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Letter of transmittal

The Honourable Greg Hunt MP Minister for Health

Parliament House Canberra ACT 2600

Dear Minister

On behalf of the Board of the Australian Commission on Safety and Quality in Health Care (the Commission), I am pleased to submit our Annual Report for the financial year ending 30 June 2019.

This report was prepared in accordance with the requirements of the *National Health Reform Act 2011* and section 46 of the *Public Governance, Performance and Accountability Act 2013*.

The report includes the Commission's audited Financial Statements, as required by section 42 of the Public Governance, Performance and Accountability Act.

The Commission's annual performance statements were prepared in accordance with the requirements of section 39 of the Public Governance, Performance Accountability Act and accurately present the Commission's performance from 1 July 2018 to 30 June 2019.

As required by section 10 of the Public Governance, Performance and Accountability Rule 2014, I certify on behalf of the Board that:

- The Commission has prepared fraud risk assessments and fraud control plans
- The Commission has in place appropriate fraud control mechanisms that meet its specific needs
- All reasonable measures have been taken to appropriately deal with fraud relating to the Commission.

This report was approved for presentation to you in accordance with a resolution of the Board on 10 September 2019.

I commend this report to you as a record of our achievements and compliance.

Yours sincerely

Professor Villis Marshall Ac Chair

Vela Mous held

Australian Commission on Safety and Quality in Health Care 10 September 2019

Contents

Letter of transmittal	1
1. Overview	4
About the Commission	6
Report from the Chair	8
Report from the Chief Executive Officer	10
Strategic Plan 2014–2019	12
2. Report on	
performance	14
Priority 1: Patient safety	16
Priority 2: Partnering with patients, consumers and communities	36
Priority 3: Quality, cost and value	40
Priority 4: Supporting health professionals to provide safe	
and high-quality care	46
The state of safety and quality in Australian health care	62
Annual performance statements	64
3. Corporate governa	nce
and accountability	72
Legislation and requirements	74
The Commission's Board	77

85

Committees

Internal governance arrangements External scrutiny	88 90	7. Indexes and references	136
4. Our organisation Organisational structure People management Staff profile Workplace health and safety Learning and development Workplace diversity Aboriginal and Torres Strait Islander employment	94 96 98 99 100 101 102	Acronyms Glossary Index of figures Index of tables Compliance index Index References	138 140 145 146 147 151 158
5. Financial Statements Independent auditor's report Financial Statements Notes to and forming part of the Financial Statements for the period ended 30 June 2019	104 106 108		
6. Appendices Appendix A: Freedom of information summary	130 132		
Appendix B: Compliance to ecologically sustainable development Appendix C: Related-entity transactions	133 135		

Overview



This section provides an overview of the Australian Commission on Safety and Quality in Health Care (the Commission) – including its mission, role, functions and accountability – and reports from the Commission's Chair and Chief Executive Officer (CEO).

About the Commission	6
Report from the Chair	8
Report from the Chief Executive Officer	10
Strategic Plan 2014–2019	12

About the Commission

In 2006, the Council of Australian Governments (COAG) established the Commission to lead and coordinate national improvements in the safety and quality of health care. The Commission's permanent status was confirmed with the passage of the *National Health and Hospitals Network Act 2011*, while its role was codified in the *National Health Reform Act 2011*. The Commission commenced as an independent statutory authority on 1 July 2011, funded jointly by the Australian Government and by state and territory governments.

Our purpose

Our purpose is to contribute to better health outcomes and experiences for all patients and consumers, and improved value and sustainability in the health system by leading and coordinating national improvements in the safety and quality of health care. Within this overarching purpose the Commission aims to ensure that people are kept safe when they receive health care and that they receive the care they should.

The functions of the Commission are specified in section 9 of the National Health Reform Act, and include:

- Formulating standards, guidelines and indicators relating to healthcare safety and quality matters
- Advising health ministers on national clinical standards
- Promoting, supporting and encouraging the implementation of these standards and related guidelines and indicators
- Monitoring the implementation and impact of the standards
- Promoting, supporting and encouraging the implementation of programs and initiatives relating to healthcare safety and quality matters
- Formulating model national schemes that provide for the accreditation of organisations that provide healthcare services and relate to healthcare safety and quality matters
- Publishing reports and papers relating to healthcare safety and quality matters.

These functions guide the Commission in undertaking its work, and are expressed in four strategic priorities that aim to ensure patients, consumers and communities have access to and receive safe and high-quality health care. These priorities, and the outcomes for the health system that the Commission seeks to achieve in each area, are as follows:



Patient safety: A health system that is designed to ensure that patients and consumers are kept safe from preventable harm



Partnering with patients, consumers and communities: A health system where patients, consumers and members of the community participate with health professionals as partners in all aspects of health care



Quality, cost and value: A health system that provides the right care, minimises waste and optimises value and productivity



Supporting health professionals to provide safe and high-quality care: A health system that supports safe clinical practice by having robust and sustainable improvement systems.

Our accountability

The Commission is a corporate Commonwealth entity and part of the Health portfolio of the Australian Government. As such, it is accountable to the Australian Parliament and the Minister for Health, the Honourable Greg Hunt MP.



Report from the Chair

Professor Villis Marshall Ac

Australia has one of the best healthcare systems in the world.
Australians experience comparatively better health outcomes than people in most other countries.
The Commission's focus is on continuously improving these outcomes by making system-wide positive changes to how health care is provided to all Australians, and this report highlights these efforts.

In 2018–19, I was proud to be involved with the launch of the National Safety and Quality Health Service Standards User Guide for Aboriginal and Torres Strait Islander Health in August 2018. The User Guide reinforces that positive improvements to the delivery of health services to Aboriginal and Torres Strait Islander people can only be achieved by working in a respectful and meaningful partnership with Aboriginal and Torres Strait Islander communities. The National Safety and Quality Health Service (NSQHS) Standards (second edition) now includes six actions that specifically address the needs of Aboriginal and Torres Strait Islander people and are integrated and designed to work holistically to raise the safety and quality of health care provided to all Australians.

The User Guide was one of several significant releases by the Commission in 2018–19. The third report on antibiotic

use and resistance in Australia, AURA 2019: Third Australian report on antimicrobial use and resistance in human health, is a key resource in Australia's fight against the threat of increased antimicrobial resistance. With the increased volume of data now captured from across Australia, the report is one of the most comprehensive of its type in the world.

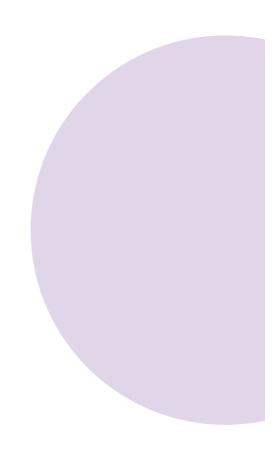
The Third Australian Atlas of Healthcare Variation, published in 2018, examines differences in healthcare use according to where people live within Australia. With the release of each Atlas we see the potential for relevant data to drive meaningful change. Produced in partnership with the Australian Institute of Health and Welfare, this Atlas identifies wide disparities in the use of some health treatments and investigations, particularly for the youngest and oldest members of our community. The Atlas series is designed to assist clinicians, consumers and policy makers across Australia to consider the most appropriate health care for the needs of the patient.

It is pleasing to see that these publications, and many others produced by the Commission, are becoming firmly embedded as valuable tools supporting the safety and quality of Australian health care.

Further driving improvements in the safety and quality of health care, this year also marked the start of accreditation to the NSQHS Standards (2nd ed.). The seamless transition on 1 January 2019 is a testament to the comprehensive program of communication, consultation and collaboration that the Commission undertook in the development and rollout of the second edition.

I am proud to say that collaboration continues to be at the heart of this work, and the partnerships that we foster and maintain with the Australian Government, states and territories, the private sector, clinical experts, patients and carers, are critical in achieving our goals.

In presenting our Annual Report for 2018–19, it is these partners who I would like to thank first for their support. I also extend my thanks to the members of the Commission's Board, for their advice and guidance. On behalf of the Board, I would like to thank Minister Hunt for his continuing leadership and support. Finally, I thank the Commission's executive team and staff whose significant achievements are described in more detail in these pages.





Report from the Chief Executive Officer

Adjunct Professor Debora Picone AO

It has been a year of impressive achievements for the Commission and its partners. This Annual Report outlines many of the Commission's successes from the past year and provides a snapshot of its work in partnership with the Australian and state and territory governments, clinicians, consumer and patient groups, and the private sector. The Commission continues to support the Australian health system through sustained and nationally coordinated actions focused on multi-faceted and meaningful improvements to the safety and quality of care.

In 2018–19, the Commission released the *State of patient safety and quality in Australian hospitals 2019*¹, a comprehensive analysis of patient safety and quality in Australia. The report is important because it draws on data from a wide range of sources and it helps people to understand their health system, what the system is doing to improve safety and quality, and how successful these efforts are. It can also help to bring about change and improvement in experiences and outcomes for patients, particularly around safety and quality.

The identification of meaningful data is fundamental to improving patient outcomes through clinically appropriate risk management responses. The Commission's partnership with the Independent

Hospital Pricing Authority continued in 2018–19, with the refinement of indicators for local monitoring of hospital-acquired complications (HACs) and sentinel events. In 2018–19, the HACs specification list was revised and includes two new HACs significant to the mental health setting. The national sentinel events list was also revised.

At the hospital and health service level. the NSQHS Standards (2nd ed.) was successfully introduced into health service organisations along with changes to the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme to improve the rigour of assessment processes. As of 30 June 2019, all health service organisations in Australia have been assessed to the NSQHS Standards (first edition) at least once, and almost 100 health service organisations have been assessed to the NSQHS Standards (2nd ed.). The reform strategies to the AHSSQA Scheme are being implemented, including a comprehensive orientation program for all assessors to the NSQHS Standards (2nd ed.), assessments at short notice and attestation statements that must be submitted by governing bodies.

An important lever for driving change is the Commission's clinical care standards. In 2018, the Commission released two new clinical care standards, Venous Thromboembolism Prevention and Colonoscopy. In late 2018, at the request of the Australian Government Department of Health, the Commission began work to support the implementation of the Colonoscopy Model, including the Colonoscopy Clinical Care Standard. This work includes the development of a quality indicator dataset, the implementation of the clinical care standard through the NSQHS Standards (2nd ed.), and the development of supporting resources for clinicians and health service organisations.

The Commission was also engaged by the Australian Government Department of Health to develop a certification framework and national standards for digital mental health services, and to develop the National Clinical Trials Governance Framework. This will provide nationally consistent accreditation for health services undertaking clinical trials.

This is just a snapshot of the important work managed by the Commission in leading and coordinating national improvements in the safety and quality of health care in Australia.

I would like to thank the Commission's Board, health ministers, and health chief executive officers for their leadership and contributions to improving the safety and quality of health care. I would also like to thank the Australian Government and state and territory partners, private sector colleagues, clinical and consumer advisors and all other stakeholders who work in partnership with the Commission. Finally, I would like to acknowledge the commitment and outstanding service of the Commission's staff for our achievements this year.

Strategic Plan 2014–2019

Figure 1: The Australian Commission on Safety and Quality in Health Care's Strategic Plan 2014–2019.

SAFETY. QUALITY. EVERY PERSON.



PATIENT SAFETY

A health system that is designed to ensure that patients and consumers are kept safe from preventable harm



PARTNERING WITH PATIENTS, CONSUMERS AND COMMUNITIES

A health system where patients, consumers and members of the community participate with health professionals as partners in all aspects of health care



QUALITY, COST AND VALUE

A health system that provides the right care, minimises waste, and optimises value and productivity



SUPPORTING HEALTH PROFESSIONALS TO PROVIDE SAFE AND HIGH-QUALITY CARE

A health system that supports safe clinical practice by having robust and sustainable improvement systems

EVERYWHERE. EVERY TIME.









Better outcomes and experiences for patients and consumers

Greater value SAFETY.
QUALITY.
EVERY PERSON.
EVERYWHERE.
EVERY TIME.

Greater sustainability

Safety and quality systems enable safe clinical practice

The Australian Commission on Safety and Quality in Health Care leads and coordinates national improvements in the safety and quality of health care based on best available evidence. The Commission works in partnership with patients, consumers, clinicians, managers, policymakers and healthcare organisations to achieve a sustainable, safe and high-quality health system.

berformance Report on



This section details the Commission's achievements against its four priority areas.

Priority 1: Patient safety	16
Priority 2: Partnering with patients, consumers and communities	36
Priority 3: Quality, cost and value	40
Priority 4: Supporting health professionals to provide safe and high-quality care	46
The state of safety and quality in Australian health care	62
Annual performance statements	64

Priority 1: Patient safety

This priority area aims to ensure patients and consumers are kept safe from preventable harm.

Implementation of the National Safety and Quality Health Service (NSQHS) Standards

The primary aim of the NSQHS Standards is to protect the public from harm and to improve the quality of health service provision. They outline safety and quality outcomes that a health service organisation must achieve, while allowing health service organisations the flexibility to decide how to achieve these outcomes in a way that is appropriate for their context. The NSQHS Standards (2nd ed.) was approved by Health Ministers in 2017 and assessment to these Standards commenced from January 2019.

All hospitals and day procedure services are required to implement the NSQHS Standards (2nd ed.). They must implement organisation-wide safety and quality processes and a comprehensive clinical governance framework. With the NSQHS Standards and a clinical governance framework in place, health service organisations can reduce the risk of harm to patients from hospital-acquired infections, the wrong medicines and errors associated with lapses in communication; and

improve the provision of comprehensive care and management of an acutely deteriorating patient.

Eight independent accrediting agencies are approved by the Commission to assess health service organisations against the NSQHS Standards. Health service organisations have to demonstrate they meet all of the requirements in the NSQHS Standards (2nd ed.) to achieve accreditation.

Since January 2013, all hospitals and day procedure services in Australia (1,312 organisations) have been assessed at least once to the standards prescribed in the NSQHS Standards (1st ed.), and 906 health service organisations have completed at least two assessment cycles. Of these organisations, 75% (675 organisations) met all core actions at the initial assessment for their second accreditation cycle, compared to 67% (609 organisations) for their first accreditation cycle, demonstrating an improvement in accreditation results over time.

The Commission supports health service organisations by providing evidence-based information, education and guidance for policy, strategy and action to improve safety and quality in high-risk areas. These include information, education and guidance on infection prevention and control; antimicrobial stewardship and medication



safety; management and prevention of deterioration in physical and mental state; management of cognitive impairment; prevention of falls and pressure injuries; and open disclosure and clinical communication.

The Commission also provides an advice centre to assist health service organisations to implement the NSQHS Standards. In 2018–19, the Commission's advice centre responded to 2,880 enquiries, which included 714 telephone enquiries and 2,166 email enquiries. The Commission continues to meet its service targets, responding to 92% of email enquiries within five business days.

National General Practice Accreditation Scheme

The National General Practice Accreditation Scheme started operation on 1 January 2018. Three accrediting agencies approved to assess general practices to the Royal Australian College of General Practitioners' Standards for General Practice are now reporting to the Commission on the outcomes of accreditation assessments. Through the National General Practice Accreditation Scheme, de-identified data on performance at accreditation assessments will be available nationally for the first time.

- 144 public hospitals, 98 private hospitals and 100 day procedure services were assessed by accrediting agencies in July–December 2018 under the NSQHS Standards (1st ed.)
- 38 public hospitals, 15 private hospitals and 34 day procedure services were assessed by accrediting agencies in January–June 2019 under the NSQHS Standards (2nd ed.)
- Assessed 2,246 general practices in 2018–19
- Conducted annual performance review meetings with accrediting agencies, with upcoming reform of the accreditation process highlighted
- Achieved service targets for responding to 92% of email enquiries within five working days.

