service to fund a transfusion project officer to support local initiatives that sustain best practice.
- Transfusion Medicine planning day, to identify key priority areas and a strategic focus for 2006–2007.

Future directions

- Full roll-out of program, including appointment of Area coordinators during 2006.
- Development and implementation of statewide workplan, with focus areas being appropriate transfusion; education; review of evidence based guidelines; and reporting of adverse transfusion events.

2005–2006 PERFORMANCE (CONT.)

TOWARDS A SAFER CULTURE (TASC)

Aligns with Key Result Areas:

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

Description

The TASC Program aims to provide evidence based treatment and secondary prevention for patients presenting to the emergency department with acute coronary syndromes (ACS) or with stroke. The NSW project builds on an earlier phase conducted by the Royal Australasian College of Physicians.

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

Key achievements

The TASC Program has implemented systems to assist managers and clinicians in translating guideline recommendations into routine clinical care that has improved outcomes for ACS and stroke patients.

The demand for timely and accurate clinical information within the public health system to support improved health outcomes is increasingly being recognised. A key component of the TASC Program for sustaining clinical practice improvement efforts includes embedding measurement into daily clinical work. This was achieved by the development of the TASC Online System, which:

- simplifies the process of recording clinical information
- records data pertaining to patient care
- monitors variance and provides feedback to clinicians on their compliance with clinical documentation.

The TASC Online System won the Information and Communications Technology section at the 2005 NSW Premier's Award Public Sector Awards in November 2005.

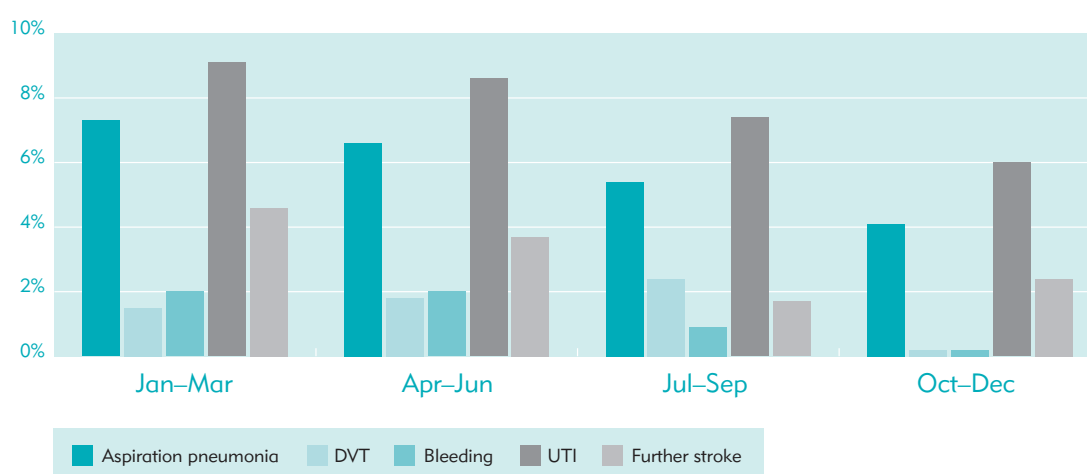
Results of the TASC Program demonstrate that:

- ACS and stroke patients receiving appropriate medications (as recommended by the guidelines) has increased
- complication rates for stroke patients during 2005 have decreased.

In hospital complications – all strokes

Figure 3: TASC online in hospital complications report – aggregated data 2005

	Jan–Mar	Total (den)	Apr–Jun	Total (den)	Jul–Sep	Total (den)	Oct–Dec	Total (den)
Aspiration pneumonia	7.3%	384	6.6%	590	5.4%	442	4.1%	389
DVT	1.5%	392	1.8%	595	2.4%	463	0.2%	418
Bleeding	2.0%	393	2.0%	596	0.9%	462	0.2%	418
UTI	9.1%	396	8.6%	595	7.4%	462	6.0%	418
Further stroke	4.6%	389	3.7%	595	1.7%	462	2.4%	418



The Rural Stroke Education program has been developed by the Greater Metropolitan Clinical Taskforce (GMCT) Stroke Services State Manager, in consultation with the Project Leader, TASC Program and the Rural Stroke Project Officer, NSW Institute of Rural Clinical Services and Training.

The one day program is being conducted for medical, nursing, general practitioners and allied health clinicians during 2006 at the following

sites: Tamworth, Orange, Coffs Harbour, Lismore, Broken Hill, Cooma, Port Macquarie, Wagga Wagga, Dubbo, Shoalhaven. Approximately 500 clinicians have participated in the program to date.

Clinicians from the NSW GMCT Stroke Services Coordinating Committee, the Rural Stroke Project Officer and the Project Leader, TASC Program provide the educational program to rural clinicians.

Future directions

The TASC Program offers an effective model for the integration of evidence-based practice, clinician ownership and clinical practice improvement. There is great potential for using the TASC Online System to improve the management and clinical outcomes of patients presenting for assessment, diagnosis and treatment for a number of important clinical conditions.

2005–2006 PERFORMANCE (CONT.)

VTE PROPHYLAXIS

Aligns with Key Result Areas:

4. Clinical improvement

Description

The prevention of deep vein thrombosis (DVT) and pulmonary embolism, collectively known as venous thromboembolism (VTE), has been identified internationally as a notable opportunity to improve patient safety in hospitals. The VTE Prophylaxis Program, an initiative of the National Institute for Clinical Studies (NICS), commenced in December 2005. The CEC has sponsored eight hospital teams from the NSW Health system to participate in the national program.

The aim of the VTE Prophylaxis Program is to improve the use of VTE preventive measures in all hospitalised patients in Australia.

Key achievements

The main focus of activity has been the development, testing and implementation of the effective VTE risk assessment and management processes and guidelines at the area health service or whole hospital level to reveal where there are practice gaps and opportunity for improvement.

Future directions

- A final workshop in Melbourne in October 2006 will bring together national teams from the project with the aim of sharing experiences and challenges, and the evidence for VTE prophylaxis.
- Support will be offered to teams throughout 2007 to build on the work already undertaken and assist with spread and sustainability of the Program.
- A practical guide is being developed by NICS that will include tips and tools to assist with improvement of VTE Prophylaxis in hospitals.

QUALITY SYSTEMS ASSESSMENT (QSA)

Aligns with Key Result Areas:

- 2. Quality Systems Assessment
- 6. Organisational development

Description

The Quality System Assessment (QSA) program is a new initiative for the NSW health system and a key component of the NSW Patient Safety and Clinical Quality Program.

The QSA program comprises an annual review of the NSW public health system, with its main objectives being to provide evidence of the following:

- Assurance with compliance of:
 - policies
 - standards
 - guidelines.
- Assessment of the level of development of:
 - patient safety system
 - clinical quality improvement.
- The level of improvement at a local, facility and systems level.
- The identification of future risks to patient safety.

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

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

Key achievements

- Review of quality and safety systems in non-health settings.
- Development of draft QSA framework.
- Development of draft area health service level tool based on quality standards.
- Selection of three area health service pilot sites (two metropolitan, one rural) to test area health service tool from July to September 2006.

Future directions

- Work with external consultants to finalise framework and AHS activity statement, based on pilot findings.
- Development of institution/clinical stream and clinical unit/department reporting tools.
- QSA program expected to be operational across the NSW health system by July 2007.

2005–2006 PERFORMANCE (CONT.)

RESEARCH

Aligns with Key Result Areas:

- 5. Capacity building
- 6. Organisational development

IAN O'ROURKE SCHOLARSHIP IN PATIENT SAFETY

A key research initiative undertaken by the CEC this year has been the establishment of the Ian O'Rourke Scholarship in Patient Safety. This will allow a suitably qualified applicant to undertake a full-time PhD degree by research into patient safety and quality improvement as they relate to indigenous health.

