



CLINICAL
EXCELLENCE
COMMISSION

Enhancing patient care Enriching workplaces

Annual Report 2008–2009





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Enhancing patient care Enriching workplaces



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The Hon Carmel Tebbutt
Minister for Health
Governor Macquarie Tower
1 Farrer Place
SYDNEY NSW 2000

Dear Minister

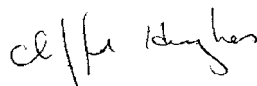
We have pleasure in submitting the Clinical Excellence Commission's 2008–09 Annual Report.

The report complies with the requirements for annual reporting under the Accounts and Audit Determination for public health organisations and the 2007/08 Directions for Health Service Annual Reporting.

Yours sincerely



Professor Bruce Barraclough AO
Chairman



Professor Clifford Hughes AO
Chief Executive Officer



Mission and Vision

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

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

The key functions of the CEC are to:

- Promote and support improvement in clinical quality and safety in health services
- Monitor clinical quality and safety processes and performance of public health organisations, and to report to the Minister thereon
- Identify, develop and disseminate information about safe practices in health care on a Statewide basis, including (but not limited to):
 - developing, providing and promoting training and education programs
 - identifying priorities for and promoting the conduct of research about better practices in health care

- Consulting broadly with health professionals and members of the community
- Providing advice to the Minister and Director-General on issues arising out of its functions.

The CEC fulfils these functions by:

- Providing advice to the Minister and Director-General of Health
- Notifying system-wide safety concerns
- Conducting quality system assessments
- Working with public health organisations to facilitate quality improvements
- Providing a source of expert advice and assistance
- Developing and promoting a Statewide approach to improving safety and quality

- Engaging clinicians and the community
- Identifying and developing training and education strategies and clinical tools
- Leading the development and system-wide dissemination of evidence-based guidelines
- Focusing on system issues for improvement across NSW.



Highlights and Achievements

Assessment

- Further development of QSA on site assessment program

For more information on Assessment, see p.16.

Education and training

- Clinical Leadership Program
- E-learning modular program for quality improvement
- Conference and seminar presentations

For more information on Clinical Leadership Program, see p.20.

New project focus areas

- Between the Flags: Development of a learning package – *DETECT* – for front line clinical staff
- Reintroduction of Hand Hygiene project under the auspices of the National Hand Hygiene Initiative
- Antibiotic Stewardship

For more information on New Project Areas, see p.22 and 34.

Public reporting

- Second and third bi-annual reports of the Incident Information Management System (IIMS)
- Chartbook 2007 distributed to all wards and workplaces across NSW Health
- Chartbook 2008 completed

For more information on Public reporting, see p.18 and 28.

Reviews

Improving early pregnancy care

For more information on Reviews, see p.44.

Partnerships

- Citizens Engagement Advisory Council
- Clinical Council
- Shared quality and safety reporting function with NSW Department of Health
- Hospital Alliance for Research Collaborative (HARC)
- Centre for Health Record Linkage (CHeReL)
- Regular meetings with Greater Metropolitan Clinical Taskforce (GMCT), Institute of Medical Education and Training (IMET), Australian Commission for Safety and Quality in Health Care (ACSQHC)
- Conduct quality and safety seminars in conjunction with ACSQHC
- Partnership with Sax Institute to fund fellowship of Dr Diane Watson

For more information on Partnerships, see p.8.

Research

- Ian O'Rourke PhD Scholar
- Database to support Collaborating Hospitals' Audit of Surgical Mortality (CHASM)
- Hospital Alliance for Research Collaborative (HARC)
- Centre for Health Record Linkage (CHeReL)

For more information on Research, see page p.61.

Strategic planning and development

- Board planning meeting to review board performance and produce Strategic Plan 2009–2012
- Recruitment of Director, Health System Improvement and expansion of QSA portfolio
- Recruitment of Director, Undergraduate Quality & Safety Education (p/t)
- Expansion of Special Committees secretariat to improve implementation and evaluation of the audits of surgical and anaesthetic mortality
- Development of project management frameworks for CEC projects
- Submitted a Response to Special Commission of Inquiry Report (Garling)

For more information on Strategic planning and development, see p.14.



Publications

- A Companion to the 'Easy Guide to Clinical Practice Improvement'
- Annual Report 2007–2008
- Between the Flags – The Way Forward
- Between the Flags – Interim Report
- Chartbook 2007 Errata
- Clean Hands Save Lives – Hand Hygiene Compliance Report
- Clinical Focus Reports from Review of RCAs and/or IIMS Data:
 - Airway Management
 - Falls
 - Management of Tracheostomy and Tracheostomy Emergencies
 - Sedation/Excess Sedation as an Adverse Outcome
 - Second Review of Acute Coronary Syndrome Incidents
 - Transfer of Unstable Patients
 - Use of Midazolam
- Collaborating Hospitals' Audit of Surgical Mortality (CHASM) brochure.
- Enhancing Project Spread and Sustainability
- Falls Prevention is Everyone's Business – CD and DVD
- Incident Management in the NSW Public Health System January–June 2008

- Medication Safety Self Assessment for Anti-Thrombotic Therapy in Australian Hospitals
- Medication Safety Self Assessment for Australian Hospitals
- Quality Systems Assessment Statewide Report
- Strategic Plan 2009–2012

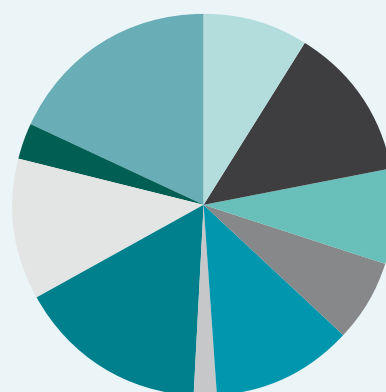
More information on CEC publications can be found on our website www.cec.health.nsw.gov.au.

Challenges

- To sustain existing programs in an era of fiscal responsibility
- To sustain the engagement, enthusiasm and cooperation of the large and diverse NSW health care workforce
- To increase the buy-in of clinicians and their ownership of CEC programs at a local/Area level
- To improve communication around quality and safety with clinical networks and the community at large
- To work with health care agencies on evaluation, measurement and public reporting of quality and safety outcomes

How we spent the money

Sixty nine per cent of CEC expenditure is allocated to our safety and quality improvement and education programs as shown below:



Quality Systems Assessment	(9%)
Patient Safety	(13%)
Information Management	(8%)
Special Committees	(7%)
Clinical Practice Improvement	(12%)
Grants	(2%)
Education	(16%)
Administration Support and Infrastructure	(12%)
Governance	(3%)
Other Staff S&W	(18%)

For full Financial information, see Audited Financial Statements on p.64.



**Professor Bruce
Barraclough AO
Board Chairman**

Chairman's Report

The work of the dedicated team at the Clinical Excellence Commission (CEC) is showing great results for patients and the health system, particularly in the achievement of a major reduction in central line associated bacteraemia in intensive care units, the more appropriate use of blood by the health system with major savings of a voluntarily contributed scarce resource and also significant financial benefit.

The Quality Systems Assessment results are identifying important safety and quality issues to be addressed by Health Area Chief Executives. It is always pleasing when successful projects become programs that are incorporated into the every day work of the health system. CEC in collaboration with NSW Health is about to embark on an exciting new program to improve the recognition of and response to the dangerously ill "deteriorating patient". A necessity identified from incident reports that is likely to save lives that may have otherwise been lost.

Special Commission

The majority of the recommendations from the "Garling" Commission of Inquiry into Acute Care Services in NSW Public Hospitals have been endorsed for implementation by the NSW Health Minister and the Director-General. The "Garling" report applauded much of the work of the Clinical Excellence Commission and particularly commented on the Hand Hygiene Program and the program to enhance the early recognition and effective management of the deteriorating patient that are actively being worked on by CEC staff. The report also made a number of positive recommendations to enhance CEC's work, which included a continuing positive collaboration with the

Quality and Safety Branch of NSW Health, and the components of the "Four Pillars" that are now called, the Agency for Clinical Innovation, The Institute of Clinical Education and Training and the Bureau of Health Information. The design of an appropriate response to the recommendations that involve the Clinical Excellence Commission, has required much negotiation and has taken considerable time and effort on the part of CEC's Chief Executive Officer, Professor Clifford Hughes and Deputy Chief Executive Officer, Dr Peter Kennedy. An appropriate collaborative outcome is now agreed.

New Opportunities

The CEC Board expects that a period of change and opportunity will open up over the next few months with the CEC moving to a shared site with the Bureau of Health Information and the Agency for Clinical Innovation. A close working collaboration between these separate organisations, sharing some central resources, will be an efficient and effective result of this move. There will also be closer working relationships with the new Institute of Clinical Education and Training. There is a strong possibility that to encompass these new arrangements, the Board of the CEC will also undergo a restructure.

This Board has put great effort into its governance and advice roles and is proud of the successes achieved through the work of the Clinical Excellence Commission. Board members have encouraged and engaged with CEC staff and have enthusiastically led, and contributed their time and expertise to Board sub-committees dealing with Research, Audit and Finance, as well as the CEC's Clinical Council and Citizens Engagement Advisory Council.

I take this opportunity to thank most sincerely, all Board members and CEC staff for their unstinting commitment to achieving the mission of the CEC. I am sure that the new opportunities that come with the proposed restructure, following the "Garling" Commission recommendations, will have beneficial results for the people of NSW.

A handwritten signature in black ink, appearing to read "B Barraclough".

**Professor Bruce Barraclough AO
Board Chairman**

Clifford F Hughes AO
Clinical Professor
Chief Executive Officer



Chief Executive Officer's Report

2008–2009 saw the Clinical Excellence Commission (CEC) continue to drive the safety and quality agenda with NSW Health.

This report is a summary of some of the activities and the results obtained across a range of clinical quality and patient safety issues. These activities have only grown by sheer hard work and commitment from a band of experts on our staff who are focused on the patients and the staff across NSW. Our work program, considered and endorsed by the Board, has been developed by a strategic view of contemporary patient safety and quality issues common to many jurisdictions around the world. It is pertinent to note that, in the final report of the Special Commission of Inquiry in to Acute Care Services in NSW Public Hospitals, the Commissioner, Mr Peter Garling SC, wrote

"...The experts all agreed.

First, NSW still has one of the better public health care systems in the developed world. Measured by per capita spending on health care, by the number of beds per 1,000 of population, by clinician to patient ratios or by expectation of life, Australia's performance ranges from close to the average up to the top 4 or 5 of the 20 leading Organisation for Economic Co-operation and Development (OECD) nations. The Australia-wide figures hold good for NSW."

The CEC has been involved in many of the safety and quality improvement issues currently in progress in NSW.

Quality systems assessment (QSA)

- Rollout of the first QSA survey across all Area Health Services, Ambulance Service and Justice Health
- Distribution of a State and also Area-based quality activity statement
- Targeted themes for the second QSA assessment program determined

Capacity building

- The Clinical Leadership Program second module completed with 170 senior members of nursing staff, allied health and mental health practitioners enrolled
- Forty senior doctors, managers and nurses completed a modular program across six weekends
- Three reports to the Director-General of NSW Health on the monitoring of the recommendations of the Hughes-Walters enquiry into midwifery services completed
- Review of pacemaker insertions in NSW submitted to Parliament

Clinical improvement

- Blood Watch project has reduced inappropriate use of blood products by approximately 10 per cent
- Interactive website – The Transfusion Question – established with worldwide uptake
- Hand Hygiene program has been reinvigorated and targeted audits of hand hygiene compliance started
- Central Line Associated Bacteraemia Project is completed with improvement in blood stream infections after insertion of these lines achieving world's best practice

The deteriorating patient

- The Recognition and Management of the Deteriorating Patient has been a major challenge for health workers around the globe
- The CEC has brought together senior leaders in intensive care to coordinate and produce education packages on the subject
- The CEC has also completed extensive diagnostic work across a range of hospitals, to identify the gaps in understanding, resources and facilities that can lead to patients deteriorating quietly and unexpectedly on our wards



Chief Executive Officer's Report (CONTINUED)

- ❑ Both bodies of work have been brought together to provide a four-pronged approach under the heading of "Between the Flags"
- ❑ This program has been endorsed by the Minister for Health, the Director-General, all Area Chief Executives and has received widespread support across all staff in NSW Health
- ❑ This work has provided the springboard for a five-year culture change program across all health workers in NSW – a first anywhere in the world!

Public reporting

- ❑ Second and third bi-annual reports of the Incident Information Management System (IIMS) reported publicly
- ❑ Chartbook 2007 distributed to all wards and workplaces across NSW Health
- ❑ Chartbook 2008 completed

Information management

- ❑ Annual Report of the Special Committee Investigating Deaths Under Anaesthesia released
- ❑ Surgical mortality review – Collaborating Hospitals' Audit of Surgical Mortality (CHASM) – rolled out across all Areas and preliminary mortality assessments begun.

Communication and culture change

- ❑ Communication project in Emergency Departments commenced in collaboration with Southern Cross University.

Engaging others

Each and all of our programs, projects and activities require extensive collaboration from many partners.

- ❑ The Citizens Engagement Advisory Council (CEAC) has begun an extensive work program supervising the communication project with Southern Cross University
- ❑ CEAC has also begun some work on health literacy
- ❑ CEAC has strengthened its own structure with the appointment of multicultural representatives
- ❑ Each month, between 30 and 35 meetings are sponsored at the CEC bringing 6 to 35 attendees to various work programs
- ❑ Each activity is scheduled to fit in with other NSW Health activities to minimise impact on transport budgets of Area Health Services
- ❑ In addition CEC staff regularly travel to rural areas to conduct workshops to support and encourage regional health care workers

- ❑ Heads of Departments have been individually engaged in the QSA program and 83 per cent have engaged in this process
- ❑ The CEC has also engaged with the Surgical Services Taskforce, Acute Care Taskforce and the Improving Early Pregnancy Care Project, with the Greater Metropolitan Clinical Taskforce, the Institute of Medical Education and Training and the Nursing and Midwifery Office
- ❑ The CEC works in partnership with the Quality and Safety Unit of NSW Department of Health and numerous committees and branches within the Department on each program
- ❑ The CEC has taken over the role of the Blood Products Advisory Committee from the Chief Health Officer's portfolio
- ❑ The CEC also has lead responsibility for the management of the Falls Program in NSW
- ❑ The CEC manages the Root Cause Analysis Review Committee which reports to the Reportable Incident Review Committee
- ❑ The IIMS data is analysed by the Patient Safety Team and, with advice from NSW Health, is put in to the six monthly reports
- ❑ The Chief Executive Officer sits on the Senior Executive Advisory Board and reports monthly to that group

The CEC has been involved in many of the safety and quality improvement issues currently in progress in NSW.

Area health services

- All CEC clinical improvement projects engage with Area Health Service teams throughout the State
- The Board has led by example with meetings in Orange and Bathurst
- The Chief Executive Officer is a member of the Clinical Governance Directors' meeting (monthly) and CEC Directors attend each meeting of that group on rotation
- The CEC provides de-identified aggregated data on the IIMS system to each Area Health Service via the Chief Executive and the Director of Clinical Governance
- The CEC has supported the establishment of Data Managers in each Area Health Service to support CHASM and, where appropriate, the Australian Society of Cardiac and Thoracic Surgeons Mortality Database
- The CEC maintains a small office in Coffs Harbour from which the Falls Program is managed
- The QSA has provided invaluable opportunities for CEC staff to meet with staff in clinical facilities as well as Area Health Service Executive Staff to review the issues in the Quality Activity Statement
- The CEC receives invaluable support from the Clinical Council and network of clinicians across the State who provide a two-way conduit to all clinicians

- The Clinical Council has identified the issues around dementia, particularly in the elderly, as a major program for the future

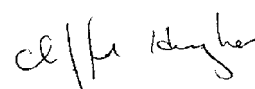
Research

- The Research Committee continues to supervise research activities, in particular, the work of Dr David Peiris who has all but completed his three year PhD scholarship
- The Research Committee has also supervised work with Southern Cross University and Centre for Clinical Governance Research and School of Aviation at the University of NSW
- In addition to regular reports to the public and to NSW Health, various staff members have been involved in scientific publications on topics ranging from management of anticoagulation, to hand hygiene, to a systems evaluation of disaster pathways and the management of implantation of cardiac pacemakers

Above and beyond

- The staff at the CEC clearly enjoys its work. The hours are long but happy. The team participates well in supporting the community, individually and together.

- The CEC staff has contributed to a community knit-a-thon to produce eight knitted wool blankets and also took part in a hand hygiene promotion campaign in Martin Place in Sydney
- The workplace is much more like a family than drudgery
- Discussions can be forceful but controlled and, at the end of the day, we move on together with a "can do" approach to each and all of the challenges thrown at us
- Our vision has not changed – we continue to focus on our patients and then on our staff
- While the problems confronting health care continue to increase, our enthusiasm to find a way under, through, round or over those obstacles remains strong
- The staff do wish to enrich lives by leading, cooperating with and supporting all others in NSW Health in "caring together"



Clifford F Hughes AO
Clinical Professor
Chief Executive Officer

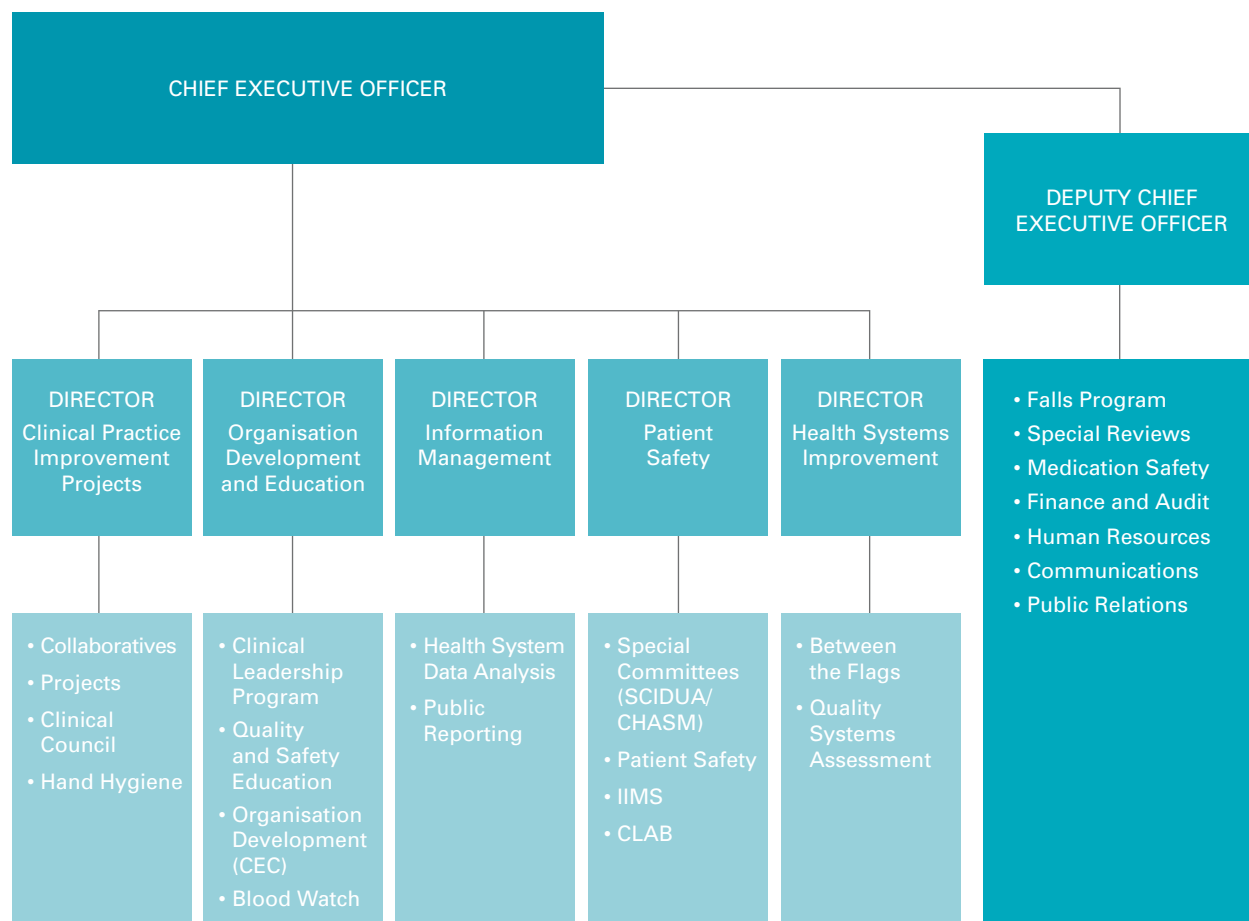
PROFILE, PURPOSE AND GOALS

The Clinical Excellence Commission (CEC) was established in 2004 and forms a major component of the NSW Patient Safety and Clinical Quality Program.