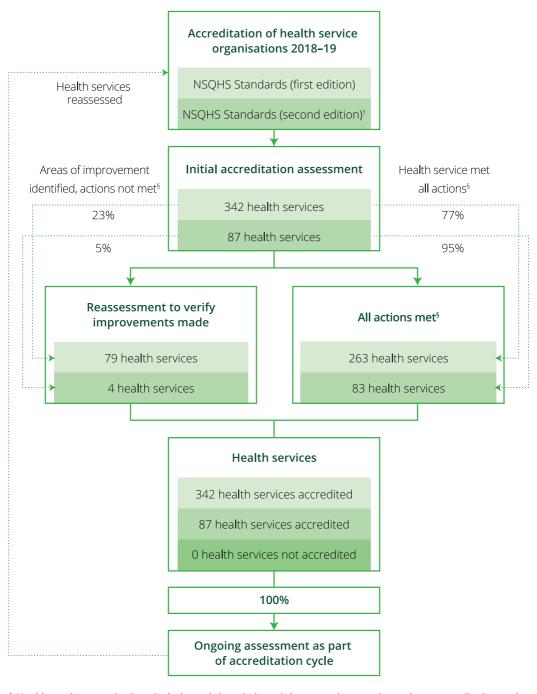


Figure 2: Health service organisation accreditation, 2018–19*

^{*} Health service organisations includes only hospitals and day procedure services, where accreditation to the NSQHS Standards is mandatory. Other services assessed to the NSQHS Standards are not included.

[†] For the NSQHS Standards (2nd ed.), these are finalised assessments as of 30 June 2019.

[§] For the NSQHS Standards (1st ed.), 'actions' refer to core actions.

Improving the reliability of the accreditation process

In 2016–17, the Commission undertook a comprehensive review of accrediting agencies, including a review of the approval process, and held performance review meetings with all approved agencies. During this, state and territory regulators and chief executives of health service organisations raised concerns about the reliability of the assessment process.

The Commission is responding to these concerns by implementing six strategies to improve the reliability of the accreditation process.

1. Improve the veracity of health service organisation assessments

- Introducing three-year accreditation cycles
- Applying a new rating scale
- Testing high-risk scenarios to ensure health service organisations are prepared
- Conducting assessments at short notice
- Requiring repeat assessments where large number of actions are not met at initial assessments
- Standardising reporting by accrediting agencies
- Engaging governing bodies of health service organisations by requiring submission of an annual attestation statement
- Using patient journey methodology
- Introducing flexible transition arrangements for 2019.

2. Improve the effectiveness and expertise of the assessment team

- Improving the feedback and oversight on performance of accreditation agencies
- Applying a structured assessment methodology to assess health service practices
- Providing orientation to assessors on the NSQHS Standards (2nd ed.).

3. Collect accreditation data to better inform assessment processes

- Using administrative safety and quality data to target assessments
- Prescribe the data to be reviewed by assessors.

4. Improve regulatory oversight

- Reducing the need for health service organisations to comply with multiple sets of standards
- Addressing conflicts of interest in accreditation processes.

5. Improve communication about the assessments and their outcomes

- Reporting publicly on assessment outcomes
- Communicating with stakeholders about accreditation.

6. Improve resources and support for health service organisations

- Supporting health service organisations preparing for assessment
- Providing guidance for internal assessment processes for health service organisations
- Providing guidance on the use of patient journey methodology by health service organisations.²

Combined, these strategies will ensure the accreditation process will more accurately assess a health service organisation's compliance against the NSQHS Standards (2nd ed.), rather than examine their preparedness for an assessment.

Implementation of these strategies commenced, along with the NSQHS Standards (2nd ed.), from January 2019.

In 2019–20, the Commission will work with relevant parties to introduce standardised assessment reporting for public reporting of accreditation outcomes.

- Improved the reliability of the accreditation process
- Health service organisations commenced assessments to the NSQHS Standards (2nd ed.)
- A total of 87 hospitals and day procedure services were assessed to the NSQHS Standards (2nd ed.) as at 30 June 2019.

Antimicrobial resistance, antimicrobial use, antimicrobial surveillance and healthcare-associated infections

The Antimicrobial Use and Resistance in Australia (AURA) Surveillance System provides data and information to support Australia's strategic response to one of the most significant challenges facing health care around the world: antimicrobial resistance (AMR).

AMR reduces the range of antimicrobials available to treat infections, and increases morbidity and mortality associated with infections caused by multi-drug resistant organisms. AMR is well established as a priority action due to its serious and growing impact on human health.

In May 2019, the Commission released *AURA* 2019: Third Australian report on antimicrobial use and resistance in human health. AURA 2019 focuses primarily on analyses of antimicrobial use and resistance data for 2016 and 2017, and includes an analysis of the National Alert System for Critical

Antimicrobial Resistances (CARAlert) data for 2018. The expansion of AURA since the publication of AURA 2017 has enhanced the capacity for analysing trends.

The AURA reports from the Australian Group on Antimicrobial Resistance (AGAR) sepsis outcome programs for data from 2015 to 2017, demonstrate that vancomycinresistant *Enterococcus faecium* (VRE) strains are now very common across Australia, exceeding 40% of all *E. faecium* since 2010. The percentage of *E. faecium* bacteraemia isolates resistant to vancomycin is now higher in Australia than in almost all European countries. *E. faecium* can cause urinary tract infections, intra-abdominal infections and septicaemia.

The Commission is working to increase vigilance in the management of VRE, using strategies from the *Australian Guidelines* for the *Prevention and Control of Infection in Healthcare*. This work will develop resources to support the prevention, identification and management of VRE; alert health professionals, health departments and hospital executives to the changing epidemiology of VRE in Australia; and provide information on VRE for health service organisations and consumers.

- Published AURA 2019: Third Australian report on antimicrobial use and resistance in human health
- Published detailed reports for each of the AURA Surveillance System programs including: AGAR; CARAlert; National Antimicrobial Prescribing Surveys; National Antimicrobial Utilisation Surveillance Program (NAUSP); and Australian Passive AMR Surveillance.

Highlights from AURA 2019

Antimicrobial use in hospitals

In hospitals, antibiotic use is increasing, but inappropriate prescribing levels remain steady. In 2017, total-hospital antibiotic use in hospitals that participated in the National Antimicrobial Utilisation Surveillance Program (NAUSP) increased for the first time since 2013. Understanding this change and identifying interventions to avoid further increases in antibiotic use will be an area of focus for the hospital sector.

The overall rate of inappropriate prescribing in hospitals that participated in National Antimicrobial Prescribing Survey (NAPS) has been static since 2013. In 2017, 23.5% of prescriptions assessed were found to be inappropriate. Encouragingly, antimicrobial stewardship programs in Australia have led to improvements in key performance indicators, such as documentation of indication and duration of surgical prophylaxis. However, the static rate of inappropriate prescribing requires further attention.

In primary care, antibiotic use is decreasing

The rate of antibiotic dispensing under the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS) declined in 2016 and further declined in 2017, following steady increases between 2013 and 2015.

This is the first downward trend in community antibiotic dispensing since the late 1990s. While the decline in overall prescribing rates is a positive step, inappropriate prescribing practices persist. As a large proportion of antimicrobials are used in primary care settings, improving prescribing in primary care continues to be a priority.

In aged care homes, levels of inappropriate antibiotic use and rates of AMR are high

Monitoring antibiotic use and AMR in aged care homes is important because multidrug-resistant organisms are well established in this setting, and aged care homes have high levels of unnecessary antimicrobial prescribing and inappropriate antibiotic use. Almost 1 in 10 residents of aged care homes that participated in the Aged Care NAPS were prescribed at least one antimicrobial.

Antimicrobials were often used for unconfirmed infections, and more than half of antimicrobial prescriptions were for residents who had no signs or symptoms of infection. The Commission will work with the Aged Care Quality and Safety Commission to provide antibiotic use and AMR data, and collaborate on the development of these strategies.



AMR is increasing for some organisms

While national rates of resistance for many priority organisms have not changed substantially, AURA 2019 reported several notable increases in AMR:

- **Escherichia coli** resistances to common agents used for treatment continue to increase. Resistance to ceftriaxone, ciprofloxacin and other fluoroquinolones has continued to rise in isolates from community-onset infections, despite restriction of access to these agents on the PBS
- Enterococcus faecium overall rates of vancomycin resistance are declining nationally, although the absolute number of isolates with vancomycin resistance continues to increase
- Neisseria gonorrhoeae rates of azithromycin resistance initially remained low, with a slight upward trend from 2012 to 2015. There has been a sharp upward trend since 2015, and 9.3% of isolates were resistant in 2017. The total number of notifiable cases also continues to increase
- Neisseria meningitides the number of notifiable cases increased, and reduced susceptibility to benzylpenicillin reached almost 45% in 2017. Resistance to benzylpenicillin is now almost 6%, which may impact on treatment guidelines
- Salmonella ciprofloxacin resistance in typhoidal species (Salmonella typhi and Salmonella paratyphi) exceeded 60% in 2017, confirming that ciprofloxacin should no longer be relied on for empirical treatment.
- Staphylococcus aureus communityassociated methicillin-resistant S. aureus has become highly prevalent in remote and very remote regions compared with urban areas.

Prescribing for chronic obstructive pulmonary disease needs improvement

There is a long-term trend in hospitals of high levels of inappropriate prescribing of antibiotics for the exacerbation of chronic obstructive pulmonary disease (COPD), a common condition for which broad-spectrum, rather than narrow-spectrum, antibiotics are prescribed. Targeted strategies and guidelines, involving collaboration between clinicians involved in AMS and specialists managing patients with COPD, are needed to improve the appropriateness of antibiotic prescribing for treatment of COPD in hospitals.

Amoxicillin-clavulanic acid and cefalexin prescribing is often inappropriate

Broad-spectrum antibiotics, such as amoxicillin–clavulanic acid and cefalexin, have greater potential to promote the development of AMR than narrow-spectrum antibiotics. They are prescribed in high volumes in both community and hospital settings. Prescribing of these agents is often inappropriate, particularly for sinusitis, and lower respiratory tract, urinary tract, and skin and soft tissue infections. Strategies to promote symptom management in place of inappropriate antibiotic prescribing, and increase the use of narrower-spectrum antibiotics, will be areas of focus for AURA.

Safety in digital health

The Commission contributes to safety in digital health by optimising safety and quality in the rollout of clinical systems. It focuses on hospital medication management programs and discharge summaries, and using digital health initiatives to improve the safety and quality of health care, including antimicrobial stewardship.

My Health Record Clinical Safety Program

The Australian Digital Health Agency (the Agency) is the My Health Record system operator. The Agency appointed the Commission to undertake a clinical safety program for the My Health Record system and other national digital health infrastructure for 2016–2019.

In 2018–19, this included three clinical safety reviews (CSRs):

CSR 16 – to analyse the use of the My Health Record system for the potential prevention of emergency department (ED) presentations, avoidable hospital readmissions and hospital-acquired complications (HACs) relating to the use of medicines

CSR 17 – to establish a contemporary baseline understanding of current electronic health record (EHR) systems in residential aged care facilities (RACFs). It will also help establish a comparative analysis of functionality available in these systems relating to the My Health Record, including workflow related insights

CSR 18 – to identify best practice and preferred reporting channels for healthcare providers to report events/ incidents related to the My Health Record system to the system operator.

In 2018, the Commission established the My Health Record External Assurance Committee. The committee provides ongoing independent external assurance to the Agency's My Health Record system clinical incident management and clinical safety risk management systems.

My Health Record in Emergency Departments project

In partnership with the Agency, the Commission is conducting the My Health Record in Emergency Departments project, to establish routine use of the My Health Record system by clinicians in hospital EDs.

A literature review and stakeholder consultation workshops were conducted to investigate the benefits, potential patient outcomes and barriers to the use of EHRs in the ED setting.

The My Health Record was found to have the potential to support healthcare providers in EDs by providing timely and secure access to a patient's clinical history. A number of the barriers and enablers of EHR use by ED clinicians identified through this project are also likely to be common to healthcare providers in other acute care settings.

A draft framework has been developed based on the literature review, international experience and My Health Record participation trials conducted in the primary health networks of Nepean Blue Mountains and Northern Queensland. In April 2019, the Commission published a supplement in the *Medical Journal of Australia* describing the key findings to date for this project.

Digital mental health services

The Australian Government Department of Health (the Department) has engaged the Commission to develop a certification framework and national standards for digital mental health services. The certification framework will support ongoing safety and quality assurance for digital mental health services, including those listed on the Australian Government's digital mental health gateway Head to Health.

The Commission conducted a broad stakeholder consultation process in March and April 2019, including six face-to-face workshops, three online workshops, and an online written survey. The Commission also conducted a literature scan and sought legal advice regarding the current regulatory and legislative requirements for digital mental health services.

The Commission recommended options to the Department for the design and development of a certification framework and national standards for digital mental health services, in June 2019. The Commission will commence the development and design of the certification framework during 2019–20.

- Conducted three clinical safety reviews of the My Health Record system and national digital health infrastructure
- Provided secretariat and expert advice to the My Health Record External Assurance Committee to provide ongoing independent external assurance to the Agency's My Health Record clinical incident-management and clinical safety risk-management systems
- Continued to establish routine use of the My Health Record system by clinicians in hospital EDs
- Commenced a project to develop a certification framework and national standards for digital mental health services.

Medication safety

The Commission is responsible for the ongoing stewardship of nationally standardised tools used in Australian hospitals to prescribe, dispense and administer medicines safely.

The Commission maintains a suite of standardised national medication charts, incorporating feedback and guidance provided by clinicians and medication safety experts. This standardised presentation of medication information for a patient reduces the risk of errors in medication prescribing, dispensing and administration.

Electronic medication management

The use of electronic medication management (EMM) systems is increasing in Australia. To assist with their implementation, the Commission has developed an EMM self-assessment tool (SAT) for hospitals.

The EMM SAT is a quality improvement, checklist-style tool developed to assist health service organisations to assess and optimise the use of EMM systems. Domains and indicators that comprise the EMM SAT were developed and reported in the Commission's publications: Electronic Medication Management Systems: A guide to safe implementation (third edition); and Electronic Medication Management Systems Business Requirements. Pilot testing of the indicators within the EMM SAT was conducted in May 2019, with testing of the online module taking place from August 2019.

Following the development of the EMM SAT, the Commission conducted a feasibility assessment to identify whether a similar tool would be useful to clinicians when applied to software used in primary care. This assessment determined that such a tool would be useful and would help to better support patient care. A literature review was conducted, and a working group will be convened in early 2020.

The Pharmaceutical Benefits Scheme Hospital Medication Chart

More than 100 public and private hospitals have implemented the PBS Hospital Medication Chart (HMC). It enables the prescribing, administering, supply and claiming of PBS eligible medicines without the need for a conventional prescription.

In early 2018, the Commission began an evaluation of the PBS HMC. Findings from the National Standard Medication Chart (NSMC) national audit in October 2018 were included in the evaluation of the PBS HMC, which was published on the Commission's website.

National Standard Medication Chart

The Commission hosts the NSMC audit system for local and national audits. The NSMC audits aim to evaluate the effect of standardised medication charts on the safety and quality of prescribing and medication documentation, and identify further areas for improvement in medication management. In October 2018, a national audit of NSMCs was conducted, involving 361 public and private hospitals, with 10,608 individual patient charts audited.