The scholarship is named in honour of the late Dr Ian O'Rourke AO who was Chief Executive Officer of the Institute for Clinical Excellence, on which the CEC is founded. The scholarship is a tribute to Dr O'Rourke's many roles in health as a surgeon, educator, academic and researcher; and to his extraordinary leadership and integrity. The focus on patient safety and quality improvement in indigenous health reflects Ian's passion for his work with Aboriginal communities at the Redfern Medical Centre, in far north Queensland, and in the Northern Territory.

Scholarship guidelines and application information have been distributed widely throughout health, academic and Aboriginal organisations and applications will close in September 2006. It is anticipated that the first

Ian O'Rourke Scholar will commence study at the beginning of the 2007 academic year, with future scholarships to be offered on a triennial, competitive basis.

HOSPITAL ALLIANCE FOR RESEARCH COLLABORATION (HARC)

Another key research initiative for the CEC during the year has been collaboration with The Sax Institute to develop the Hospital Alliance for Research Collaboration (HARC), which seeks to support NSW hospitals to become leading providers of efficient, safe and effective health services, supported by high quality research. HARC is in the initial stages of development, and will be consolidated more fully in the coming year.

MEMBERSHIP OF ADVISORY BOARD COUNCIL

The CEC has joined the US-based Advisory Board Council of International Hospitals. Membership will expand the CEC's research capacity by offering access to annual meetings and teleconferences; strategic research publications; customised short-answer research reports; email briefings on key health matters; study tours and hospital site visits.

PATIENT SAFETY RESEARCH

The NSW Centre for Clinical Governance Research at the University of NSW has been commissioned by the CEC to undertake a series of research initiatives relating to patient safety and quality. During 2005–2006, the following monographs have been produced:

- Evaluation of the Safety Improvement Program in NSW: Overview of Studies.
- Patient Safety Research: A Review of the Technical Literature.

RESEARCH TOOLS

Information Management initiatives to support research by CEC staff as well as those in the broader health system, include involvement in the new Health Record Linkage, a listing of health-related research facilities in NSW, and compiling a Stocktake record of health-related research publications and datasets.

SPECIAL COMMITTEES

Aligns with Key Result Areas:

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

SPECIAL COMMITTEE INVESTIGATING DEATHS ASSOCIATED WITH SURGERY (SCIDAWS)

SCIDAWS was established in 1994 under the Health Administration Act 1982 to review deaths associated with surgical practice in New South Wales. It has privilege under Section 23 of the NSW Health Administration Act, 1992.

In December 2005, the committee's functions were reviewed, with the CEC recommending to the Minister that a systematic audit of deaths associated with surgical care be implemented in NSW, based on the successful Scottish and Western Australian audits of surgical mortality. The committee's terms of reference have since been redrafted and approved by the Minister for Health.

The systematic audit of surgical mortality in NSW is CHASM (Collaborating Hospitals' Audit of Surgical Mortality). Participation by surgeons in the program will ensure all deaths associated with surgical care are reviewed by an

independent surgeon in a way that meets the professional standards and expectations of the Royal Australasian College of Surgeons. Individual surgeons have opportunities to participate by submitting cases for review and acting as an assessor for their sub-specialty.

CHASM will be progressively rolled out across the state, starting in Sydney West and Hunter New England area health services. When fully implemented, the NSW audit will not only be the largest undertaking of its kind but will take place in one of the most complex health systems in the world.

Key achievements

- Engagement of key stakeholders and personnel.
- Ministerial endorsement of expanded terms of reference for SCIDAWS.
- NSW customisation of data collection instruments.
- Agreement with Sydney West to pilot initial implementation phase.
- Information pack for participating surgeons is currently under development.
- Specific NSW software has been commissioned and is under development.
- Reconstitution and appointment of new SCIDAWS membership has commenced.

Membership of SCIDAWS until December 2005, drawn from:

- Royal Australasian College of Surgeons
- Australian and New Zealand College of Anaesthetists
- Royal College of Pathologists of Australia
- NSW Department of Health
- Departments of Surgery from universities of Sydney, NSW and Newcastle
- professional associations concerned with the various surgical sub-specialties.

2005–2006 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 and reports to the Minister for Health. The committee is privileged and makes recommendations for the prevention of morbidity and mortality associated with anaesthesia in NSW, specifically those reportable to the Coroner under the NSW Coroner's Act.

In October 2005, SCIDUA ended its long association with Royal Prince Alfred Hospital following relocation of its secretariat to the CEC.

Since January 2006, the Committee has classified its cases according to the latest version of the Royal Australasian College of Anaesthetists coding classification scheme for anaesthesia-related deaths. This has subsequently increased the secretariat's workload.

During the reporting period, the CEC has worked with the committee to address its changing information management and data handling needs. This has led to the commissioning and development of an upgraded database with appropriate security safeguards. The report entitled

Guide to the Activities of the Special Committee Investigating Deaths under Anaesthesia 2000–2003 has been made available to the health system and general public.

The CEC is pleased to report that the significant gains achieved last year in operational efficiency of the committee, have been maintained this year through the strenuous efforts of the SCIDUA members and the anaesthetists of NSW.

SCIDUA membership is drawn from:

- Australian & New Zealand College of Anaesthetists
- Australian Society of Anaesthetists
- Royal Australian & NZ College of Obstetricians & Gynaecologists
- Departments of Anaesthesia at the University of Newcastle, University of Sydney
- Department of Surgery at the University of Sydney, University of NSW
- The Special Committee Investigating Deaths Associated with Surgery
- Royal College of Pathologists of Australasia.

SPECIAL REVIEWS

Aligns with Key Result Areas:

1. Public reporting
5. Capacity building
6. Organisational development

The Director-General may, from time to time, require the CEC to conduct reviews in relation to the quality and safety of healthcare on his or her behalf, with the specific nature of such a 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 will not investigate matters of individual performance, nor will it deal with individual patient incidents of complaints.

The following lists Special Reviews undertaken by the CEC over the year in review:

- Review of the Liverpool Hospital Incident Management System.
Report completed July 2005.
- 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.
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 the CEC Directions Statement and CEC Strategic Plan 2005–2008.

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

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

The number of full time equivalent staff at the CEC as at 30 June 2006 was 23.76. Staff come from a mixture of medical, nursing, management, allied health and administration backgrounds, with key portfolio areas being executive leadership, project management, and clerical support.

Full time equivalent staff as at 30 June:

2004–2005	13.70
2005–2006	23.76

EXECUTIVE REPORTS

Name

Clifford F Hughes AO

Health service

Clinical Excellence Commission

Period in position

1 July 2005 to 30 June 2006

STRATEGIC INITIATIVES

- Implementation and review of organisational strategic plan and key result areas.
- Appointment of 2nd tier director team and associated support staff
- Memorandum of Understanding with NSW Department of Health regarding purchase of Incident Information Management System (IIMS).
- Development of strategies in key portfolios of Quality Systems Assessment, Clinical Practice Improvement Projects, Information Management and Organisation Development and Education.
- Contribution to statewide safety and quality planning workshop in collaboration with NSW Department of Health, May 2006.
- Strategic planning workshop for patient safety convened by CEC, June 2006.
- Publication of 2nd Report on Adverse Events, in collaboration with NSW Department of Health.
- Special Reviews in the areas of meningococcal disease, incident management, communication of inaccurate pathology results, and pacemakers.
- Development of strategic partnerships including Health Record Linkage, Hospitals Alliance Research Collaborative (HARC) with Sax Institute and development of a statewide database for cardiac surgery (with GMCT).