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

Organisation Chart

Clinical Excellence Commission Organisation Structure





Directors and Titles

Chief Executive Officer

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

Deputy Chief Executive Officer

Dr Peter Kennedy MBBS, FRACP

Director Clinical Practice Improvement Projects

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

Director Information Management A/Director Corporate Services

André Jenkins BA (Hons)

Director Organisation Development & Education

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

Director Patient Safety

Adjunct Professor Tony Burrell
MBBS, FFARACS, FANZCA,
FFICANZCA, FJFICM, BA

Director, Health Systems Improvement

Dr Charles Pain LRCP (Lond.),
MRCS (Eng.), MSc, FFPH (UK),
FAFPHM, AFCHSE (from June 2009)

LEFT TO RIGHT:
Dr Peter Kennedy, Dr Annette Pantle,
André Jenkins, Bernie Harrison, Adjunct Professor
Tony Burrell, Dr Charles Pain

ALLIANCE WITH STATE HEALTH PLAN'S STRATEGIC DIRECTIONS

1

Make prevention everybody's business

- ▣ NSW Falls Program
- ▣ Management of the Deteriorating Patient – *Between the Flags* Project
- ▣ Hand Hygiene
- ▣ Medication Safety
- ▣ Central Line Associated Bacteraemia Collaborative
- ▣ Blood Watch Program
- ▣ Undergraduate Education in Quality and Safety
- ▣ Special Reviews
- ▣ Special Committees
- ▣ Review of incident management data

2

Create better experiences for people using health services

- ▣ Implementation of Clinical Leadership Program across NSW
- ▣ Recognition and Management of the Deteriorating Patient – *Between the Flags*
- ▣ Blood Watch
- ▣ Hand Hygiene
- ▣ Central Line Associated Bacteraemia Collaborative
- ▣ NSW Falls Program
- ▣ Medication Safety
- ▣ Citizens Engagement Advisory Council (CEAC)
- ▣ Fostering of partnerships via the CEC Clinical Council
- ▣ Review of incident management data and investigations
- ▣ Participation in Statewide Incident Information Management System Project

3

Strengthen primary health care and continuing care in the community

- ▣ NSW Falls Program
- ▣ Citizens Engagement Advisory Council (CEAC)
- ▣ Clinical Leadership Program across NSW
- ▣ Partnerships with primary health care providers and managers
- ▣ Review of incident management data and investigations

4

Build regional and other partnerships for health

- ▣ Citizens Engagement Advisory Council (CEAC)
- ▣ Clinical Leadership Program provided across NSW
- ▣ Visits by CEC staff to health services across NSW
- ▣ Shared quality and safety reporting function with Department of Health
- ▣ Partnerships with key stakeholders within and outside health sector

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

5

Make smart choices about the costs and benefits of health services

- Quality Systems Assessment (QSA) Program
- Partnership with Department of Health regarding quality and safety data
- Participation in Statewide Incident Information Management System Project
- Release of incident management data and recommendations to the system
- Blood Watch program
- Medication Safety

6

Build a sustainable health workforce

- Clinical Leadership Program across NSW
- Recognition and Management of the Deteriorating Patient – *Between the Flags*
- Quality Systems Assessment (QSA) Program
- Recruitment of skilled workers to key positions within the CEC
- In-services and training opportunities available to all CEC staff

7

Be ready for new risks and opportunities

- Review of internal risk management framework and strategy
- Participation in Statewide Incident Information Management System Project
- Partnership with Department of Health regarding quality and safety data
- Special Reviews
- Undergraduate education in quality and safety
- Quality Systems Assessment Program



PERFORMANCE STRATEGIC PLAN 2005–2009

KEY RESULT AREAS AND GOALS TO ACHIEVE BY 2009

1. PUBLIC REPORTING

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

STRATEGIES 2005–09

- 1.1 Develop and deliver an annual public report on adverse events
- 1.2 Develop and deliver an annual public report on quality system improvements
- 1.3 Engage the community in an informed discussion around the quality and safety of health care

ACHIEVEMENTS DURING 2008–09

- 1.1 Bi-annual report of incident (IIMS) data (July–December 2008) issued in collaboration with DoH
- 1.2 Development of Clinical Focus Reports on
 - Management of Acute Care Syndrome (ACS)
 - Management of Tracheostomy and Tracheostomy Emergency
 - Use of Midazolam
 - Patient Falls
 - Transfer of the Unstable Patient
- 1.3 Chartbook 2007 on safety and quality indicators released
- 1.4 Chartbook 2008 underway
- 1.5 Citizens Engagement Advisory Council further developed

2. QUALITY SYSTEMS ASSESSMENT

Implement a Quality Systems Assessment (QSA) program across NSW Health, including identification of assessment criteria that allow themselves to be measured, benchmarked and trended over time

- 2.1 Develop the methodology for the QSA program
- 2.2 Conduct pilot QSA in two health services (one metro, one rural), then roll-out to all health services
- 2.3 Complete baseline measures based on NSW Department of Health assessment criteria across the system

- 2.1 QSA second stage development project completed
- 2.2 Staged roll-out of QSA program completed April 2008
- 2.3 Reporting of results and verification of data underway

3. INFORMATION MANAGEMENT

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

- 3.1 Develop and implement an Information Management Strategic Plan to support the work of the CEC
- 3.2 Work with the Department of Health to implement an incident and adverse event reporting system across NSW Health
- 3.3 Develop and implement effective information and reporting system for deaths associated with surgery and anaesthesia

- 3.1 Information Management Strategic Plan continued
- 3.2 Shared quality and safety reporting function with Department of Health established early 2007, continued
- 3.3 Surgical mortality database expanded; committees continue to meet, with secretariat services provided by the CEC

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

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

KEY RESULT AREAS AND GOALS TO ACHIEVE BY 2009	STRATEGIES 2005–09	ACHIEVEMENTS DURING 2008–09
4. CLINICAL IMPROVEMENT Assist health services to implement effective clinical improvement programs in partnership with clinicians	4.1 Assist health services to undertake quality improvement projects 4.2 Enhance professional skills within health services to implement effective improvement programs and methodologies 4.3 Conduct Statewide quality and safety initiatives	4.1 Existing programs developed. New programs launched in Recognition and Management of the Deteriorating Patient – <i>Between The Flags</i> . CPI workshops conducted via Clinical Leadership program 4.2 Collaborative initiatives with area clinical governance units and Department of Health; Clinical Leadership Program continued 4.3 Statewide programs in place in falls, medication safety, transfusion medicine, recognition and management of deteriorating patient
5. CAPACITY BUILDING Provide clinical leaders and the Clinical Excellence Commission with skills and tools to effectively lead quality and safety improvement	5.1 Develop and implement clinical leadership development and education programs 5.2 Identify the specific role of the CEC in the knowledge management framework under development 5.3 Support rural health services by identifying and developing individual CEC/health service initiatives 5.4 Develop capacity within the CEC to undertake special reviews	5.1 Statewide Clinical Leadership program continued, with over 200 participants in the two modules in 2008. A similar cohort is participating in 2009 5.2 Continued participation in Statewide knowledge management committees 5.3 Rural outreach in collaboration with rural area health services continued during 2008–09 5.4 Improving early pregnancy care project assessed the quality of new and enhanced public antenatal services at 46 regional and rural hospitals
6. ORGANISATIONAL DEVELOPMENT Design and build the Clinical Excellence Commission as an organisation characterised by excellence in governance	6.1 Strengthen the CEC's governance arrangements, particularly in relation to project management, communication and budget planning 6.2 Develop and implement robust risk management practices 6.3 Invest in the CEC's people 6.4 Develop strong partnerships	6.1 Risk management framework reviewed and incorporated into Audit and Risk Management Committee schedule 6.2 Range of professional development and education programs offered throughout the year, as outlined in teaching and training section of report 6.3 CEC continues to develop partnerships with stakeholders, such as Department of Health, area health services, GMCT, IMET, ACSQHC, SAX Institute, HCCC and the community
7. COMMUNICATION AND CULTURE CHANGE Influence current and future decision makers, at all levels of NSW Health, to apply improvement programs and methodologies	7.1 Develop and implement with health services, a communication strategy that provides the Minister, the CEC board, CEC Clinical Council, decision makers and the NSW health system with key safety and quality messages and evidence-based information 7.2 Work with area health services in effective uptake and implementation of workplace cultural change relating to clinical improvement strategies	7.1 Communications officer in place, website reviewed, Citizens Engagement Advisory Council (CEAC) further developed to assist with providing clear and effective community messages regarding health-related incidents and activities 7.2 Continued liaison with area health services by holding Board meetings in rural area health services, Clinical Council, directors of clinical governance. Staff working on CEC projects making regular visits to urban and rural public health organisations 7.3 Development of a project to explore ways of delivering quality and safety education at undergraduate level to NSW medical, nursing and allied health students



CLINICAL PROGRAMS AND PROJECTS

Quality Systems Assessment (QSA)

Aligns with CEC Key Result Areas:

- 2 Quality Systems Assessment
- 6 Organisational Development

Aligns with State Health Plan Objectives:

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

Aligns with Recommendations 64 & 66:

Final Report of the Special Commission of Inquiry – Acute Care Services in NSW Public Hospitals. Available at www.lawlink@nsw.gov.au

Description

- The QSA is a key component of the NSW Patient Safety and Clinical Quality Program and is one of the major system wide programs undertaken by the Clinical Excellence Commission (CEC)
- The QSA Program is a world first for the assessment of quality and safety processes in a health system
- The QSA methodology represents an innovative approach to the assessment of safety and quality in health care and is based on a risk management framework which aims to evaluate the systems and processes organisations have in place to control risks to patient safety using self assessment and independent verification
- The QSA engages all Public Health Organisations (PHO) in NSW which comprises eight Area Health Service (AHS), the Ambulance Service of NSW, Justice Health and The Children's Hospital at Westmead
- The QSA features a multi-level approach with assessment tools tailored to the different levels within each of the PHOs. This allows responses at the different levels of the organisation to be compared to assess the effectiveness of governing and reporting structures

- There are four components of the QSA (see Figure 1).

- 1 Completion of a self assessment survey**
- 2 Verification of the self assessment surveys** This will occur using: comparison of activity statements from each level to confirm operational dependencies and linkages: a 'desk top review' of cited documentation and an external audit process to verify a sample of the activity statements
- 3 Feedback and reporting to respondents, the health system and the community**
- 4 Development of improvement plans.** These would respond to the issues identified in the self assessment process. The improvement plans will be subject to review in subsequent QSA assessments.

Key achievements

- The QSA Statewide report: Summary of Findings from the Area Health Services and the Children's Hospital at Westmead was released in November 2008. This report presents the results of the first QSA self-assessment survey and provides a baseline measure of the performance of each level of the system in the implementation of various quality and safety programs and policies Report available <http://www.cec.health.nsw.gov.au>

The QSA is a key component of the NSW Patient Safety and Clinical Quality Program and is one of the major system wide programs undertaken by the Clinical Excellence Commission (CEC).



Figure 1. The QSA model

The four components of the QSA model

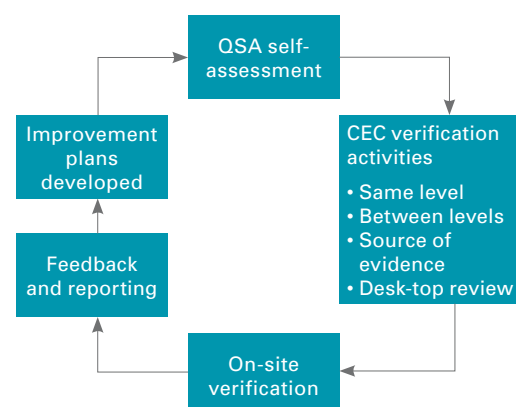
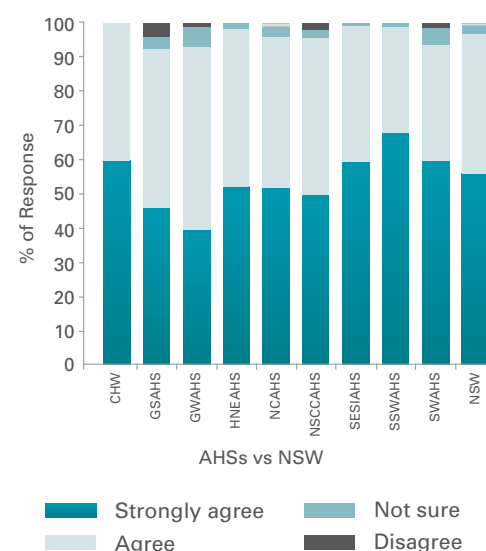


Figure 2. Department/clinical unit level response to the question: "Is there a positive safety and quality culture in the unit?"

At department/clinical unit level ninety seven per cent of staff believe that there is a positive safety and quality culture in their unit



- Analysis of results clearly identified areas of exemplary performance within the whole of the system, particularly in relation to incident management policies. It further identified areas for improvement, for example the need to develop standardised mortality review and peer review systems
- In response to the question "Is there a positive safety and quality culture in the unit?" 97 per cent of respondents strongly agreed/agreed (Figure 2). Given that the major developments in addressing system-wide clinical quality and the safety of patient care have occurred in the past ten years, such a positive response represents a strong endorsement of the impact of these measures
- The Statewide report made eleven key recommendations with each AHS expected to develop an improvement plan to address them as well as areas in which their own performance falls below the State average
- The CEC will regularly monitor and review progress around the improvement plans
- The findings from the initial QSA demonstrated not only that the program is an efficient assessment methodology but that it can yield a wealth of valuable information, based on which the CEC has made important new recommendations

for improving patient safety and quality of care

- The onsite verification program has been developed, piloted and will start in July 2009

Future directions

- As the QSA self assessment occurs annually, it has the capacity to continually provide the health system with contemporary insights regarding its key risks to patient safety and clinical quality
- Verification including on site visits will occur for a sample of respondents. The aim is to add further depth to information provided in the self assessment, identify areas of exemplary practice and innovation and to collect information that will be used to inform subsequent assessments
- Future QSA surveys will focus on areas requiring further policy development and identified high risk areas which impact on the quality and safety of care for patients

Challenges

- The challenge is to make the QSA of increasing practical value to departments, facilities or clinical streams and area health services



Patient Safety and Incident Management

Aligns with CEC Key Result Areas:

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

Aligns with State Health Plan Objectives:

- 1 Make prevention everybody's business
- 2 Create better experiences for people using health services
- 3 Strengthen primary health care and continuing care in the community
- 4 Build regional and other partnerships for health
- 6 Build a sustainable workforce
- 7 Be ready for new risks and opportunities

Description

The CEC's Patient Safety Program is aligned with the NSW Patient Safety and Clinical Quality Program, which seeks to deliver a standardised, system-wide approach to ongoing improvements in the safety and quality of health care provided across the NSW health system. A key component is analysis of Statewide clinical incident data within the Incident Information Management System (IIMS). IIMS continues to provide a wealth of information about how NSW Health staff address risks to safe and effective patient care. Root Cause Analysis (RCA) of serious incidents provides further detail of where clinical care systems can fail. The patient safety team recognises that the greatest benefit of the incident reporting system is provision of timely and open feedback to clinical staff, their managers and the patients and families they care for. In this way we can work together to provide the high level of clinical care for which NSW Health is recognised.

Achievements

During 2008-09, the newly expanded CEC patient safety team promoted learning from the information provided by IIMS by:

- Bi-annual public reporting of IIMS data
- individualised annual reporting to each area health service
- provision of de-identified IIMS data to clinical groups for State-level quality improvement.

The incident reporting system is also routinely monitored to identify trends or emerging issues. These are followed up with the relevant organisations and project groups, both within and external to the CEC.

There were several positive outcomes from the use of IIMS and RCA data during the year. These included a State equipment tender group analysing IIMS data to identify issues associated with use of infusion pumps used to administer fluids and medications intravenously. The findings of this analysis were then presented to a National workshop on medical devices to raise awareness of potential risks to patient safety. A group of trauma clinicians also used IIMS data to identify education needs for their staff.

The CEC's Patient Safety Program is aligned with the NSW Patient Safety and Clinical Quality Program, which seeks to deliver a standardised, system-wide approach to ongoing improvements in the safety and quality of health care provided across the NSW health system.

Another highlight has been the development of *Clinical Focus Reports* which utilise IIMS and RCA data to inform clinical staff about risks identified in relation to specific aspects of care.

One report on **Management of Acute Coronary Syndrome (ACS)** has been widely distributed and utilised. It highlights the importance of early recognition and treatment of ACS, regardless of which public hospital a patient attends. The actions prompted by this report have ranged from clinical practice improvement projects at the local (area health service) level to a State-level collaboration between the Rural Critical Care Taskforce, Greater Metropolitan Clinical Taskforce Cardiology Group, the Emergency Care Taskforce and the NSW Health Clinical Redesign Service. A Safety Alert Broadcast was also issued by NSW Health in response to the report findings.

Other *Clinical Focus Reports* released this year include:

Management of Tracheostomy and Tracheostomy Emergency Use of Midazolam
Patient Falls and Transfer of the Unstable Patient.

Review of RCA methodology started in February 2009 and culminated in a position paper which proposed strengthening of the methodology being forwarded to the Director-General at the end of June 2009.

The patient safety team also provides the secretariat for the NSW RCA Review Committee. The committee has developed a taxonomy to classify issues identified, so that more detailed analysis can occur.

Future directions

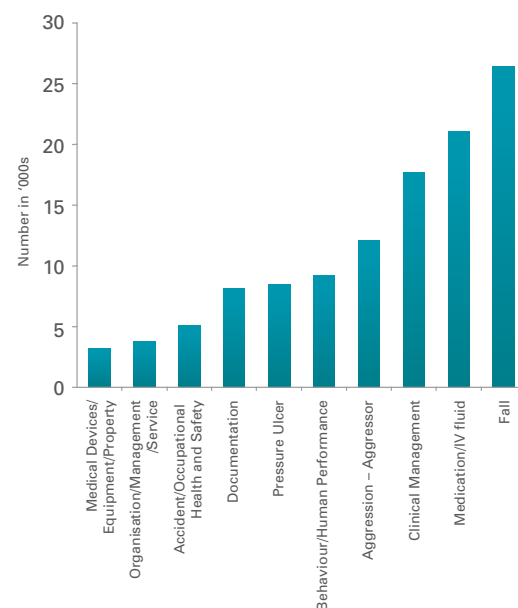
To further facilitate ongoing learning from the incident reporting system, the CEC is also working with the University of NSW, which obtained an Australian Research Council Linkage Grant, to improve analysis and understanding of the impact of human error in health care incidents.

Together, we are also developing training for NSW Health staff who lead RCA teams, to improve identification of human factors within serious clinical incidents.

Challenges

- Maintaining a focus on reporting
- Improving the quality of RCAs undertaken

Figure 3:
Shows the most frequently reported incident types in IIMS 2008–2009





Clinical Leadership Program

Aligns with CEC Key Result Areas:

- 5 Capacity building
- 6 Organisational development

Aligns with State Health Plan Objectives:

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

Description

The CEC Clinical Leadership Program was launched in 2007, with over 400 participants completing the Modular or Statewide programs in the first two years. Similar enrolments have been evident in 2009, indicating that the program is well received and beneficial to the health system.

The Modular Program is delivered as five intensive modules in Sydney, to senior clinician managers. The Statewide Program is multidisciplinary, delivered in five modules by local Facilitators within an area health service.

The value of investing in clinical leadership programs has been highlighted in recent Statewide (Garling) and national (National Health and Hospitals Reform Commission) reports. Both reports support the linkage of leadership with patient safety and governance, recognising that patients and staff are at the heart of health care.

Key achievements

Evaluation of the CEC Clinical Leadership Program

A major undertaking in 2008 was the completion of an interim evaluation of the Clinical Leadership program. The report reviewed program outcomes and made recommendations for future consideration.

It highlights a number of lessons from the first two years and provides recommendations for future directions.

Findings from the evaluation report demonstrate that the concept of a CEC CLP is strong and that the content is well aligned to participants' needs. In many cases, the expectations of participants and other stakeholders were exceeded. Outcomes of the Program have resulted in improvements in clinical processes and systems due to the leadership behaviours of participants. Some stated that the Program has contributed significantly to their decision to remain working in NSW Health.

ABOVE

Participants in the 2008 Modular Clinical Leadership Program – Presentation Day, 8 November 2008

BACK ROW LEFT TO RIGHT:

Greg Hugh (GWAHS), Frank Moloney (GWAHS), Michael Golding (SESIAHS), James Donnelly (SESIAHS), Doug Andrews (NCAHS), Stuart Turner (HNEAHS), Pablo Fernandez- Penas (SWAHS),

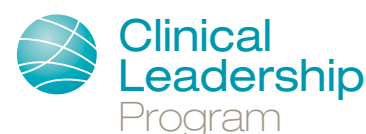
MIDDLE ROW LEFT TO RIGHT:

Christine Packer (GSAHS), Liz Mullins (Program Facilitator), Katherine Brown (SESIAHS), Wendy Cox (Director CGU SESIAHS), Leonie Watterson (NSCCAHS), Joanne Ging (NSCCAHS), Frances Monypenny (NSCCAHS), Kathryn Carmo (CHW), Mark Cross (SSWAHS), Helen Gillespie (NSCCAHS), Keven Quan (GWAHS)

FRONT ROW LEFT TO RIGHT:

Wolfgang Weninger (SSWAHS), Michael Peregrina (NSCCAHS), Patricia Saccasan-Whelan (GSAHS), Mark Dexter (SWAHS), Bernie Harrison (CEC), Bruce Barraclough (CEC Board), Teresa Pudo (CEC), Kay Wright (CEC).

The CEC Clinical Leadership Program was launched in 2007 and over 400 participants have completed the Modular or Statewide programs in the first two years.



A statewide initiative of the
Clinical Excellence Commission

Recommendations from the evaluation report are strongly in favour of the continuation of such a program within NSW. The recommendations suggest a mixture of program and system enhancement, some of which the CEC can lead and others would be in collaboration with the Department of Health and area health services. A key theme in the recommendations is the need for ongoing funding of the program, to ensure that gains are maintained and program sustainability is addressed.

"The true capacity building in the CEC CLP is the development of leaders who work with staff on local initiatives in context. There is considerable evidence that highlights the extent to which leadership behaviours that enable and develop others in work teams was an outcome of the CLP"
Evaluation Report

The Modular program

- Thirty senior clinician managers successfully completed the Modular Program in 2008 and a further forty are expected to also successfully complete the 2009 program
- A re-union day held in November 2008 for the 2007 modular participants with a video-link presentation by Dr Brent James, Intermountain Health Care, Utah

- A clinical service challenge was completed by each participant with most using Clinical Practice Improvement methodology to improve a health care process. This has served to equip participants to be advocates for patient safety along with assisting them to integrate health system improvement into their everyday clinical practice

The Statewide program

- Over 170 people successfully completed the program in 2008 and 180 people are expected to successfully complete in 2009
- Rural facilitators are providing support to the Institute of Rural Clinical Services and Teaching Clinical Team Leadership Program, which is based on and integrates with the CEC Statewide CLP

A booklet, showcasing clinical improvement projects undertaken in the 2007 CLP (Statewide and Modular) is now available.

Future directions

The CEC will actively promote the continuation of the Clinical Leadership Program, building on linkages between leadership, patient safety and governance within the NSW Health system.

Challenges

- To build on and sustain the momentum gained in 2008 in delivery of both the Modular and Statewide programs
- To ensure continued funding of the programs



Between the Flags

Aligns with CEC Key Result Areas:

- 4 Clinical improvement
- 7 Communication and culture change

Aligns with State Health Plan Objectives:

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

Description

Failure to recognise and appropriately manage deteriorating patients is a significant issue in hospitals and health care organisations around the world. The Garling Inquiry into Public Hospitals has further highlighted this issue in NSW.

The Clinical Excellence Commission (CEC) has worked in close collaboration with the Greater Metropolitan Clinical Taskforce (GMCT), an expert group of clinicians and the Quality and Safety Branch of NSW Department of Health to develop the *Between the Flags* Program. The Program is specifically designed to establish a 'safety net' in all NSW public hospitals and health care facilities that reduces the risks of patients deteriorating unnoticed and/or failing to receive appropriate care in response to their deterioration.

The program uses the analogy of Surf Life Saving Australia where Lifeguards and LifeSavers aim to keep people safe by ensuring they are under close observation, and, should something go wrong, are rapidly rescued.