The Commission has also undertaken a number of other medication safety projects in 2018–19, including:

- User testing of dispensed prescription medicine labels to inform development of a national standard
- Stewardship of a secure clearing house portal for states and territories to share alerts and advisories pertaining to medicines and medical devices.

Response to the Third World Health Organization Global Patient Safety Challenge

The Commission was tasked by the Department to develop Australia's response to the Third World Health Organization Global Patient Safety Challenge – Medication without harm. In Australia, the goal is to reduce avoidable medication errors, adverse drug events and medication-related hospital admissions by 50% by 2025.

During 2018–19, the Commission consulted with its committees, stakeholders and the general public on initiatives and programs to reduce severe, avoidable medication-related harm in Australia. Literature reviews were completed for the three flagship areas: inappropriate polypharmacy, high-risk medicines, and transitions of care.

High-risk medicines education courses

The Commission is coordinating an intergovernmental deed of agreement for the development of online courses on high-risk medicines, in partnership with SA Health. The Commission adapted four topics for national use: Introduction to high-risk medicines, Anticoagulants, Clozapine, and Insulin. The next topic to be developed will be Opioid analgesics.

National dispensed labelling standard

The Commission commenced a project to develop a national dispensed labelling standard, as part of its work plan for partnering and communicating with consumers.

Misunderstandings around how and when to take a medicine can lead to their unintentional misuse with potentially adverse health outcomes for consumers. Dispensed medicine labels should present information for consumers to use their medicine safely and effectively, in a way that is clear and easy to understand. Prototype labels were developed for solid oral dose forms, oral liquids, creams and eye drops. These were assessed for consumer understanding in two rounds of user testing.

This testing has informed the formatting and positioning of information and the optimal presentation of dosing intervals for consumer understanding. Three hospitals are testing the prototype labels on patients awaiting discharge from hospital. The hospitals will evaluate patient understanding and the behaviours invoked by the information presented on the label. Results from user testing and the hospital evaluations will be used to inform the national dispensed labelling standard.

- Developed an EMM SAT
- Conducted an evaluation of the uptake and use of the PBS HMC
- Coordinated the national audit of the NSMC
- Completed literature reviews for the three flagship areas of the Third World Health Organization Global Patient Safety Challenge
- Developed online high-risk medicines courses in partnership with SA Health
- Completed user testing of dispensed prescription medicine labels
- Provided stewardship of a secure clearing house portal for states and territories to share alerts and advisories pertaining to medicines and medical devices.

Mental health

The Commission has an ongoing commitment to supporting safety and quality in the delivery of health care for people with mental health issues. In 2018–19, the Commission's mental health work included the release of new resources to support implementation of the NSQHS Standards (2nd ed.), the development of new indicators specific to mental health, scoping of the safety of digital mental health services, and wide-ranging attention to the use of antipsychotics.

The Commission released the NSQHS Standards User Guide for Health Services Providing Care for People with Mental Health Issues (the User Guide). This complements existing resources such as the NSQHS Standards Guide for Hospitals and the NSQHS Standards Accreditation Workbook. It provides additional information about how specific actions in the NSQHS Standards (2nd ed.) address issues identified by people with mental health issues that affect their experience of health care. The User Guide includes examples of innovative approaches to providing optimal care for people with comorbid mental and physical health issues.

In 2018–19, the Commission also developed new indicators for HACs specific to mental health, and hosted a roundtable to review the sentinel event of suicide in a mental health inpatient unit.

The Commission also considered the use of antipsychotics in a number of ways in 2018–19: the Commission's cognitive impairment team continued work to reduce the inappropriate use of antipsychotics to control the behaviour of people with behavioural and psychological symptoms of dementia, the *Third Australian Atlas of Healthcare Variation*

included a repeat analysis of rates of prescription of antipsychotics across the life span, and antipsychotics are included as high-risk medicines as part of the Third World Health Organization Global Patient Safety Challenge.

The Commission continues its work with partners to implement actions in the *Fifth National Mental Health and Suicide Prevention Plan*

Highlight

 Released NSQHS Standards User Guide for Health Services Providing Care for People with Mental Health Issues.



Cognitive impairment

People with cognitive impairment in hospital are at increased risk of harm, preventable complications and poor outcomes. For some people admitted to hospital, delirium can be prevented with the right care.

During 2018–19, the Commission continued the Caring for Cognitive Impairment campaign to assist health service organisations to improve care and prepare for assessment of the new cognitive impairment items in the NSOHS Standards (2nd ed.).

As at 30 June 2019, 2,259 individuals and 229 hospitals have joined the campaign. A total of 36 external organisations have supported the campaign. As part of the campaign, the Commission participated in a number of educational events. For example, in March 2019 the Commission sponsored the Western Australian Acute Care Symposium where local hospital cognitive champions showcased their work.

In 2018–19, the Commission also released the NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium, which provides further guidance for health service organisations. The NSQHS Standards relevant for cognitive impairment are summarised in the Cognitive Impairment: Actions in the National Safety and Quality Health Service Standards Actions for Health Service Organisations.

A Better Way to Care: Safe and high quality care for patients with cognitive impairment or at risk of delirium in acute health services (second edition) was also released to guide clinicians. The key steps of the safety and quality pathway for patients with cognitive impairment or at risk of delirium were outlined in the released fact sheet, Cognitive Impairment: Clinicians can take action to reduce the risk of harm.

The Commission's work to reduce inappropriate use of antipsychotics continued in 2018–19. The Commission made recommendations for regulatory changes following a repeat analysis of the use of antipsychotic medicines in the *Third Australian Atlas of Healthcare Variation*, released in December 2018.

The Commission provided representatives and expert advice to the Ministerial Aged Care Clinical Advisory Committee and the stakeholder group examining regulations to reduce chemical and physical restraint. The Commission also contributed to the Senate Community Affairs Reference Committee inquiry into Effectiveness of the Aged Care Quality Assessment and Accreditation Framework, and provided a submission to the Royal Commission into Aged Care Quality and Safety.

Caring for Cognitive Impairment campaign supporters

2,259 individuals
229 hospitals

Highlights

- Released NSQHS Standards User Guide for health service organisations providing care for patients with cognitive impairment or at risk of delirium
- Released A Better Way to Care: Safe and high quality care for patients with cognitive impairment or at risk of delirium in acute health services (2nd ed.)
- Released fact sheet *Cognitive Impairment: Clinicians can take* action to reduce the risk of harm
- Continued the Caring for Cognitive Impairment campaign, with 229 hospitals, 2,259 individuals and 36 supporting organisations participating in the campaign

• Continued to provide advice to reduce inappropriate use of antipsychotics.



Communicating for safety

Communication is a key safety and quality issue and effective communication plays a vital role in ensuring safe high-quality care. Risks to patient safety occur when clinical information about care is not adequately communicated, documented or shared between healthcare teams, the patient and their support people.

In 2018–19, the Commission continued work to improve clinical communications and to support implementation of the NSQHS Standards (2nd ed.).

The online Communication for Safety resource portal provides an easily navigable repository of resources that support clinicians and health service managers to improve clinical communication. Since its launch in 2018, the portal has been continuously updated and enhanced with additional tools and guidance, and it now contains links to over 100 resources.

To support actions in the NSQHS Standards (2nd ed.), the Commission commenced scoping work to better understand what is currently in place to support multidisciplinary teamwork, collaboration and effective communication skills acquisition in Australian health services. This work aims to identify initiatives, lessons learned and best-practice examples that can be shared nationally, and areas where there may be gaps or opportunities for improvement.

In early 2018, the Commission commenced a project to review the extent to which the Australian Open Disclosure Framework (Framework) is being implemented in health services. The Framework was endorsed by all Australian health ministers in December

2013. Under the NSQHS Standards (2nd ed.), health services are required to use an open disclosure program that is consistent with the Framework; and monitor and act to improve the effectiveness of open disclosure processes. An Open Disclosure Advisory Group has been appointed to provide advice on the project. Outcomes of this review will inform future work and resources to support open disclosure practices that meet the needs of patients, families, carers, the workforce and the health system.

- Updated and enhanced the online Communicating for Safety resource portal
- Commenced a scoping review to improve multidisciplinary teamwork and acquisition of clinical communication skills
- Commenced a project to review the extent to which the Australian Open Disclosure Framework is being implemented in Australian health services.

Comprehensive care

The Comprehensive Care Standard is one of the new components of the NSQHS Standards (2nd ed.). The intent of the standard is to ensure that patients receive comprehensive care – the coordinated delivery of the total health care required or requested by a patient. This care should be aligned with the patient's expressed goals of care and healthcare needs, considerate of the impact of the patient's health issues on their life and wellbeing, and clinically appropriate.

The standard aims to address the crosscutting issues which underlie many adverse events, and to optimise each person's health care while considering how risk and harm can be minimised along each patient journey.

The Commission is developing a suite of resources to support implementation of the Comprehensive Care Standard. Resources developed in 2018–19 included:

- Implementing the Comprehensive Care Standard: Essential elements for delivering comprehensive care
- Implementing the Comprehensive Care Standard: Approaches to person-centred risk screening

- Implementing the Comprehensive Care Standard: Identifying goals of care
- Implementing the Comprehensive Care Standard: Developing a single comprehensive care plan
- 13 fact sheets supporting the Comprehensive Care Standard.

Two advisories were developed to support health service organisations to understand the requirements of actions in the Comprehensive Care Standard. The Commission also presented on the Comprehensive Care Standard at approximately 11 conferences, seminars and training sessions for clinicians, managers and consumers.

The Commission will continue to develop and provide guidance to health service organisations on the delivery of comprehensive care, in alignment with the requirements of the NSQHS Standards (2nd ed.). This will include future guidance on issues such as clinical assessment and diagnosis, and how to review and improve the delivery of comprehensive care.

- Published four guides, a series of fact sheets and two advisories to support implementation of the Comprehensive Care Standard
- Provided presentations on the Comprehensive Care Standard at approximately 11 events.

Patient safety in primary health care

Primary care' is the first point of contact within the health system for most Australians. It provides a range of services for the diagnosis and management of acute and chronic conditions³, and represents a significant proportion of all health care provided in Australia.

While the current primary care system performs well and most health care is associated with good clinical outcomes, some people do not receive the care that is recommended to them, and others are inadvertently harmed by the care they receive.⁴

Internationally, evidence about the nature and magnitude of patient harm in primary care settings is scarce but growing. To date, the majority of the work on patient safety has focused on the care provided within the acute hospital sector and, and to a lesser extent, on general practice settings.⁵

The evidence available on effective and sustainable patient safety solutions in primary care is also limited. This has led to a global call for action to better understand the nature and number of adverse patient outcomes in primary care, and how they can be addressed in these settings.

In 2018–19, the Commission moved to implement recommendations from consultation processes undertaken in 2017–18, and outlined in the Consultation Report: Patient safety and quality improvement in primary care.

The Commission continues to work in partnership with primary care partners and consumers to:

- Develop and implement national safety and quality standards for primary care services
- Scope the technical and operational requirements for a national incident reporting system for Australian primary healthcare services
- Partner with primary healthcare and acute care services to scope communication and care issues between the sectors
- Develop resources for primary healthcare services to support their partnering with consumers and enhance their clinical governance systems.

- Released the Consultation Report: Patient safety and quality improvement in primary care
- Commenced public consultation on national primary care safety and quality standards.

Transvaginal mesh

The Commission has developed a suite of resources for consumers, clinicians and health services on the use of transvaginal mesh devices for the treatment of stress urinary incontinence (SUI) and pelvic organ prolapse (POP). In developing these resources, the Commission reviewed the evidence on the use of transvaginal mesh, and worked with a reference group that included consumers, state and territory health departments, the Therapeutic Goods Association (TGA), and clinical experts nominated by relevant colleges and surgical specialty organisations.

The consumer resources provide information on treatment options and a series of questions to support women in decision making and discussions with their healthcare provider. These resources were developed in consultation with women who had mesh implanted, health consumer organisations, clinicians and state and territory health departments.

Care pathways for SUI, POP and mesh complications describe the clinical considerations to be made when assessing treatment options for women with SUI and POP, and have two components. The first

pathway is predominantly for general practitioners and the second supports specialists and uses a traffic light approach (red, yellow, green) to identify pathway options for surgical treatments, based on the level of evidence for each type of procedure. The mesh complications pathway provides guidance for general practitioners. These pathways have been shared with Primary Health Networks and state and territory health departments for integration into primary and acute care, as appropriate.

The Commission has also released a service model framework to support state and territory health departments in their planning for services for the use of transvaginal mesh devices and management of mesh-related complications.

The Commission is working collaboratively with the states and territories to promote: prospective data collection for women having mesh procedures now and into the future; improved data collection by senior medical officers being credentialed to undertake these procedures; and the establishment of appropriate services for women experiencing complications following mesh procedures.

- Released information for consumers on treatment options for mesh complications, including mesh removal
- Released general practitioner care pathways for SUI, POP and mesh complications
- Released surgical pathways for SUI and POP
- Released a service model framework for transvaginal mesh complications and removal.

Priority 2: Partnering with patients, consumers and communities

The aim of this priority area is to ensure the health system enables patients, consumers and members of the community to participate as partners with health professionals in all aspects of health care.

Person-centred healthcare organisations

Placing people at the centre of health care can improve the value delivered by health service organisations as it is integral to delivering care that matters to the patient. 'Person-centred care' is where patients, consumers and members of the community are treated as partners in all aspects of healthcare planning, design, delivery and evaluation; and is the foundation for achieving safe, high-quality care.

In 2018–19, the Commission continued to support health service organisations to foster the key attributes that are shared by high-performing person-centred healthcare organisations, through the development and release of a series of short videos describing person-centred care.

The Commission completed a review of the Australian Charter of Healthcare Rights, including two phases of online public consultation, workshops in three states, and revision and review by a range of key experts and advisory groups. The second edition of the Charter will be released in late 2019.

The Commission presented on personcentred care and the Partnering with Consumers Standard at 14 conferences, seminars and training sessions for clinicians, managers and consumers.

The Commission will continue to examine different ways to support the health system move towards a more consistently personcentred approach, building on findings and identifying and sharing information about excellence in person-centred care.

This will assist and support health service organisations in implementing a range of actions to meet the requirements of the NSQHS Standards (2nd ed.) including for actions within the Partnering with Consumers Standard, Comprehensive Care Standard and Clinical Governance Standard.



Highlights

- Reviewed the Australian Charter of Healthcare Rights
- Released three videos to support understanding of what person-centred care looks like in practice
- Provided presentations on person-centred care and Partnering with Consumers at 14 events.

Shared decision making and health information

Health decisions often have no single 'best choice' and may require a choice to be made from multiple options. For patients (and carers) to understand risks and have the opportunity to actively be involved in sharing decisions, clinicians need to provide clear and relevant information about treatment options, and the potential benefits, risks, trade-offs and uncertainties of each. This information should reflect the best available evidence and take into account the patient's personal opinions, preferences, values and priorities.

Over the past three years, the Commission, in partnership with a number of Australian specialist colleges, has developed and adapted an online education module for clinicians on risk communication and shared decision making. In 2018–19, the Commission worked with the Academy of Medical Royal Colleges

2. Report on performance

(United Kingdom) to adapt this module to the UK context, and the UK version of the education module was released in late 2018.

Decision support tools provide high-quality, synthesised information about particular conditions. They can help patients and clinicians compare the risks and benefits of treatment options, clarify what matters most to the patient, and assist patients and clinicians to make a shared decision about what is the best option for the individual.

In 2018–19, the Commission user-tested, finalised and released a decision support tool on osteoarthritis of the knee. The tool provides a summary of the evidence and potential impacts of key treatment options, and can be used by consumers when discussing their options, considering what matters most to them, sharing decisions and being involved in planning their care.