- Development and piloting of an Area Health Service level assessment tool as part of Quality Systems Assessment.
- Establishment of Clinical Council
- Establishment of Ian O'Rourke Scholarship to fund PhD research in patient safety and quality improvement in indigenous health.

MANAGEMENT ACCOUNTABILITIES

- Re-location to new office premises.
- Ongoing management of CEC projects in collaboration with executive staff.
- Development of internal audit charter.
- Development and implementation of support to Board Chair and Board activities.
- Observation of all statutory and financial reporting requirements.
- Development and implementation of internal policies, including risk assessment policy and framework, code of conduct, and performance development.

EQUAL EMPLOYMENT OPPORTUNITY

Consistent with the organisation's values of a just culture, integrity, honesty and accountability, the CEC applies the principles of equity, fairness and merit-based selection in its employment policies and practices.

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 utilises SESIAHS EEO strategies regarding recruitment, and has developed a targeted professional development program to ensure that the skills and experience of CEC staff are enhanced during their periods of secondment or employment with the organisation.

Consistent with the previous reporting period, the CEC did not receive any EEO-related complaints during the current reporting period.

OCCUPATIONAL HEALTH AND SAFETY

The CEC recognises its legal obligations under the NSW Occupational Health and Safety Act 2000 and Occupational Health and Safety Regulations 2001. It is committed to maintaining the best possible standard of occupational health and safety for staff and visitors.

At 30 June 2006, the CEC had not received any workers' compensation claims and there were no reported incidents.

This was consistent with the previous reporting period.

TEACHING AND TRAINING INITIATIVES

Professional development for CEC staff is fundamental to building knowledge and keeping staff aware of updates and initiatives in the field of safety and quality and other organisational capabilities related to the work of the CEC. In response to this need, a development program has been created to provide regular professional

development opportunities and a forum for sharing information and knowledge.

Internal professional development courses and workshops have been held in the CEC since February 2006, including internal presentations/workshops by CEC staff, staff from the area health services showcasing initiatives, and external consultants. Topic areas have included:

- Searching the Clinical Information Access Program (CIAP) for Evidence Based Medicine
- Knowledge Management
- Writing and Publishing Your Work
- Failure to Rescue – the Medical Early Warning System (MEWS)
- Presenting and Facilitating in Workshops
- Evaluating Projects and Improvement Strategies
- Clinical Information Management in the AHS
- Cost Centre Management in the CEC
- Giving and Receiving Feedback as part of the Performance Development Program
- Facilitation and Presentation Masterclass
- An Overview of Root Cause Analysis Training and Trend Data.

A journal club was established early 2006 as a professional development forum for CEC staff to promote professional discussion around key quality and safety topics with reference to the literature and to enhance skills in critical review. Four journal club meetings were held during the past year.

OUR PEOPLE (CONT.)

A range of overseas conferences on quality and safety were attended by Professor Cliff Hughes, Dr George Bearham and Dr Annette Pantle, with Dr Pantle being joined by Ms Mary Mitchelhill at the Institute for Healthcare Improvement for a short program on Breakthrough Series Improvement Methodology.

RESEARCH

Research initiatives undertaken by the CEC during the year are outlined in a previous section. No individual staff members undertook formal research for the CEC or its agencies throughout the year.

Research initiatives and activities to support research by CEC and health staff include:

- development of a Hospitals Alliance Research Collaboration with The Sax Institute
- stocktake of major health related research publications and data sets
- foundational membership of the Centre for Health Record Linkage.
- internal information management resources.

CONFERENCE PRESENTATIONS

The following outlines presentations at major conferences by CEC staff during the review year. It does not include the large number of professional inservices or seminars in which staff also presented.

Professor Cliff Hughes

- 'Communication and human factors understanding in reducing litigation risk and improving safety.' International Society for Quality in Health Care Conference, Vancouver, 26 October 2005.
- 'CEC and the Quality and Safety Agenda.' Royal Australian College of Surgeons (ACT) and Royal Australian College of Physicians (ACT), Canberra, 12 November 2005.
- 'Structuring a senior executive leadership team that will drive cultural change.' Medical Error: A National Framework for Safety and Quality of Healthcare, Sydney, 3 April 2006
- 'Health funds, quality and safety – a partnership of benefits.' Australian Health Insurance Association (AHIA), Brisbane, 5 April 2006.
- 'Clinical governance and culture change in NSW.' Australian College of Health Service Executives (ACHSE), NSW state conference, Sydney, 7 April 2006
- 'Leadership and change management: Breaking down the barriers of resistance in changing culture and behaviour.' 6th Adverse Events Congress, Melbourne, 14 June 2006.
- 'The Clinical Excellence Commission and Royal Australasian College of Surgeons.' Royal Australian College of Surgeons Council, Melbourne, 30 June 2006.

- 'Railways – precision or just huff and puff?' Royal Australian College of Surgeons Council, Melbourne, 30 June 2006.

Ms Cate Ferry

- 'Building an integrated information management system for translating evidence into clinical practice.' International Society for Quality in Health Care Conference, Vancouver, 26 October 2005.

Ms Sarah Michael

- 'RCA training for New Zealand Teams'. Christchurch: 31 October 2005, 1 November 2005; Auckland: 3–4 November 2005.
- Operating Theatres Association (OTA) North Coast Conference – Incident Management in NSW, Ballina, 11 November 2005.
- 'Redesigning Patient Care after RCA.' Australasian Society for Healthcare Risk Management (AUSHRM), Sydney, 25th November 2005.
- 'Nurses and Medication Errors.' AUSMED Conference, Sydney, 8 December 2005.
- Operating Theatres Association (OTA) conference, Sydney, 16 March 2006.
- IIR Adverse Events Conference – Ethical Practice and Communication with Patients, Melbourne, 16 June 2006.

Ms Marilyn Cruickshank

Children's Emergency Care Project, presented at:

- Australian College of Critical Care Nurses, Sydney, 21 July 2005
- NSW Rural Critical Care Conference, August, 2005, Coffs Harbour
- Australian NZ Intensive Care Annual Scientific Meeting, Adelaide, 20–23 October 2005
- College of Emergency Nurses Australasia Conference, Sydney, October 2005
- Australian College of Critical Care Nurses, Nowra, 19 May 2006.

OFFICIAL OVERSEAS TRAVEL BY CEC STAFF

Professor Clifford F Hughes

Chief Executive Officer

- Halifax 5 – Advancing the Culture of Safety
Calgary Canada
20–22 October 2005
- 22nd International Conference of International Society for Quality in Health Care
Vancouver, Canada
25–28 October 2005

Dr George P Bearham

Deputy Chief Executive Officer

- 6th International Conference on the Scientific Basis of Health Services: Improving Health by Advancing Healthcare. Linking Research, Policy and Action*
Montreal, Canada
18–20 September 2005

Ms Cate Ferry

Project Leader, TASC Program

- 22nd International Conference of International Society for Quality in Health Care
Vancouver, Canada
26–28 October 2005

Dr Annette Pantle

Director Clinical Practice Improvement Projects

- 11th European Forum on Quality Improvement in Health Care*
Prague Congress Centre, Czech Republic
26–28 April 2006
- Breakthrough Series College, Spring 2006 College Session.*
Wellesley, Massachusetts
7–9 May 2006

Ms Mary Mitchelhill

Project Leader, Organisation Development and Education

- Breakthrough Series College, Spring 2006 College Session.
Wellesley, Massachusetts
7–9 May 2006

All visits were funded from General Funds except those marked with an asterisk, which were funded from staff specialist TESL entitlement.