The "Five Element Strategy"

The essential components of a sustainable *Between the Flags* Program are:

1. Establish guidelines for a governance structure to oversee sustainable implementation in all the State's acute hospitals
2. Minimum standards for the criteria used for early recognition of the deteriorating patient (clinical observation and 'track and trigger' system)
3. Minimum standards for a process of escalation of concerns and a rapid response to the deteriorating patient (Rapid Response System).
4. Minimum standards for key performance indicators to be collected, collated and utilised to inform the users of the system and those managing the implementation and continuation of the strategies
5. Tiered education packages aimed at ensuring skills for the recognition and management of the deteriorating patient, awareness of the track and trigger and rapid response systems and essential skills and knowledge necessary to operate in the Rapid Response System

Between the Flags Program, was specifically designed to establish a 'safety net' in all NSW public hospitals and health care facilities that reduces the risks of patients deteriorating unnoticed and/or failing to receive appropriate care in response to their deterioration.



Key achievements

- Establishment of the *Between the Flags* Management Committee to oversee the Statewide implementation of the Program
- Development and endorsement of a Standard Adult General Observation (SAGO) Chart for use in all facilities
- Development of a learning package for all clinical staff who are first line responders, to enhance their understanding and management of clinical deterioration called: Detecting Deterioration Evaluation Treatment Escalation and Communication in Teams



- Key Performance Indicators developed in collaboration with clinical experts, and leaders in the field
- Engagement of key stakeholder groups from metropolitan and rural facilities, medical, nursing and allied health professional backgrounds
- Development of a Draft Policy in conjunction with the Department of Health Quality and Safety Unit, for Statewide implementation of the Program

- Development of an implementation toolkit, including a template Implementation Plan for all Areas to complete
- Agreement to a timeframe for full implementation by the end of October 2010

Publications

Between the Flags Project:
'The Way Forward, October 2008

Between the Flags Project:
Interim Report, November 2008

Future directions

- The Program will be launched in October 2009
- A paediatric component of the program is also under development and there will be a specific maternity variation to the chart
- Development of a State-wide database to collect and report on performance of the Between the Flags Program

Challenges

- The challenging timeframes for implementation, given the major culture change that is required across the system. A key determinant of the success of the Program will be the delivery of the education components to all relevant staff across the NSW public health system
- The establishment of governance structures and processes to support program implementation is another key success factor
- Concerns that standardisation will override and undermine local efforts by clinical leaders who have long been advocating the need for such a system
- Maintaining dialogue, listening and learning, working with clinical and administrative colleagues to make sure that the above challenges do not become barriers to implementation.



Reducing Central Line Associated Bacteraemia in Intensive Care Units (CLAB-ICU)

Aligns with CEC Key Result Areas:

- 4 Clinical improvement
- 7 Communication and culture change

Aligns with State Health Plan Objectives:

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

Description

Central line associated bacteraemia (CLAB) is a recognised preventable complication of central line insertion and contributes to patient morbidity and mortality. International studies show that compliance with evidence based insertion processes can reduce the incidence of CLAB.

The Central Line Associated Bacteraemia in Intensive Care Units project (CLAB-ICU) is a NSW initiative that aimed to improve patient outcomes by reducing CLAB in 36 participating ICUs. It was based on the work of Pronovost et al (*Pronovost P, Needham D, Berenholtz S, et al, 2006, An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU, The New England Journal of Medicine, Vol 355, No 26, pp2725-2732*). The project was overseen by the Intensive Care Coordination and Monitoring Unit (ICCMU) and the Clinical Excellence Commission, with the cooperation of the NSW Health Department of Health, Quality and Safety Branch.

An expert group of clinicians was established to develop a guideline and checklist to promote standardised aseptic central line insertion.

The checklist was used to implement and measure compliance with the guideline. Completed checklists were analysed to monitor the CLAB rate and provide regular reports to participating units.

The CLAB-ICU project has affirmed international studies that compliance with evidence based bundles of care can reduce the incidence of CLAB.

Key achievements

Data collected from over 12 000 checklists shows that the CLAB-ICU project has resulted in a 60 per cent decrease in CLAB rates in participating intensive care units (ICUs). The current rate is 1.2 infections per 1000 patient line days. This is consistent with international best practice. The success is considered to be multifactorial including increased aseptic insertion, greater communication between intensive care and infection control practitioners and increasing ownership by intensive care clinicians following reporting of individual ICU CLAB data.

Central line associated bacteraemia (CLAB) is a recognised preventable complication of central line insertion and contributes to patient morbidity and mortality.



Future directions

The CLAB-ICU project has influenced policy at a Statewide level and planning is underway to implement the principles of the project hospital wide.

The CLAB-ICU checklist has been modified to apply beyond the ICU and to create a more comprehensive record of the insertion. This record will be printed in triplicate to facilitate local auditing.

The project team is leading the development of an online data collection and reporting system for CLAB, to ensure that reporting to Intensive Care Units remains accessible and timely. The system is an important first step towards providing real-time reports to clinicians.

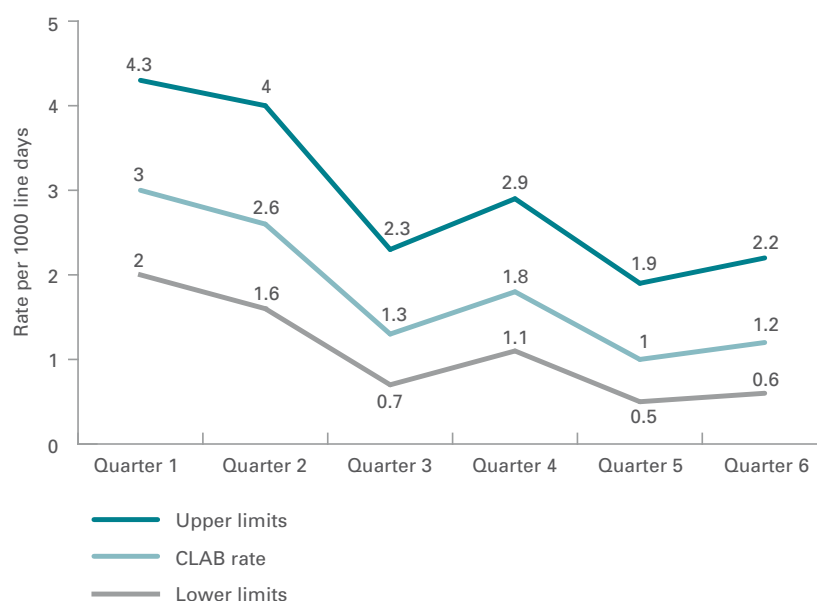
The team has also facilitated the development of a standardised procedure pack for purchase across the State and an educational framework to support new clinicians to perform central line insertion safely.

Challenges

The key challenge facing the CEC and ICU clinicians is to sustain the excellent results of the CLAB-ICU project in the intensive care environment in the long term and to assist in the roll out of the project principles hospital wide.

Figure 4:
CLAB rate/1000 line-days by Quarterly project periods

This graph shows a 60 per cent reduction in the incidence of CLAB during the 18 month period to December 2008





Hand Hygiene

Aligns with CEC Key Result Areas:

- 1 Public Reporting
- 4 Clinical Improvement
- 7 Communication and culture change

Aligns with State Health Plan Objectives:

- 1 Make prevention everybody's business
- 2 Create better experiences for people using health services
- 3 Strengthen primary health care and continuing care in the community
- 4 Build regional and other partnerships for health
- 5 Make smart choices about the costs and benefits of health services
- 6 Build a sustainable health workforce
- 7 Be ready for new risks and opportunities

Description

Hospital acquired infections can be life-threatening, especially for people with serious pre-existing conditions, and are a significant problem in all health care systems. We know that improving hand hygiene among health care workers is currently the single most effective intervention to reduce the risk of health care associated infections.

In 2006-2007 the CEC conducted the successful Clean Hands Save Lives Campaign and made 12 key recommendations for the NSW health system. (<http://www.cec.health.nsw.gov.au/files/clean-hands/publications/final-report.pdf>)

In July 2008, CEC coordinated a re-audit of hand hygiene compliance across the State. This showed that those Area Health Services that continued to apply the strategies employed during the campaign continued to improve. Overall however the NSW hand hygiene compliance rate fell from 62.2 per cent in February 2007 to 57.9 per cent in July 2008.

A report was provided to all AHSs and NSW Department of Health in August 2008. The report is available on www.cec.health.nsw.gov.au

In February 2009, the CEC was nominated by the NSW Department of Health to coordinate the implementation of the National Hand Hygiene Initiative (NHHI) in NSW as part of the program developed by Hand Hygiene Australia (HHA) for the Australian Commission on Safety and Quality in Health Care.

The National Hand Hygiene Initiative is based on the "5 Moments for Hand Hygiene" promoted by the World Health Organization (WHO) – World Alliance for Patient Safety campaign – "Clean Care is Safer Care" program. The 5 moments are:

1. Before touching a patient
2. Before a procedure
3. After a procedure
4. After touching a patient
5. After touching the patient's environment.

Program activities include auditing hand hygiene compliance through training and accreditation of Gold Standard Hand Hygiene Assessors; placement and use of alcohol-based hand rub (ABHR); collection of *Staphylococcus aureus* bacteraemia (SAB) data as the key outcome measure and education of health care workers.

ABOVE

World Hand Hygiene Day on 5 May was a real opportunity to press home the message that good hand hygiene saves lives! CEC had a stand in Martin Place, Sydney and staff spread the word of the importance of hand hygiene by showing passers-by how to use alcohol based hand rubs and distributing leaflets on hand hygiene.

LEFT TO RIGHT:
Teresa Mastroserio, Kay Wright, Annette Pantle, Maree Connolly, Kimberley Fitzpatrick, Sharon Hogan.

Improving hand hygiene among health care workers is currently the single most effective intervention to reduce the risk of health care associated infections.

Clean hands save lives 

Key achievements

- Responded to Recommendation 87 of the Final Report of the Special Commission of Inquiry – Acute Care Services in NSW Public Hospitals that *within 9 months the CEC to review appropriateness of Bare Below the Elbows Policy*. Report provided to NSW Department of Health ahead of schedule
- Oral presentation of the Clean Hands Save Lives Campaign at the International Quality Forum in Berlin (March 2009)
- Recruitment of Jurisdictional Project Officer at CEC, to implement training of key health care workers across NSW as Gold Standard Assessors (April 2009)
- Infection Control Professional Hand Hygiene Initiative Workshop (1 May 2009)
- World Hand Hygiene Day – Martin Place, Sydney (5 May 2009)
- Start of rolling schedule of Gold Standard Assessor training in GSAHS (May 2009) and SESIAHS (June 2009).

Future directions

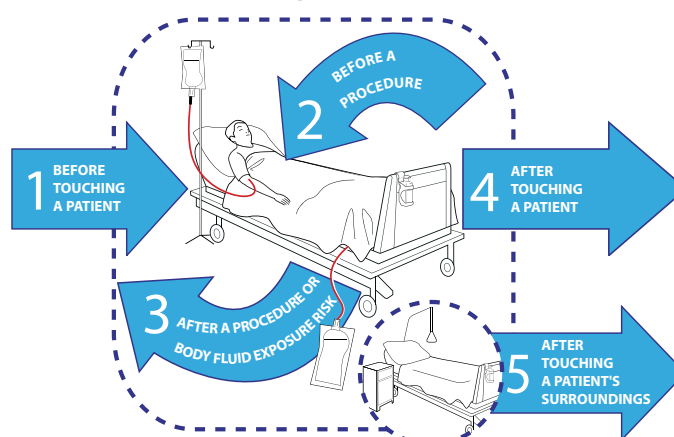
- Staged implementation of Gold Standard Assessor training across all NSW health facilities
- Statewide data collection for hand hygiene compliance and SAB
- Participate in the review of the Statewide contract for hand hygiene products
- Advocate consistent Infection Prevention and Control Governance Structures across NSW.

Challenges

- Ensuring a clear governance structure for Infection Prevention and Control at all levels of the system
- Geographical size and number of NSW health facilities requires NSW to move progressively to audit program using the “5 moments for hand hygiene” and that all hospitals submit data using this tool by June 2010 (Agreement with HHA)
- Participation in Hand Hygiene Initiative requires complex process of training, collection and Alcohol Based Hand Rub (ABHR) placement and usage audits.

Figure 5:
Five Moments for Hand Hygiene

Your 5 moments for hand hygiene at the point of care





Chartbook

Aligns with CEC Key Result Areas:

- 1 Public reporting
- 3 Information management

Aligns with State Health Plan Objectives:

- 1 Make prevention everybody's business
- 3 Strengthen primary health care and continuing care in the community
- 5 Make smart choices about the costs and benefits of health services
- 7 Be ready for new risks and opportunities

Description

As part of its goal to provide assurance through credible public reporting, the CEC publishes an annual chartbook of health system indicators. Preparation of the second edition commenced in August 2008. It is now complete and in press with 84 indicators and accompanying text. The second edition builds on the first containing 63 charts and accompanying text that was released the previous year and was very well received by the health system.

Expert analysis and advice has been provided by the placement within the CEC of a trainee biostatistician from NSW Health's biostatistical training program, and the creation of a permanent biostatistical position.

The Chartbook demonstrates that the NSW health system is doing a number of things well, e.g., a significant sustained reduction in asthma admission rates following the introduction of the State Asthma Plan in 2001 and a decline in the rate of live term births with a low APGAR (viability) score.

It also highlights areas which need improvement – like the increasing need for treatment of diabetes across most of NSW, and areas that require further investigation – such as significant Aboriginal health differentials and differences in hysterectomy rates between urban and rural areas for women under 35 that may indicate differences in practice.

The Chartbook is a tool to drive change, to facilitate self-examination by doctors, nurses and health professionals and managers of our health care system. The real value of a tool such as *The Chartbook* is that it allows us to monitor quality improvement initiatives over time and keep our eyes firmly focussed on those areas where the greatest quality gains are to be made.

As part of its goal to provide assurance through credible public reporting, the CEC publishes an annual chartbook of health system indicators.

Key achievements

Following the success of the first edition, and clinician feedback, the second edition expands analysis into areas including Aboriginal health, neonatal intensive care, ambulance cardiac care, and reports on a series of safety and quality indicators. The second edition also introduced thematic maps for selected indicators.

The CEC Chartbook series provides:

- ▣ a tool for measuring and reporting safety and quality in the NSW health system at a State and Area Health Service level
- ▣ a key resource for driving change within the NSW health system
- ▣ a simple overview of the state of knowledge of the safety and quality of health care services in NSW for use by the public and non-specialist audiences
- ▣ relevant time-series information in tabular and graphical formats, with interpretive text that interprets the findings, and describes the importance and implications for Area Health Services and clinical governance units
- ▣ reports on outcomes of key initiatives of the CEC and NSW Health that address safety and quality issues.

Future directions

Preparation of the third edition – Chartbook 2009 – is underway. Several proposals regarding how the document can be made more relevant to clinicians, the health system and the public are being considered. Suggestions include different analyses, different ‘views’ of the analyses and different ways of presenting the data. The more relevant it is, the more health professionals will be enabled to identify and take up opportunities for improvement. Importantly, the more accessible it is, the more the public – the people we serve – will be informed about the safety and quality issues of health care in NSW and how these are changing over time.

Challenges

Ensuring that the information contained in Chartbook is fresh and relevant for clinicians and accessible to the public without over simplifying important issues.

Ensuring that the information contained in Chartbook is fresh and relevant for clinicians and accessible to the public without over simplifying important issues.



NSW Falls Prevention Program

Aligns with CEC Key Result Areas:

- 4 Clinical improvement
- 7 Communication and culture change

Aligns with State Health Plan Objectives:

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

Description

The NSW Falls Prevention Program aims to reduce falls and fall injury among older people and takes a quality improvement approach to enhancing patient safety, generating a low-risk population, improving the effectiveness of health and other systems, reducing adverse events. Each Area Health Service has a falls prevention plan and the CEC Program Leader and Project Officer liaise with Area Health Service Falls Prevention Co-ordinators in the development and implementation of initiatives across community, hospital and residential aged care settings.

Falls in hospital are the most commonly reported incident notified in the Incident Information Management system (IIMS). Reducing falls and fall injury are important components of patient safety and the implementation of best practice falls prevention guidelines is a priority. There is evidence that the biggest effect for improvements in fall injury in older people and reduction in admissions to hospital will be the implementation of community-based initiatives. Building capacity within the system and developing partnerships with other agencies is a priority.

Achievements

Department of Veterans Affairs Innovative Funding Grant – Falls Prevention using QuickScreen® Project

Workshops trained 120 health professionals on falls prevention and the use of *QuickScreen®* (a Falls Risk Assessment Tool). This project highlighted that there was good engagement by community clinicians but there is a need for resources to enable comprehensive falls risk assessment and coordination of referrals for follow-up

Distribution to Area Health Services Falls Prevention CD/DVDs. Four hospital-based scenarios show specific fall related incidences and provide best-practice interventions

Falls Prevention is everyone's business: 1st April – April Falls Day supporting Area Health Services to raise awareness and provide information in hospitals, and community settings

29 April CEC April Falls Day Showcase focussed this year on key good practice falls initiatives

in hospital (community-based fallers presenting to Emergency Departments, medication prescribing and falls, education and ward falls champions)

ABOVE

In February 2009 Area Falls Coordinators from around the state attended a workshop at the CEC

LEFT TO RIGHT:
Lorraine Lovitt – CEC, Kathy Richardson – South Eastern Sydney/Illawarra, Ingrid Hutchinson – CEC, Patsy Bourke – Hunter/New England, Mary-Clare Maloney – North Coast, Esther Vance – NSW Falls Prevention Network, Jackie Kelly – Greater Southern, Sue Weston – Greater Southern, Jenny Bawden – Sydney West, Margaret Armstrong – Northern Sydney/Central Coast

The NSW Falls Prevention Program aims to reduce falls and fall injury among older people and takes a quality improvement approach to enhancing patient safety, generating a low risk population, improving the effectiveness of health and other systems, and reducing adverse events.



- ❑ in the community (care for high-risk fallers in the community, exercise programs) and
- ❑ in residential aged care sector (managing falls risk and providing exercise)
- ❑ **Videoconference forum** held with 203 participants across 10 sites in Greater Western Area Health Service. Key experts provided updates in research evidence and Area initiatives
- ❑ One hundred and ninety six professionals attended **NSW Falls Prevention Network Forum** from hospitals, community services, residential aged care, local government and the community sectors. This year CD/DVDs of this event are available for distribution
- ❑ **Community Resources Review Project.** A review of the types of evidence-based falls prevention information and resources currently available for consumers and recommendations for the development of future materials in NSW
- ❑ The Program Leader is a member of the National Injury Prevention Working Group (NIPWG) which has a number of priorities for falls prevention activity across the continuum of care

Future directions

- ❑ The development of a new Statewide plan and evaluation framework to prevent falls in older people in 2009/10
- ❑ The Program Leader is a member of an Expert Advisory Group to review the falls prevention best-practice guidelines for hospitals and residential aged care, conducted by the Australian Commission on Safety and Quality in Health Care. The revised versions will be available for distribution in early 2010 and will include community best-practice guidelines.

Challenges

- ❑ Limited capacity of workforce to evaluate good models of practice
- ❑ The need to re-skill the workforce in meeting the care needs of an older frailer population who are at risk of a fall
- ❑ Maintain the high level of involvement of clinician groups and the benefits that have accrued from the project

Falls in hospital are the most commonly reported incident notified in the Incident Information Management System.



Blood Watch – Transfusion Medicine Improvement Program

Aligns with CEC Key Result Areas:

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

Aligns with State Health Plan Objectives:

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

Description

The CEC Blood Watch Program coordinates the implementation of improvements in transfusion practice across NSW based on priority areas identified by the NSW Health's Fresh Products Advisory Committee which is now the Blood Clinical and Scientific Advisory Committee.

Key improvement objectives include

- the establishment of clinical governance structures such as Transfusion Committees
- improving the appropriateness of transfusion of fresh products through the vetting of transfusion requests
- developing and implementing education strategies to inform and support changes in clinical practice
- consistent quality reporting of adverse events through systems such as IIMS
- establishing a flow of information patterns between the CEC, NSW Health, clinicians, patients and other key stakeholders.

Within each Area Health Service local transfusion improvement teams made up of nursing, scientist and medical clinicians with expertise in transfusion, drive and support local initiatives to sustain transfusion best practice.

Key achievements

- The Red Cell Utilisation results for 2006–2008 show an average 10 per cent reduction in usage for all inpatient activity in NSW hospitals despite an increase in hospital activity. This reduction equates to a direct product cost of \$2,383,855 savings (based on AU\$260 per unit). This figure is inclusive of the Commonwealth Government's 63 per cent contribution to the State's blood budget. Local red cell audits support this downward trend
- The BloodSafe e-Learning program, endorsed by the CEC, has been supported and implemented across most NSW public hospitals. Over 4000 NSW registrants have successfully completed the modules on blood administration and safety
- The CEC, in partnership with the National Blood Authority, ran a highly successful communications campaign directed at senior orthopaedic and cardio thoracic surgeons with the aim of influencing their prescribing behaviours. The multi-channel approach included direct email marketing to the target group, advertising in key publications and an on-line debate at www.thetransfusionquestion.com.au which was supported by an international "virtual faculty".

The CEC Blood Watch program coordinates the implementation of improvements in transfusion practice across NSW based on priority areas identified by the NSW Health's Fresh Products Advisory Committee which is now the Blood Clinical and Scientific Advisory Committee.



Over 1700 unique visitors entered the site during the three month campaign and they spent an average 4.05 minutes reading the debates. Visitors from over 40 countries entered the site and over 60 comments were posted on the debate pages.

Challenges

- Continuous improvement of transfusion practice and sustaining those improvements

Future directions

- Extension of The Transfusion Question campaign to other surgical specialties such as gastroenterology, obstetrics and gynaecology and anaesthetics
- Implementation of Blood Watch work plan 2009-2011 with particular emphasis on the recognition and treatment of iron deficiency anaemia as a way of reducing inappropriate red cell transfusion
- Evaluation of the Blood Watch program
- Establishment of a haemovigilance reporting system

The cost of blood should influence the decision to prescribe

A transfusion will increase your patient's risk of wound infection

Two units are better than one

30% of all red blood cell transfusions are inappropriate



Examples of **The Transfusion Question** advertisements used to drive clinicians to the on-line debate.



Medication Safety Self Assessment (MSSA)

Aligns with CEC Key Result Areas:

- 3 Information management
- 4 Clinical improvement

Aligns with State Health Plan Objectives:

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

Description

The Clinical Excellence Commission is actively involved in improving the quality and safety of medicines use. The medication safety/quality use of medicines program of the CEC has focussed around the provision of tools and resources which enable hospitals to analyse and improve their systems. The major tools developed have been the:

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

These tools provide hospitals with a method of assessing their medication management systems for inherent risks. They also provide a mechanism for measuring performance improvement over time.

In addition to providing these tools, the Clinical Excellence Commission has actively supported facilities in completing them, and in responding to the results obtained.

The Clinical Excellence Commission is actively involved in improving the quality and safety of medicines use.

The medication safety / quality use of medicines program of the CEC has focussed around the provision of tools and resources which enable hospitals to analyse and improve their systems.