The Commission also undertook a structured review of consumer information on heavy menstrual bleeding, and identified a range of high-quality information resources that can be used to support consumers' decision making. The findings of this review were released in a report in late 2018.

During 2018–19, the Commission presented on health literacy and shared decision making at six conferences, seminars and training sessions for clinicians, managers and consumers.

- Facilitated the adaptation and release of an online education module on risk communication and shared decision making by the Academy of Medical Royal Colleges (UK)
- User-tested and released a decision support tool for patients with osteoarthritis of the knee
- Undertook a review of consumer information on heavy menstrual bleeding, and released a report identifying a range of highquality resources
- Provided presentations on health literacy at six events.

End-of-life care

'Safe and high-quality end-of-life care' is care that considers the needs, preferences and wishes of the patient. The health care that people receive in the last years, months and weeks of their lives can minimise the distress and grief associated with death and dying for the individual and for their family, friends and carers.

The Commission provides guidance and tools for healthcare organisations, clinicians and consumers to help identify where improvement can be made to the delivery of safe and high-quality end-of-life care. Core elements of these have been incorporated into the Comprehensive Care Standard, as part of the NSQHS Standards (2nd ed.).

In 2018–19, the Commission provided advice, support and guidance to health service organisations on meeting the requirements of the end-of-life care actions of the Comprehensive Care Standard, as part of the implementation of the NSQHS Standards (2nd ed.).

In addition, the Commission began development of a practical guide for health service organisations and clinicians for achieving end-of-life care that aligns with both the NSQHS Standards (2nd ed.) and the National Consensus Statement: Essential elements for delivering safe and high-quality end-of-life care (National Consensus Statement). This guide is expected to be released in 2019–20.

In partnership with the Department, work has also commenced to support the identification of patients at the end of life. It is anticipated this work will inform the development of tools and resources in this area in 2019–20.

During 2018–19 the Commission presented on end-of-life care at 12 events.

- Commenced development of a practical guide for achieving high-quality end-of-life care that aligns with the NSQHS Standards (2nd ed.) and the National Consensus Statement
- Commenced work to support identification of patients at the end of life, in collaboration with the Department
- Provided presentations on delivering safe and high-quality end-of-life care at 12 events.

Priority 3: Quality, cost and value

The aim of this priority area is to have a health system that provides the right care, minimises waste and optimises value and productivity.

Identifying healthcare variation

Australia is fortunate to have one of the best healthcare systems in the world; however, there are large variations in the way health care is currently delivered. Some geographic variation is expected as it can reflect differences in the health of specific populations or patient preferences; however when a difference in use does not reflect these factors it is unwarranted variation and represents an opportunity for the health system to improve patient care.

This improvement may involve increasing access to treatment options that produce better outcomes for patients, or reducing treatment with little or uncertain benefit. Addressing unwarranted healthcare variation can therefore benefit patients and improve the value gained from the health budget.

The Australian Atlas of Healthcare Variation series

To investigate clinical variation, the Commission has produced the *Australian Atlas of Healthcare Variation* series. Published in 2015, 2017 and 2018, the Atlases map differences in healthcare use according to where people live.

They reveal substantial variation in the use of many treatments and diagnostic procedures, and have raised important questions about why this variation might be occurring.

The Commission has worked closely with clinicians and government health departments to understand the reasons for variation for each of the mapped interventions, and what can be done to improve the appropriateness of care where unwarranted variation is suspected.

new clinical areas

repeat analyses

45

findings and recommendations



In December 2018, the Commission released the *Third Australian Atlas of Healthcare Variation*. The third Atlas focuses on:

- Patterns of use for 13 new data items, including interventions in neonatal and paediatric health, gastrointestinal investigations and treatments, thyroid investigations and treatments, and cardiac tests
- Reporting of changes over time for seven data items from the first Atlas to examine variation in behaviour in prescribing antimicrobial, opioid and psychotropic medicines
- Responses across the healthcare system to variation in healthcare use following the release of the first and second Atlases.

With the release of the third Atlas, the Commission has now made 161 recommendations for action across the series, including 43 for the Commission to address.

Highlights from the third Atlas

Antibiotics in children

The Atlas found high rates of antibiotic use in children, with more than 3 million antibiotic prescriptions dispensed for children aged 0–9 years in 2016–17. The rate of antibiotic use for children in Australia is high compared with other similar countries. For example, Australia's use in children 0–9 years is three times higher than in Norway and the Netherlands.

Overuse of antibiotics contributes to bacterial resistance, meaning antibiotics may be less effective in the future for children and others in the community. Emerging research also suggests changes to the normal gut bacteria caused by antibiotics may increase the risk of chronic disease in children, such as asthma and Crohn's disease.

Inappropriate prescribing of proton pump inhibitor medicines for infants

Proton pump inhibitor (PPI) medicines are sometimes used to treat infants with simple reflux or colicky symptoms, such as irritability or crying, even though there is evidence that they are not effective in these situations. The Atlas found an approximate four-fold difference between the lowest and highest state and territory rate in PBS dispensing of PPI medicines for infants aged 1 year and under in Australia.

These medicines reduce the level of stomach acid and children taking them are more likely to get infections such as gastroenteritis and pneumonia.

PPI medicines can also change the gut microbiome, which may increase the child's risk of developing allergies.

Colonoscopy

Most colonoscopies are performed to detect bowel cancer. Australia's National Bowel Cancer Screening Program recommends colonoscopy for people who have a positive faecal occult blood test. The Atlas found low rates of hospitalisation for colonoscopy in the following groups, raising concerns about their access to colonoscopy services:

- Aboriginal and Torres Strait Islander people
- People living in outer regional and remote areas
- People living in areas of low socioeconomic status.

Inappropriate rates of gastroscopy

Gastroscopy is used predominantly to investigate upper gastrointestinal symptoms such as heartburn and dyspepsia. It is also used to exclude a diagnosis of cancer. Rates of gastroscopy in Australia have risen by 3% per year between 2008 and 2017, despite low and relatively stable rates of oesophageal and stomach cancers.

The Atlas found that the rate of hospitalisation for gastroscopy varies seven-fold between local areas in Australia. The pattern of use suggests over-use of gastroscopy. In 2016–17, 274,559 gastroscopies and colonoscopies were performed during the same hospitalisation, representing 1,044 hospitalisations per 100,000 people of all ages. Both investigations are indicated in only a limited number of conditions, so the high rates reported suggest inappropriate use.

Proton pump inhibitor medicines in adults

PPI medicines are among the most commonly used medicines in Australia. Most use is for gastro-oesophageal reflux disease. The Atlas found that the rate of dispensing of PPI medicines in adults varies five-fold between local areas in Australia. There is good evidence that PPI medicines are overused and that many people are inappropriately using them for long periods. Lifestyle changes can reduce symptoms of reflux in many patients, without the risk of long-term complications that may be caused by PPI medicines.



Improving appropriateness of care

Clinical care standards aim to support the delivery of appropriate care, reduce unwarranted variation in care and promote shared decision-making between patients, carers and clinicians.

Clinical care standards target key areas where opportunities exist to better align clinical practice with the best available evidence. They identify and define the care people can expect to be offered or receive, regardless of where they are treated in Australia. They also include clinical indicators to help health service organisations and clinicians monitor and evaluate the care they provide.

In 2018, the Commission released two clinical care standards, on colonoscopy and preventing venous thromboembolism (VTE).

To support the implementation of the Colonoscopy Model, including the Colonoscopy Clinical Care Standard, the Commission is working with clinicians, health service organisations, consumers, peak bodies and the Department to develop supporting tools, finalise the quality indicator dataset, incorporate the Colonoscopy Clinical Care Standard into the NSQHS Standards (2nd ed.) and perform a pilot implementation.

An educational resource, Case for Change, has been developed to support clinicians and health service organisations to implement the VTE Prevention Clinical Care Standard.

Based on findings from the first and second Atlases, the Commission has developed the Cataract Clinical Care Standard in collaboration with ophthalmic professionals, consumers and health service organisations. The clinical care standard aims to ensure that patients with cataract are offered cataract surgery or non-surgical alternatives to suit their clinical needs. The Cataract Clinical Care Standard will be released in late 2019.

In response to recommendations contained in the second Atlas, the Commission is developing a clinical care standard on managing and preventing third and fourth degree perineal tears during birth. The Atlas identified a wide geographical variation in rates of tears across Australia. The clinical care standard aims to reduce the variation in care provided before birth to women at risk of severe perineal tears and to improve

the care provided to women who experience a severe perineal tear, including assessment of the injury, repair and holistic follow-up after leaving hospital. The Prevention and Management of Third and Fourth Degree Perineal Tears Clinical Care Standard will be released in early 2020.

The goal of the Peripheral Venous Access Clinical Care Standard is to promote the judicious use of peripheral intravenous catheters (PIVCs) and to raise awareness of the importance of maintaining a patient's blood vessel health.

The insertion of a PIVC is one of the most common clinical procedures performed, with up to 70% of patients requiring a PIVC during their hospital stay. However, PIVCs are associated with frequent complications including device failure for one-intwo devices inserted. The clinical care standard aims to support clinicians and health service organisations implement the delivery of high-quality care to reduce the complications associated with the insertion, management and removal of PIVCs. The Peripheral Venous Access Clinical Care Standard will be released in early 2020.

- Released the Colonoscopy Clinical Care Standard and the VTE Prevention Clinical Care Standard in late 2018
- Developed the Cataract Clinical Care Standard for release in late 2019
- Developing new clinical care standards on peripheral venous access, and managing and preventing severe perineal tears
- Developed and released a suite of materials to support clinicians and health service organisations to implement clinical care standards.

Priority 4: Supporting health professionals to provide safe and high-quality care

The aim of this priority area is to have a health system that supports safe clinical practice by implementing robust and sustainable improvement systems.

Indicators and data set specifications

In 2018–19, the Commission continued to develop and maintain indicators and dataset specifications that help to improve the safety and quality of health care.

Clinical care standard indicators

The Commission has continued to develop and specify indicators to support the implementation of clinical care standards. This has involved reviewing indicators to support stroke and acute coronary syndrome to ensure they remain fit for purpose, relevant and appropriate. Work to refine and develop the indicator set to support the cataract, peripheral venous access, and third and fourth degree perineal tear clinical care standards continues.

Accreditation

In 2018–19, the Commission developed an online data submission portal (the

portal) which enables accrediting agencies to submit accreditation outcomes data to the Commission. The purpose of the portal is to increase the transparency of accreditation processes and outcomes. The portal has the functionality to validate accreditation outcomes data and will only allow accrediting agencies to submit data that meet the specifications set by the Commission.

The portal supports data submission for the NSQHS Standards (2nd ed.) and the National General Practice Accreditation Scheme. The portal is now online, and the Commission has started receiving accreditation outcomes data for the NSQHS Standards (2nd ed.).

Core hospital-based outcome indicators

Core hospital-based outcome indicators (CHBOI) are a succinct set of indicators that can be generated by hospitals, states, territories and private hospital ownership groups. They are not intended to be used as performance measures.



The Commission has developed a CHBOI Toolkit to allow hospitals to assess their mortality and readmission outcomes, and to compare these to national figures. The toolkit includes statistical software codes, technical notes and nationallygenerated coefficients and reference sets.

In 2018–19, the Commission updated the nationally generated coefficients and reference sets in the CHBOI Toolkit. This update incorporated changes to ICD-10AM (the coding set used in admitted patient data in Australia) and admitted patient data for the years 2014–15 to 2016–17. Also, as part of this update, the Commission improved the functionality of the toolkit by including the current and previous ICD-10-AM editions and AN-DRG versions.

The Commission continued development work on the Australian Composite Model Hospital Standardised Mortality Ratio (ACM HSMR), which is a revised mortality outcome indicator. This included working with the Australian Institute of Health and Welfare (AIHW) to explore state and territory variations in palliative care

coding, along with updating coefficients and reference sets. The mortality outcome indicator has been made available in prototype format to those states and territories that have expressed interest.

- Reviewed and developed indicators to support clinical care standards
- Launched an online data submission portal which enables accrediting agencies to submit accreditation outcomes data to the Commission in a secure and consistent manner
- Developed data specifications to support the NSQHS Standards (2nd ed.) and the National General Practice Accreditation Scheme.

Patient-reported outcome measures

Patient-reported outcome measures (PROMs) provide a systematic way to assess the effectiveness of healthcare interventions from the consumer's perspective. They complement and extend more traditional measures of effectiveness, such as clinical indicators and measures of output or efficiency.

Momentum for the implementation of PROMs is building rapidly in Australia and internationally, with PROMs seen as key mechanisms for achieving two important health policy objectives: person-centred care and value-based care.

Australia is in the early stages of using PROMs. The Commission has developed a national work program to maximise the benefits of PROMs and support local innovation and information sharing as PROMs develop in Australia.

In 2018–19, the Commission developed a website to host information and evidence on the Australian and international use of PROMs and to provide a mechanism for knowledge sharing between early adopters of PROMs.

The Commission has also been involved in the development and piloting of PROMs internationally through involvement with the Organisation for Economic Cooperation and Development (OECD).

The Commission will continue to take a leading role in the strategic, policy and practical support for the largescale, evidence-based collection and meaningful use of PROMs in Australia.

Highlight

 Developed a website to host information on PROMs.

Measuring patient experience

Consistent and routine measurement of patient experience across all providers of hospital and day procedure services can provide an essential indicator of the quality and safety of a service and of a whole system in a way that is meaningful to consumers, funders and providers.

The Australian Hospital Patient Experience Question Set (AHPEQS) was developed by the Commission and funded by Australian Health Ministers' Advisory Council (AHMAC). In 2018, the Commission released the AHPEQS to assess patient experience in Australian health service organisations.

The AHPEQS is a non-proprietary, short and generic 12-question survey instrument which assesses core aspects of patient experience, without placing undue time burdens on the consumer. The 12 questions address issues which are meaningful to Australian patients regardless of their health condition, type of care or setting of treatment.

In 2018–19, the Commission launched the AHPEQS website, developed technical specifications to assist health services and established an AHPEQS implementers' community of practice (ACOP) closed email group. Health services will be able to use results from the AHPEQS for local quality improvement initiatives and to measure progress towards person-centred care.

Highlights

- Launched the AHPEQS website, which provides information for consumers and organisations implementing AHPEQS
- Established the AHPEQS implementers' community of practice (ACOP). The ACOP is a closed email group facilitated by the Commission, which enables early adopters to share implementation experiences and ideas
- Developed technical specifications for the AHPEQS, which will assist organisations to measure patient experience in an evidence-based and consistent manner.

Minimising harm

Although most health care in Australia is associated with good clinical outcomes, preventable adverse events and complications continue to occur across the Australian healthcare system. To assist in identifying instances of harm, the Commission's work includes the development of indicators for local monitoring of safety and quality relating to HACs and sentinel events.

Australian governments agree to implement reforms to improve safety and quality in our hospitals

In June 2017, all Australian Governments committed to develop and implement reforms to improve health outcomes for patients and decrease potentially avoidable demand for public hospital services through the National Health Reform Agreement (NHRA) Addendum.

The Addendum includes a focus on 'delivering safe, high-quality care in the right place at the right time'. It also outlines that the national health agreement will include 'funding and pricing for safety and quality, to avoid funding unnecessary or unsafe care, and reducing avoidable readmissions to hospital'.

The Commission has partnered with the Independent Hospital Pricing Authority (IHPA) and the state and territory health departments to develop the following indicators that are suitable for inclusion into these funding arrangements:

- HACs
- Sentinel events
- Avoidable hospital readmissions.