OUR COMMUNITY

During the year, the organisation reviewed systems of community engagement, to propose a workable model that would enable the CEC to meet its objective of 'engaging with healthcare providers and the community in the development of a statewide approach to safety and quality improvement'.

The resulting model, a **Citizens Engagement and Advisory Council (CEAC)**, was endorsed by the Board mid-2006.

The CEAC will be an expert group whose members have a broad community perspective and which, collectively, comprises high-level skills and experience in areas such as communications, social change, marketing, health administration, media skills, journalism, politics, community/adult education, safety and quality.

The role of the CEAC will be to:

- effectively 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 known by the CEC, and
- 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 will complement existing links the CEC has with the statewide **Health Care Advisory Council**, which is attended by the Chairman of the CEC Board and which provides a valuable link between the CEC and Area Health Care Advisory Councils. It will also complement the CEC Clinical Council.

The CEAC will be formally established during the coming year.

FREEDOM OF INFORMATION (FOI) REPORT

The CEC did not receive any applications under the FOI Act for the period 1 July 2005 to 30 June 2006.

This was consistent with the previous reporting period.

FOI Requests

2004–2005	0
2005–2006	0

A full-page photograph of a female nurse with dark hair, smiling warmly at the camera. She is wearing a bright blue short-sleeved uniform with white piping on the collar and cuffs. A small identification badge is pinned to her left chest. She is leaning over a patient, whose hand is visible in the foreground, and appears to be adjusting a medical sensor or electrode on the patient's finger. The patient is lying under a white sheet. The background is a plain, light blue wall. On the left side of the image, there is a vertical white rectangular area containing the text 'FINANCIAL REPORTS' in blue capital letters.

FINANCIAL
REPORTS

EXECUTIVE SUMMARY

for the year ended 30 June 2006

The audited financial statements presented for the Clinical Excellence Commission for the 2005–2006 financial year provides for a Net Cost of Services budget of \$11.656 million, against which the audited actuals of \$5.959 million represents a variation of \$5.697 million or 49%.

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 costs throughout the year. This in turn was due to the need to secure additional office space to accommodate increasing staff numbers in line with the expanded responsibilities of the CEC. New staff have commenced progressively throughout calendar year 2006. The result also reflects higher than expected revenue.

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 twelve months is provided in the following table.

	2004–2005 \$000	2005–2006 \$000	Comparison \$000	Movement %
Employee Related Expenses	1,606	3,020	1,414	88
Other Operating Expenses	1,551	1,645	94	6
Depreciation & Amortisation	3	32	29	100+
Grants & Subsidies	0	1,438	1,438	100
Total Expenses	3,160	6,135	2,975	94
Sale of Goods & Services	6	146	140	100+
Investment Income	17	27	10	59
Grants & Contributions	100	0	-100	100
Other Revenue	0	3	3	100
Total Revenues	123	176	53	43
Gain/Loss on Disposal of Non Current Assets				
Net Cost of Services	3,037	5,959	2,922	96

INDEPENDENT AUDIT REPORT

for the year ended 30 June 2006



GPO BOX 12
Sydney NSW 2081

INDEPENDENT AUDIT REPORT CLINICAL EXCELLENCE COMMISSION

To Members of the New South Wales Parliament

Audit Opinion

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

- presents fairly the Commission's and the consolidated entity's (defined below) financial position as at 30 June 2006 and their performance for the year ended on that date, in accordance with Accounting Standards and other mandatory financial reporting requirements in Australia, and
- complies with section 45E of the *Public Finance and Audit Act 1983* (the Act) and the *Public Finance and Audit Regulation 2005*.

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

Scope

The Financial Report and the Board's Responsibility

The financial report comprises the operating statements, statements of changes in equity, balance sheets, cash flow statements and accompanying notes to the financial statements for the Commission and consolidated entity, for the year ended 30 June 2006. The consolidated entity comprises the Commission and the entities it controlled during the financial year.

The Board is responsible for the preparation and true and fair presentation of the financial report in accordance with the Act. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial report.

Audit Approach

I conducted an independent audit in order to express an opinion on the financial report. My audit provides reasonable assurance to Members of the New South Wales Parliament that the financial report is free of material misstatement.

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

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

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

INDEPENDENT AUDIT REPORT (CONT.)

for the year ended 30 June 2006

My opinion does not provide assurance:

- about the future viability of the Commission or its controlled entities,
- 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.

Audit Independence

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

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



Peter Carr
Director, Financial Audit Services

SYDNEY
27 November 2006

CERTIFICATION OF PARENT/ CONSOLIDATED FINANCIAL STATEMENTS

for the year ended 30 June 2006

Certification of Parent / Consolidated Financial Statements

The attached financial statements of the Clinical Excellence Commission for the year ended 30 June 2006;

1. 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. Where there are inconsistencies between the above requirements, the legislative provisions have prevailed. Statements of Accounting Concepts are used as guidance in the absence of applicable Accounting Standards and other mandatory professional legislative requirements;
2. present fairly the financial position and transactions of the Clinical Excellence Commission; and
3. have no circumstances that would render any particulars in the financial statements to be misleading or inaccurate.


Professor Bruce Barracough, AO
Chairman


Professor Clifford Hughes, AO
Chief Executive Officer


Rhonda Tepp
Director, Corporate Services

OPERATING STATEMENT

for the year ended 30 June 2006

		PARENT			CONSOLIDATION		
		Actual 2006 \$000	Budget 2006 \$000	Actual 2005 \$000	Actual 2006 \$000	Budget 2006 \$000	Actual 2005 \$000
	Notes						
Expenses excluding losses							
Operating Expenses							
Employee Related	3	2,139	4,017	1,606	3,020	4,017	1,606
Personnel Services	4	881	–	–	–	–	–
Other Operating Expenses	5	1,645	7,639	1,551	1,645	7,639	1,551
Depreciation and Amortisation	2(h), 6	32	–	3	32	–	3
Grants and Subsidies	7	1,438	–	–	1,438	–	–
Total Expenses excluding losses		6,135	11,656	3,160	6,135	11,656	3,160
Retained Revenue							
Sale of Goods and Services	8	146	–	6	146	–	6
Investment Income	9	27	–	17	27	–	17
Grants and Contributions	10	16	–	100	–	–	100
Other Revenue	11	3	–	–	3	–	–
Total Retained Revenue		192	–	123	176	–	123
NET COST OF SERVICES	21	5,943	11,656	3,037	5,959	11,656	3,037
Government Contributions							
NSW Health Department Recurrent Allocations	2(d)	7,436	7,436	2,580	7,436	7,436	2,580
Acceptance by the Crown Entity of Employee Superannuation Benefits	2(a)	40	49	97	56	49	97
Total Government Contributions		7,476	7,485	2,677	7,492	7,485	2,677
RESULT FOR THE YEAR	18	1,533	(4,171)	(360)	1,533	(4,171)	(360)

The accompanying notes form part of these Financial Statements.

STATEMENT CHANGES IN EQUITY

for the year ended 30 June 2006

		PARENT			CONSOLIDATION		
		Actual 2006 \$000	Budget 2006 \$000	Actual 2005 \$000	Actual 2006 \$000	Budget 2006 \$000	Actual 2005 \$000
	Notes						
TOTAL INCOME AND EXPENSE RECOGNISED DIRECTLY IN EQUITY		–	–	–	–	–	–
Result for the year	18	1,533	(4,171)	(360)	1,533	(4,171)	(360)
TOTAL INCOME AND EXPENSE RECOGNISED IN RESULT FOR THE YEAR		1,533	(4,171)	(360)	1,533	(4,171)	(360)

The accompanying notes form part of these Financial Statements.