Key achievements

- The MSSA has been completed by over 200 hospitals nation wide including 139 in NSW
- Facilities completing the tools have been from all Australian States and from both the public and private sectors
- Health Departments in South Australia and Victoria have begun actively supporting the MSSA
- The Australian Commission on Safety and Quality in Health Care has approached the CEC, seeking approval to actively promote use of the MSSA and MSSA-AT tools at a national level
- An in depth analysis of data submitted by 84 NSW public hospitals was conducted and a report on the findings released in November 2008
- Results obtained using the MSSA have been presented at national and international conferences
- Data obtained using the Medication Safety Self Assessment has been instrumental in informing NSW medication safety initiatives
- A number of the Indicators for Quality Use of Medicines in Australian Hospitals have been adopted by the Australian Council on Health care Standards (ACHS) and included in their Hospital-Wide Clinical Indicators set and their Adverse Drug Reaction Clinical Indicator set

Future directions

- The CEC will continue to support and promote the MSSA and MSSA-AT tools and the Indicators for Quality Use of Medicines in Australian Hospitals
- The CEC is currently in discussions with the International Society of Oncology Pharmacy Practitioners about the development of a Chemotherapy Safety Self Assessment which can be used by Australian hospitals to analyse their chemotherapy related practices and systems
- The CEC will continue to work with individual hospitals and Area Health Services in developing medication safety action plans informed by data collected using the CEC medication safety tools

Challenges

The MSSA tools have been very useful in identifying opportunities for improving medication management systems. The challenge is to move from this diagnostic process to active systems improvement.

A review of IIMS data by the CEC identified a medication incident, reported in an area health service, where a patient received a higher than normal dose of a widely-used pain-relief agent, fentanyl, when being transported to hospital. The patient had been quickly treated and sustained no ongoing harm from the incident. The CEC advised the ambulance service of the incident.

The Statewide IIMS database was searched to see if there were other similar incidents related to use of this medication. A review of international literature was also undertaken. Although only a small number of incidents were identified (mostly SAC3), when the information was conveyed to the ambulance service, they responded promptly by:

- reviewing and adjusting their pain-relief protocol
- conducting internal review of all relevant cases
- advising staff of the incident so that this effective medication could continue to be used safely

The reporting of near-miss incidents, such as this one, is an essential component of a learning culture, as it can help to prevent harm to future patients.



Quality Education

Undergraduate Quality & Safety Education

Aligns with CEC Key Result Areas:

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

Aligns with State Health Plan Objectives:

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

Description

Through the work of the Clinical Excellence Commission and other bodies, the principles of quality and safety and role modelling safe behaviour now receives some emphasis as part of postgraduate training in medicine, nursing and allied health. However, there is surprisingly little of this type of teaching in the undergraduate years.

In January 2009 the CEC established a project to explore ways of delivering quality and safety education to NSW medical students. This project was subsequently broadened to include Nursing and Allied Health Schools.

Key Achievements

- A literature review of quality and safety teaching in undergraduate health courses in Australia and internationally. This included a review of the WHO Patient Safety Curriculum Guide for Medical Schools which will provide the basis for some of the modules to be used in the CEC undergraduate teaching program
- An audit of quality and safety teaching in NSW Medical, Nursing and Allied Health schools, followed by visits to key schools to discuss proposals for quality and safety teaching

The principles of quality and safety and role modelling safe behaviour now receive some emphasis as part of postgraduate training in medicine, nursing and allied health.

- ❑ Liaison with the U.S. Institute for Health Care Improvement to gain free access to their Open School, an on-line course in quality and safety designed specifically for students
- ❑ Broad interest from Medical, Nursing and Allied Health schools in working with them to provide quality of safety courses for their students
- ❑ Agreement with one medical school and one nursing school to deliver a modular quality and safety teaching course commencing in 2010. This will also include a teach the teacher component

Future directions

- ❑ A workshop: "Why wait until graduation? Teaching the principles of safe care in the undergraduate years" featuring Professor David Mayer and attended by clinical teachers from across the State will be held in September 2009
- ❑ Providing elective courses in Q&S for students in addition to the core Q&S program to be undertaken by all students. Emphasis would be on cross-disciplinary electives
- ❑ The establishment of a series of post-graduate Fellowships in Quality and Safety as a way of providing the next generation of leaders in this field. This has already received support from GMCT and IMET
- ❑ Discussions with the learned Colleges to have quality and safety modules taught to undergraduates count towards postgraduate training

Challenges

- ❑ Obtaining teaching time in already overcrowded undergraduate curricula
- ❑ Providing teaching in a form which is interactive, exciting, stimulating and which encourages students to learn more about this field
- ❑ Securing funding for the Fellowship program

The CEC established a project to explore ways of delivering quality and safety education to NSW medical students. This project was subsequently broadened to include Nursing and Allied Health Schools.



Information Management Initiatives

Supporting CEC's information initiatives and reporting activities

Aligns with CEC Key Result Areas:

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

Aligns with State Health Plan Objectives:

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

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

Key achievements

The CEC Information Directorate has provided support and advice regarding:

- the QSA, Blood Watch, CLAB-ICU, CHASM and SCIDUA databases
- records management and TRIM
- privacy, security, secure storage, and disposal of paper and electronic record collections

Future directions

The Information Directorate continues to have a key support role for all functional areas within CEC.

Challenges

The biggest challenge remains providing and supporting an adequate range of services and technologies and meeting NSW legislative regulations in a relatively small organisation.

The CEC's Information Management Team supports all CEC programs in their acquisition, use and management of information.

Website

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

Key achievements

- The CEC Information Directorate has started a review of the website particularly looking at functionality, corporate presence and ease of use
- The CEC website receives thousands of unique visitors and download requests every month. It is a key component of our ability to disseminate our work and make it easily available to clinicians and the public

Future directions

Following the review, a new-look website will be launched. (*Note: due to the retrospective nature of Annual Reports, visitors clicking on the link will see the new completed site launched in Sept 2009).

Challenges

Ensuring that the website is up to date and informative

The CEC website receives thousands of unique visitors and download requests every month.





The Collaborating Hospitals' Audit of Surgical Mortality (CHASM)

Aligns with CEC Key Result Areas:

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

Aligns with State Health Plan Objectives:

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

Description

The Collaborating Hospitals' Audit of Surgical Mortality (CHASM) is an external, independent peer review audit of surgically related deaths in NSW. It is supported by the NSW State Office of the Royal Australasian College of Surgeons (RACS), the NSW Clinical Excellence Commission (CEC) and NSW Health.

CHASM is overseen by a Committee, which was established under section 20 of the *Health Administration Act 1982* and appointed by the Minister for Health. Its terms of reference are to review hospital deaths that occur within 30 days after an operation or during the last hospital admission under the care of a surgeon, irrespective of whether or not an operation has been performed. The CHASM peer review methodology is based on the Scottish Audit of Surgical Mortality established in 1994. Information collected for CHASM is privileged from subpoena under section 23 of the same Act.

CHASM is a partner of the Australian and New Zealand Audit of Surgical Mortality (ANZASM), which coordinates the development and implementation of surgical mortality audits in the two countries.

Key achievements

- From 1 July 2008 to 30 June 2009, CHASM:
 - Recorded 2231 deaths notified by all Area Health Services
 - Received 1128 Surgical Case Forms providing information about the deaths from surgeons; representing a response rate of 50.6 per cent
 - Completed the audit of 800 (35.9 per cent) notified deaths
- By June 2009, 563 surgeons were participating in CHASM, with 261 of them also agreeing to be first line assessors and 185 to be second line assessors
- Figure 5 shows the percentage distribution of participating surgeons by surgical specialties. General Surgery, Orthopaedics, Urology, Neurosurgery and Vascular Surgery are the top five surgical specialties participating in CHASM

The Collaborating Hospitals Audit of Surgical Mortality (CHASM) is an external, independent peer review audit of surgically related deaths in NSW.

- At the April 2009 meeting, the CHASM Committee endorsed widening of the current audit scope to include paediatric surgical deaths
- The CEC and the Western Australia Safety and Quality of Surgical Care Project at Curtin University of Technology jointly developed an electronic reporting template to produce an individual report for all participating surgeons in CHASM

Future directions

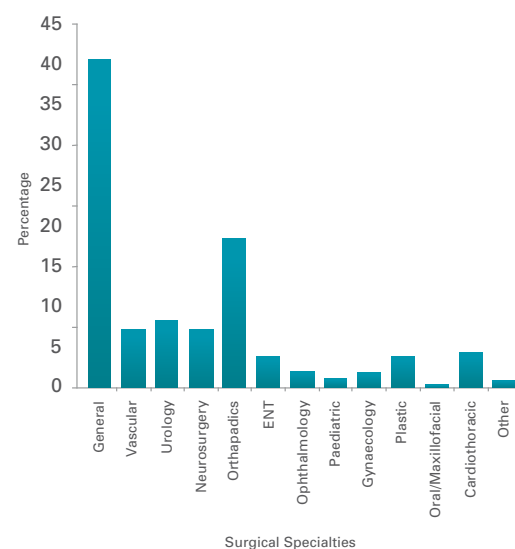
- CHASM will produce the following reports for the period from 1 January 2008 to 30 June 2009
 - First program report
 - Individual surgeon reports
 - A report for Area Health Services
- The CHASM Committee will develop a plan of actions to address adverse events and areas of concerns identified from the audit

Challenges

- Improve the efficiency and effectiveness of the business processes that support the auditing of an annual estimate of 2,500 to 3,000 deaths
- Encourage surgeon participation in and as assessors for CHASM
- Ensure that process is of value to participating surgeons

Figure 6:
Total number of participating surgeons = 563

Shows the total number of surgeons participating in CHASM – 563 – by surgical specialty



The CEC and the Western Australia Safety and Quality of Surgical Care Project at Curtin University of Technology jointly developed an electronic reporting template to produce an individual report for all participating surgeons in CHASM.



Special Committee Investigating Deaths Under Anaesthesia (SCIDUA)

Aligns with CEC Key Result Areas:

- 1 Public reporting
- 3 Information management
- 4 Clinical improvement

Aligns with State Health Plan Objectives:

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

Description

The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) was established in 1960, and is the longest serving committee of its kind in the world. It is an expert committee appointed by the Minister for Health under section 20 of the *Health Administration Act 1982*.

SCIDUA reviews deaths which occur while under, as a result of, or within 24 hours after the administration of anaesthesia or sedation for procedures of a medical, surgical, dental or investigative nature to identify any area of clinical management where alternative methods could have led to a more favourable result. Information collected for SCIDUA is privileged from subpoena under section 23 of the same Act.

Key achievements

- From 1 July 2008 to 30 June 2009, SCIDUA:
 - Recorded 186 deaths notified via the coronial mechanism
 - Completed the review of 199 cases
 - Classified 176 cases
- SCIDUA submitted a report on audits undertaken in 2008 to the Minister for Health
- At its June 2009 meeting, SCIDUA elected Dr David Pickford as the next Chairman to succeed Professor Ross Holland, when his term expires in August 2009

The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) was established in 1960 and is the longest serving committee of its kind in the world.

Future directions

- SCIDUA will continue to work with NSW Health to include the reporting of deaths to SCIDUA in the new Public Health Bill
- SCIDUA will explore the feasibility of online notification

Challenges

Ensure that all deaths that fall within the scope for review are reported to SCIDUA.

SCIDUA reviews deaths which occur while under, as a result of, or within 24 hours after the administration of anaesthesia or sedation for procedures of a medical, surgical, dental or investigative nature.





Special Reviews and Audits

Aligns with CEC Key Result Areas:

- 1 Public reporting
- 3 Information management
- 4 Clinical improvement

Aligns with State Health Plan Objectives:

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

There were no Special Reviews conducted under the *Health Services Act 1997* for the reporting period.

However, we can report that the NSW Department of Health engaged the CEC to conduct an audit on the implementation of the Improving Early Pregnancy Care Project which resulted from the Hughes/Walters Inquiry when a woman had a miscarriage in the Emergency Department at Royal North Shore Hospital.

Aim of the Improving Early Pregnancy Care Project

The aim of the project was to provide a coordinated and integrated Statewide service for women encountering problems in early pregnancy (prior 20 weeks gestation) with greater access to quality health care and support in a timely and sustained manner.

This included:

- ❑ Establishing fourteen Early Pregnancy Units (EPUs)
- ❑ Establishing thirteen Early Pregnancy Assessment Services (EPAS)
- ❑ Providing improved access to publicly funded antenatal clinics across regional and rural NSW
- ❑ Providing improved access to publicly funded, hospital based, shared models of antenatal care

The role of the CEC was to conduct on-site audits at each of the fourteen hospitals with new Early Pregnancy Assessment Services (EPAS) and Early Pregnancy Units (EPU) and to assess the quality of the services provided to women with problems in early pregnancy.

Role of the CEC

The role of the CEC was to conduct on-site audits at each of the fourteen hospitals with new EPAS and EPUs and the eight hospitals with established EPAS and EPUs to assess the quality of the services provided to women with problems in early pregnancy. In addition, audits were conducted to assess the quality of new and enhanced public antenatal services at 46 regional and rural hospitals in NSW.

Key achievements

- Audit of 22 EPUs and EPAS completed on time and on budget
- Audit of 46 public antenatal services completed on time and on budget
- Individual reports provided to all hospitals involved in the audits
- Commenced a prevalence study on the service delivery characteristics of women who present with problems in early pregnancy
- Commenced an audit on the telephone advice line for women to call when they have a problem in early pregnancy
- Commenced an ethics application to conduct a small qualitative study on women's experience of early pregnancy care in Emergency Departments

Future directions

- Complete the prevalence study and the audit of the telephone advice line
- Achieve ethics approval and commence the qualitative study
- Communicate the findings on the Improving Early Pregnancy Care Project to the community and health care providers in NSW

Audits were conducted to assess the quality of new and enhanced public antenatal services at 46 regional and rural hospitals in NSW.



CORPORATE GOVERNANCE STATEMENT

This statement sets out the main corporate governance practices in operation throughout the 2008–09 financial year.

The CEC Board

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

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

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

Board membership consists of a chair, ten other non-executive members and the chief executive officer. One of the co-chairs of the Clinical Council attends board meetings on an ex-officio basis.

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

- Setting strategic directions
- Ensuring compliance with statutory requirements
- Monitoring organisational performance
- Monitoring the quality of health services
- Board appraisal
- Community consultation
- Professional development

The board identifies each member, noting the:

- Qualifications, specific skills and experience they bring to the board
- Term of appointment of board members
- Frequency of 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. They include advice of the external auditor (the Auditor-General or the nominee of that office), the internal auditor (IAB Services), who is available to give advice direct to the board, and professional advice.

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

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

Strategic directions

The board has in place processes for the effective planning, delivery and monitoring of programs and projects to improve the safety and quality of health care in NSW. These include the setting of strategic direction for the organisation and providing strong and positive leadership on patient safety and quality. For the major period of this report the CEC worked to Strategic Plan 2005-2008. In March 2009 the Board approved the Strategic Plan to set the direction for the remainder of 2009 to 2012.

Code of ethical behaviour

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

Risk management

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

The Board approved the appointment of IAB Services to perform internal audit. This is associated with moving away from transactional issues to reviewing key processes that support day to day work on safety and quality, eg a review of project management processes. The board receives and considers all reports of the external and internal auditors and, through the Audit and Risk Management Committee, ensures that audit recommendations are implemented.

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

Committee structure

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

Performance appraisal

The board has processes in place to:

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

A Board Review was conducted in March 2009.



CEC Board

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

Professor Bruce H Barraclough AO

Bruce Barraclough is Chair of the Board of the NSW Clinical Excellence Commission. He is President of the International Society for Quality in Health Care, Board Chair, Australian e-Health Research Centre, Associate Dean (clinical strategy) of the University of Western Sydney Medical School, Chair of a WHO working party to develop a medical school curriculum in Safety and Quality and is a Senior Clinical Advisor to NSW Health Minister and Director-General, NSW Health. He was President of the Royal Australasian College of Surgeons (1998–2001), Professor / Director of Cancer Services, Northern Sydney Health and the University of Sydney, (2000–2005) and Chair of the Australian Council for Safety & Quality in Health Care (2000–2005).

Board Chair since:
1 February 2005

Appointment expires:
31 January 2010

Professor Clifford Hughes AO

Cliff Hughes is the CEO of the Clinical Excellence Commission in NSW. For 25 years, until January 2005, he was a Senior Partner in an extremely busy cardiothoracic surgical practice at Sydney's Royal Prince Alfred Hospital. He has led five medical teams to China and performed numerous cardiac (open heart) procedures in six provinces in China. He has also operated in Hong Kong, Singapore, Malaysia, India and Bangladesh. He was a Member of the Australian Council on Safety and Quality in Health Care and chaired taskforces on Safe Hours, Fatigue and Device Tracking. He holds fellowships in the Royal Australasian College of Surgeons, the American College of Surgeons, the American College of Cardiology and the American College of Chest Physicians as well as the Cardiac Society of Australia and New Zealand. He was awarded the Order of Australia in 1998 for "service to cardiac surgery, international relations and the community".

Board member since:
1 February 2005

Appointment reviewed:
4 January 2010



Dr Alan Amadeo

Alan Amodeo has over twenty years experience in the private and public health care 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. He has a strong commitment to the community including many years in various positions on the board of Telstra Child Flight.

Board member since:
1 February 2005

Appointment expired:
31 January 2009



Major General Peter Dunn AO (retired)

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

Board member since:
1 February 2005

Appointment expires:
31 January 2010



Professor Phillip Harris AM

Phillip Harris is a Clinical Director of the Cardiovascular Service in Sydney South West Area Health Service, the Chair of the Patient Care Committee at Royal Prince Alfred Hospital and former Head of the Department of Cardiology and the Division of Medicine. He is Clinical Professor of Medicine at The University of Sydney, a former Board member of the Heart Foundation and Heart Research Institute and past President of the Cardiac Society of Australia and New Zealand and the National Heart Foundation of Australia (NSW Division).

Board member since:
1 February 2005

Appointment expires:
31 January 2010



CEC Board (CONTINUED)

Dr Mark Henschke OAM

Mark Henschke has been a Visiting Medical Officer (VMO) (GP/Obstetrician) at the Armidale Rural Referral Hospital since 1981. He has taught medical students and worked as a supervisor in the GP training programs since 1990. In 2007 he was awarded RAMUS (Rural Australian Medical Undergraduate Scheme) Mentor of the Year for his work with medical graduates interested in a career in rural General Practice. He has also been an examiner for the Diploma of Obstetrics (DRANZCOG) for more than 20 years.

In 2005, he was awarded the Order of Australia Medal (OAM) for his *'Services to medicine as a General Practitioner and to the community of Armidale'*.

Board member since:
18 August 2008

Appointment expires:
31 January 2011

Robyn Kruk AM

Robyn Kruk has extensive executive experience in human services, natural resources and central agencies. She has served as the Director-General of NSW Health (2002–2007) and the Director-General of NSW National Parks and Wildlife (1994–1998). Robyn also held executive positions in both the NSW Cabinet Office and the Department of Premier and Cabinet, culminating as Director-General of the Department of Premier and Cabinet (2007–2008). Robyn is the Deputy Chair of the Reforming States Group (RSG). The RSG is a US based not for profit organisation to support reform in the delivery of health services. She is currently Secretary of the Commonwealth Environment, Water, Heritage and the Arts portfolio.

Board member since:
3 February 2009

Appointment expires:
31 December 2012

Professor Ron McCallum AO

Ron McCallum is Professor of Labour Law in the Faculty of Law of the University of Sydney. He was formerly Dean of Law University of Sydney from July 2002 to September 2007, and formerly Blake Dawson Waldron Professor in Industrial Law from January 1993 to September 2007. He is a Deputy-Chair of Vision Australia, and also Chair of Radio for the Print Handicapped of NSW Cooperative Ltd which operates 2RPH for vision impaired and other print handicapped listeners. He is the inaugural President of the Australian Labour Law Association and was the Asian regional Vice-President of the International Society for Labour and Social Security Law from 2006 to 2009. He has assisted with the drafting of labour legislation for the NSW and Queensland governments. In January 2009, he commenced his two year term as a member of the United Nations Committee on the Rights of Persons with Disabilities whose function it is to monitor the United Nations Convention on the Rights of Persons with Disabilities. In February 2009, he was appointed as the General Rapporteur of this Committee.

Board member since:
3 December 2007

Appointment expires:
31 January 2010



Associate Professor Brian McCaughan AM

Brian McCaughan is a cardiothoracic surgeon and his major clinical interest is the management of lung cancer. He is a Clinical Associate Professor at the University of Sydney and held a number of positions with the Royal Australasian College of Surgeons culminating in the Chairmanship of the NSW State Committee from 1992 to 1994. He was a member of the Ministerial Advisory Committee on Quality in Health Care. He was appointed to the NSW Health Council, and served as the President of the NSW 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. He was recently awarded Member of the Order of Australia for his services to medicine.

Board member since:
1 February 2005

Appointment expires:
31 January 2009

Noel O'Brien OAM

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

Board member since:
1 February 2005

Appointment expires:
31 January 2010

Professor Janice Reid AM

Janice Reid has been Vice-Chancellor and President of the University of Western Sydney since 1998. She is a recipient of several awards and honours both in Australia and overseas, and has been a member of the boards of public agencies at State and Federal levels in the areas of health information and research, welfare, schools, arts, higher education, energy and international relations. She is currently a member of: Unisuper Ltd Board; NSW Clinical Excellence Commission Board; Salvation Army Greater Western Sydney Advisory Board; and a Trustee of the Art Gallery of NSW. In January 1998 she was made a Member of the Order of Australia for services to cross-cultural public health research and the development of health services for socio-economically disadvantaged groups in the community, and in 2003 received the Centenary Medal for service to Australian society through health and university administration.

Board member since:
3 December 2007

Appointment expires:
31 January 2010



CEC Board (CONTINUED)

Dr Gabriel Shannon

Gabriel Shannon has practised as a General and Renal Physician at Orange in central western NSW since 1980. He helped establish renal dialysis services and a diabetic education centre in Orange servicing the surrounding area in the early 1980's. In 2001 he took a senior staff specialist position at Orange and became the Director of Physician Training at that site. In 2002 he was appointed Sub Dean of the Orange Campus of the School of Rural Health, University of Sydney. He is currently Clinical Leader of the Clinical Governance Unit, Greater Western Area Health Service.

Board member since:
19 August 2008

Appointment expires:
31 January 2011

Professor Debra Thoms

Debra Thoms completed her general nursing education at Prince Henry/ Prince of Wales Hospitals, Sydney and her midwifery education at the Royal Darwin Hospital, NT. She holds a Bachelor of Arts in economics and Psychology and a Masters of Nursing Administration. In addition she holds a Graduate Certificate in Bioethics and an Advanced Diploma in Arts in History. She has worked in metropolitan, rural and remote health settings in NSW, the Northern

Territory and South Australia in both acute and community health services. Prior to starting as the Chief Nursing Officer of NSW in May 2006, Debra was the Chief Nursing Officer of South Australia. She was made an Adjunct Professor Nursing at the University of Technology, Sydney in 2003.