These indicators are currently incorporated in the NHRA, and are outlined further in this section.

Hospital-acquired complications list

The NHRA Addendum states that the Commission will 'curate the... hospital-acquired complications (HACs) for the purposes of ensuring they remain robust and relevant for clinical improvement purposes'. The Commission began this process in 2018–19, with advice from clinical specialty specific panels and the Hospital-Acquired Complications Curation Clinical Advisory Group (HACs CCAG).

All conditions listed on the HACs list were reviewed, with the exception of healthcare-associated infections, which will be reviewed in 2019–20. The outcomes of this review are reflected in Version 2 of the HACs specification on the Commission's website.

In 2018–19, the Commission also identified and included the following HACs significant to the mental health setting:

- Movement disorders due to psychotropic medications
- Serious alterations to conscious state due to psychotropic medications.

The work to expand mental health HACs will continue in 2019–20. An environmental scan, literature review and state and territory health department interviews have been conducted to identify what indicators are currently in use to measure mental health patient adverse events. These indicators will be presented to mental health experts and committees in late 2019, so that they can be considered for inclusion on the HACs list.

Table 1: Hospital-acquired complications list

Complication	Diagnosis		
Pressure injury	 Stage III ulcer Stage IV ulcer Unspecified decubitus ulcer and pressure area Unstageable pressure injury Suspected deep tissue injury 		
Falls resulting in fracture or intracranial injury	 Intracranial injury Fractured neck of femur Other fractures 		
Healthcare-associated infection	 Urinary tract infection Surgical site infection Pneumonia Blood stream infection Central line and peripheral line associated bloodstream infection Multi-resistant organism Infection associated with prosthetics/ implantable devices Gastrointestinal infections 		
Surgical complications requiring unplanned return to theatre	 Post-operative haemorrhage/haematoma requiring transfusion and/or return to theatre Surgical wound dehiscence Anastomotic leak Vascular graft failure Other surgical complications requiring unplanned return to theatre 		
Unplanned intensive care unit admission	Unplanned admission to intensive care unit		
Respiratory complications	 Respiratory failure including acute respiratory distress syndrome requiring ventilation Aspiration pneumonia Pulmonary oedema 		

Table 1: continued

Complication	Diagnosis	
Venous thromboembolism	Respiratory failure including acute respiratory distress syndrome requiring ventilation	
	Aspiration pneumonia	
	Pulmonary embolism	
Renal failure	Renal failure requiring haemodialysis or continuous veno-venous haemodialysis	
Gastrointestinal bleeding	Gastrointestinal bleeding	
Medication complications	Drug related respiratory complications/depression	
	 Haemorrhagic disorder due to circulating anticoagulants 	
	Hypoglycaemia	
	Movement disorders due to psychotropic medication	
	 Serious alteration to conscious state due to psychotropic medication 	
Delirium	Delirium	
Persistent incontinence	Urinary incontinence	
Malnutrition	Malnutrition	
Cardiac complications	Heart failure and pulmonary oedema	
	 Arrhythmias 	
	Cardiac arrest	
	 Acute coronary syndrome including unstable angina, STEMI and NSTEMI 	
	Infective endocarditis	
Third and fourth degree perineal laceration during delivery	Third and fourth degree perineal laceration during delivery	
Neonatal birth trauma	Neonatal birth trauma	
	Hypoxic ischaemic encephalopathy	



National sentinel events list

The NHRA Addendum states that the Commission will 'curate the sentinel events list... for the purposes of ensuring they remain robust and relevant for clinical improvement purposes.' The Commission reviewed the Australian sentinel events list in 2017–18, with the outcome of this review endorsed by the COAG Health Council (CHC) in 2018–19. The revised sentinel event list (Version 2) is available on the Commission's website.

In 2018–19, the Commission also developed a user guide for the reviewed sentinel events list. The user guide will assist hospitals to identify and review sentinel events, and includes case studies relating to each of the sentinel events.

Additionally in 2018–19, the Commission convened a roundtable to review the suspected suicide sentinel event, at the request of the Mental Health Information Strategy Standing Committee (MHISSC) and the Safety and Quality Partnership Standing Committee (SQPSC).

As a result of this review, it was agreed that the Commission will provide support to the MHISSC and SQPSC in developing alternative ways of monitoring rates of suicide in hospital. This work will continue in 2019–20.

Table 2 provides a summary of the revised sentinel events list endorsed by AHMAC on 8 December 2017 compared to the original Australian list of sentinel events that was determined by health ministers in 2002.

Table 2: Comparison of revised Australian sentinel events list (Version 2) with original sentinel events list

Revised Australian sentinel events list (2017) endorsed by AHMAC 8 December 2017	Original Australian sentinel events list (2002)
1. Surgery or other invasive procedure performed on the wrong site resulting in serious harm or death	 Procedures involving the wrong patient or body part resulting in death or major permanent loss of function
2. Surgery or other invasive procedure performed on the wrong patient resulting in serious harm or death	2. Suicide of a patient in an inpatient unit
Wrong surgical or other invasive procedure performed on a patient resulting in serious harm or death	3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure
4. Unintended retention of a foreign object in a patient after surgery or other invasive procedure resulting in serious harm or death	4. Intravascular gas embolism resulting in death or neurological damage
5. Haemolytic blood transfusion reaction resulting from ABO incompatibility resulting in serious harm or death	5. Haemolytic blood transfusion reaction resulting from ABO incompatibility
6. Suspected suicide of a patient in an acute psychiatric unit or acute psychiatric ward	6. Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs
7. Medication error resulting in serious harm or death	7. Maternal death associated with pregnancy, birth and the puerperium
8. Use of physical or mechanical restraint resulting in serious harm or death	8. Infant discharged to the wrong family
9. Discharge or release of an infant or child to an unauthorised person	
10. Use of an incorrectly positioned oro- or naso-gastric tube resulting in serious harm or death	

Avoidable hospital readmissions

The NHRA Addendum states that the Commission is responsible for developing a list of conditions that can be considered 'avoidable hospital readmissions'. In 2017–18 the Commission worked with clinicians from across Australia to develop such a list, with timeframes for each condition within which a return to hospital would be deemed avoidable. AHMAC has agreed the list of conditions to be avoidable hospital readmissions (Table 3). The list is available on the Commission's website.

In 2018–19, in line with the NHRA Addendum, IHPA developed three potential funding approaches, informed by public consultation, for the list of avoidable hospital readmissions, to be shadowed for two years from 1 July 2019. The Commission will work closely with IHPA to support this work.

In response to a request from AHMAC, the Commission has commenced work to lead a process to develop a 'nationally consistent definition of avoidable hospital readmissions'. This work will continue over 2019–20, with the outcome provided to the CHC for advice.

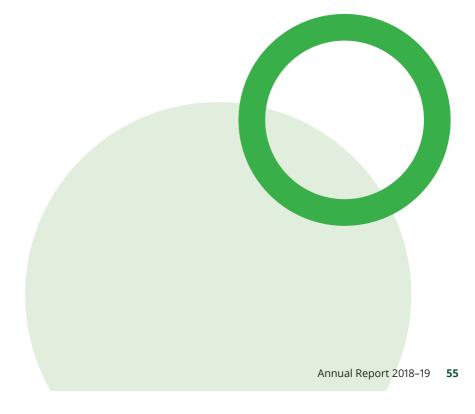


Table 3: List of conditions AHMAC has agreed are considered to be avoidable hospital readmissions and associated readmission intervals

Readmission condition*	Readmission diagnosis	Readmission interval
Pressure injury	Stage III ulcer	14 days
	Stage IV ulcer	7 days
	Unspecified decubitus and pressure area	14 days
Infections	Urinary tract infection	7 days
	Surgical site infection	30 days
	Pneumonia	7 days
	Blood stream infection	2 days
	Central line and peripheral line associated blood stream infection	2 days
	Multi-resistant organism	2 days
	Infection associated with devices, implants and grafts	90 days
	Infection associated with prosthetic devices, implants and grafts in genital tract or urinary system	30 days
	Infection associated with peritoneal dialysis catheter	2 days
	Gastrointestinal infections	28 days
Surgical	Postoperative haemorrhage/haematoma	28 days
complications	Surgical wound dehiscence	28 days
	Anastomotic leak	28 days
	Pain following surgery	14 days
	Other surgical complications	28 days
Respiratory complications	Respiratory failure including acute respiratory distress syndromes	21 days
	Aspiration pneumonia	14 days

Table 3: continued

Readmission condition*	Readmission diagnosis	Readmission interval
Venous thromboembolism	Venous thromboembolism	90 days
Renal failure	Renal failure	21 days
Gastrointestinal bleeding	Gastrointestinal bleeding	2 days
Medication complications	Drug related respiratory complications/ depression	2 days
	Hypoglycaemia	4 days
Delirium	Delirium	10 days
Cardiac	Heart failure and pulmonary oedema	30 days
complications	Ventricular arrhythmias and cardiac arrest	30 days
	Atrial tachycardia	14 days
	Acute coronary syndrome including unstable angina, STEMI and NSTEMI	30 days
Other	Constipation	14 days
	Nausea and vomiting	7 days

^{*} The conditions on the list were agreed by AHMAC as avoidable hospital readmissions on 2 June 2017.

Aligning public reporting of public and private hospitals

There is little publicly available information on health service quality and patient safety, and reporting standards and measures differ across states and territories and between the private and public sectors. Consumers, carers and patients find such information difficult to interpret and often not relevant to their needs.

Governments, the private sector and the community are interested in improving national public reporting of safety and quality, and in making this information consistent, transparent and useful to the public.

In 2018–19, at the request of the CHC, the Commission identified options to align public reporting standards for safety and quality of health care across public and private hospitals nationally. This work included an environment scan and literature review, expert interviews and focus groups of clinicians and consumers, and was guided by a steering committee of consumer and carer representatives, clinical experts, representatives from state and territory health departments, and representatives of the private sector and private health insurance sector.

Following this work, the Commission submitted an options paper on aligning public reporting on quality health care and patient safety to the CHC. This paper also contained recommendations for an implementation framework, including five measures suitable for reporting on quality healthcare and patient safety across public and private hospitals nationally.

- Commenced development of a new mental health HAC relating to movement disorders due to psychotropic medications
- Commenced development of a new mental health HAC relating to serious alterations to conscious state due to psychotropic medications
- Developed five measures suitable for reporting on quality healthcare and patient safety across public and private hospitals nationally.

Severe incident management

A 'patient safety incident' is an event or circumstance that could have resulted, or did result in, unnecessary harm to a patient. Incident management systems are used to capture patient safety incidents or near misses. The critical function of an incident management system is to learn from serious incidents or near misses and to develop actions for safety and quality improvement initiatives.

In Australia, hospital patient safety incidents are captured through local incident management systems. Currently, health service organisations have an established process for data analysis and investigations. Due to health service organisations using a large variety of incident management systems, the learning from any severe incident or near miss, and its associated safety and quality actions, are mostly shared at a local or state and territory level.

The Commission is investigating a national approach to severe incident analysis to enhance patient safety. The main purpose of this project is to identify options for a national approach and to develop technical specifications to facilitate national analysis.

The focus of a national approach is not to duplicate or replace current processes but to identify options to enhance learning, which otherwise might not be achieved at a local or state and territory level. In particular, a potential area of focus may be to detect rare but significant events.

Highlight

• Investigating a national approach to severe incident analysis to enhance patient safety.

Patient safety culture

Measuring patient safety culture from the perspective of staff can provide insights that lead to improvements in care. Hospital staff are often the first to identify concerning patterns of unsafe practice and the conditions that increase or decrease the likelihood of unsafe practice.

Australia currently has no nationally consistent way of collecting information on patient safety culture from the perspective of staff. Health service organisations and governments use a variety of staff survey tools. Some of these tools are generic satisfaction or organisational culture instruments and some assess patient safety culture explicitly.

The Commission is developing a toolkit to support local monitoring of patient safety culture. The toolkit will include validated surveys for regular monitoring of patient safety culture and an implementation guide to provide advice on more detailed measurement, alongside advice on how this information can be used to improve care.

In 2018–19, the Commission undertook:

- Consultation with health service organisations to support the development of the toolkit, and identification of a number of established validated surveys with the potential for modification for the Australian context
- An environmental scan which identified a number of state and territory based surveys on organisational culture and staff experience
- Mapping of the state and territory organisational culture surveys to understand the constructs measured by these surveys.

The Commission also established an expert advisory group to support this national work program.

Work will continue in 2019–20 to develop the toolkit and share lessons learned from services that are already measuring patient safety culture.

- Identified a number of validated patient safety culture surveys with the potential for modification for the Australian context
- Completed an environmental scan which identified a number of state and territory based surveys on organisational culture and staff experience
- Completed mapping of the state and territory organisational culture surveys to understand the constructs measured by these surveys.

National clinical quality registries

Clinical quality registries (CQRs) collect, analyse and report on patient-related information to help improve the safety and quality of health care.

The Commission has continued existing work on national CQRs. This work supports CQR use through the facilitation of prioritisation, governance and indicator development, and encourages the development and use of CQRs when clinical guidelines are developed.

The Commission has also worked with the Australian Government Department of Health to develop a national strategy for CQRs. The national strategy will identify the opportunities and challenges to applying data-sharing arrangements to CQRs. This will allow for the data linkage, interoperability and integration of CQRs into Australia's healthcare information systems to systematically drive patient-centred improvements across the health system.

Highlight

 Ongoing work to develop a governance framework and accreditation standard for national CORs.

National Clinical Trials Governance Framework

In 2018–19, the Commission undertook a project with the Department, on behalf of all states and territories and the Commonwealth, to develop the National Clinical Trials Governance Framework (Governance Framework), as a first step toward a nationally consistent accreditation approach for health services undertaking clinical trials.

This project stems from recognition by the CHC that, while jurisdictions have worked to improve the environment for clinical trials, some issues remained concerning fragmentation and inefficiencies that impact on Australia's attractiveness as a preferred location for clinical trials. The Clinical Trials Project Reference Group, representing all states and territories and the Commonwealth, is an expert advisory sub-group within the Clinical Principal Committee under AHMAC, which is tasked with progressing the CHC agenda.

The Clinical Trials Governance Framework Steering Committee comprising clinical trial, consumer, government, healthcare and industry experts has overseen a literature review and mapping exercise on clinical trials governance frameworks. These have informed the development of the draft Governance Framework. Extensive national consultation on the draft Governance Framework has been undertaken. The Governance Framework will be finalised by mid-2019.

Highlight

 Drafted and carried out extensive national consultation on the National Clinical Trials Governance Framework.

The state of safety and quality in Australian health care

As part of its legislative function, the Commission is required to report on the state of safety and quality in the Australian health system.

In 2018–19, the Commission released the *State of patient safety and quality in Australian hospitals 2019*, a comprehensive report on key safety and quality themes in Australian health care. The full report can be found on the Commission's website.

Patients, consumers and the community trust clinicians and health service organisations to provide safe, high-quality health care, and most Australians have access to such care. Australians experience comparatively better health outcomes and live longer than people from most other highly developed countries. The Australian health system is more efficient than many other similar health systems⁶, and Australia's clinicians are highly regarded as skilled professionals who are committed to meeting the healthcare needs of their patients.

Although most health care in Australia leads to good outcomes, patients do not always receive the care that is most appropriate for them, and preventable adverse events occur across the Australian health system.⁷ Lapses in safety and quality, and unwarranted variation in health care provided to different populations within Australia have substantial costs, in terms of both the effect on people's lives and finances.⁸

Australia has adopted a nationally consistent approach to improving the safety and quality of health care.

The Australian approach to safety and quality has been to identify systemic risks to patients, to mitigate those risks and to improve patient outcomes through clinically appropriate risk management responses.