BALANCE SHEET

for the year ended 30 June 2006

		PARENT			CONSOLIDATION		
		Actual 2006 \$000	Budget 2006 \$000	Actual 2005 \$000	Actual 2006 \$000	Budget 2006 \$000	Actual 2005 \$000
ASSETS	Notes						
Current Assets							
Cash and Cash equivalents	12	133	(3,718)	447	133	(3,718)	447
Receivables	13	665	1	1	665	1	1
Total Current Assets		798	(3,717)	448	798	(3,717)	448
Non-Current Assets							
Plant and Equipment	14	676	68	68	676	68	68
Investment Property							
Intangible Assets	15	708	–	–	708	–	–
Total Non-Current Assets		1,384	68	68	1,384	68	68
Total Assets		2,182	(3,649)	516	2,182	(3,649)	516
LIABILITIES							
Current Liabilities							
Payables	16	90	324	324	90	324	324
Provisions	17	555	108	227	555	108	227
Total Current Liabilities		645	432	551	645	432	551
Non-Current Liabilities							
Provisions	17	39	126	–	39	126	–
Total Non-Current Liabilities		39	126	–	39	126	–
Total Liabilities		684	558	551	684	558	551
Net Assets/(Liabilities)		1,498	(4,207)	(35)	1,498	(4,207)	(35)
EQUITY							
Accumulated Funds	18	1,498	(4,207)	(35)	1,498	(4,207)	(35)
Total Equity		1,498	(4,207)	(35)	1,498	(4,207)	(35)

The accompanying notes form part of these Financial Statements.

STATEMENT OF CASH FLOWS

for the year ended 30 June 2006

		PARENT			CONSOLIDATION		
		Actual	Budget	Actual	Actual	Budget	Actual
		2006	2006	2005	2006	2006	2005
	Notes	\$000	\$000	\$000	\$000	\$000	\$000
CASH FLOWS FROM OPERATING ACTIVITIES							
Payments							
Employee Related		(1,716)	(3,960)	(1,358)	(2,597)	(3,960)	(1,358)
Other Operating Expenses		(2,765)	(7,639)	(1,447)	(1,884)	(7,639)	(1,447)
Grants and Subsidies		(1,438)	–	–	(1,438)	–	–
Total Payments		(5,919)	(11,599)	(2,805)	(5,919)	(11,599)	(2,805)
Receipts							
Sale of Goods and Services		146	–	6	146	–	6
Investment Income		27	–	17	27	–	17
Grants		–	–	100	–	–	100
Other		3	–	1	3	–	1
Total Receipts		176	–	124	176	–	124
CASH FLOWS FROM GOVERNMENT							
NSW Health Department Recurrent Allocations		7,436	7,436	2,580	7,436	7,436	2,580
Net Cash Flows from Government		7,436	7,436	2,580	7,436	7,436	2,580
Net cash flows from operating activities	21	1,693	(4,163)	(101)	1,693	(4,163)	(101)
CASH FLOWS FROM INVESTING ACTIVITIES							
Purchases of Plant and Equipment and Intangible Assets		(1,348)	–	(34)	(1,348)	–	(34)
Net cash flows from investing activities		(1,348)	–	(34)	(1,348)	–	(34)
CASH FLOWS FROM FINANCING ACTIVITIES							
Payment of Borrowing and Advances		(659)	–	–	(659)	–	–
Net cash flows from financing activities		(659)	–	–	(659)	–	–
Net increase/decrease in cash							
Opening Cash and Cash Equivalents		447	445	582	447	445	582
Closing cash and cash equivalents	12	133	(3,718)	447	133	(3,718)	447

The accompanying notes form part of these Financial Statements.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

for the year ended 30 June 2006

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 20 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 on 23.11.06

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 (AIFRS)), 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 property, plant and equipment and infrastructure systems, 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 AIFRS. This is the first financial report prepared based on AIFRS, however there is no impact on, (and thus no requirement to restate), the comparative figures.

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 amounts expected to be paid when the liabilities are settled. All Annual Leave employee benefits are reported as "Current" as there is an unconditional right to payment. Current liabilities are then further classified as "Short Term" or "Long Term" based on past trends and known resignations and retirements. Anticipated payments to be made in the next 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 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 17.4% for short term entitlements and 7.6% for long term entitlements above the salary rates immediately payable at 30 June 2006 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".

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 (i.e. Basic Benefit and First State Super) is calculated as a percentage of the employees' salary. For other superannuation schemes (i.e. State Superannuation Scheme and State Authorities Superannuation Scheme), the expense is calculated as a multiple of the employees' superannuation contributions.

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

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

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) Borrowing Costs

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

d) Revenue 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.

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 plant and equipment costing \$5,000 and above are capitalised.

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.

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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

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 Commission'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]).

l) 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

Other financial assets are generally recognised at cost.

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 5.45% as compared with 4.7% 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) Payables

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.

q) 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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

r) The Financial Impact Of Adopting Australian Equivalents To International Financial Reporting Standards (AEIFRS)

The Clinical Excellence Commission has applied the AEIFRS for the first time in the 2005–2006 financial report. There is no instance in which changes in accounting policies have impacted the financial report; i.e. no impact on the Financial Statements arising because AEIFRS requirements are different from previous AASB requirements (AGAAP), or from options in AEIFRS that were not available or not applied under previous AGAAP. The Clinical Excellence Commission has considered the options mandated by NSW Treasury for all NSW public sector agencies

3. EMPLOYEE RELATED EXPENSES

	PARENT		CONSOLIDATION	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
Employee related expenses comprise the following:				
Salaries and Wages	1,673	1,347	2,362	1,347
Long Service Leave [see note 2(a)]	65	43	92	43
Annual Leave [see note 2(a)]	159	98	225	98
Other Agency Payments	72	3	102	3
Other Agency Commissions	–	35	–	35
Salary Packaging	–	(17)	–	(17)
Superannuation [see note 2(a) defined benefit plans]	40	22	56	22
Superannuation [see note 2(a) defined contributions]	130	75	183	75
	2,139	1,606	3,020	1,606

Salaries and Wages include \$123,000 in 2005–2006 and \$89,000 in 2004–2005, paid to members of the Clinical Excellence Commission Board, consistent with the statutory determination by the Minister for Health, which provided remuneration effective from 1 July 2001.

The payments have been made within the following bands:

\$ range	Number paid
\$0 to \$15,000	8
\$15,000 to \$30,000	1

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

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

4. PERSONNEL SERVICES

	PARENT		CONSOLIDATION	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
Personnel Services comprise the purchase of the following:				
Salaries and Wages	689	—	—	—
Superannuation [see note 2(a)] – defined benefit plans	16	—	—	—
Superannuation [see note 2(a)] – defined contributions	53	—	—	—
Long Service Leave [see note 2(a)]	27	—	—	—
Annual Leave [see note 2(a)]	66	—	—	—
Other Agency Payments	30	—	—	—
	881	—	—	—

5. OTHER OPERATING EXPENSES

	PARENT		CONSOLIDATION	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
(a) Expenses on goods and services comprise the following:				
Information Management Expenses	61	27	61	27
Domestic Supplies and Services	6	6	6	6
Food Supplies	8	4	8	4
Fuel, Light and Power	1	1	1	1
General Expenses [see note 4(b)]	773	989	773	989
Insurance	2	1	2	1
Maintenance (see (c) below)				
New Replacement Equipment under \$5,000	84	20	84	20
Repairs	1	8	1	8
Other	3	–	3	–
Postage	1	4	1	4
Printing and Stationery	241	93	241	93
Rental of Premises	182	31	182	31
Special Service Departments	61	–	61	–
Staff Related Costs	95	143	95	143
Telephone	20	12	20	12
Travel Related Costs	105	211	105	211
Rates and Charges	1	1	1	1
	1,645	1,551	1,645	1,551