Board member since:
3 December 2007

Appointment expires:
31 January 2010

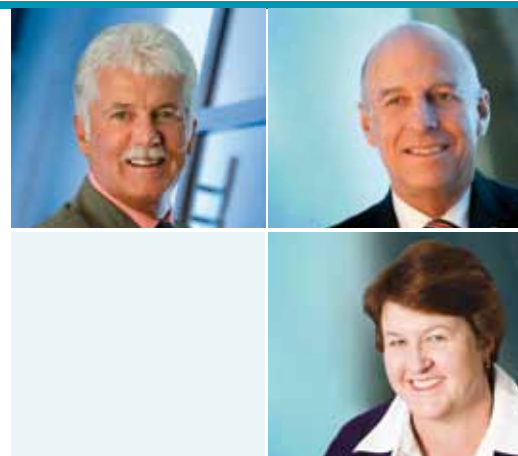
Table 1: Board member meeting attendance 2008–09

The board meets bi-monthly.

Directors	19 Aug 2008	6 Nov 2008	16 Dec 2008	17 Feb 2009	21 Apr 2009	23 June 2009
Prof B Barraclough	✓	✓	✓	✓	✓	✓
Dr A Amodeo	✓			Term ended 31 Jan 09		
Maj Gen P Dunn	✓	✓	✓			✓
Prof P Harris		✓	✓	✓	✓	✓
Dr M Henschke	Appointed 18 Aug 08	✓	✓	✓	✓	✓
Prof C Hughes	✓	✓	✓	✓	✓	✓
R Kruk	Appointed 3 Feb 09			✓	✓	✓
Prof R McCallum			✓	✓	✓	
Assoc Prof B McCaughan	✓	✓	✓	Term ended 31 Jan 09		
N O'Brien	✓	✓		✓	✓	✓
Prof J Reid	✓	✓	✓		✓	✓
Dr G Shannon	Appointed 19 Aug 08		✓	✓	✓	✓
Prof D Thoms	✓	✓		✓	✓	✓

**Board Sub-committee:
Audit and Risk Management**

LEFT TO RIGHT:
Noel O'Brien OAM (chair),
Major-General Peter Dunn AO,
Professor Debra Thoms



Board Sub-committee: Audit and Risk Management

Membership

Noel O'Brien OAM (chair)
Major General Peter Dunn AO
Professor Debra Thoms
Professor Clifford Hughes AO

In attendance

Deputy CEO
Representatives from IAB Services
Representatives from
NSW Audit Office
Manager Executive Support

The committee meets quarterly.

Objective

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

Functions

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

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

Activities include:

Internal Audit

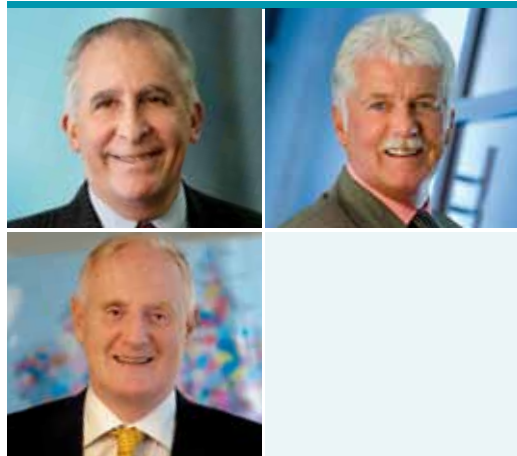
- ▣ Review and approval of the internal audit charter
- ▣ Concurrence with the service agreement with provider for the provision of internal audit function
- ▣ Review and approval of audit plans and budgets
- ▣ Review of audit results
- ▣ Suggestions for audit topics
- ▣ Support for communication with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

External Audit

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

Audit & Risk Management Committee meetings during 2008–09

15 July 2008
23 September 2008
16 December 2008
17 March 2009
23 June 2009



Board Sub-committee: Finance

LEFT TO RIGHT:
Dr Alan Amodeo (Chair),
Noel O'Brien OAM,
Professor Ron McCallum AO

Board Sub-committee: Finance

Membership

Dr Alan Amodeo (Chair)

Noel O'Brien OAM

Professor Ron McCallum AO

Professor Clifford Hughes AO

CEC staff in attendance

Deputy CEO

Finance Officer

Manager Executive Support.

The committee meets monthly, excluding January.

Objective

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

Functions

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

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

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

Finance Committee meetings during 2008–09

15 July 2008

19 August 2008

23 September 2008

21 October 2008

18 November 2008

16 December 2008

17 February 2009

17 March 2009

21 April 2009

19 May 2009

23 June 2009

Board Sub-committee: Research

LEFT TO RIGHT:

Professor Phillip Harris AM (Chair), Noel O'Brien OAM,
Professor Janice Reid AM, Dr Mark Henschke OAM



Board Sub-committee: Research

Membership

Professor Phillip Harris AM (Chair)

Noel O'Brien OAM

Professor Janice Reid AM

Dr Mark Henschke OAM

Professor Clifford Hughes AO

CEC staff in attendance

Deputy CEO

Manager Executive Support

The committee meets quarterly.

Objective

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

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 conjoint research
- Oversee the Ian O'Rourke PhD Scholarship

Research Committee meetings during 2008–09

15 July 2008

21 October 2008

17 February 2009

6 April 2009

19 May 2009



Citizens Engagement Advisory Council (CEAC)

LEFT TO RIGHT:

Cliff Hughes, Eda Calabria, Christian Damstra, Sue West, Mike Peterson, Peter Dunn, Darren Ah See, Ted Quan, Sandra Gav, Maha Abdo

ABSENT:

Don Palmer, David Hirsch, Ian Stewart

Board Sub-committee: Citizens Engagement Advisory Council (CEAC)

Membership

Major General Peter Dunn AO (Chair)

Maha Abdo

Darren Ah See

Christian Damstra

Sandra Gav

David Hirsch

Don Palmer

Ted Quan

Dr Ian Stewart

Sue West

Professor Clifford Hughes AO

Advisory Councils (AHACs), media specialists, medico-legal specialists and experienced health professionals.

The CEAC is continuing to develop working relationships with existing consultation mechanisms, such as AHAC's and other government initiatives and agencies. Representatives from four AHAC's were appointed as members of the CEAC in 2008–2009 and broader representation is planned for 2009–2010.

Key achievements

The CEAC has focused on communication in the health care setting and has guided the development of an exciting research project funded by the CEC.

The project is headed by Professor John Jenkins of the Southern Cross University and aims to increase understanding of communication and improve service quality in hospital emergency departments in NSW.

The project will gather information about the many aspects of communication used in emergency departments, including spoken and written words, voice quality and volume and tone, signage, technology and facility design. Hospitality and hotel management principles and practices will be applied to this information to develop education and training materials designed to improve service quality in emergency departments.

CEAC has supported CEC projects by assisting the project officers with community insights and advice on how to engage with the community to facilitate the spread of important health care information. Two projects that have benefited from CEAC assistance are Hand Hygiene and Early Pregnancy Care.

Future directions

The CEAC is focussing on key messages to promote and develop community awareness of quality and safety issues.

It is working closely with CEC project officers to facilitate consumer engagement in CEC projects and is guiding the development of project communication plans for specific CEC projects.

The CEAC is conscious of the differences that exist between consumers and clinicians and is looking to develop resources that will empower patients in their relationships with health providers.

Challenges

A variety of mechanisms exist across NSW to draw information from the community regarding their health care experience. The CEAC must continue to tap into these existing mechanisms and focus on using this feedback to drive quality and safety improvements.

In attendance

Deputy CEO

Manager Executive Support,
(to May 2009)

CEAC Project Officer
(from May 2009)

CEC Media Advisor

Description

The CEAC was established to provide a two way path for information on quality and safety matters in the NSW health system to be provided to the general community and for the community to pass views into the health system. The CEAC has been established as a sub-committee of the Board of the CEC. It comprises members with experience in safety in other industries (for example mining), representatives of various cultural communities, representatives of Area Health

The CEC uses videoconferencing for its monthly Clinical Council meetings. This facility allows busy clinicians around the state to take an active part in the meetings without the need for time consuming and expensive travel



Clinical Council

Membership

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

Professor Mary Chiarella* (co-chair)
 Dr Austin Curtin (co-chair)
 Patricia Bradd
 Professor Patricia Davidson
 Anthony Dombkins
 Phillip Ebbs
 Julie Gawthorne
 Dr Bill Lancashire
 Dr Michael McGlynn*
 Dr Sandy Middleton
 Anne Moehead
 Dr Fenton O'Leary
 Dr Gabriel Shannon
 Dr Ajeet Sidhu
 Trent Taylor
 Penny Thornton*
 Catriona Wilson

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

Description

The Clinical Council was established in April 2005 to contribute to the development and delivery of the Commission's programs and to advise the Board on strategies to achieve comprehensive clinician participation. The Clinical Council is comprised

of a group of practicing clinicians representing a variety of disciplines from across the State including nursing, medical, allied health and ambulance service who have volunteered to participate on the council. Council is currently chaired by Dr Austin Curtin (a rural specialist surgeon and chair of the Institute for Rural Clinical Services and Teaching). Prior to April 2009, Professor Mary Chiarella (former Chief Nurse of NSW and currently a professor of Nursing at the University of Sydney) was Co-Chair.

Activities

The group meets monthly via videoconference and twice yearly in a face-to-face workshop. It provides advice on strategies to engage doctors, nurses, allied health professionals and managers in the development of programs to improve the safety and quality of health services in NSW. Council also assists in the development, communication and implementation of the Commission's programs, discusses the development of strategic solutions to systemic safety and quality issues and members act as advocates across the NSW health system about the importance and benefits of a Statewide approach to improving safety and quality in health care.

Key achievements

- Continuance of an issues-based agenda whereby each month two council members report on issues of significance to their area of practice or AHS which are amenable to Statewide action
- Development of a project proposal for funding in collaboration with GMCT and GP NSW to improve the recognition and management of delirium in older people (response to issues raised by Council members).

Future directions

- Consolidate achievements of 2008–2009
- Convene a workshop to examine issues around transfer of care in October 2009 and develop practical solutions for implementation (response to issues raised by Council members).

Challenges

- Variety of interests and priorities of a diverse range of clinical members
- Coordination of multiple sites of regular videoconferencing meetings
- Review of membership has been on hold awaiting outcome of Garling Inquiry.



OUR PEOPLE

Staff profile

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

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

Deputy Chief Executive Officer
Clinical Practice Improvement
Patient Safety
Health System Improvement
Information Management
Organisation Development and Education, incorporating Quality Systems Assessment.

Professor Kim Oates commenced in November 2008 as Director, Undergraduate Quality and Safety Education (p/t).

Dr Charles Pain commenced in June 2009 as Director Health System Improvement.

The number of full-time equivalent staff at 30 June 2009 was 35.3, (4.5 of these medical).

Full-Time Equivalent Staff at 30 June:

2008–2009	35.30
2007–2008	29.87
2006–2007	29.63
2005–2006	23.76
2004–2005	13.70

Executive reports

Name:

Professor Clifford F Hughes AO

Health Service:

Clinical Excellence Commission

Period in Position:

18 January 2005 to 30 June 2009

Strategic Initiatives

- Continued development of additional strategies in key portfolios of Quality Systems Assessment, Clinical Practice Improvement Projects, Information Management and Organisation Development and Education
- Provided Statewide leadership, support and guidance for clinical practice improvement projects, including falls; medication safety; transfusion medicine; CLAB-ICU, recognition and management of the deteriorating patient – *Between the Flags*
- Rollout of the first QSA survey across all Area Health Services, Ambulance Service and Justice Health
- Continuation of Statewide Clinical Leadership Program
- Publication of second and third bi-annual reports of IIMS Statewide data
- The first annual CEC Chartbook – 2007 containing NSW safety and quality indicators released and *Chartbook* distributed to all wards and workplaces across NSW Health
- *Chartbook* 2008 completed
- Blood Watch Transfusion Medicine Improvement Program has reduced inappropriate use of blood products by approximately 10 per cent
- The Citizens Engagement Advisory Council (CEAC) has begun an extensive work program supervising the communication project with Southern Cross University
- Rollout of the Collaborating Hospitals Audit of Surgical Mortality (CHASM) has been completed in all Area Health Services and preliminary mortality assessments begun
- Developed strong partnerships which include regular meetings with the Quality and Safety Branch of the Health Department, the Greater Metropolitan Clinical Taskforce (GMCT) and the Institute of Medical Education and Training (IMET)
- The inaugural Ian O'Rourke Scholar, Dr David Peiris, is mid way through the final year of his three year doctoral research program and is progressing very well
- The Board of the CEC visited an Area Health Service and it is intended to continue such visits to country health facilities
- Each month between 30–35 meetings are sponsored at the CEC bringing six to 35 attendees to various work programs
- The CEC has engaged with Surgical Services Taskforce, Acute Care Taskforce and the Improving Early Pregnancy Care Project, with the Greater Metropolitan Clinical Taskforce, the Institute of Medical Education and Training and the Nursing and Midwifery Office

The CEC is committed to having a skilled and valued workforce, to enable it to meet key objectives.

Management accountabilities

- ▣ Appointment of a Director Health System Improvement
- ▣ Ongoing management of CEC projects in collaboration with executive staff
- ▣ Engagement of IAB Services as Internal Auditor
- ▣ All statutory and financial reporting requirements completed
- ▣ Review of legislative compliance
- ▣ Review of project management process
- ▣ Continued review and development of corporate risk register
- ▣ Development of performance review process
- ▣ Transition to Health Support Services for Finance, Human Resources and Payroll services

Equal employment opportunity

The CEC applies Department of Health EEO strategies regarding recruitment, and has developed a targeted professional development program to ensure that the skills and experience of its staff are enhanced during their periods of employment.

Ethnic affairs priority statement

In undertaking its core duties and in developing and implementing projects and strategies, the CEC is committed to supporting and endorsing the principles

of multiculturalism contained within the *Community Relations Commission and Principles of Multiculturalism Act 2000* and the white paper, *Cultural harmony: The next decade 2002 – 2012*.

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

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

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

- ▣ Continuing to fund a three-year PhD scholarship in indigenous health, via the Ian O'Rourke Scholarship
- ▣ Offering its services and knowledge to all people of NSW, irrespective of linguistic, religious, racial or ethnic background
- ▣ Broadening its multicultural staff base via merit-based recruitment

- ▣ Development of a Citizens Engagement Advisory Council, which links in with multicultural and indigenous agencies, and identifies strategies to enable the CEC to engage effectively with its diverse community
- ▣ Including representatives from multicultural communities to participate in project steering committees

Occupational Health & Safety

At 30 June 2009, the CEC had not received any workers compensation claims.

There were three reported incidents and corrective action taken in each instance to remove the hazard.

This year, as a staff health initiative, the CEC arranged a program of lunchtime, evening and weekend walks. While leaving the desk for even a short break can be a challenge, many staff joined the group's activities and felt better for it. A group of sixteen signed up for *City2Surf2009* and are planning to continue walking and even running together to maintain the health benefits gained. Both the CEO and Deputy CEO led by example and were active participants in the initiative.

Conference presentations

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

Training for the City2Surf2009

RIGHT:
Dr Annette Pantle, Lesley Harvey



Our People (CONTINUED)

Professor Clifford Hughes AO Chief Executive Officer

- ❑ CHASM Information Session and Surgeons Breakfast meeting, Tamworth & Armidale, 1 July 2008
- ❑ CZANZ, 11th Annual EP & Pacing Meeting, Barossa Valley, SA, 6–7 August 2008
- ❑ Statewide Medication Safety Committee, Strategic Planning Day (NSW Health), North Sydney, 14 August 2008
- ❑ NSW Child Health Networks Conference, Brighton Beach, Sydney, 4 September 2008
- ❑ RACS – Mastering Intercultural Communication in NSW, Darling Harbour, Sydney, 10 September 2008
- ❑ ACSQHC, Workshop on Antibiotic Stewardship, Sydney Airport, 11 September 2008
- ❑ Managing across the Generations, Overcoming Differences between Gen X, Y and Older Generations to achieve Win-Win Outcomes, Clinical Excellence Commission, 12 September 2008
- ❑ HSA Group Professional Conference, Coogee Beach, Sydney, 12 September 2009
- ❑ Charles Vincent, workshop with Senior Patient Safety Managers and Directors of Clinical Governance, Clinical Excellence Commission, 16 September 2008
- ❑ BUNSW AGM, Sydney Olympic Sports Centre, Homebush, Sydney, 18 September 2008
- ❑ National Blood Sector Conference, Coogee, Sydney, 6–7 November 2008

- ❑ Clinical Excellence Commission Conference, Measuring Hospital Performance, State Library of NSW, Sydney, 13 November 2008
- ❑ ACSQHC Innovation Workshop “Are you working in the Area of Patients at Risk?”, Sydney, 14 November 2008
- ❑ ACSQHC, Clinical Handover Workshop, Adelaide, 24 November 2008
- ❑ South Australian Health, Leadership Development, 18 December 2008
- ❑ Improving Learnings from Patient Safety Incidents – Clinical Handover and Patient Identification, UniNSW, Coogee Campus, 2 March 2009
- ❑ Human Factors in Health Care, Crown Plaza, Darling Harbour, 3 March 2009
- ❑ Patient Safety Seminar, University of Sydney, Darlington Centre, Sydney, 9 March 2009
- ❑ General Practice, NSW Forum, Sydney, 1 April 2009
- ❑ IIR 8th Annual Adverse Event Management Conference, Melbourne, 2–3 April 2009
- ❑ Clinical Excellence Commission April Falls Day, Sydney, 29 April 2009
- ❑ ACHSE 2009 State Conference, Sydney, 1 May 2009
- ❑ RACS 78th Annual Scientific Congress, Brisbane Convention & Exhibition Centre, 6–9 May 2009
- ❑ Clinical Senate, “NSW Directions: the Clinical Excellence Commission, the Garling Commission and NSW Plans”, Adelaide, SA, 25 May 2009
- ❑ Clinical Leadership Program, Sydney, 28 May 2009

- ❑ Quality Indicators Seminar, (Monash University), The Royal Prince Alfred Hospital, Sydney, 11 June 2009

Dr Annette Pantle Director Clinical Practice Improvement Projects

- ❑ Changing Health care Organisations, University of Technology, Sydney – Masters in Health Management Students, 27 October 2008
- ❑ Quality and Safety in Action, University of Technology, Sydney – Masters in Health Management Students, 9 March 2009
- ❑ Clinical Handover, NSW Health Acute Care Taskforce, 13 February 2009
- ❑ Risky Scenarios for Clinical Handover – What IIMS and RCA data tells us, NSW Health Acute Care Taskforce, 8 May 2009

Bernie Harrison Director Organisation Development & Education

- ❑ Guest lecture: Managing Quality, Risk and Cost in Health Care, University of Technology Sydney, 4 August 2008
- ❑ ‘Managing for quality – aligning your organisational efforts’, Centre for Clinical Governance Research Faculty of Medicine, University of NSW, 12 August 2008
- ❑ “Improving health care quality”, “Spot on DD” Conference, Sydney, 4 September 2008
- ❑ “Bloodwatch – achieving change through data”, National Blood Sector Conference, Sydney, 6 November 2008

- Blood Transfusions in 2008: Realising Potential and Managing Risk – Bloodwatch Program, Transfusion Outcomes Research Collaborative (TORC), a partnership between the Department of Epidemiology and Preventive Medicine at Monash University and the Australian Red Cross Blood Service, Monash University Melbourne, 19 November 2008
- Iron Deficiency – Anaemia Management National workshop with National Blood Authority, Sydney, 1 May 2009

Official overseas travel by CEC staff

Professor Clifford Hughes AO Chief Executive Officer

5th Mulu Rafflesia Heart Valve Symposium, & The Asia Pacific Warfarin Management Expert Advisory Panel Meeting, Danang, Vietnam. 25–31 August 2008.

25th International Conference of the International Society for Quality in Health Care in Copenhagen, Denmark, 19–22 October 2008.

Kings Fund, “Improving Patient Experiences” London, England, 27 October 2008.

Participation in Roundtable on Leadership for Improvement at The Clinical Leadership Symposium of The Health Foundation, London, 16 March 2009.

The International Forum on Quality and Safety in Health Care Held at The International Congress Centre in Berlin, 18–21 March 2009.

The Annual Conference of The Society of Cardiothoracic Surgeons of Great Britain and Ireland, Bournemouth, 22–24 March 2009.

The Second Annual Conference of The Guidelines and Audit Implementation Network of Northern Ireland (Gain), 25 March 2009.

Dr Annette Pantle Director Clinical Practice Improvement

Australasian Association for Quality in Health care Conference, Christchurch, New Zealand, 1–3 September 2008 – presented two papers and an interactive workshop on Quality Tools and Clinical Practice Improvement methodology.

* International Forum on Quality and Safety, Berlin, 17–20 March 2009.

Bernie Harrison Director Organisation Development & Education

Clinical Leadership Workshops (2), Ministry of Health, Fiji and Ausaid, Suva and Nadi, 10–14 November 2008.

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

Research

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

- The research committee has supervised work with the Southern Cross University, Centre for Clinical Governance Research, and the School of Aviation at the University of NSW
- The CEC is eligible, through its membership of the Centre for Health Record Linkage (CHeReL), to a large percentage of its membership fees back in data linkage services. Through its Research Committee, these services are available to the NSW Health system for research projects on health care safety and quality that require linked data. Further details and applications are available on CEC’s website
- In addition to regular reports to the public and to NSW Health, various staff members have been involved in scientific publications on topics including management of anticoagulation, hand hygiene, a systems evaluation of disaster pathways, and the management of implantation of cardiac pacemakers
- The CEC is a partner with the Sax Institute and the Greater Metropolitan Clinical Taskforce in the Hospital Alliance for Research Collaboration (HARC) which is a Statewide network committed to improving hospital services, and patients’ experiences through research.



Ian O'Rourke PhD Scholar

LEFT:
Dr David Peiris

Our People (CONTINUED)

Ian O'Rourke Scholarship in patient safety

The Clinical Excellence Commission awards one Ian O'Rourke Scholarship every three years in NSW. The inaugural awardee, Dr David Peiris, is approaching the final six months of his three year research program. Dr Peiris' doctoral study is entitled *Improving health outcomes for Indigenous Australians at high cardiovascular risk through strategies to reduce systems barriers to quality care*. The quality and quantity of David Peiris' work has been of a consistently high standard and he has made invited conference presentations, submitted successful conference abstracts and published journal articles over the last year. In addition some of his achievements/awards to date include

- 2009 Cross Cultural Public Health Research Award, Faculty of Medicine, University of Sydney
- Appointed Member, Information Computer Technology/Information Management Reference Group, Aboriginal Health and Medical Research Council
- Appointed Reviewer, RACGP/ Australian Primary Health Care Research Institute, National Research Awards Committee
- Appointed Technical Reference Group member advising the Department of Health and Ageing on Pharmaceutical Benefits Scheme Measures for the National partnership Agreement on Closing the Gap in Indigenous Health Outcomes

- Appointed Technical Reference Group member advising the Department of Health and Ageing on the development of Clinical Guidelines and Decision Support for the National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

David Peiris remains on track for the scheduled thesis submission date of March 2010.