Measurement is foundational to this, as meaningful metrics are required to understand what the major safety issues are across the care continuum, proactively mitigate patient safety risks and engender improvement.

As global understanding of the nature of safety and quality issues improves, and as new issues emerge, the Commission and partners have continued to evolve Australia's approach to supporting improvement across the health system. Internationally, and within the Australian health system, there has been an increasing focus on delivering value-based health care for consumers and funders – achieving the best care possible for each patient while maintaining an efficient use of resources.⁹

The Commission has been fostering system change in five key areas to:

- Focus on people
- Measure and report on safety and quality
- Use evidence-based guidance and policy
- Strengthen clinical governance
- Embed safety and quality into national systems.

Moving forward, over the coming year the Commission will be building on existing work in these areas, and specifically focusing on supporting implementation of the NSQHS Standards (2nd ed.) and improving the reliability of accreditation processes; setting national goals to reduce HACs; promoting rapid knowledge exchange on safety and quality practices; and supporting quality improvement through a health learning system for measurement and monitoring of safety and quality.

Sustained and nationally coordinated action in these areas provides health service organisations with the guidance and tools required to make multi-faceted and meaningful improvement to the safety and quality of care delivered within the Australian health system. Box 1 provides a description and definition of the term 'safety and quality'.

Box 1: What is safety and quality?

Patient safety and quality is often summarised as 'the right care, in the right place, at the right time and cost'. The Commission defines patient safety as 'prevention of error and adverse effects associated with health care'; and quality as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge'.¹⁰

Annual performance statements

As the accountable authority of the Australian Commission on Safety and Quality in Health Care, the Board presents the 2018–19 annual performance statements of the Commission, as required under paragraph 39(1)(a) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act). In the opinion of the Board, based on advice from Commission management and the Audit and Risk Committee, these annual performance statements accurately reflect the performance of the Commission and comply with subsection 39(2) of the PGPA Act.

Professor Villis Marshall Ac

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Board Chair

Commission's purpose

The purpose of the Commission is to contribute to better health outcomes and experiences for all patients and consumers, and improved value and sustainability in the health system, by leading and coordinating national improvements in the safety and quality of health care. Within this overarching purpose the Commission aims to ensure that people are kept safe when they receive health care and that they receive the care they should.

The functions of the Commission are specified in section 9 of the National Health Reform Act, and include:

- Formulating standards, guidelines and indicators relating to healthcare safety and quality matters
- Advising health ministers on national clinical standards
- Promoting, supporting and encouraging the implementation of these standards and related guidelines and indicators
- Monitoring the implementation and impact of the standards
- Promoting, supporting and encouraging the implementation of programs and initiatives relating to healthcare safety and quality matters
- Formulating model national schemes that provide for the accreditation of organisations that provide healthcare services and relate to healthcare safety and quality matters
- Publishing reports and papers relating to healthcare safety and quality matters.

Performance against the Health Portfolio Budget Statements and the Commission's Corporate Plan 2018–19

The Commission's Corporate Plan 2018–19 was prepared under section 35(1)(a) of the PGPA Act, and published in accordance with section 16E(3) of the Public Governance, Performance and Accountability Rule 2014. The Corporate Plan describes the planned program of work for the four-year period to 2021–22 and specifies how the Commission will measure its performance during that period. The Corporate Plan can be accessed on the Commission's website.

The Commission's performance measures for 2018–19 were published in the Corporate Plan and also formed the basis of the 2018–19 Health Portfolio Budget Statements. Table 4 provides a report against these performance measures.

Table 4: Report against performance measures in the Corporate Plan and Health Portfolio Budget Statements, 2018–19

Performance criteria	Target 2018-19	Result against performance criteria
Implement the NSQHS Standards (2nd ed.) and coordinate the Australian Health Service Safety and	Implementation of the NSQHS Standards (2nd ed.).	Achieved.
		93 health service organisations have been assessed to the NSQHS Standards (2nd ed.) commenced from January 2019.
Quality Accreditation	Provision of guidance and resources to support health services to meet the NSQHS Standards	Achieved.
(AHSSQA) Scheme.		Resource material to support the NSQHS Standards (2nd ed.) were produced and released throughout 2018–19 and made available on the Commission's website.
		Examples of these resources include:
	(2nd ed.).	 Guides for each sector – Hospitals, Day Procedure Services, Small Hospitals and Multi-Purpose Services
		User guides for specific issues, groups or conditions, including governing bodies, Aboriginal and Torres Strait Islander people, paediatrics, cognitive impairment, mental health, Partnering with Consumers Standard, medication management in cancer care
		 Fact sheets for consumers on the NSQHS Standards, accreditation and the Partnering with Consumers Standard
		Electronic monitoring tool for organisations to undertake a gap analysis
		Animated video on the use of the electronic monitoring tool.
	Accrediting agencies approved to assess health services to the NSQHS Standards.	Achieved.
		Eight accrediting agencies are approved to assess health services to the NSQHS Standards.

Table 4: continued

Performance criteria	Target 2018–19	Result against performance criteria
Percentage of hospitals and day procedure services assessed to the NSQHS Standards.	100%	Achieved. 100% of hospitals and day procedure services assessed to either the first or second edition of the NSQHS Standards.
Percentage of public hospitals meeting the benchmark for hand hygiene compliance.	≥80%	Achieved. 85% This data was collected during the 12 month period 1 April 2018 – 31 March 2019.
Support health services, health professionals, patients and consumers to form effective partnerships.	Provision of guidance to health services and health professionals about forming effective partnerships with patients and consumers.	Achieved. The Commission released a decision support tool on osteoarthritis of the knee, developed and finalised the <i>Australian Charter of Healthcare Rights</i> (2nd ed.), and developed consumer resources in Braille, AUSLAN, Easy English and 19 languages to support partnerships between healthcare organisations, clinicians and consumers.
	Australian Charter of Healthcare Rights reviewed.	Achieved. The Australian Charter of Healthcare Rights was reviewed. The Charter (2nd ed.) was officially launched at an online webinar on 8 August 2019. Electronic copies of the Charter were circulated to stakeholders, and the A4 Charter, a poster, infographic, translated versions in 19 languages, an Auslan version, Easy English version, and large print version are available on the website. A Braille version is also available on request.
Examine healthcare variation and work to reduce unwarranted variation to improve quality and appropriateness of care.	Release of the Third Australian Atlas of Healthcare Variation.	Achieved. The Commission released the <i>Third</i> Australian Atlas of Healthcare Variation in December 2018.

Table 4: continued

Performance criteria	Target 2018–19	Result against performance criteria
	Release of	Achieved.
	interactive maps of healthcare variation.	The Commission released the interactive online version of the <i>Third Australian Atlas of Healthcare Variation</i> in December 2018.
	Production of	Achieved.
	clinical care standards and other resources focusing on high impact, high burden and high variation areas	The Commission released the following audio-visual resources for consumers:
		 Heavy Menstrual Bleeding Clinical Care Standard – Interview with a family planning expert and a GP with experience in heavy menstrual bleeding
	of clinical care.	 Colonoscopy Clinical Care Standard Interview with an expert
		 Venous Thromboembolism Prevention Clinical Care Standard – Case for Improvement for clinicians and health services to support implementation.
		In addition, the Commission is developing supporting tools, finalising the quality indicator dataset, incorporating the Colonoscopy Clinical Care Standard into the NSQHS Standards (2nd ed.) and performing a pilot implementation.
Clinical care	2 (developed)	Achieved.
standards developed or reviewed.	2 (reviewed)	The Commission released the clinical care standards for Colonoscopy in September 2018 and Venous Thromboembolism Prevention in October 2018.
		Cataract Clinical Care Standard has been prepared and is scheduled for release in late 2019.
		Acute Stroke Clinical Care Standard and Acute Coronary Syndromes Clinical Care Standard were reviewed, including a refresh

Table 4: continued

Performance criteria	Target 2018–19	Result against performance criteria
		of the literature and the local indicators for monitoring. Both revisions will be released in late 2019.
		Work has commenced on the Peripheral Venous Access Clinical Care Standard and the Prevention Management of Third and Fourth Degree Perineal Tears Clinical Care Standard.
Identify, specify and	Provision of	Achieved.
refine clinical and patient-reported measures and safety	nationally agreed health information	The Commission developed and maintains the:
and quality indicators.	standards,	Core hospital-based outcome indicators
	measures and indicators for	• Indicators for the clinical care standards
	safety and	• HACs
	quality.	 Submission portals and supporting information for national accreditation processes.
	Provision of	Achieved.
	guidance and tools for health	The Commission has developed:
	services to support local use	 A toolkit for use of the core hospital-based outcome indicators
	of data for safety and quality improvement.	 Specifications for use of the indicators for the clinical care standards
		 Information kits and technical information for use of the hospital-acquired complications.
Condition specific	3	Achieved.
clinical indicator sets developed.		Clinical indicator sets developed for colonoscopy, venous thromboembolism prevention and stroke/ acute coronary syndrome.

Table 4: continued

Performance criteria	Target 2018-19	Result against performance criteria
Percentage of consumers participating in the Commission's consultation and advisory processes who report positively on the work of the Commission.	70%	Achieved.
Percentage of clinicians participating in the Commission's consultation and advisory processes who report positively on the work of the Commission.	70%	Achieved.

Analysis of performance against purpose

In 2018–19, the Commission accomplished a number of achievements in alignment with the *Health Portfolio Budget Statements* 2018–19 and the *Corporate Plan 2018–19*.

The Commission continued to focus its work on areas that can best be improved through national action. Improvements in healthcare safety and quality are best achieved through national partnerships that are supported by local activities and implementation. To facilitate this, the Commission maintains strong, positive relationships with its partners, including patients and consumers, consumer groups, healthcare providers, public and private health service

organisations, governments and other agencies. The Commission works with its partners to support the implementation of safety and quality initiatives by developing guidance, resources, tools and educational materials. The Commission also supports the evaluation of its activities and measurement of the impact of safety and quality improvement initiatives on the health system. The Commission continually looks to identify new and emerging safety and quality issues, while being responsive to the evolving needs of its partners.

There was no change to the framework in which the Commission operated in 2018–19, and no change to the Commission's purpose, activities or organisational capability.

The following examples highlight the Commission's key achievements in 2018–19 and demonstrate the benefits of its national approach:

- The NSQHS Standards (2nd ed.) has been successfully introduced into health service organisations along with changes to the AHSSQA Scheme to improve the rigour of assessment processes.
- As of 30 June 2019, all health service organisations in Australia have been assessed to the NSQHS Standards (1st ed.) at least once, and over 93 health service organisations have been assessed to the NSQHS Standards (2nd ed.).
- The reform strategies to the AHSSQA Scheme are being implemented, including a comprehensive orientation program for all assessors to the NSQHS Standards (2nd ed.), assessments at short notice and attestation statements that must be submitted by governing bodies.
- AURA 2019: Third Australian report on antimicrobial use and resistance in human health was launched in May 2019. The AURA Surveillance System enables the identification and tracking of national trends in antimicrobial use and antimicrobial resistance. Encouragingly, AURA 2019 found that overall use of antibiotics in the community fell between 2015 and 2017 the first decline in 20 years.
- The Commission continues to conduct a clinical safety program for the My Health Record system. The program aims to provide quality assurance and enhance clinical safety of the My Health Record system and other national digital health infrastructure.
- The print and online interactive versions of the *Third Australian Atlas of Healthcare Variation* were launched in December 2018. The third Atlas focuses on appropriateness

- of care in primary and acute care settings, examining the topic areas of cardiac tests, thyroid investigations and treatments, gastrointestinal investigations and treatments and paediatric and neonatal health. The third Atlas also looks at changes over time from the first Atlas that indicated high-volume prescribing behaviour. This repeat analysis included the antimicrobial, opioid and psychotropic medicines data items.
- The Commission released clinical care standards on colonoscopy and the prevention of venous thromboembolism. A clinical care standard on cataract will be released in late 2019. The clinical care standards on acute stroke and acute coronary syndromes have been reviewed and both revisions will be released in late 2019. Clinical care standards identify and define the care people should expect to receive or be offered, and can play an important role in delivering appropriate care and reducing unwarranted variation.
- In response to a request from state and territory health departments, the Commission has responded to a number of safety issues that have been raised in relation to the use of transvaginal mesh devices. In collaboration with the TGA, states, territories, clinicians and consumers, the Commission has developed and released information for consumers about treatment options, and guidance documents regarding hospital credentialing processes for the use of mesh

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This section of the report outlines the Commission's legislative requirements, corporate governance, and accountability processes, including internal and external scrutiny arrangements and procedures for risk management and fraud control. It also includes profiles of the Commission's Board and committee members.

Legislation and requirements	74
The Commission's Board	77
Committees	85
Internal governance arrangements	88
External scrutiny	90

Legislation and requirements

The Commission is a corporate Commonwealth entity of the Australian Government, accountable to the Australian Parliament and the Australian Minister for Health. The Commission's principal legislative basis is the National Health Reform Act, which sets out its purpose, powers, functions, and administrative and operational arrangements. The National Health Reform Act also sets out the Commission's Constitution, the process for appointing members of the Board and the CEO, and the operation of Board meetings.

The Commission must fulfil the requirements of the PGPA Act, which regulates certain aspects of the financial affairs of Commonwealth entities; their financial and performance reporting, accountability, banking and investment obligations; and the conduct of their accountable authorities and officials.

Compliance with legislation

The Commission has complied with the provisions and requirements of the:

- Public Governance, Performance and Accountability Act 2013
- Public Governance, Performance and Accountability Rule 2014
- Appropriation Acts
- Other instruments defined as 'finance law' including relevant Ministerial directions.

The Commission did not have any significant non-compliance issues with finance law during the 2018–19 reporting period.

Strategic planning

These functions guide the Commission in undertaking its work, and are expressed in four strategic priorities that aim to ensure patients, consumers and communities have access to and receive safe and high-quality health care. These priorities, and the outcomes for the health system that the Commission seeks to achieve in each area, are as follows:



Patient safety: A health system that is designed to ensure that patients and consumers are kept safe from preventable harm



Partnering with patients, consumers and communities: A health system where patients, consumers and members of the community participate with health professionals as partners in all aspects of health care



Quality, cost and value: A health system that provides the right care, minimises waste and optimises value and productivity



Supporting health professionals to provide safe and high-quality care: A health system that supports safe clinical practice by having robust and sustainable improvement systems.

Ministerial directions

Section 16 of the National Health Reform Act empowers the Australian Government Minister for Health to make directions with which the Commission must comply. The Minister for Health made no such directions during the 2018–19 reporting period.

Related-entity transactions

In accordance with the requirements prescribed by the Public Governance, Performance and Accountability Rule 2014 section 17BE and Department of Finance Resource Management Guide 136 – Annual reports for corporate Commonwealth entities, related-entity transactions for 2018–19 are disclosed in Appendix C.

Indemnity and insurance

The Commission holds directors' and officers' liability insurance cover through Comcover, the Australian Government's self-managed fund. As part of its annual insurance renewal process, the Commission reviewed its insurance coverage in 2018–19 to ensure the coverage was still appropriate for its operations. During the year, no indemnity-related claims were made, and the Commission knows of no circumstances likely to lead to such claims being made. Many liability limits under the Commission's schedule of cover are standard Australian Government limits, such as \$100 million in cover for general liability and professional indemnity, as well as directors' and officers' liability. The Commission's business interruption indemnity cover is for a period of up to 24 months. Motor vehicle, third-party property damage and expatriate cover have not been taken out, as they do not apply to the Commission.