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

5. OTHER OPERATING EXPENSES CONTINUED

	PARENT		CONSOLIDATION	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
(b) General expenses include				
Advertising	4	33	4	33
Audio Visual Supplies	–	2	–	2
Books and Magazines	6	1	6	1
Consultancies	154	56	154	56
Courier and Freight	2	1	2	1
Auditors' Remuneration – Audit of financial reports	15	13	15	13
Auditors' Remuneration – Other Services	–	16	–	16
Legal Expenses	15	6	15	6
Membership/Professional Fees	1	1	1	1
Motor Vehicle Expenses	–	1	–	1
Motor Vehicle Operating Leases	–	4	–	4
Other Operating Lease Expense	6	7	6	7
Project Payments:				
CEC Administration and Program Development	91	281	91	281
Special Committee Investigating Death under Anaesthetic	16	–	16	–
Towards a Safer Culture (TASC)	–	77	–	77
Safety & Flow Collaborative	–	2	–	2
Safety Improvement Program	197	36	197	36
Safer System Saving Lives	154	–	154	–
Emergency Care for Children	55	3	55	3
Chronic Care Collaborative	–	449	–	449
Quality System Assessment	2	–	2	–
Other	55	–	55	–
	773	989	773	989
(c) Reconciliation Total Maintenance				
Maintenance Expense	88	28	88	28
	88	28	88	28

6. DEPRECIATION AND AMORTISATION

	PARENT		CONSOLIDATION	
Depreciation – Plant and Equipment	32	3	32	3
	32	3	32	3

7. GRANTS AND SUBSIDIES

	2006 \$000	2005 \$000	2006 \$000	2005 \$000
Research and Evaluation Program: Safety and Quality	240	–	240	–
Safer System Saving Lives Program	298	–	298	–
Transfusion Medicine Programs	900	–	900	–
	1,438	–	1,438	–

8. SALE OF GOODS AND SERVICES

Sale of Goods and Services comprise the following:

Commercial Activities	131	–	131	–
Conference and Training Receipts	–	6	–	6
Services to Non-NSW Health Organisations	12	–	12	–
Other	3	–	3	–
	146	6	146	6

9. INVESTMENT INCOME

Interest	27	17	27	17
	27	17	27	17

10. GRANTS AND CONTRIBUTIONS

Personnel Services – Superannuation Defined Benefits	16	–	–	–
Commonwealth Grants	–	30	–	30
Grants from NSW Health	–	70	–	70
	16	100	–	100

11. OTHER REVENUE

Other Income	3	–	3	–
	3	–	3	–

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

12. CURRENT ASSETS – CASH

	PARENT		CONSOLIDATION	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
Cash at bank	133	447	133	447
	133	447	133	447
Cash assets recognised in the Balance Sheet are reconciled to cash at the end of the financial year; as shown in the Statement of Cash Flows as follows:				
Cash (per Balance Sheet)	133	447	133	447
Closing Cash and Cash Equivalents (per Cash Flow Statement)	133	447	133	447

13. CURRENT RECEIVABLES

Current

Debtors Intra Health	659	–	659	–
Prepayments Salaries and Wages	6	1	6	1
	665	1	665	1

14. PLANT AND EQUIPMENT

At Gross Carrying Amount	715	75	715	75
Less Accumulated Depreciation	39	7	39	7
Total Plant and Equipment at Net Carrying Value	676	68	676	68

PARENT AND CONSOLIDATED**Plant and Equipment – Reconciliation**

	Plant and Equipment \$000	Total \$000
2006		
Carrying Amount at 1 July, 2005	68	68
Additions	640	640
Depreciation Expense	(32)	(32)
Carrying Amount at 30 June, 2006	676	676
2005		
Carrying Amount at 1 July, 2004	37	37
Additions	34	34
Depreciation Expense	(3)	(3)
Carrying Amount at 30 June, 2005	68	68

15. INTANGIBLE ASSETS

	PARENT		CONSOLIDATION	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
At Gross Carrying Amount	708	–	708	–
Less Accumulated Amortisation	–	–	–	–
Total Intangible Assets at Net Carrying Value	708	–	708	–

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

PARENT AND CONSOLIDATED

Intangibles – Reconciliation

	Other \$000	Total \$000
2006		
Carrying Amount at 1 July, 2005	–	–
Additions	708	708
Amortisation	–	–
Carrying Amount at 30 June, 2006	708	708

16. PAYABLES

	PARENT		CONSOLIDATION	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
Current				
Creditors				
Other Creditors	85	211	85	211
– Intra Health	–	108	–	108
– Other	5	5	5	5
	90	324	90	324

17. PROVISIONS

	PARENT		CONSOLIDATION	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
Current Employee Benefits and related on-costs				
Employee Annual Leave – Short Term Benefit	–	64	64	64
Employee Annual Leave – Long Term Benefit	–	36	171	36
Employee Long Service Leave – Short Term Benefit	–	127	46	127
Employee Long Service Leave – Long Term Benefit	–	–	274	–
Provision for Personnel Services Liability	555	–	–	–
Total Current Provision	555	227	555	227
Non-Current Employee Benefits and related on-costs				
Employee Long Service Leave – Conditional		–	39	–
Provision for Personnel Services Liability	39	–	–	–
Total Non Current Provisions	39	–	39	–
Aggregate Employee Benefits and Related On-costs				
Provisions – Current	555	227	555	227
Provisions – Non-Current	39	–	39	–
Total Provisions	594	227	594	227

18. EQUITY

	PARENT		CONSOLIDATION	
	Total Equity 2006 \$000	2005 \$000	Accumulated Funds 2006 \$000	2005 \$000
Balance at the beginning of the financial reporting period	(35)	325	(35)	325
Result for the year	1,533	(360)	1,533	(360)
Balance at the end of the reporting period	1,498	(35)	1,498	(35)

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

19. COMMITMENTS FOR EXPENDITURE

	PARENT		CONSOLIDATION	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
a) Other Expenditure Commitments				
Aggregate other expenditure contracted for at balance date and not provided for in the accounts:				
Not later than one year	91	1,158	91	1,158
Between one and five years	383	514	383	514
Later than five years	43	–	43	–
Total Other Expenditure Commitments	517	1,672	517	1,672

b) Capital Commitments

Aggregate capital expenditure contracted for at balance date and not provided for in the accounts:

Not later than one year	841	841	841	841
Between one and five years	841	1,682	841	1,682
Later than five years	–	–	–	–
Total Capital Commitments	1,682	2,523	1,682	2,523

c) Lease Commitments

Commitments in relation to non-cancellable operating leases are payable as follows:

Not later than one year	200	171	200	171
Between one and five years	847	796	847	796
Later than five years	232	–	232	–
Total Lease Commitments	1,279	967	1,279	967

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

20. CONTINGENT LIABILITIES

There are no contingent liabilities.