Membership of Advisory Board

The CEC continued its membership of the Advisory Board Company in Washington DC, USA and our staff have used this valuable resource for research purposes.

Teaching and training initiatives

The CEC is committed to professional development of its staff. Sharing knowledge on safety and quality initiatives from around the world is fundamental to the work of the CEC. In response to this need, a development program provides regular opportunities and a forum for sharing information and knowledge.

Internal professional development courses and workshops have been held in the CEC – including presentations/workshops by CEC staff, journal club and external consultants. Topic areas have included:

- Patient Safety/Aviation Safety
- Managing across the generations – Baby Boomers/Gen X/Gen Y

- Basic Life Support
- eLearning – OD&E team presentation
- Patient Safety – team presentation
- Building Evaluation into CEC programs
- Special Committee Investigating Deaths Under Anaesthesia – Team presentation

Our community

Citizens Engagement Advisory Council

The role of the Citizens Engagement Advisory Council is outlined in more detail in an earlier section of this report (p.56). In summary, it is designed to:

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

The model complements existing links the CEC has with the Statewide Health Care Advisory Council, which is attended by the CEC chairman and a member of the Executive team and which provides a valuable link between the CEC and Area Health Care Advisory Councils.

The CEC is committed to professional development of its staff. Sharing knowledge on safety and quality initiatives from around the world is fundamental to the work of the CEC.

Sponsorship

The CEC provided sponsorship and hosted an information stand at the 6th Australasian Conference on Safety and Quality in health Care, in Christchurch New Zealand in September 2008.

Freedom Of Information (FOI) Report

In FOI statistical reports, agencies are required to report on the previous year and the current year.

A. New applications

During the 2008–09 financial year the Clinical Excellence Commission received one request for information under the *Freedom of Information Act 1989 (FOI)* and one of the four requests received the previous year was brought forward and three completed.

B. Discontinued applications

No applications were discontinued in the previous or current years.

C. Completed applications

In 2007–08, one application was granted in full, one application was granted in part and no documents were held for the third application. In the current year one application was granted in part and no documents were held for one application.

D. Applications granted or otherwise available in full

For the application granted in full in 2007–2008, all the documents requested were provided to the applicant.

E. Applications granted or otherwise available in part

In 2007–08 one application was granted in part and the documents were provided to the applicant. In the current year one application was granted in part and the documents were provided to the applicant.

F. Refused FOI Applications

No applications were refused in 2007–08 or 2008–09.

G. Exempt Documents

In 2007–08 there were no exempt documents. In 2008–09 one application was granted in part due to exempt documents under G7 (Documents affecting business affairs).

H. Ministerial certificates (S.59)

No Ministerial Certificates were issued in 2007–08 or 2008–09.

I. Formal consultations

In 2007–08 three applications required formal consultation and six persons were formally consulted. In the current year one application required formal consultation and ten persons were formally consulted.

J. Amendment of personal records

No personal records were amended in 2007–2008 or 2008–2009.

K. Notation of personal records

There were no applications for notation of personal records in 2007–2008 or 2008–2009.

L. Fees and costs

In the financial year 2007–2008 assessed costs relating to FOI requests were \$120 and \$120 was received. In 2008–2009 assessed costs were \$210 and \$210 was received.

M. Fee discounts

There were no fee waivers or discounts in 2007–2008 or 2008–2009.

N. Fee refunds

There were no fees refunded in 2007–2008 or 2008–2009 as a result of significant correction of personal records.

O. Days taken to complete request

In the period 2007–2008 two applications were completed within the statutory determination period and one application took 22–35 days to complete consultations. In 2008–2009 one application was completed in the statutory determination period and one application took 22–35 days to complete consultations.

P. Processing time – hours

In 2007–2008 two applications were processed in less than ten hours and one application was processed in 11–20 hours. In 2008–2009 one application was processed in less than ten hours and one application was processed in 11–20 hours.

Q. Number of reviews

There were no reviews undertaken in 2007–2008 or 2008–2009.

R. Results of internal reviews

Not applicable – see Q above



FINANCIAL REPORTS

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Financial Overview

For the year ended 30 June 2009

The audited financial statements presented for the Clinical Excellence Commission for the 2008-2009 financial year provide for a Net Cost of Services budget of \$11.648 million, against which the audited actuals of \$7.481 million represent a variation of \$4.167 million or 36%.

Activity has increased during this financial year and has resulted in higher expenditure than in previous years. However, the actual result was better than projected budget due primarily to lower than expected operational costs throughout the year.

This was due mainly to several projects which are still in their early stages of development for implementation in the current financial year. The result also reflects a higher than expected actual investment revenue which has contributed to a lower Net Cost of Services result.

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:

	2007-2008 \$000	2008-2009 \$000	Comparison \$000	Movement %
EXPENSES EXCLUDING LOSSES				
Employee Related	3,735	5,618	1,883	50
Other Operating Expenses	3,104	1,847	(1,257)	(40)
Depreciation and Amortisation	671	494	(177)	(26)
Grants and Subsidies	85	91	6	7
Total Expenses	7,595	8,050	455	6
Sale of Goods and Services	151	80	(71)	(47)
Investment Income	48	352	304	633
Grants and Contributions	55	132	77	140
Total Revenue	254	564	310	122
Gain/(Loss) on Disposal	(9)	5	14	(156)
Net Cost of Services	7,350	7,481	131	2

Certification of Financial Statement Overview

For the year ended 30 June 2009

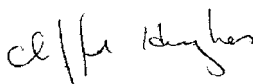
The attached financial statements of the Clinical Excellence Commission for the year ended 30 June 2009:

- i) Have been prepared in accordance with the requirements of applicable Australian Accounting Standards (which include Australian Accounting Interpretations), 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.
- iii) Have no circumstances which would render any particulars in the financial statements to be misleading or inaccurate;



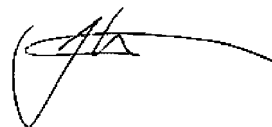
Professor Bruce Barraclough, AO
Chairman

22 October 2009



Professor Clifford Hughes, AO
Chief Executive Officer

22 October 2009



Mr Andre Jenkins
A/Director, Corporate Services

22 October 2009

Independent Audit Report

For the year ended 30 June 2009



GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

Clinical Excellence Commission

To Members of the New South Wales Parliament

I have audited the accompanying financial report of the Clinical Excellence Commission (the Commission), which comprises the balance sheets as at 30 June 2009, the operating statements, statements of recognised income and expense, cash flow statements, a summary of significant accounting policies and other explanatory notes for both the Commission and the consolidated entity. The consolidated entity comprises the Commission and the entities it controlled at the year's end or from time to time during the financial year.

Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Commission and the consolidated entity as at 30 June 2009, and of their financial performance for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2005

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

Chief Executive's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

Independent Audit Report (cont.)

For the year ended 30 June 2009

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

My opinion does *not* provide assurance:

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

Independence

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

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



Peter Achterstraat
Auditor-General

26 October 2009
SYDNEY

Operating Statement

For the year ended 30 June 2009

		PARENT			CONSOLIDATION		
	Notes	Actual 2009 \$000	Budget 2009 \$000	Actual 2008 \$000	Actual 2009 \$000	Budget 2009 \$000	Actual 2008 \$000
EXPENSES EXCLUDING LOSSES							
Operating Expenses							
Employee Related	3	0	4,961	0	5,618	4,961	3,735
Personnel Services	4	5,618	0	3,735	0	0	0
Other Operating Expenses	5	1,847	6,147	3,104	1,847	6,147	3,104
Depreciation and Amortisation	2(h), 6	494	490	671	494	490	671
Grants and Subsidies	7	91	50	85	91	50	85
Total Expenses excluding losses		8,050	11,648	7,595	8,050	11,648	7,595
REVENUE							
Sale of Goods and Services	8	80	0	151	80	0	151
Investment Revenue	9	352	0	48	352	0	48
Grants and Contributions	10	132	0	55	132	0	55
Total Revenue		564	0	254	564	0	254
Gain/(Loss) on Disposal	11	5	0	(9)	5	0	(9)
Net Cost of Services	22	7,481	11,648	7,350	7,481	11,648	7,350
GOVERNMENT CONTRIBUTIONS							
NSW Health Department							
Recurrent Allocations	2(d)	7,723	7,723	10,131	7,723	7,723	10,131
Acceptance by the Crown Entity of employee benefits	2(a)(ii)	114	55	56	114	55	56
Total Government Contributions		7,837	7,778	10,187	7,837	7,778	10,187
Result for the year		356	(3,870)	2,837	356	(3,870)	2,837

The accompanying notes form part of these Financial Statements.

Balance Sheet

As at 30 June 2009

		PARENT		CONSOLIDATION			
	Notes	Actual 2009 \$000	Budget 2009 \$000	Actual 2008 \$000	Actual 2009 \$000	Budget 2009 \$000	Actual 2008 \$000
ASSETS							
Current Assets							
Cash and Cash Equivalents	12	5,647	1,017	4,498	5,647	1,017	4,498
Receivables	13	539	419	419	539	419	419
Financial Assets at Fair Value	14	669	0	0	669	0	0
Total Current Assets		6,855	1,436	4,917	6,855	1,436	4,917
Non-Current Assets							
Plant and Equipment	15	569	917	604	569	917	604
Intangible Assets	16	1,311	1,105	1,747	1,311	1,105	1,747
Total Non-Current Assets		1,880	2,022	2,351	1,880	2,022	2,351
Total Assets		8,735	3,458	7,268	8,735	3,458	7,268
LIABILITIES							
Current Liabilities							
Payables	17	660	98	97	660	98	97
Provisions	18	1,284	813	755	1,284	813	755
Total Current Liabilities		1,944	911	852	1,944	911	852
Non-Current Liabilities							
Provisions	18	71	53	52	71	53	52
Total Non-Current Liabilities		71	53	52	71	53	52
Total Liabilities		2,015	964	904	2,015	964	904
Net Assets		6,720	2,494	6,364	6,720	2,494	6,364
EQUITY							
Accumulated Funds	19	6,720	2,494	6,364	6,720	2,494	6,364
Total Equity		6,720	2,494	6,364	6,720	2,494	6,364

The accompanying notes form part of these Financial Statements.

Statement of Recognised Income and Expense

For the year ended 30 June 2009

	Notes	PARENT		Actual 2008 \$000	CONSOLIDATION		Actual 2008 \$000
		Actual 2009 \$000	Budget 2009 \$000		Actual 2009 \$000	Budget 2009 \$000	
TOTAL INCOME AND EXPENSE RECOGNISED DIRECTLY IN EQUITY		0	0	0	0	0	0
Result for the Year		356	(3,870)	2,837	356	(3,870)	2,837
TOTAL INCOME AND EXPENSE RECOGNISED FOR THE YEAR		356	(3,870)	2,837	356	(3,870)	2,837

The accompanying notes form part of these Financial Statements.

Cash Flow Statement

For the year ended 30 June 2009

		PARENT		CONSOLIDATION			
	Notes	Actual 2009 \$000	Budget 2009 \$000	Actual 2008 \$000	Actual 2009 \$000	Budget 2009 \$000	Actual 2008 \$000
CASH FLOWS FROM OPERATING ACTIVITIES							
Payments							
Employee Related		0	(4,906)	0	(4,836)	(4,906)	(3,535)
Other Operating Expenses		(6,266)	(6,147)	(6,873)	(1,430)	(6,147)	(3,338)
Grants and Subsidies		(91)	(50)	(85)	(91)	(50)	(85)
Total Payments		(6,357)	(11,103)	(6,958)	(6,357)	(11,103)	(6,958)
Receipts							
Sale of Goods and Services		(112)	0	793	(112)	0	793
Interest Received		90	0	48	90	0	48
Grants and Contributions		132	0	55	132	0	55
Other		290	0	0	290	0	0
Total Receipts		400	0	896	400	0	896
Cash Flows From Government							
NSW Health Department Recurrent Allocations		7,723	7,723	10,131	7,723	7,723	10,131
Net Cash Flows from Government		7,723	7,723	10,131	7,723	7,723	10,131
Net cash flows from Operating Activities	22	1,766	(3,380)	4,069	1,766	(3,380)	4,069
CASH FLOWS FROM INVESTING ACTIVITIES							
Proceeds from Sale of Land and Buildings, Plant and Equipment and Infrastructure Systems		36	0	0	36	0	0
Purchases of Land and Buildings, Plant and Equipment, Infrastructure Systems and Intangible Assets		(53)	0	(9)	(53)	0	(9)
Purchases of Investments		(600)	0	0	(600)	0	0
Net Cash Flows from Investing Activities		(617)	0	(9)	(617)	0	(9)
CASH FLOWS FROM FINANCING ACTIVITIES							
Proceeds from Borrowings and Advances		0	0	0	0	0	0
Net Cash Flows from Financing Activities		0	0	0	0	0	0
Net Increase / (Decrease) in Cash		1,149	(3,380)	4,060	1,149	(3,380)	4,060
Opening Cash and Cash Equivalents		4,498	1,017	438	4,498	1,017	438
CLOSING CASH AND CASH EQUIVALENTS	12	5,647	(2,363)	4,498	5,647	(2,363)	4,498

The accompanying notes form part of these Financial Statements.

Notes to and forming part of the Financial Statements

For the year ended 30 June 2009

1. The Clinical Excellence Commission

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

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

With effect from 17 March 2006 fundamental changes to the employment arrangements of the Clinical Excellence Commission were made through amendment to the Public Sector Employment and Management Act 2002 and other Acts including the Health Services Act 1997.

The status of the previous employees of the Clinical Excellence Commission changed from that date. They are now employees of the Government of New South Wales in the service of the Crown rather than employees of the Clinical Excellence Commission. Employees of the Government are employed in Divisions of the Government Service.

In accordance with Accounting Standards these Divisions are regarded as special purpose entities that must be consolidated with the financial 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, 18 and 24 being especially relevant.

In the process of preparing the consolidated financial statements for the economic entity consisting of the controlling and controlled entities, all inter-entity transactions and balances have been eliminated.

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

These financial statements have been authorised for issue by the Chief Executive Officer on 22 October 2009.

2. Summary of Significant Accounting Policies

The Clinical Excellence Commission's Financial Report is a general purpose financial report which has been prepared in accordance with applicable Australian Accounting Standards, (which include Australian Accounting Interpretations), the requirements of the Health Services Act 1997 and its regulations including observation of the Accounts and Audit Determination for Area Health Services and Public Hospitals.

Property, plant and equipment, investment property and assets held for trading and available for sale are measured at fair value. Other financial statement items are prepared in accordance with the historical cost convention.

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

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

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

No new or revised accounting standards or interpretations are adopted earlier than their prescribed date of application. Set out below are changes to be effected, their date of application and the possible impact on the financial report of the Clinical Excellence Commission.

ACCOUNTING STANDARD/INTERPRETATION

AASB 127 and AASB 2008-3, Business Combinations, has application in reporting periods beginning on or after 1 July 2009 and determines information to be disclosed in respect of business acquisitions. Its applicability to not for profit entities is yet to be determined.

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

AASB 8 and AASB 2007-3 Operating Segments, has application in reporting periods beginning on or after 1 January 2009. It relates to for profit entities specifically and is therefore not applicable to the Commission

AASB 101, Presentation of Financial Statements, effective for reporting periods beginning on 1 July 2009, has reduced the disclosure requirements for various reporting entities. However, in not for profit entities such as the Commission there is no change required.

AASB 123 Borrowing Costs, has application in reporting periods beginning on or after 1 January 2009. The Standard, which requires capitalisation of borrowing costs, has not been adopted in 2008/09 nor is adoption expected prior to 2009/10.

AASB 1039, Concise Financial Reports, responds to changes in Section 314 of the Corporations Law. It is not applicable to the Commission.

AASB 2008-1, Share Based Payments has no applicability to the Commission.

AASB 2008-2, Puttable Financial Instruments and Obligations Arising on Liquidation, effective from 1 July 2009 has no application to the Commission.

AASB 2008-5 and AASB 2008-6, Annual Improvements Project, has application from 1 July 2009 and comprises changes for presentation, recognition or measurement purposes which are currently assessed as having no material impact on the Commission.

AASB 2008-7 Investment in a Subsidiary, Jointly Controlled Entity or Associate, has no impact on the Commission.

AASB 2008-8 Eligible Hedged Items, has application from 1 July 2009 but has no current applicability to the Commission.

AASB 2008-9 Amendments to AASB 1049 for Consistency with AASB 101, has mandatory application from 1 July 2009 and will not be early adopted by the Commission.

AASB 2008-11 Business Combinations Among Not for Profit, has application from 1 July 2009 and focuses largely on Local Government

AASB 2008-13, Distribution of Non Cash Assets to Owners, has application in reporting periods beginning on or after 1 July 2009 but is assessed as having no applicability to the Commission.

AASB 2009-2, Improving Disclosures about Financial Instruments, has mandatory application from 1 July 2009. Changes to be advised by NSW Treasury concerning fair value measurement and liquidity risk will be adopted by the Commission.

Interpretation 15 Construction of Real Estate, applies from 1 July 2009 but has no impact on the Commission which is not involved in the construction of real estate for sale.

Interpretation 16, Agreements for the Hedges of a Net Investment in a Foreign Operation, has application from 1 July 2009 but has no relevance to the Commission.

Interpretation 17 & AASB 2008-13 Distributions of Non Cash Assets to Owners, applies from 1 July 2009 and principally addresses share holder distributions. It is not applicable to the Commission.

Other significant accounting policies used in the preparation of these financial statements are as follows:

a) Employee Benefits and Other Provisions

i) Salaries & Wages, Annual Leave, Sick Leave and On Costs

At the consolidated level of reporting liabilities for salaries and wages (including non monetary benefits), annual leave and paid sick leave that 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" or "Long Term" based on past trends and known resignations and retirements. Anticipated payments to be made in the next twelve months are reported as "Short Term". On costs of 17% are applied to the value of leave payable at 30 June 2009, such on costs being consistent with actuarial assessment (Comparable on costs for 30 June 2008 were also 17%).

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

The outstanding amounts of workers' compensation insurance premiums and fringe benefits 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

"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 twelve 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 9.8% (8.1% at 30 June 2008) for all employees with five or more years of service. The escalation applied is consistent with actuarial assessment and is affected in the main by the fall in the Commonwealth Government 10 year bond yield which is used as the discount rate.

The Clinical Excellence Commission's liability for the closed superannuation pool schemes (State Authorities Superannuation Scheme and State Superannuation Scheme) is assumed by the Crown Entity. The Clinical Excellence Commission accounts for the liability as having been extinguished resulting in the amount assumed being shown as part of the non-monetary revenue item described as "Acceptance by the Crown Entity of Employee Benefits". Any liability attached to Superannuation Guarantee Charge cover is reported in Note 17 "Payables".

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

iii) Other Provisions

Other provisions exist when: the Clinical Excellence Commission has a present legal or constructive obligation

as a result of a past event; it is probable that an outflow of resources will be required to settle the obligation; and a reliable estimate can be made of the amount of the obligation.

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

b) Insurance

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

c) Finance Costs

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

d) Income Recognition

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

Sale of Goods and Services

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

Investment Revenue

Interest revenue is recognised using the effective interest method as set out in AASB139, "Financial Instruments: Recognition and measurement". Rental revenue is recognised in accordance with AASB117 "Leases" on a straight line basis over the lease term. Dividend revenue is recognised in accordance with AASB118 "Revenue" when the Clinical Excellence Commission's right to receive payment is established.

Debt Forgiveness

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

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

Grants and Contributions

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

NSW Department of Health Allocations

Payments are made by the NSW Department of Health on the basis of the allocation for the Clinical Excellence Commission as adjusted for approved supplementations mostly for salary agreements, patient flows between Clinical Excellence Commissions 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 Clinical Excellence Commission provided on behalf of the Department. Allocations are normally recognised upon the receipt of Cash.

e) Accounting for the Goods & Services Tax (GST)

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 up until the 28 February 2009.

Income, expenses and assets are recognised net of the amount of GST, except where:

- ▣ the amount of GST incurred by the Health Service as a purchaser that is not recoverable from the Australian Taxation Office is recognised as part of the cost of acquisition of an asset or as part of an item of expense;
- ▣ receivables and payables are stated with the amount of GST included.

Cash flows are included in the Cash Flow Statement on a gross basis. However, the GST components of cash flows arising from investing and financing activities which is recoverable from, or payable to, the Australian Taxation Office are classified as operating cash flows.

f) Acquisition of Assets

The cost method of accounting is used for the initial recording of all acquisitions of assets controlled by the Clinical Excellence Commission. Cost is the amount of cash or cash equivalents paid or the fair value of the other

consideration given to acquire the asset at the time of its acquisition or construction or, where applicable, the amount attributed to that asset when initially recognised in accordance with the specific requirements of other Australian Accounting Standards.

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and revenues at their fair value at the date of acquisition except for assets transferred as a result of an administrative restructure. (Note 2(z) refers)

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) Capitalisation Thresholds

Individual items of property, plant & equipment are capitalised where their cost is \$10,000 or above.

h) Depreciation

Depreciation is provided for on a straight line basis for all depreciable assets so as to write off the depreciable amount of each asset as it is consumed over its useful life to the Clinical Excellence Commission. Land is not a depreciable asset.

Details of depreciation rates initially applied for major asset categories are as follows:

Buildings	2.5%
Electro Medical Equipment	
– Costing less than \$200,000	10.0%
– Costing more than or equal to \$200,000	12.5%
Computer Equipment	20.0%
Infrastructure Systems	2.5%
Motor Vehicle Sedans	12.5%
Motor Vehicles, Trucks & Vans	20.0%
Office Equipment	10.0%
Plant and Machinery	10.0%
Linen	25.0%
Furniture, Fittings and Furnishings	5.0%

"Infrastructure Systems" means assets that comprise public facilities and which provide essential services and enhance the productive capacity of the economy including roads, bridges, water infrastructure and distribution works, sewerage treatment plants, seawalls and water reticulation systems.