The Commission's Board

The Commission's Board governs the organisation and is responsible for the proper and efficient performance of its functions. The Board establishes the Commission's strategic direction, including directing and approving its strategic plan and monitoring management's implementation of the plan.

The Commission's Board also oversees its operations and ensures that appropriate systems and processes are in place so that the Commission operates in a safe, responsible and ethical manner, consistent with its regulatory requirements.

The Board is established and governed by the provisions of the National Health Reform Act and the PGPA Act.

Board membership 2018–19

The Australian Government Minister for Health appoints the Commission's Board, in consultation with all state and territory health ministers. The Board includes members who have extensive experience and knowledge in the fields of healthcare administration, provision of health services, law, management, primary health care, corporate governance and improvement of safety and quality.

Professor Villis Marshall AC (Chair)

Professor Villis Marshall brings to the Board experience in providing healthcare services, managing public hospitals, and improving safety and quality. Professor Marshall has had significant clinical experience as a urologist, and as Clinical Director (Surgical Specialties Service) for the Royal Adelaide Hospital and Clinical Professor of Surgery at the University of Adelaide.

Professor Marshall was awarded a Companion of the Order of Australia (AC) in 2006 for services to medicine, particularly urology and research into kidney disease, to the development of improved healthcare services in the Defence forces, and to the community through distinguished contributions to the development of prehospital first aid care provided by St John Ambulance Australia.

His previous appointments include General Manager at Royal Adelaide Hospital, Senior Specialist in Urology and Director of Surgery at Repatriation General Hospital, and Professor and Chair of Surgical and Specialty Services at Flinders Medical Centre.

Qualifications: MD, MBBS, FRACS

Board membership: Appointed to Board on 1 April 2012; appointed as Chair on 1 April 2013 and re-appointed as Chair on 1 July 2017.

Mr Martin Bowles

Mr Martin Bowles is the National Chief Executive Officer at Calvary Health Care. Prior to this appointment, Mr Bowles was Secretary of the Australian Government Department of Health and Secretary of the Department of Immigration and Border Protection. Before this, he held the positions of Deputy Secretary in the Department of Climate Change and Energy Efficiency and the Department of Defence. In 2012, he was awarded a Public Service Medal for delivering highly successful energy efficiency policies and remediation programs for the Home Insulation and Green Loans programs. In 2019, he was awarded an Officer of the Order of Australia for his distinguished service to public administration at the senior level, and to policy development and program implementation.

Before joining the Australian Government, Mr Bowles held senior executive positions in the education and health portfolios in the Queensland and New South Wales public sectors. He is a Fellow of the Australian Society of Certified Practising Accountants.

Qualifications: BBus, GCPubSecMgmnt

Board membership: Appointed on 14 May 2015.

Dr David Filby

PSM

Dr David Filby has worked extensively across the Australian healthcare landscape in a number of significant policy and executive roles. He has held senior national health policy roles and senior executive positions in Queensland and South Australia. In July 2016, he completed a term of six and a half years as Executive Consultant for South Australia Health and the Australian Health Ministers' Advisory Council.

Dr Filby was a board member of the National Health Performance Authority until June 2016, a board member of the Australian Institute of Health and Welfare for 14 years and in August 2016 finished a nine-year term, including six as Chair, with Helping Hand Aged Care Inc. He is a member of the board of Pedare School and holds an Adjunct Professorship in the Faculty of Health Sciences at Flinders University. In 2008, he was awarded a Public Service Medal and in 2007 was awarded the Sidney Sax Medal by the Australian Healthcare and Hospitals Association. Previously, he was on the board of South Australia's Child Health Research Institute Council.

Qualifications: PhD

Board membership: Appointed on 29 July 2016.

Adjunct Professor John Walsh AM

Adjunct Professor John Walsh was a partner at PricewaterhouseCoopers, where he worked for 20 years, and has expertise in the areas of social policy and funding across accident compensation, health and disability, with an Adjunct Professor appointment at the University of Sydney.

Professor Walsh is a board member of the National Disability Insurance Agency, having previously been a Productivity Commissioner and part of the reference group which recommended a National Disability Insurance Scheme in 2011.

Professor Walsh was also the Deputy Chair of the Board of the National Health Performance Authority until June 2016, chaired the independent panel overseeing Caring Together: A Health Action Plan for NSW and has held memberships on several boards including the NSW Motor Accidents Authority and the NSW Home Care Service.

Qualifications: BSc, FIAA, FRACP (Hons)

Board membership: Appointed on 29 July 2016.

Ms Christine Gee

Ms Christine Gee brings to the board extensive experience in private hospital administration, having held executive management positions for over 25 years. She has been the CEO of Toowong Private Hospital since 1997 and is Chair of the Commission's Private Hospital Sector Committee.

Ms Gee is also involved in numerous national boards and committees, including the Australian Private Hospitals Association, the Queensland Board of the Medical Board of Australia, the Australian Institute of Health and Welfare, the Safety and Quality Partnership Standing Committee, the Private Hospitals Association of Queensland and the Government's Second Tier Advisory Committee.

Qualifications: MBA

Board membership: Appointed as a Commission member in March 2006;

appointed to the Board on 1 July 2011 and re-appointed on 1 July 2018.

Ms Wendy Harris

Ms Wendy Harris QC is a barrister who specialises in commercial law. She was admitted to the Victorian Bar in 1997 and was appointed Senior Counsel in 2010.

Between 2011 and 2015 she was Board Chair of the Peter MacCallum Cancer Centre, Australia's only public hospital dedicated to cancer treatment, research and education. Other past directorships include 10 years on the Board of Barristers' Chambers Limited, which is the repository of the substantial property assets of the Victorian Bar, and provider of chambers accommodation and ancillary services to its members.

Ms Harris is also Senior Vice President of the Victorian Bar Inc.

Qualifications: LLB (Hons)

Board membership: Appointed on 1 July 2015.

Dr Helena Williams

Dr Helena Williams brings to the Board active clinical expertise as a general practitioner and leadership experience as a previous Clinical Director of the Southern Adelaide-Fleurieu-Kangaroo Island Medicare Local Ltd. She is also currently the Medical Adviser for the Royal District Nursing Service SA and a General Practice Adviser for Return to Work South Australia.

Dr Williams' governance experience includes six years as the Presiding Member of the Southern Adelaide Local Health Network Governing Council and past directorships include the Southern Adelaide

Health Service, the Cancer Council South Australia, Noarlunga Health Services, the South Australian Divisions of General Practice, and the Australian General Practice Network.

Qualifications: MBBS, FRACGP

Board membership: Appointed as a Commission member in April 2008; appointed to the Board on 1 July 2011, term concluded 30 June 2018, and reappointed on 1 April 2019.

Professor Alison Kitson

Professor Alison Kitson is recognised internationally as a leading translational science researcher, nurse leader and champion of the fundamentals of nursing care. Professor Kitson spent several years in executive and academic leadership roles in the UK before moving to Australia to take up the role of Head of School of Nursing at the University of Adelaide in 2009. In 2017 she was appointed as the inaugural Vice President and Executive Dean of the College of Nursing and Health Sciences at Flinders University. Professor Kitson has also been Executive Director of Nursing at Central Adelaide Local Health Network, where she was responsible for the nursing innovation and reform agenda.

Professor Kitson has been awarded a Fellowship of the Australian Academy of Health and Medical Sciences (2015), an honorary doctorate from Malmo University (2013) in Sweden and a Fellowship of the American Nurses Association (2011) for her work on standards of nursing care.

Qualifications: RN, BSc (Hons), DPhil, FRCN, FAAN, FAHMS

Board membership: Appointed on 1 July 2017. Term concluded on 30 June 2019.

Adjunct Professor Veronica Casey AM

Adjunct Professor Veronica Casev has held nursing and midwifery executive leadership positions in Queensland Health since 1997. She worked in nursing and midwifery director roles at The Princess Charles Hospital District, the Royal Brisbane Hospital and the Royal Women's Hospital prior to her appointment as Executive Director, Nursing Services Princess Alexandra Hospital and Executive Director Nursing and Midwifery Services, Metro South Health. During her time at Princess Alexandra Hospital, she has been instrumental in helping the hospital achieve re-designation under the Magnet® credentialing program, and the introduction of the Nurse Sensitive Indicator performance monitoring system. All Nurses and Midwives within Metro South Health Service have achieved Pathways to Excellence. Professor Casey's experience and expertise in the nursing profession extends to national and international platforms, holding membership on the National Nursing and Midwifery Board of Australia, and she has served as an inaugural International Magnet Commissioner for the American Nurses Credentialing Centre (ANCC) from 2010–December 2017. She has also been recognised for her contribution to the nursing and midwifery profession by being awarded the ANCC HRH Princess Muna Al-Hussein Award for international contribution to nursing in 2011, the QUT Outstanding Alumni Award, Faculty of Health, 2018 for contribution to nursing and healthcare, and appointment as a Member (AM) of the Order of Australia (General Division) in 2019.

Professor Casey's special interests are workforce planning and development; change management – changing cultures within work environments that enhance a positive practice environment; providing mentorship

to nurses and other disciplines; participating in the educational development of undergraduate and post-graduate students on an academic and practical level; governance structures that are inclusive for all levels of staff, establishing credentialing requirements within nursing and quality and safety systems that support professional and clinical standards.

Qualifications: RN, RM, BN, MN-Leadership, Grad. Dip. Nursing – Geriatrics, Grad Dip – Management (Dist), FCNA

Board membership: Appointed on 1 April 2019.

Ms Glenys Beauchamp PSM

Ms Glenys Beauchamp was appointed Secretary of the Australian Government Department of Health on 18 September 2017. Glenys has had an extensive career in the Australian Public Service at senior levels with responsibility for a number of significant government programs covering economic and social policy areas. She has more than 25 years' experience in the public sector and began her career as a graduate in the Industry Commission.

Prior to her current role, Ms Beauchamp was Secretary of the Department of Industry, Innovation and Science (2013–2017) and Secretary of the Department of Regional Australia, Local Government, Arts and Sport (2010–2013). She has served as Deputy Secretary in the Department of the Prime Minister and Cabinet (2009–2010) and the Department of Families, Housing, Community Services and Indigenous Affairs (2002–2009).

Ms Beauchamp has held a number of executive positions in the ACT Government including Deputy Chief Executive, Department of Disability, Housing and Community Services and Deputy Chief Executive Officer, Department of Health. She has also held senior positions in housing, energy and utilities functions with the ACT Government.

Glenys was awarded a Public Service Medal in 2010 for coordinating Australian Government support during the 2009 Victorian bushfires.

Qualifications: BEcon, MBA

Board membership: Appointed on 1 July 2018.

Professor Shaun Larkin

Professor Shaun Larkin joined the Menzies Centre for Health Policy and School of Public Health at the University of Sydney as a Professor in Health Policy and Financing in February 2018.

Prior to taking up his current role, Professor Larkin worked at HCF for 20 years. After serving as a General Manager in a number of executive roles (Strategic Development; Benefits Management; Corporate Ventures; and Operations) in December 2009 he was selected to be the Managing Director and for seven years led an organisation with health funding responsibilities for more than 1.5 million Australians, revenues in excess of \$2.5 billion and over 1.300 staff.

Upon its establishment in 2000, Professor Larkin also guided the development of the HCF Research Foundation's research funding program that saw over \$16 million invested in more than 50 projects spread across Australia for the benefit of the wider Australian community.

Prior to joining HCF, Professor Larkin was based in Singapore for four years where he led the establishment of a chain of ambulatory medical centres throughout Asia and the CIS. Before this he worked for eight years as an executive for a large private hospital operator (Ramsay Health Care) in Australia and the United States.

Qualifications: HlthScD, MHSc, MBA, BHA

Board membership: Appointed on 1 April 2013, term concluded 31 March 2019.

Mrs Cheryle Royle

Mrs Cheryle Royle commenced her career as a nurse and midwife. She became the CEO of her first hospital in 1995. Following that time, she has managed a number of hospitals in both Victoria and Queensland, crossing a wide range of medical specialties.

In 1998, Mrs Royle was awarded the Telstra Business Woman of the Year (VIC) for the Private Sector and went on to be a National Finalist that year, highlighting her business acumen and achievements. Her most recent appointment was at St Vincent's Private Hospital Brisbane until June 2017, following which time she returned to Victoria. She has served on a number of boards in Victoria.

Mrs Royle's passion for safety and quality in health care is known and recognised by those who have worked with or alongside her and she brought to the Board her extensive management skills and knowledge.

Qualifications: RN, RM, BN, GDip Nursing Administration

Board membership: Appointed on 4 September 2014, term concluded 31 March 2019.

Table 5: Board meetings and attendance

Name	Board	meeting			
	12 July 2018	11 September 2018	11 October 2018	28 March 2019	20 June 2019
Professor Villis Marshall Ac (Chair)	~	✓	~	V	~
Ms Christine Gee	×	✓	~	~	~
Professor Shaun Larkin*	~	~	~	~	_
Mrs Cheryle Royle*	~	✓	~	~	-
Mr Martin Bowles AO PSM	×	✓	~	~	~
Ms Wendy Harris oc	×	✓	~	~	~
Adjunct Professor John Walsh AM	×	✓	~	~	✓
Dr David Filby _{PSM}	~	✓	×	~	~
Professor Alison Kitson	~	✓	×	×	×
Ms Glenys Beauchamp PSM	~	~	~	~	×
Dr Helena Williams†	_	-	_	-	~
Adjunct Professor Veronica Casey AM [§]	-	-	-	-	×

[✓] Present X Absent - N/A

^{*} Term concluded 31 March 2019.

[†] Term concluded 30 June 2018 and reappointed on 1 April 2019.

[§] Appointed 1 April 2019.

Board developments and review

New Board members undertake a formal induction to their role, including a meeting with the Chair and CEO. They receive an induction manual that includes the *Board Operating Guidelines*, which informs the conduct of Board members and describes their responsibilities and duties under legislation.

Board members are briefed on relevant topics at meetings as appropriate, and are required to undertake ongoing professional development relevant to, and in line with, the Commission's needs. The Commission supports Board members to pursue these activities.

Ethical standards

The Commission's Board Operating Guidelines provide a Board Charter that outlines the function, duties and responsibilities of the Board, and a code of conduct that defines the standard of conduct required of Board members and the ethics and values they are bound to uphold. The Duty to Disclose Interests Policy for Board Members requires Board members to recognise, declare and take reasonable steps to avoid or appropriately manage any conflicts of interest. This includes the duty to disclose material personal interests, as required under section 29 of the PGPA Act.

Committees

The Audit and Risk Committee assists the Board discharge its responsibilities under the National Health Reform Act and the PGPA Act with respect to financial reporting, performance reporting, the system of risk oversight and management, and the system of internal control.

The Inter-Jurisdictional Committee meets regularly to provide advice to the Commission and the Board on the Commission's work and safety and quality matters in the states and territories.

Additional standing committees and reference groups provide sector– and topic-specific advice on the Commission's programs and projects.

Audit and Risk Committee

The Board established the Audit and Risk Committee in compliance with section 45 of the PGPA Act and section 17 of the Public Governance, Performance and Accountability Rule. Its primary role is to assist the Board to discharge its responsibilities in respect of financial reporting, performance reporting, risk oversight and management, internal control and compliance with relevant laws and policies.

The Committee's responsibilities include:

- Reviewing the appropriateness of risk management frameworks, including the identification and management of the Commission's business and financial risks, including fraud
- Monitoring the Commission's compliance with legislation including the PGPA Act and Rule
- Monitoring the preparation of the Commission's annual Financial Statements and recommending their acceptance by the Board
- Reviewing the appropriateness of the Commission's performance measures and how these are assessed and reported
- Assessing whether relevant policies are in place to maintain an effective internal control framework, including for security arrangements and business continuity
- Reviewing the work undertaken by the Commission's outsourced internal auditors, including approving the internal audit plan and reviewing all audit reports and issues identified in those reports.