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

	PARENT		CONSOLIDATION	
	2006	2005	2006	2005
	\$000	\$000	\$000	\$000
Net Cash Flows from Operating Activities	1,693	(101)	1,693	(101)
Depreciation	(32)	(3)	(32)	(3)
(Increase)/Decrease in Employee Entitlements	(367)	(151)	(367)	(151)
Acceptance by the Crown Entity of Superannuation Benefits	(40)	(97)	(56)	(97)
Decrease in Other Debtors	–	(1)	–	(1)
Increase in Prepayments	5	1	5	1
(Increase)/Decrease in Creditors	234	(105)	234	(105)
NSW Health Department Recurrent Allocations	(7,436)	(2,580)	(7,436)	(2,580)
Net Cost of Services	(5,943)	(3,037)	(5,959)	(3,037)

22. UNCLAIMED MONIES

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

23. BUDGET REVIEW**Net Cost of Services**

The actual Net Cost of Services was lower than budget by \$5.69m. This was primarily due to actual operating expenditure being lower than budget by \$5.52m, which continues to reflect the timing differences between budget allocation and service delivery, itself dependent on the specialised resource requirements for the Clinical Excellence Commission objectives. Greater than budgeted actual revenue of \$176k represented mainly commercial activity revenue from health campaign resource development and dissemination on behalf of NSW Health, and training consultancy fees. The balance sheet classification of the Incident Information Management System as an intangible asset further reduced the impact on the Net Cost of Services.

Result for the Year

The result for the year was higher than budget by \$5.70m due to the favourable Net Cost of Services position.

Assets and Liabilities**Current Assets**

Current Assets were greater than budget by \$4.51m. This is principally due to the difference of \$3.85m in budget allocation and cash receipts. Grant payments to Area Health Services for Clinical Excellence Commission Projects, in addition to the reduction in actual Creditors has resulted in the reduced actual cash balance at the end of the year, however this is still greater than budget expectation. The Clinical Excellence Commission negotiates its cash allocation depending on its expenditure requirements. Higher than budgeted receivables comprise intra-health debtors.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

Non-Current Assets

Non-current assets were higher than budget by \$1.31m. Increased staffing levels and activity is reflected in increased capital equipment purchases, and the IIMS licence is recognised as an intangible asset.

Liabilities

Current and Non-current Liabilities are materially within budget.

Cash Flows

Operating Activities

The better than expected actual result is largely attributable to lower actual expenditure and higher than anticipated actual revenue, however this continues to reflect timing differences between budget allocation and provision of services.

Investing Activities

Increased capital expenditure over budget by \$1.35m is due largely to additional plant and equipment purchases because of increased staffing levels.

Government Contributions

Movements in the level of the NSW Health Department Recurrent Allocation that have occurred since the time of the initial allocation on 12th August 2005 are as follows:

	PARENT		CONSOLIDATION	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000
Initial Allocation 12th August 2005	7,095	5,580	7,095	5,580
Secretariat Funding/Enhancements	4,284	(2,784)	4,284	(2,784)
CEC NSW Chronic Care	–	424	–	424
Government Cash Payments 2005–2006	(3,718)	–	(3,718)	–
Children's Emergency Care Program	–	–	–	–
Patient Safety	–	(640)	–	(640)
Best Practice	–	–	–	–
Hand Hygiene Program	(605)	–	(605)	–
Paediatric Clinical Practice Guidelines	27	–	27	–
NSW Management Policy: Falls Prevention	202	–	202	–
Super Guarantee Charge	151	–	151	–
Balance as per Operating Statement	7,436	2,580	7,436	2,580

24. PROGRAMS/ACTIVITIES OF THE CLINICAL EXCELLENCE COMMISSION

The Clinical Excellence Commission operates under a single program, as such a program statement has not been prepared.

Program 6.1 Teaching and Research

Objective To develop the skills and knowledge of the health workforce to support patient care and population health. To extend knowledge through scientific enquiry and applied research aimed at improving the health and wellbeing of the people of NSW.

25. FINANCIAL INSTRUMENTS

Parent and Consolidated

a) Interest Rate Risk

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

Financial instruments	Floating interest rate		Non-interest bearing		Total carrying amount as per the Balance Sheet		Weighted average effective interest rate*	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000	2006 \$000	2005 \$000	2006 %	2005 %
Financial Assets								
Cash	133	447	–	–	133	447	5.45	4.70
Receivables	–	–	665	1	665	1		
Total Financial Assets	133	447	665	1	798	448		
Financial Liabilities								
Accounts payable	–	–	90	324	90	324		
Total Financial Liabilities	–	–	90	324	90	324		

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

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

b) Credit Risk

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

The Clinical Excellence Commission's maximum exposure to credit risk is represented by the carrying amounts of the financial assets included in the Balance Sheet.

Credit Risk by classification of counterparty

	Banks		Other		Total	
	2006 \$000	2005 \$000	2006 \$000	2005 \$000	2006 \$000	2005 \$000
Financial Assests						
Cash	133	447	–	–	133	447
Receivables	–	–	665	1	665	1
Total Financial Assests	133	447	665	1	798	448

There is no significant concentration of credit risk.

c) Net Fair Value

As stated in Note 2(o) all financial instruments are carried at net fair value, the values of which are reported in the statement of financial position.

d) Derivative Financial Instruments

The Clinical Excellence Commission holds no derivative financial instruments.

END OF AUDITED FINANCIAL STATEMENTS

INDEPENDENT AUDIT REPORT CLINICAL EXCELLENCE COMMISSION SPECIAL PURPOSE ENTITY

for the year ended 30 June 2006



GPO BOX 12
Sydney NSW 2081

INDEPENDENT AUDIT REPORT

CLINICAL EXCELLENCE COMMISSION SPECIAL PURPOSE SERVICE ENTITY

To Members of the New South Wales Parliament

Audit Opinion

In my opinion, the financial report of the Clinical Excellence Commission Special Purpose Service Entity (the Entity):

- presents fairly the Entity's financial position as at 30 June 2006 and its performance for the period 17 March 2006 to 30 June 2006, in accordance with Accounting Standards and other mandatory financial reporting requirements in Australia, and
- complies with section 41B of the *Public Finance and Audit Act 1983* (the Act) and the *Public Finance and Audit Regulation 2005*.

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

Scope

The Financial Report and Chief Executive's Responsibility

The financial report comprises the balance sheet, income statement, statement of changes in equity, cash flow statement and accompanying notes to the financial statements for the Entity, for the period ended 30 June 2006.

The Chief Executive of the Entity is responsible for the preparation and true and fair presentation of the financial report in accordance with the Act. This includes responsibility for the maintenance of adequate accounting records and internal controls that are designed to prevent and detect fraud and error, and for the accounting policies and accounting estimates inherent in the financial report.

Audit Approach

I conducted an independent audit in order to express an opinion on the financial report. My audit provides *reasonable assurance* to Members of the New South Wales Parliament that the financial report is free of material misstatement.

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

- assessed the appropriateness of the accounting policies and disclosures used and the reasonableness of significant accounting estimates made by the Chief Executive in preparing the financial report, and
- examined a sample of evidence that supports the amounts and disclosures in the financial report.

CERTIFICATION OF CLINICAL EXCELLENCE COMMISSION SPECIAL PURPOSE ENTITY

for the year ended 30 June 2006

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

My opinion does not provide assurance:

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

Audit Independence

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

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



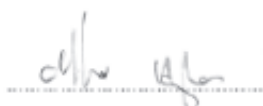
Peter Carr
Director, Financial Audit Services

SYDNEY
27 November 2006

**Certification of Clinical Excellence Commission Special Purpose Entity for
Period Ended 30 June 2006**

The attached financial statements of the Clinical Excellence Commission Special Purpose Entity for the year ended 30 June 2006:

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



Chief Executive Officer
Clinical Excellence Commission

November 2006



Director Corporate Services
Clinical Excellence Commission

November 2006

INCOME STATEMENT OF THE CLINICAL EXCELLENCE COMMISSION SPECIAL PURPOSE ENTITY

for the year ended 30 June 2006

	2006 \$000
Income	
Personnel services	881
Acceptance by the Crown Entity of Employee Superannuation Scheme Benefits	16
Total Income	897
Expenses	
Salaries and Wages	689
Defined Benefit Superannuation	16
Defined Contributions Superannuation	53
Long Service Leave	27
Annual Leave	66
Agency Payments	30
Grants and Subsidies	16
Total Expenses	897
Operating Result	0

The accompanying notes form part of these Financial Statements.