Depreciation rates are subsequently varied where changes occur in the assessment of the remaining useful life of the assets reported.

i) Revaluation of Non Current Assets

Non-specialised assets with short useful lives are measured at depreciated historical cost, as a surrogate for fair value.

j) Impairment of Property, Plant and Equipment

As a not-for-profit entity with no cash generating units, the Clinical Excellence Commission is effectively exempt from AASB 136 "Impairment of Assets" and impairment testing. This is because AASB136 modifies the recoverable amount test to the higher of fair value less costs to sell and depreciated replacement cost. This means that, for an asset already measured at fair value, impairment can only arise if selling costs are regarded as material. Selling costs are regarded as immaterial.

k) Intangible Assets

The 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 7 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

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 commencement of the lease term. The corresponding liability is established at the same amount. Lease payments are allocated between the principal component and the interest expense.

Operating lease payments are charged to the Operating Statement in the periods in which they are incurred.

n) Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the operating statement when impaired, derecognised or through the amortisation process.

Short-term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

o) Investments

Investments are initially recognised at fair value plus, in the case of investments not at fair value through profit or loss, transaction costs. The Clinical Excellence Commission determines the classification of its financial assets after initial recognition and, when allowed and appropriate, re-evaluates this at each financial year end.

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

▣ *Fair value through profit or loss* – The Clinical Excellence Commission subsequently measures investments classified as “held for trading” or designated upon initial recognition “at fair value through profit or loss” at fair value. Financial assets are classified as “held for trading” if they are acquired for the purpose of selling in the near term. Derivatives are also classified as held for trading. Gains or losses on these assets are recognised in the operating statement.

The Hour-Glass Investment facilities are designated at fair value through profit or loss using the second leg of the fair value option i.e. these financial assets are managed and their performance is evaluated on a fair value basis, in accordance with a documented risk management strategy, and information about these assets is provided internally on that basis to the agency’s key management personnel.

The risk management strategy of the Clinical Excellence Commission has been developed consistent with the investment powers granted under the provision of the Public Authorities (Financial Arrangements) Act. T Corp investments are made in an effort to improve interest returns on cash balances otherwise available whilst also providing secure investments guaranteed by the State market exposures.

The movement in the fair value of the Hour-Glass Investment facilities incorporates distributions received as well as unrealised movements in fair value and is reported in the line item ‘investment revenue’.

▣ *Held to maturity investments* – Non-derivative financial assets with fixed or determinable payments and fixed maturity that the Clinical Excellence Commission has the positive intention and ability to hold to maturity are classified as “held to maturity”. These investments are measured at amortised cost using the effective interest method. Changes are recognised in the operating statement when impaired, derecognised or though the amortisation process.

▣ *Available for sale investments* – Any residual investments that do not fall into any other category are accounted for as available for sale investments and measured at fair value directly in equity until disposed or impaired, at which time the cumulative gain or loss previously recognised in equity is recognised in the operating statement. However, interest calculated using the effective interest method and dividends are recognised in the operating statement.

Purchases or sales of investments under contract that require delivery of the asset within the timeframe established by convention or regulation are recognised on the trade date; i.e. the date the Health Service commits to purchase or sell the asset.

The fair value of investments that are traded at fair value in an active market is determined by reference to quoted current bid prices at the close of business on the balance sheet date.

p) Impairment of financial assets

All financial assets, except those measured at fair value through profit and loss, are subject to an annual review for impairment. An allowance for impairment is established when there is objective evidence that the entity will not be able to collect all amounts due.

For financial assets carried at amortised cost, the amount of the allowance is the difference between the asset’s carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. The amount of the impairment loss is recognised in the operating statement.

When an available for sale financial asset is impaired, the amount of the cumulative loss is removed from equity and recognised in the operating statement, based on the difference between the acquisition cost (net of any principal repayment and amortisation) and current fair value, less any impairment loss previously recognised in the operating statement.

Any reversals of impairment losses are reversed through the operating statement, where there is objective evidence, except reversals of impairment losses on an investment in an equity instrument classified as “available for sale” must be made through the reserve. Reversals of impairment losses of financial assets carried at amortised cost cannot result in a carrying amount that exceeds what the carrying amount would have been had there not been an impairment loss.

q) De-recognition of financial assets and financial liabilities

A financial asset is derecognised when the contractual rights to the cash flows from the financial assets expire; or if the agency transfers the financial asset:

- ▣ where substantially all the risks and rewards have been transferred; or

- where the Clinical Excellence Commission has not transferred substantially all the risks and rewards, if the entity has not retained control.

Where the Clinical Excellence Commission has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Clinical Excellence Commission's continuing involvement in the asset.

A financial liability is derecognised when the obligation specified in the contract is discharged or cancelled or expires.

r) Payables

These amounts represent liabilities for goods and services provided to the Clinical Excellence Commission and other amounts. Payables are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method. Short-term payables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

Payables are recognised for amounts to be paid in the future for goods and services received, whether or not billed to the Clinical Excellence Commission.

s) Borrowings

Loans are not held for trading or designated at fair value through profit or loss and are recognised at amortised cost using the effective interest rate method. Gains or losses are recognised in the operating statement on derecognition.

t) Equity Transfers

The transfer of net assets between agencies as a result of an administrative restructure, transfers of programs/ functions and parts thereof between NSW public sector agencies is designated as a contribution by owners and is recognised as an adjustment to "Accumulated Funds".

Transfers arising from an administrative restructure between Health Services/Government Departments are recognised at the amount at which the asset was recognised by the transferor Health Service/Government Department immediately prior to the restructure. In most instances this will approximate fair value. All other equity transfers are recognised at fair value.

All other equity transfers are recognised at fair value, except for intangibles. Where an intangible has been recognised at (amortised) cost by the transferor because there is no active market, the agency recognises the asset at the transferor's carrying amount. Where the transferor is prohibited from recognising internally generated intangibles, the agency does not recognise that asset.

The Statement of Recognised Income and Expense does not reflect the Net Assets or change in equity in accordance with AASB 101 Clause 97.

u) Budgeted Amounts

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

v) Service Group Statements

The Clinical Excellence Commission only operates under one program, that program being 6.1 Teaching & Research (see below). Separate group statements are therefore not required.

Program 6.1 Teaching & Research

To develop the skills and knowledge of the health workforce to support patient care and population health. To extend knowledge through scientific enquiry and applied research aimed at improving the health and well being of people of New South Wales.

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
3. Employee Related				
Employee related expenses comprise the following:				
Salaries and Wages	0	0	4,365	2,790
Awards	0	0	0	0
Superannuation – defined benefit plans	0	0	114	56
Superannuation – defined contributions	0	0	260	190
Long Service Leave	0	0	364	192
Annual Leave	0	0	411	344
Sick Leave and Other Leave	0	0	105	133
Workers Compensation Insurance	0	0	15	14
Fringe Benefits Tax	0	0	(16)	16
	0	0	5,618	3,735
4. Personnel Services				
Personnel Services comprise the purchase of the following:				
Salaries and Wages	4,365	2,790	0	0
Superannuation – defined benefit plans	114	56	0	0
Superannuation – defined contributions	260	190	0	0
Long Service Leave	364	192	0	0
Annual Leave	411	344	0	0
Sick Leave and Other Leave	105	133	0	0
Workers Compensation Insurance	15	14	0	0
Fringe Benefits Tax	(16)	16	0	0
	5,618	3,735	0	0

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
5. Other Operating Expenses				
Domestic Supplies and Services	6	9	6	9
Food Supplies	61	12	61	12
Fuel, Light and Power	1	7	1	7
General Expenses (See (a) below)	664	1,960	664	1,960
Information Management Expenses	100	236	100	236
Maintenance (See (b) below)				
Maintenance Contracts	6	5	6	5
New/Replacement Equipment under \$10,000	29	9	29	9
Repairs	24	1	24	1
Postal and Telephone Costs	61	56	61	56
Printing and Stationery	199	147	199	147
Rates and Charges	0	1	0	1
Rental	358	296	358	296
Special Service Departments	41	21	41	21
Staff Related Costs	25	90	25	90
Travel Related Costs	272	254	272	254
	1,847	3,104	1,847	3,104

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
5. Other Operating Expenses				
(a) General Expenses include:-				
Advertising	2	13	2	13
Audio Visual	51	31	51	31
Books, Magazines and Journals	14	4	14	4
Consultancies	148	813	148	813
Courier and Freight	4	2	4	2
Sitting Allowance Committee Membership Fees	7	4	7	4
Auditor's Remuneration – Audit of financial reports	26	15	26	15
Auditor's Remuneration – Other Services	48	42	48	42
Legal Services	30	57	30	57
Membership/Professional Fees	102	150	102	150
Motor Vehicle Expenses	19	0	19	0
Other Management Services	178	777	178	777
Other	35	52	35	52
	664	1,960	664	1,960
(b) Maintenance				
Reconciliation Total Maintenance				
Maintenance (non employee Maintenance expense – contracted labour and other related), included in Note 5	59	15	59	15
Total maintenance expenses included in Notes 3, 4 and 5	59	15	59	15

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
6. Depreciation and Amortisation				
Depreciation – Plant and Equipment	57	95	57	95
Amortisation – Intangible Assets	437	576	437	576
	494	671	494	671
7. Grants and Subsidies				
Research Organisations	56	50	56	50
Ian O'Rourke Scholarship Fund (University of Sydney)	35	35	35	35
	91	85	91	85
8. Sale of Goods and Services				
(a) Sale of Goods comprise the following:-				
Commercial Activities	19	(4)	19	(4)
Other	61	155	61	155
	80	151	80	151
9. Investment Revenue				
Interest	283	48	283	48
T Corp Hour Glass Investment Facilities designated at Fair Value through profit & loss	69	0	69	0
	352	48	352	48
10. Grants and Contributions				
NSW Government grants	0	55	0	55
Other grants	132	0	132	0
	132	55	132	55

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
11. Gain/(Loss) on Disposal				
Property Plant and Equipment	59	34	59	34
Less Accumulated Depreciation	28	0	28	0
Written Down Value	31	34	31	34
Less Proceeds from Disposal	36	25	36	25
Gain/(Loss) on Disposal of Property Plant and Equipment	5	(9)	5	(9)
Total Gain/(Loss) on Disposal	5	(9)	5	(9)
12. Cash & Cash Equivalent Assets				
Cash at bank and on hand	1,147	4,498	1,147	4,498
Short Term Deposits	4,500	0	4,500	0
	5,647	4,498	5,647	4,498
Cash & cash equivalent assets recognised in the Balance Sheet are reconciled to cash at the end of the financial year as shown in the Cash Flow Statement as follows:				
Cash and cash equivalents (per Balance Sheet)	5,647	4,498	5,647	4,498
Closing Cash and Cash Equivalents (per Cash Flow Statement)	5,647	4,498	5,647	4,498
Refer to Note 25 for details regarding credit risk, liquidity risk and market risk arising from financial instruments				
13. Receivables				
Current				
(a) Sale of Goods and Services:				
NSW Health Department	83	37	83	37
Debtors Intra Health	120	373	120	373
Goods & Services Tax	107	0	107	0
Other Debtors	198	3	198	3
Sub Total	508	413	508	413
Sub Total	508	413	508	413
Prepayments S&W	6	6	6	6
Prepayments Rent	25	0	25	0
Total	539	419	539	419

Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired are disclosed in Note 25.

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
14. Financial Assets at Fair Value				
Current				
Treasury Corporation – Hour Glass Investment Facilities	669	0	669	0
	669	0	669	0

Refer Note 25 for further information regarding credit risk, liquidity risk and market risk arising from financial investments.

15. Plant and Equipment

Plant and Equipment

At Fair Value	756	722	756	722
Less Accumulated depreciation and impairment	(187)	(118)	(187)	(118)
Net Carrying Amount	569	604	569	604
Total Plant and Equipment At Net Carrying Amount	569	604	569	604

	2009		2008	
PARENT AND CONSOLIDATION	Plant and Equipment \$000	Total \$000	Plant and Equipment \$000	Total \$000
Plant and Equipment – Reconciliations				
Carrying amount at start of year	604	604	699	699
Additions	53	53	34	34
Disposals	(31)	(31)	(34)	(34)
Depreciation expense	(57)	(57)	(95)	(95)
Carrying amount at end of year	569	569	604	604

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
16. Intangible Assets				
Software				
Cost (Gross Carrying Amount)	2,390	2,390	2,390	2,390
Less Accumulated Amortisation and Impairment	(1,079)	(643)	(1,079)	(643)
Net Carrying Amount	1,311	1,747	1,311	1,747
Total Intangible Assets at Net Carrying Amount	1,311	1,747	1,311	1,747

	2009		2008	
	Software \$000	Total \$000	Software \$000	Total \$000
PARENT AND CONSOLIDATION				
Intangibles – Reconciliation				
Net Carrying amount at start of year	1,747	1,747	2,323	2,323
Additions (from internal development or acquired separately)	0	0	0	0
Amortisation (recognised in depreciation and amortisation)	(436)	(436)	(576)	(576)
Net Carrying amount at end of year	1,311	1,311	1,747	1,747

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
17. Payables				
Current				
Accrued Salaries and Wages	126	5	126	5
Taxation & Payroll Deductions	113	0	113	0
Creditors	291	92	291	92
Other Creditors				
– Intra Health Liability	130	0	130	0
	660	97	660	97

Details regarding credit risk, liquidity risk and market risk, including financial assets that are either past due or impaired are disclosed in Note 25

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
18. Provisions				
Current Employee benefits and related on-costs				
Employee Annual Leave – Short Term Benefit	0	0	287	212
Employee Annual Leave – Long Term Benefit	0	0	259	157
Employee Long Service Leave – Short Term Benefit	0	0	39	92
Employee Long Service Leave – Long Term Benefit	0	0	699	294
Provision for Personnel Services Liability	1,284	755	0	0
Total Current Provisions	1,284	755	1,284	755
Non Current Employee benefits and related on-costs				
Employee Long Service Leave – Conditional	0	0	71	52
Provision for Personnel Services Liability	71	52	0	0
Total Non Current Provisions	71	52	71	52
Aggregate Employee Benefits and Related On-costs				
Provisions – current	1,284	755	1,284	755
Provisions – non-current	71	52	71	52
Accrued Salaries and Wages and on costs (Note 17)	126	5	126	5
	1,481	812	1,481	812

Tax and Payroll Deductions (\$113,000)

	ACCUMULATED FUNDS		TOTAL EQUITY	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
19. Parent and Consolidation – Equity				
Balance at the beginning of the financial year	6,364	3,527	6,364	3,527
Restated Opening Balance	6,364	3,527	6,364	3,527
Changes in equity other than transactions with owners as owners				
Result for the year	356	2,837	356	2,837
Balance at the end of the financial year	6,720	6,364	6,720	6,364

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
20. Commitments for Expenditure				
(a) Other Expenditure Commitments				
Aggregate other expenditure contracted for at balance date but not provided for in the accounts:				
Not later than one year	448	110	448	110
Later than one year and not later than five years	0	457	0	457
Later than five years	0	114	0	114
Total Other Expenditure Commitments (Including GST)	448	681	448	681
The amount payable to HSS in any year is determined using a number of criteria, including the level of activity and full cost recovery by HSS. A commitment figure cannot be readily determined and has not been included within the commitments above.				
(b) Operating Lease Commitments				
Commitments in relation to non-cancellable operating leases are payable as follows:				
Not later than one year	319	280	319	280
Later than one year and not later than five years	26	290	26	290
Later than five years	0	0	0	0
Total Operating Lease Commitments (Including GST)	345	570	345	570

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

(c) Contingent Asset related to Commitments for Expenditure

The total of "Commitments for Expenditure" \$782,748 as at 30 June 2009 includes input tax credits of \$71,158 that are expected to be recoverable from the Australian Taxation Office.

21. Contingent Liabilities

There are no contingent liabilities.

22. Reconciliation of Net Cash flows from Operating Activities to Net Cost of Services	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
Net Cash Flows from Operating Activities	1,766	4,069	1,766	4,069
Depreciation	(494)	(671)	(494)	(671)
Acceptance by the Crown Entity of Employee Superannuation Benefits	(114)	(56)	(114)	(56)
(Increase)/ Decrease in Employee Provisions	(548)	(144)	(548)	(144)
(Increase) / Decrease in Goods and Services Debtors	265	29	265	29
(Increase) / Decrease in Other Debtors (Intra Hlth)	(170)	(671)	(170)	(671)
Increase / (Decrease) in Prepayments	25	(40)	25	(40)
(Increase)/ Decrease in Creditors	(563)	274	(563)	274
Net Gain/ (Loss) on Sale of Property, Plant and Equipment	5	(9)	5	(9)
(NSW Health Department Recurrent Allocations)	(7,723)	(10,131)	(7,723)	(10,131)
Fair Value (T-Corp)	70	0	70	0
Net Cost of Services	(7,481)	(7,350)	(7,481)	(7,350)

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

23. Unclaimed Moneys

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

24. Budget Review – Parent and Consolidated

Net Cost of Services

The actual Net Cost of Services was lower than budget by \$4.18m. This was primarily due to some major projects still in their service delivery stage, which continues to reflect the timing differences between budgeted allocation and actual projected expenditure. Greater than budgeted actual revenue of \$564K represents mainly investment income from short term fixed deposits. Additional project funding from various NSW Health Organisations for short term projects has been brought to account in the profit & loss for this financial year. The remainder represents commercial activity revenue from health campaign resource development and dissemination on behalf of NSW Health.

Result for the Year

The result for the year was higher than budget by \$4.24m due to the favourable Net Cost of Services position.

ASSETS AND LIABILITIES

Current Assets

Current Assets were greater than budget by \$5.39m. This was primarily due to higher than budgeted cash comprising of the 07/08 rollover allocated to the Clinical Excellence Commission for 08/09 from the NSW Department of Health. The Clinical Excellence Commission has been in a position to negotiate its cash allocation based on its expenditure requirements.

Non-Current Assets

Non-current assets were less than budget by \$142K reflecting the IIMS increase in depreciation to reflect its true value.

Current Liabilities

The current creditors are more than budget due to the Clinical Excellence Commission's complete separation from SESIAH resulting in our own set of accounts.

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

Non-Current Liabilities

Non-Current Liabilities were more than budget due to an increase in staff leave transfers in.

CASH FLOWS

Operating Activities

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

Investing Activities

Actual capital expenditure has no significant variance compared to budget. Short Term Investments have significantly increased to budget

Financing Activities

There are no Financing activities currently undertaken by the Clinical Excellence Commission.

Movements in the level of the NSW Health Department Recurrent Allocation that have occurred since the time of the initial allocation on 30th July 2008 are as follows:

	2009 \$000	2008 \$000
Initial Allocation, 30th July 2008	7,581	11,418
Blood Watch Program	169	(262)
Central Line Associated Bloodstream Infection	157	311
Statewide Clinical Leadership Program	(547)	(1,495)
Improving Early Pregnancy Care	90	0
Falls Prevention Program	271	125
Super Guarantee Charge	2	34
Balance as per Operating Statement	7,723	10,131

25. Financial Instruments

The Clinical Excellence Commission's principal financial instruments are outlined below. These financial instruments arise directly from the Clinical Excellence Commission's operations or are required to finance its operations. The Clinical Excellence Commission does not enter into or trade financial instruments, including derivative financial instruments, for speculative purposes.

The Clinical Excellence Commission's main risks arising from financial instruments are outlined below, together with the Health Service's objectives, policies and processes for measuring and managing risk. Further quantitative and qualitative disclosures are included throughout this financial report.

The Chief Executive has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. Risk management policies are established to identify and analyse the risk faced by the Clinical Excellence Commission, to set risk limits and controls and monitor risks. Compliance with policies is reviewed by the Audit Committee/Internal auditors on a continuous basis.

a) Financial Instrument Categories

	PARENT		CONSOLIDATION	
	2009 \$000	2008 \$000	2009 \$000	2008 \$000
Financial Assets				
Class: Category				
Cash and Cash Equivalents (note 12)	5,647	4,498	5,647	4,498
Receivables at Amortised Cost (note 13) ¹	401	413	401	413
Financial Assets at Fair Value designated as such per initial recognition (note 14)	669	0	669	0
Total Financial Assets	6,717	4,911	6,717	4,911
Financial Liabilities				
Payables (Note 17) ²	547	97	547	97
Total Financial Liabilities	547	97	547	97

Notes

1 Excludes statutory receivables and prepayments (ie not within scope of AASB 7)

2 Excludes statutory payables and unearned revenue (ie not within scope of AASB 7)

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

b) Credit Risk

Credit risk arises when there is the possibility of the Entity's debtors defaulting on their contractual obligations, resulting in a financial loss to the Entity. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from financial assets of the Entity i.e receivables. No collateral is held by the Entity nor has it granted any financial guarantees.

Credit risk associated with the Clinical Excellence Commission's financial assets, other than receivables, is managed through the selection of counterparties and establishment of minimum credit rating standards.

Authority deposits held with NSW Tcorp are guaranteed by the State.

Cash

Cash comprises cash on hand and bank balance deposited in accordance with Public Authorities (Financial Arrangements) Act approvals. Interest is earned on daily bank balances at rates of approximately 3.03% in 2008/09 compared to 6.71% in the previous year. The TCorp Hour Glass cash facility is discussed in para (d) below.

Receivables – trade debtors

All trade debtors are recognised as amounts receivable at balance date. Collectibility of trade debtors is reviewed on an ongoing basis. Procedures as established in the NSW Department of Health Accounting Manual and Fee Procedures Manual are followed to recover outstanding amounts, including letters of demand. Debts which are known to be uncollectable are written off. An allowance for impairment is raised when there is objective evidence that the entity will not be able to collect the amounts due. The evidence includes past experience and current and expected changes in economic conditions and debtor credit ratings. No interest is earned on trade debtors.

The Clinical Excellence Commission is not materially exposed to concentrations of credit risk to a single trade debtor or group of debtors. Based on past experience, debtors that are not past due (2009: \$0.315m; 2008: \$0.371m) and not more than [3] months past due (2009: \$15k; 2008:\$0k) are not considered impaired and together these represent 82% of the total trade debtors.

The only financial assets that are past due or impaired are 'sales of goods and services' in the 'receivables' category of the balance sheet.

	2009			2008		
	Total	Past due but not impaired	Considered impaired	Total	Past due but not impaired	Considered impaired
< 3 months overdue	15	15	0	0	0	0
3 months – 6 months overdue	71	71	0	0	0	0
> 6 months overdue	0	0	0	42	42	0
	86	86	0	42	42	0

The ageing analysis excludes statutory receivables, as these are not within the scope of AASB 7.

Authority Deposits

The Clinical Excellence Commission has placed funds on deposit with TCorp, which has been rated “AAA” by Standard and Poor’s. These deposits are similar to money market or bank deposits and can be placed “at call” or for a fixed term. For fixed term deposits, the interest rate payable by TCorp is negotiated initially and is fixed for the term of the deposit, while the interest rate payable on at call deposits vary. The deposits at balance date were earning an average interest rate of 4.49%, while over the year the weighted average interest rate was 5.64% on a weighted average balance during the year of \$1.569 mil. None of these assets are past due or impaired.

c) Liquidity risk

Liquidity risk is the risk that the Clinical Excellence Commission will be unable to meet its payment obligations when they fall due. The Clinical Excellence Commission continuously manages risk through monitoring future cash flows and maturities planning to ensure adequate holding of high quality liquid assets. The objective is to maintain a balance between continuity of funding and flexibility through effective management of cash, investments and liquid assets and liabilities.

The Clinical Excellence Commission has negotiated no loans outside of arrangements with the NSW Department of Health or the Sustainable Energy Development Authority.

No assets have been pledged as collateral. The Clinical Excellence Commission exposure to liquidity risk is deemed insignificant based on prior periods’ data and current assessment of risk.

The liabilities are recognised for amounts due to be paid in the future for goods or services received, whether or not invoiced. Amounts owing to suppliers (which are unsecured) are settled in accordance with the policy set by the NSW Department of Health. If trade terms are not specified, payment is made no later than the end of the month following the month in which an invoice or a statement is received.

The table below summarises the maturity profile of the Health Service’s financial liabilities together with the interest rate exposure.

	INTEREST RATE EXPOSURE					MATURITY DATES			Weighted Average Effective int rate \$000
	Fixed Interest Rate %	Variable Interest Rate %	Nominal Amount ¹ \$	Variable Interest Rate \$000	Non- Interest Bearing \$000	< 1 Yr \$000	1–5 Yr \$000	> 5Yr \$000	
2009									
Payables									
Accrued salaries			126		126	126			
Creditors			291		291	291			
Intra-Health Creditors			130		130	130			
			547		547	547			
2008									
Payables									
Accrued salaries			5		5	5			
Creditors			92		92	92			
			97		97	97			

Notes:

- 1 The amounts disclosed are the contractual undiscounted cash flows of each class of financial liabilities, therefore the amounts disclosed above will not reconcile to the balance sheet in respect of non interest bearing loans negotiated with the NSW Department of Health.

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

Market risk

Market risk is the risk that the fair value of future cash flows of a financial instrument will fluctuate because of changes in market prices. The Clinical Excellence Commission exposures to market risk are primarily through interest rate risk on the Clinical Excellence Commission's investments and other price risks associated with the movement in the unit price of the Hour Glass Investment facilities. The Clinical Excellence Commission has no exposure to foreign currency risk and does not enter into commodity contracts.

The effect on profit and equity due to a reasonably possible change in risk variable is outlined in the information below, for interest rate risk and other price risk. A reasonably possible change in risk variable has been determined after taking into account the economic environment in which the Clinical Excellence Commission operates and the time frame for the assessment (i.e. until the end of the next annual reporting period). The sensitivity analysis is based on risk exposures in existence at the balance sheet date. The analysis is performed on the same basis for 2008. The analysis assumes that all other variables remain constant.

Interest rate risk

Exposure to interest rate risk arises primarily through the Health Service's interest bearing liabilities.

However, the Clinical Excellence Commission are not permitted to borrow external to the NSW Department of Health (Sustainable Energy Development Authority loans which are negotiated through Treasury excepted).

Both SEDA and NSW Department of Health loans are set at fixed rates and therefore are generally not affected by fluctuations in market rates. For financial instruments a reasonably possible change of +/-1% is consistent with trends in interest. The Clinical Excellence Commission exposure to interest rate risk is set out below.

		-1%		+1%	
	Carrying amount	Profit	Equity	Profit	Equity
2009					
Financial assets					
Cash and cash equivalents	5,647	-56	-56	56	56
Receivables	401	-4	-4	4	4
Financial assets at fair value	669	-7	-7	7	7
Other financial assets					
Financial liabilities					
Payables	547	-5	-5	5	5
2008					
Financial assets					
Cash and cash equivalents	4,498	-45	-45	45	45
Receivables	413	-4	-4	4	4
Financial liabilities					
Payables	97	-1	-1	1	1

Other price risk – TCorp Hour Glass facilities

Exposure to 'other price risk' primarily arises through the investment in the TCorp Hour Glass Investment facilities, which are held for strategic rather than trading purposes. The Clinical Excellence Commission has no direct equity investments. The Clinical Excellence Commission holds units in the following Hour-Glass investment trusts:

Facility	Investment Sectors	Investment horizon	2009 \$000	2008 \$000
Cash facility	Cash, money market instruments	Up to 2 years	669	0

The unit price of each facility is equal to the total fair value of net assets held by the facility divided by the total number of units on issue for that facility. Unit prices are calculated and published daily.

NSW TCorp as trustee for each of the above facilities is required to act in the best interest of the unitholders and to administer the trusts in accordance with the trust deeds. As trustee, TCorp has appointed external managers to manage the performance and risk of each facility in accordance with a mandate agreed by the parties. However, TCorp, acts as manager for part of the Cash facility. A significant portion of the administration of the facilities is outsourced to an external custodian.

Investment in the Hour Glass facilities limits the Clinical Excellence Commission exposure to risk, as it allows diversification across a pool of funds, with different investment horizons and a mix of investments.

NSW TCorp provides sensitivity analysis information for each of the facilities, using historically based volatility information. The TCorp Hour Glass Investment facilities are designated at fair value through profit or loss and therefore any change in unit price impacts directly on profit (rather than equity).

A reasonable possible change is based on the percentage change in unit price multiplied by the redemption price as at 30 June each year for each facility of 1% (as advised by TCorp).

IMPACT ON PROFIT/LOSS

	Change in unit price	2009 \$000	2008 \$000
Hour Glass Investment – Cash	+ 1%	7	0

Fair Value

Financial instruments are generally recognised at cost, with the exception of the TCorp Hour Glass facilities, which are measured at fair value. As discussed, the value of the Hour Glass Investments is based on the Clinical Excellence Commission's share of the value of the underlying assets of the facility, based on the market value. All of the Hour Glass facilities are valued using 'redemption' pricing.

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

Except where specified below, the amortised cost of financial instruments recognised in the balance sheet approximates the fair value because of the short term nature of many of the financial instruments. The following table details the financial instruments where the fair value differs from the carrying amount:

	2009 \$000		2008 \$000	
	Carrying amount	Fair value	Carrying amount	Fair value
Financial assets				
T-Corp (Hour glass on call)	0	669	0	0
Fixed cash Investment	0	0	0	0
	0	669	0	0

26. Post Balance Date Events

Since the reporting date, there are no events that have come to light that require the financial report to be amended.

Special Purpose Service Entity

Certification of Financial Statement

For the year ended 30 June 2009

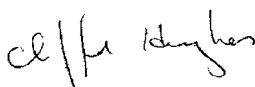
The attached financial statements of the Clinical Excellence Commission Special Purpose Service Entity for the year ended 30 June 2009:

- i) Have been prepared in accordance with the requirements of applicable Australian Accounting Standards (which include Australian Accounting Interpretations), 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 Service Entity; and
- iii) Have no circumstances which would render any particulars in the financial statements to be misleading or inaccurate.



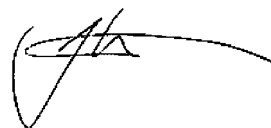
Professor Bruce Barraclough, AO
Chairman

22 October 2009



Professor Clifford Hughes, AO
Chief Executive Officer

22 October 2009



Mr Andre Jenkins
A/Director, Corporate Services

22 October 2009

Special Purpose Service Entity

Independent Audit Report

For the year ended 30 June 2009



GPO BOX 12
Sydney NSW 2001

INDEPENDENT AUDITOR'S REPORT

Clinical Excellence Commission

Special Purpose Service Entity

To Members of the New South Wales Parliament

I have audited the accompanying financial report of the Clinical Excellence Commission Special Purpose Service Entity (the Entity), which comprises the balance sheet as at 30 June 2009, the income statement, statement of recognised income and expense, and cash flow statement for the year then ended, a summary of significant accounting policies and other explanatory notes.

Auditor's Opinion

In my opinion, the financial report:

- presents fairly, in all material respects, the financial position of the Entity as at 30 June 2009, and its financial performance for the year then ended in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations)
- is in accordance with section 45E of the *Public Finance and Audit Act 1983* (the PF&A Act) and the Public Finance and Audit Regulation 2005.

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

Chief Executive's Responsibility for the Financial Report

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

Auditor's Responsibility

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

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

Special Purpose Service Entity

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

My opinion does *not* provide assurance:

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

Independence

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

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



Peter Achterstraat
Auditor-General

26 October 2009
SYDNEY

Special Purpose Service Entity

Income Statement of the Clinical Excellence Commission

For the year ended 30 June 2009

	2009 \$000	2008 \$000
INCOME		
Personnel Services	5,618	3,735
Acceptance by the Crown Entity of Employee Benefits	114	56
Total Income	5,732	3,791
EXPENSES		
Salaries and Wages	4,365	2,790
Defined Benefit Superannuation	114	56
Defined Contribution Superannuation	260	190
Long Service Leave	364	192
Annual Leave	411	344
Sick Leave and Other Leave	105	133
Workers Compensation Insurance	15	14
Fringe Benefits Tax	-16	16
Grants & Subsidies	114	56
Total Expenses	5,732	3,791
Result For The Year	0	0

The accompanying notes form part of these Financial Statements.

Special Purpose Service Entity

Balance Sheet of the Clinical Excellence Commission

As at 30 June 2009

	Notes	2009 \$000	2008 \$000
ASSETS			
Current Assets			
Receivables	2	1,410	760
Total Current Assets		1,410	760
Non-Current Assets			
Receivables	2	71	52
Total Non-Current Assets		71	52
Total Assets		1,481	812
LIABILITIES			
Current Liabilities			
Payables	3	126	5
Provisions	4	1,284	755
Total Current Liabilities		1,410	760
Non-Current Liabilities			
Provisions	4	71	52
Total Non-Current Liabilities		71	52
Total Liabilities		1,481	812
Net Assets		0	0
EQUITY			
Accumulated funds		0	0
Total Equity		0	0

The accompanying notes form part of these Financial Statements.

Special Purpose Service Entity

Statement of Recognised Income and Expense for the Clinical Excellence Commission

For the year ended 30 June 2009

	2009 \$000	2008 \$000
Total Income and Expense Recognised Directly in Equity	0	0
Result for the Year	0	0
Total Income and Expense Recognised for the year	0	0

The accompanying notes form part of these Financial Statements.

Special Purpose Service Entity

Cash Flow Statement of the Clinical Excellence Commission

For the year ended 30 June 2009

	2009 \$000	2008 \$000
Net Cash Flows from Operating Activities	0	0
Net Cash Flows from Investing Activities	0	0
Net Cash Flows from Financing Activities	0	0
Net Increase/(Decrease) in Cash	0	0
Closing Cash and Cash Equivalents	0	0

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

The accompanying notes form part of these Financial Statements.

Special Purpose Service Entity

Notes to and forming part of the Financial Statements

For the year ended 30 June 2009

1. Summary of significant accounting policies

a) The Clinical Excellence Commission Special Purpose Service Entity

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

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

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

The financial report was authorised for issue by the Chief Executive Officer on 22 October 2009. 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 (which include Australian Accounting Interpretations), the requirements of the Health Services Act 1997 and its regulations including observation of the Accounts and Audit Determination for Area Health Services and Public Hospitals.

Generally, the historical cost basis of accounting has been adopted and the financial report does not take into account changing money values or current valuations. However certain provisions are measured at fair value. See note (j).

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

The financial statements and notes comply with Australian Accounting Standards which include AEIFRS. Comparative figures are, where appropriate, reclassified to give meaningful comparison with the current year.

d) New Australian Accounting Standards Issued But Not Effective

No new or revised accounting standards or interpretations are adopted earlier than their prescribed date of application. Set out below are changes to be effected, their date of application and the possible impact on the financial report of the Clinical Excellence Commission Special Purpose Service Entity.

Accounting Standard/Interpretation

AASB 127 and AASB 2008-3, Business Combinations, has application in reporting periods beginning on or after 1 July 2009 and determines information to be disclosed in respect of business acquisitions. Its applicability to not for profit entities is yet to be determined.

AASB 8 and AASB 2007-3 Operating Segments, has application in reporting periods beginning on or after 1 January 2009. It relates to for profit entities specifically and is therefore not applicable to the Entity.

AASB 101, Presentation of Financial Statements, effective for reporting periods beginning on 1 July 2009, has reduced the disclosure requirements for various reporting entities. However, in not for profit entities there is no change required.

AASB 123 Borrowing Costs, has application in reporting periods beginning on or after 1 January 2009. The Standard, which requires capitalisation of borrowing costs, has not been adopted in 2008/09 nor is adoption expected prior to 2009/10.

AASB 1039, Concise Financial Reports, responds to changes in Section 314 of the Corporations Law. It is not applicable to the Entity.

AASB 2008-1, Share Based Payments has no applicability to the Entity.

AASB 2008-2, Puttable Financial Instruments and Obligations Arising on Liquidation, effective from 1 July 2009 has no application to the Entity.

Special Purpose Service Entity

AASB 2008-5 and AASB 2008-6, Annual Improvements Project, has application from 1 July 2009 and comprises changes for presentation, recognition or measurement purposes which are currently assessed as having no material impact on the Entity.

AASB 2008-7 Investment in a Subsidiary, Jointly Controlled Entity or Associate, has no impact on the Entity.

AASB 2008-8 Eligible Hedged Items, has application from 1 July 2009 but has no current applicability to the Entity.

AASB 2008-9 Amendments to AASB 1049 for Consistency with AASB 101, has mandatory application from 1 July 2009 and will not be early adopted by the Entity.

AASB 2008-11 Business Combinations Among Not for Profit, has application from 1 July 2009 and focuses largely on Local Government.

AASB 2008-13, Distribution of Non Cash Assets to Owners, has application in reporting periods beginning on or after 1 July 2009 but is assessed as having no applicability to the Entity.

AASB 2009-2, Improving Disclosures about Financial Instruments, has mandatory application from 1 July 2009. Changes to be advised by NSW Treasury concerning fair value measurement and liquidity risk will be adopted by the Entity.

Interpretation 15 Construction of Real Estate, applies from 1 July 2009 but has no impact on the Entity which is not involved in the construction of real estate for sale.

Interpretation 16, Agreements for the Hedges of a Net Investment in a Foreign Operation, has application from 1 July 2009 but has no relevance to the Entity.

Interpretation 17 & AASB 2008-13 Distributions of Non Cash Assets to Owners, applies from 1 July 2009 and principally addresses share holder distributions. It is not applicable to the Entity.

e) Income

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

f) Receivables

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.

Receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. These financial assets are recognised initially at fair value, usually based on the transaction cost or face value. Subsequent measurement is at amortised cost using the effective interest method, less an allowance for any impairment of receivables. Any changes are accounted for in the operating statement when impaired, derecognised or through the amortisation process.

Short term receivables with no stated interest rate are measured at the original invoice amount where the effect of discounting is immaterial.

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) Impairment of Financial Assets

As both receivables and payables are measured at fair value through profit and loss there is no need for annual reviews for impairment.

h) De-recognition of Financial Assets and Financial Liabilities

A financial asset is derecognised when the contractual rights to the cash flows from the financial assets expire, or if the agency transfers the financial asset:

- where substantially all the risks and rewards have been transferred; or
- where the Entity has not transferred substantially all the risks and rewards,
- if the Entity has not retained control.

Special Purpose Service Entity

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

Where the Entity has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the Entity's continuing involvement in the asset.

A financial liability is derecognised when the obligation specified in the contract is discharged or cancelled or expires.

i) Payables

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

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

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

j) Employee benefit provisions and expenses

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

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

All Annual Leave employee benefits are reported as "Current" as there is an unconditional right to payment. Current liabilities are then classified as "Short Term" and "Long Term" based on past trends and known resignations and retirements. Anticipated payments to be made in the next 12 months are reported as "Short Term". On costs of 17% are applied to the value of leave payable at 30 June 2009, such on costs being consistent with actuarial assessment (comparable on costs for 30 June 2008 were also 17%).

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

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

ii) Long Service Leave and Superannuation Benefits

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

Long Service Leave provisions are measured on a short hand basis at an escalated rate of 9.8% above the salary rates immediately payable at 30 June 2009 (8.1% at 30 June 2008) for all employees with five or more years of service. The escalation applied is consistent with the actuarial assessment and is affected in the main by the fall in the Commonwealth Government 10 year bond yield which is used as the discount rate.

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

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

Special Purpose Service Entity

	2009 \$000	2008 \$000
2. Receivables		
Current		
Accrued Income – Personnel Services Provided	1,410	760
Non-Current		
Accrued Income – Personnel Services Provided	71	52
Total Receivables	1,481	812
3. Payables		
Current		
Accrued Salaries and Wages and On Costs	126	5
Total Payables	126	5
Details regarding credit risks, liquidity risk and market risk, including financial assets that are either part due or impaired are disclosed in Note 5.		
4. Provisions		
Current Employee benefits and related on-costs		
Annual Leave – Short Term Benefit	287	212
Annual Leave – Long Term Benefit	259	157
Long Service Leave – Short Term Benefit	39	92
Long Service Leave – Long Term Benefit	699	294
Total Current Provisions	1,284	755
Non-Current Employee Benefits and Related On Costs		
Long Service Leave – Conditional	71	52
Total Non-Current Provisions	71	52
Aggregate Benefits and Related On Costs		
Accrued Salary & Wages & on-costs	126	5
Provision – Current	1,284	755
Provision – Non-Current	71	52
Total	1,481	812

Special Purpose Service Entity

Notes to and forming part of the Financial Statements (CONTINUED)

For the year ended 30 June 2009

5. Financial instruments

The Clinical Excellence Commission Special Purpose Service Entity's financial instruments are outlined below. These financial instruments arise directly from the Entity's operations or are required to finance its operations. The Entity does not enter into or trade financial instruments, including derivative financial instruments for speculative purposes.

The Chief Executive has overall responsibility for the establishment and oversight of risk management and reviews and agrees policies for managing each of these risks. The Entity carries minimal risks within its operation as it carries only the value of employee provisions and accrued salaries and wages offset in full by accounts receivable from the Parent Entity. Risk management policies are established by the Parent Entity to identify and analyse the risk faced by the Entity, to set risk limits and controls and monitor risks. Compliance with policies is reviewed by the Audit Committee/Internal auditors of the Parent Entity on a continuous basis.

	TOTAL CARRYING AMOUNTS AS PER THE BALANCE SHEET	
	2009 \$000	2008 \$000
Financial Assets		
Receivables at Amortised Cost ¹ (Note 2)	1,481	812
Total Financial Assets	1,481	812
Financial Liabilities		
Class:		
Payables (Note 3 ¹)	126	5
Total Financial Liabilities	126	5

¹ Excludes statutory receivables and prepayments, i.e. not within the scope of AASB 7.

Special Purpose Service Entity

b) Credit Risk

Credit risk arises when there is the possibility of the Entity's debtors defaulting on their contractual obligations, resulting in a financial loss to the Entity. The maximum exposure to credit risk is generally represented by the carrying amount of the financial assets (net of any allowance for impairment).

Credit risk arises from financial assets of the Entity i.e receivables. No collateral is held by the Entity nor has it granted any financial guarantees.

Receivables – trade debtors

Receivables are restricted to accrued income for personnel services provided and employee leave provisions and are recognised as amounts receivable at balance date. The parent entity of the Clinical Excellence Commission Special Purpose Service Entity is the sole debtor of the Entity and it is assessed that there is no risk of default. No accounts receivables are classified as "Past Due but not Impaired" or "Considered Impaired".

c) Liquidity Risk

Liquidity risk is the risk that the Entity will be unable to meet its payment obligations when they fall due. No such risk exists with the Entity not having any cash flows. All movements that occur in Payables are fully offset by an increase in Receivables from the Clinical Excellence Commission parent entity.

d) Market Risk

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. The Entity's exposures to market risk are considered to be minimal and the Entity has no exposure to foreign currency risk and does not enter into commodity contracts.

Interest rate risk

Exposure to interest rate risk arises primarily through interest bearing liabilities.

However the Entity has no such liabilities and the interest rate is assessed as Nil. Similarly it is considered that the Entity is not exposed to other price risks.

e) Fair Value

Financial instruments are generally recognised at cost.

The amortised cost of financial instruments recognised in the balance sheet approximates fair value because of the short term nature of the financial instruments.

6. Related parties

The Clinical Excellence Commission is deemed to control the Clinical Excellence Commission Special Purpose Service Entity in accordance with Australian Accounting Standards. The controlling entity is incorporated under the Health Services Act 1997.

Transactions and balances in this financial report relate only to the Entity's function as provider of personnel services to the controlling entity. The Entity's total income is sourced from the Clinical Excellence Commission.

Cash receipts and payments are effected by the Clinical Excellence Commission on the Entity's behalf.

7. Post balance date events

No post balance date events have occurred which warrant inclusion in this report.

Abbreviations

ARCHI	Australian Resource Centre for Healthcare Innovations	ICU	Intensive Care Unit
CEAC	Citizens Engagement and Advisory Council	IIMS	Incident Information Management System
CEC	Clinical Excellence Commission	MRO	Multi-resistant organisms
CEO	Chief Executive Officer	MSSA	Medication Safety Self Assessment
CGU	Clinical Governance Unit	NICS	National Institute of Clinical Studies
CHASM	Collaborating Hospitals' Audit of Surgical Mortality	NSW	New South Wales
CheReL	Centre for Health Record Linkage	OH&S	Occupational Health and Safety
CIAP	Clinical Information Access Project (online information resource)	QSA	Quality Systems Assessment
CLAB	Central Line Associated Bacteraemia	QSB	Quality and Safety Branch, NSW Department of Health
CLP	Clinical Leadership Program	RCA	Root Cause Analysis
CNC	Clinical Nurse Consultant	SAC	Severity Assessment Code
CPI	Clinical Practice Improvement	SCIDAWS	Special Committee Investigating Deaths Associated With Surgery
DOH	Department of Health	SCIDUA	Special Committee Investigating Deaths Under Anaesthesia
EEO	Equal Employment Opportunity	SESAHS	South Eastern Sydney & Illawarra Area Health Service
FOI	Freedom of Information	TAG	Therapeutic Advisory Group
GMCT	Greater Metropolitan Clinical Taskforce	TESL	Training, Education and Study Leave for salaried medical practitioners
HARC	Hospital Alliance for Research Collaboration		

Glossary

Adverse Event

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

Area health service (AHS)

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

Clinical Excellence Commission (CEC)

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

Clinical Information Access Program (CIAP)

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

Clinical Practice Improvement (CPI)

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

Clinician

A health practitioner or health service provider.

Director-General

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

IIMS

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

Incident

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

Incident Management

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

Minister

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

Near-Miss

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

NSW Department of Health (the Department)

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

Open Disclosure

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

Public Health Organisation (PHO)

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

Quality Systems Assessment (QSA)

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

Reportable Incident Brief (RIB)

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

Root Cause Analysis (RCA)

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

Severity Assessment Code (SAC)

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

Statutory (Health) Corporation

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

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