BALANCE SHEET OF THE CLINICAL EXCELLENCE COMMISSION SPECIAL PURPOSE ENTITY

for the year ended 30 June 2006

	Notes	2006 \$000
ASSETS		
Current Assests		
Receivables	2	555
Total Current Assets		555
Non-Current Assets		
Receivables	2	39
Total Non-Current Assets		39
Total Assets		594
LIABILITIES		
Current Liabilities		
Provisions	3	555
Total Current Liabilities		555
Non-Current Liabilities		
Provisions	3	39
Total Non-Current Liabilities		39
Total Liabilities		594
Net Assets		0
EQUITY		
Accumulated funds		0
Total Equity		0

The accompanying notes form part of these Financial Statements.

STATEMENT
OF CHANGES
IN EQUITY OF
THE CLINICAL
EXCELLENCE
COMMISSION
SPECIAL PURPOSE
ENTITY

	2006 \$000
Opening Equity	0
Results for the Year	0
Balance as at 30 June 2006	0

CASH FLOW STATEMENT OF THE CLINICAL EXCELLENCE COMMISSION SPECIAL PURPOSE ENTITY

for the year ended 30 June 2006

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

The Clinical Excellence Commission Special Purpose Entity does not hold any cash or cash equivalent assets and therefore there are nil cash flows.

The accompanying notes form part of these Financial Statements.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

for the year ended 30 June 2006

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

a) The Clinical Excellence Commission Special Purpose Entity

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

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

The Entity commenced operations on 17 March 2006 when it assumed responsibility for the employees and employee-related liabilities of the 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 23 November 2006. The report will not be amended and reissued as it has been audited.

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 Hospitals.

This is the first financial report prepared on the basis of Australian equivalents to International Financial Reporting Standards.

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

As this is the Entity's first financial report, comparative information for the previous year is not provided.

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) Goods and Services Tax (GST)

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

f) 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 short-term 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.

g) Payables

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

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

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

h) 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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

Long Service Leave provisions are measured on a short hand basis at an escalated rate of 17.4% for short term entitlements and 7.6% for long term entitlements above the salary rates immediately payable at 30 June 2006 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 the "Payables" Note .

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 Commission beyond that date.

i) Accounting standards issued but not yet effective

The following Accounting Standards are being early adopted since the formation of the entity 17 March 2006:

- AASB 2005-4 regarding the revised AASB 139 fair value option;
- UIG 9 regarding the reassessment of embedded derivatives; and
- AASB 2005-06, which excludes from the scope of AASB 3, business combinations involving entities or businesses under common control.

j) Financial Instruments

Financial instruments give 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 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 good and services received, whether or not billed to the Commission.

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.

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS (CONT.)

for the year ended 30 June 2006

2006
\$000

2. RECEIVABLES

Current

Accrued Income – Personnel Services Provided	555
--	-----

Non-Current

Accrued Income – Personnel Services Provided	39
--	----

Total Receivables	594
--------------------------	------------

3. PROVISIONS

Current Employee benefits and related on-costs

Employee Annual Leave – Short Term Benefit	64
--	----

Employee Annual Leave – Long Term Benefit	171
---	-----

Employee Long Service Leave – Short Term Benefit	46
--	----

Employee Long Service Leave – Long Term Benefit	274
---	-----

	555
--	------------

Non-Current Employee benefits and related on-costs

Employee Long Service Leave – Conditional	39
---	----

	39
--	-----------

Aggregate Employee Benefits and Related On-costs

Provision – Current	555
---------------------	-----

Provision – Non-Current	39
-------------------------	----

	594
--	------------

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:

Financial instruments	Non-interest bearing	Total carrying amount as per the Balance Sheet	Weighted average effective interest rate*
	2006 \$000	2006 \$000	2006 %
Financial Assets			
Receivables	594	594	
Total Financial Assets	594	594	

*The weighted 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.

Credit Risk by classification of counterparty	Governments	Banks	Patients	Other	Total
	2006 \$000	2006 \$000	2006 \$000	2006 \$000	2006 \$000
Financial Assests					
Receivables	594	—	—	—	594
Total Financial Assests	594	—	—	—	594

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 Entity holds no Derivative Financial Instruments.

END OF AUDITED FINANCIAL STATEMENTS

INDEX

A

Adverse events, 5–7, 24–25
Audit, 14

B

Board, 9–15, 18

C

Capacity building, 21
Chairman's report, 4
Chief Executive Officer's report, 5–7
Children's Emergency Care Project, 26
Citizens Engagement & Advisory Council, 7, 8, 46
Clinical Council, 7, 16
Clinical leadership, 6, 22
Clinical practice improvement, 5, 8, 21, 26–36
Communication, 21, 29
Community engagement, 21, 46
Conference presentations, 44
Corporate governance statement, 18–19

D

E

Emergency departments, 26
Equal employment opportunity, 43
Evidence-based practice, 26, 27, 34–35
Executive reports, 42–43
Executive team, 17

F

Falls prevention, 30
Finance committee, 14–15
Financial statements, 49
Freedom of Information, 47
Foreword, 3
Functions, 18

G

Guidelines, 26, 27, 34–35

H

Hand hygiene, 27–28
Highlights, 8

I

Incident management, 20, 24–25
IIMS, 23–25, 29
Independent audit report, 51, 79
Information management, 5, 6, 8, 23–24

J K

L

Leadership, clinical, 6, 22

M

Medication safety, 31
Mission statement, 18

N

NSW Safety and Clinical Quality Program, 9

O

Occupational health and safety, 43
Organisational chart, 17
Organisational development, 6, 21
O'Rourke, Ian, 38
Overseas travel, 45

P

Partnerships, 6, 8, 21, 23, 44
Patient Safety Program, 5, 24–25
Performance, 19–21
Planning, 8, 19, 20–21, 24
Projects, 26–36
Public reporting, 5, 20
Purpose and goals, 18

Q

Quality Systems Assessment, 6, 20–21

R

Reportable Incident Brief, 24–25
Research, 8, 15, 38, 44
Reviews, 6, 8, 41
Risk management, 14, 19
Root cause analysis, 8, 25
Rural, 21, 35

S

Safer Systems – Saving Lives, 32
Severity Assessment Code (SAC), 24–25
Scholarship, 38
Special committees, 39–40
Staff profile, 42
Strategic planning, 8, 20–21, 24
Stroke, 34–35
Surgical mortality, 39

T

Teaching and training, 43
Towards A Safer Culture (TASC), 34–35
Toolkits, 8, 26
Transfusion medicine, 33

U

V

Venous thromboembolism (VTE) prophylaxis, 36
Vision statement, 18

W

Workshops, 6, 22, 25, 33, 44

X Y Z

Published by:
Clinical Excellence Commission

Designed by:
Cobé Design

Cost breakdown (incl. GST):
Design & artwork \$10,769
Printing \$18,073
Total \$28,842

The report is available online at
www.cec.health.nsw.gov.au



Printed on recycled paper.



CLINICAL
EXCELLENCE
COMMISSION

Offices

Level 3, 65 Martin Place
Sydney NSW 2000
1st Floor
Administration Building
Sydney Hospital
8 Macquarie St
Sydney NSW 2000

Correspondence

GPO Box 1614
Sydney NSW 2001
Tel 61 2 9382 7600
Fax 61 2 9382 7615
www.cec.health.nsw.gov.au