The Audit and Risk Committee met five times during the 2018–19 financial year. Table 6 summarises members' attendance at the committee meetings.

Table 6: Audit and Risk Committee attendance, 2018–19

Jennifer Clark (Chair)	Dana Sutton	Peter Achterstraat (New member)	Trevor Burgess (Retired)	Shaun Larkin (Retired)
5/5	5/5	1/1	5/5	4/4

The Committee is chaired by Ms Jennifer Clark. Ms Dana Sutton is a senior executive in the Department of Finance and an external member of the Committee. Professor Larkin was a member of the Audit and Risk Committee representing the Board. His tenure ended in March 2019 and Adjunct Professor John Walsh has been appointed as a new Board representative to attend the meetings from 2019–20. Mr Trevor Burgess was an external member of the Audit and Risk Committee during 2018–19. Mr Burgess retired at the end of the financial year. Mr Peter Achterstraat is a new external member who was appointed in April 2019. In accordance with the Public Governance, Performance and Accountability Rule, while members of the Commission's senior management attended meetings as advisors, they were not members of the Audit and Risk Committee.

Inter-Jurisdictional Committee

The Inter-Jurisdictional Committee is made up of senior safety and quality managers from the Australian Government and state and territory governments. It is responsible for advising the Commission on policy development and facilitating engagement with state and territory and Australian Government health departments. The role of Committee members is to:

- Advise the Commission on the adequacy of the policy development process, particularly policy implementation
- Ensure health departments and ministries are aware of new policy directions and are able to review local systems accordingly
- Monitor national actions to improve patient safety, as approved by health ministers
- Help collect national data on safety and quality
- Build effective mechanisms within states and territories to enable national public reporting.



Other committees and consultations

The Board has established two sub-committees that provide specific advice and support across all relevant areas of its work, and are chaired by members of the Board. These are the:

- Private Hospital Sector Committee
- Primary Care Committee.

The Private Hospital Sector Committee is chaired by Ms Christine Gee and the Primary Care Committee is chaired by Dr Helena Williams.

The Commission also works closely with a number of time-limited expert committees, working parties and reference groups to inform and support its own work. These groups allow the Commission to draw on expert knowledge, consult with relevant key individuals and organisations and develop appropriate implementation strategies.

The Commission consults widely with subject-matter experts, peak bodies, state and territories, consumers and other relevant organisations and individuals. This includes ongoing discussions with key national and other organisations, and with an extensive network for formal reference and advisory groups. The Commission also undertakes formal consultation on specific issues.

Internal governance arrangements

The CEO manages the Commission's day-to-day administration and is supported by an executive management team and internal management committees. The Commission's internal governance arrangements include internal management, risk management, fraud control and internal audit.

Internal management

The Commission has two internal management groups and two committees.

The Leadership Group and the Business Group meet regularly to facilitate information sharing and help with decision-making.

The Workplace Consultative Committee facilitates regular consultation and employee participation in the development and review of human resources and operational policies and procedures. The Information and Records Management Steering Committee assesses the Commission's recordkeeping, promotes good records management practices across the Commission, and develops strategies to ensure all records are digitised.

Risk management

Risk management is part of the Commission's strategy to promote accountability through good governance and robust business practices. The Commission is committed to embedding risk-management principles and practices consistent with the Australian Standard of *Risk Management – Principles and Guidelines* (ISO 31000:2018) and the Commonwealth Risk Management Policy into its:

- · Organisational culture
- Governance and accountability arrangements
- Reporting, performance review, business transformation and improvement processes.

Through the risk-management framework and its supporting processes, the Commission formally establishes and communicates its approach to ongoing risk management, and guides employees in their actions and ability to accept and manage risks.



Fraud control

The Commission recognises the responsibility of all Australian Government entities to develop and implement sound financial, legal and ethical decisionmaking. The Commission's Fraud Control and Anti-Corruption Plan complies with the Attorney-General's Commonwealth Fraud Control Policy. The plan minimises the potential for instances of fraud within the Commission's programs and activities by employees or people external to the Commission. Fraud risk assessments help the Commission understand fraud risks, identify internal control gaps or weaknesses and develop strategies to mitigate those risks. These assessments are conducted regularly across the organisation, taking into consideration the Commission's business activities, processes and accounts. The Commission also delivers regular fraud awareness training to staff.

Internal audit

Internal audit is a key component of the Commission's Governance Framework, providing an independent, ongoing appraisal of the organisation's internal control systems. The internal audit process provides assurance that the Commission's financial and operational controls can manage the organisation's risks and are operating in an efficient, effective and ethical manner

The Commission has appointed Crowe Horwath as its internal auditor. The firm provides assurance of the overall state of the Commission's internal controls and on any systemic issues that require management attention.

External scrutiny



Agencies subject to the *Freedom of Information Act 1982* are required to publish information to the public as part of the Information Publication Scheme. In accordance with Part II of the Act, each agency must display on its website a plan showing what information it publishes in accordance with the requirements of the scheme. The Commission's plan and freedom of information disclosure log are available on its website.

See Table 11 in Appendix A for a summary of freedom of information activities for 2018–19.



Judicial decisions and reviews by external bodies

No judicial decisions or external reviews affected the Commission significantly in 2018–19.

There have been no reports on the operations of the Commission by the Auditor-General (other than the reports on Financial Statements), or a parliamentary committee or the Commonwealth Ombudsman or the Office of the Australian Information Commissioner in 2018–19.

Parliamentary and ministerial oversight

The Commission is a corporate Commonwealth entity of the Australian Government and part of the Health Portfolio. As such, it is accountable to the Australian Parliament and the Minister for Health

Executive remuneration

The Chief Executive Officer and Board member remuneration and other benefits are set by the Remuneration Tribunal. Employees are covered by either the Commission's Enterprise Agreement 2019-22 or other employing legislation (determinations). Employees covered by the Enterprise Agreement may also have an individual flexibility agreement in operation.

Table 7: Remuneration paid to key management personnel, 2018–19

		Post-employment Short-term benefits benefits Long-term benefits							
Name	Position title	Base salary (\$)	Bonuses (\$)	Other benefits and allowances (\$)	Superannuation contributions (\$)	Long- service leave (\$)	Other long-term benefits (\$)	Termination benefits (\$)	Total remuneration (\$)
Debora Picone	Chief Executive Officer	429,898	-	9,648	20,466	14,620	-	-	474,632
Michael Wallace	Chief Operating Officer	257,698	33,033	36,562	47,811	9,679	-	-	384,783
Villis Marshall	Board Chair	75,835	-	-	7,204	-	-	-	83,039
Wendy Harris	Board Member	25,255	-	-	2,399	-	-	-	27,654
Christine Gee	Board Member	25,295	-	-	2,403	-	-	-	27,698
David Filby	Board Member	25,255	-	-	2,399	-	-	=	27,654
John Walsh	Board Member	25,255	-	-	2,399	-	_	-	27,654
Cheryle Royle	Board Member	19,218	-	-	1,826	-	-	-	21,043
Shaun Larkin	Board Member	19,218	-	-	1,826	-	-	-	21,043
Alison Kitson	Board Member	25,255	-	-	2,399	=	-	-	27,654
Martin Bowles	Board Member	25,255	-	-	2,399	=	-	-	27,654
Helena Williams	Board Member	6,037	-	-	574	-	-	-	6,611
Total		959,473	33,033	46,210	94,105	24,298	-	-	1,157,119

Table 8: Remuneration paid to executives, 2018–19

		Post-employment Short-term benefits benefits Long-term benefits							
Remuneration band (\$)	Number of senior executives	Average base salary (\$)	Average bonuses (\$)	Average other benefits and allowances (\$)	Average superannuation contributions (\$)	Average long- service leave (\$)	Average other long-term benefits (\$)	Average termination benefits (\$)	Average total remuneration (\$)
\$270,001 to \$295,000	1	220,286	26,321	-	37,558	7,081	-	=	291,245
\$295,001 to \$320,000	0	-	-	-	-	-	-	-	-
\$320,001 to \$345,000	1	212,097	25,707	36,562	40,938	6,817	-	-	322,121

Table 9: Remuneration paid to other highly paid staff, 2018–19

		Post-employment Short-term benefits benefits Long-term bene				m benefits			
Remuneration band (\$)	Number of executives	,	Average bonuses (\$)	Average other benefits and allowances (\$)	Average superannuation contributions (\$)	Average long- service leave (\$)	Average other long-term benefits (\$)	Average termination benefits (\$)	Average total remuneration (\$)
\$220,001 to \$245,000	1	177,951	6,301	18,876	30,860	6,327	-	-	240,314
\$245,001 to \$270,000	1	184,676	18,768	9,648	32,772	5,936	-	=	251,799
\$270,001 to \$295,000	2	213,639	24,409	4,824	40,046	6,867	-	-	289,785
\$295,001 to \$320,000	0	-	-	-	-	-	-	=	-
\$320,001 to \$345,000	2	228,935	26,304	23,105	41,053	7,359	-	-	326,756
\$345,001 to \$370,000	-	-	-	-	-	-	-	-	-
\$370,001 to \$395,000	-	-	-	-	-	-	-	-	-

Developments and significant events

The Commission is required under paragraph 19(1) of the PGPA Act to keep the Health Minister and the Finance Minister informed of any significant decisions or issues that have affected or may affect its operations. In 2018–19, there were no such decisions or issues.

Environmental performance and ecologically sustainable development

Section 516A of the *Environment Protection and Biodiversity Conservation Act 1999* requires Australian Government organisations and authorities to include information in their annual reports about their environmental performance and their contribution to ecologically sustainable developments. The Commission is committed to making a positive contribution to ecological sustainability. The Commission's ecologically sustainable activities are detailed in Appendix B.

Advertising and market research

Section 331A of the *Commonwealth Electoral Act 1918* requires Australian Government departments and agencies to include particulars in their annual reports of amounts over \$13,200 that were paid to advertising agencies, market research organisations, polling organisations,

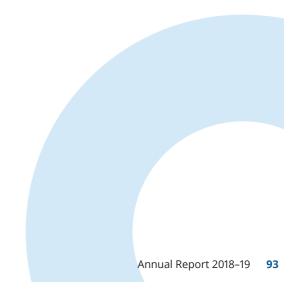
direct mail organisations or media advertising organisations. In 2018–19, the Commission did not make any payments over \$13,200 to advertising or market research organisations.

National Health Reform Act amendments

No amendments to the National Health Reform Act were made during the 2018–19 financial year.

Government policy orders

No new government policy orders applicable to the Commission were issued in 2018–19.



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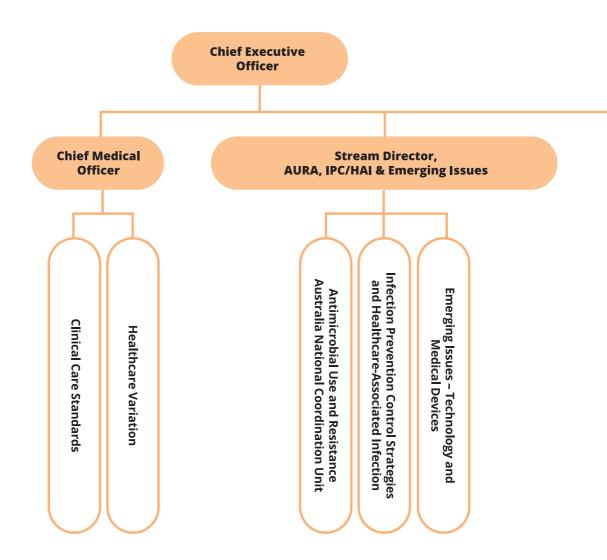
The Commission employs a diverse range of highly skilled professionals with experience across the healthcare industry. Because of the nature of its work, the Commission has a strong national presence in safety and quality in both the public and private sectors.

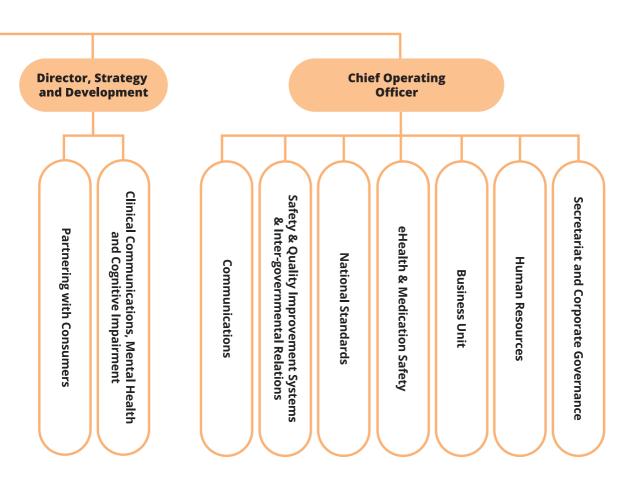
The Commission is committed to managing and developing its employees to achieve the objectives and outcomes contained in its work plan.

Organisational structure	96
People management	98
Staff profile	99
Workplace health and safety	100
Learning and development	101
Workplace diversity	102
Aboriginal and Torres Strait Islander employment	103

Organisational structure

Figure 3: Organisational structure





People management

The Commission continues to deliver high performance by providing ongoing support through its performance management systems and through embedding a strong sense of direction across the organisation.

The Commission's performance development scheme places emphasis on employees and managers having regular, meaningful performance discussions. All employees are required to have an individual performance and development plan in place, and managers and employees have joint accountability for capability and career development.

The Commission participates in the online induction program offered by the Australian Public Service Commission, giving new employees the opportunity to learn how the Australian Public Service operates and understand the behaviours expected of all staff members.

In May 2019, the Commission encouraged all staff members to participate in the Public Service Commission's employee census survey.



Staff profile

As of 30 June 2019, the Commission employed 75.4 full-time equivalent employees. Most employees are located in Sydney. Table 10 provides a breakdown of the Commission's employee profile by classification, gender, full-time or part-time status, and ongoing or non-ongoing status.

Table 10: Employee profile as of 30 June 2019

	Female					M	ale		Total
	Ong	oing	Non-o	ngoing	Ong	oing			
Classification	Full time	Part time	Full time	Part time	Full time	Part time	Full time	Part time	
CEO			1.0						1.0
MO6	1.0					0.8			1.8
EL 2	7.9	2.6		1.0	8.0				19.5
EL 1	17.4	6.6	2.3	1.3	6.0				33.5
APS 6	6.0	3.0	4.0	1.2	2.4				16.5
APS 5			1.3		0.6				1.9
APS 4	1.0								1.0
APS 2								0.2	0.2
Total	33.3	12.2	8.5	3.4	17.0	0.8		0.2	75.4

Note: Figures have been rounded to nearest decimal place.

Workplace health and safety

The Commission promotes a healthy and safe workplace and is committed to meeting its obligations under the Work Health and Safety Act 2011 and the Safety, Rehabilitation and Compensation Act 1988. All new staff members are required to complete online work health and safety training as part of their induction.

The Commission undertook a number of activities during 2018–19 to encourage employees to adopt healthy work and lifestyle practices, including:

- Conducting ergonomic workstation assessments as required and providing access to standing desks
- Conducting biannual workplace inspections and encouraging all staff members to report incidents, accidents or hazards in the workplace
- Providing access to an employee assistance program
- Making influenza vaccinations available to all staff members
- Providing access to reimbursement of eyewear costs for use with screenbased equipment.

One minor incident was reported in 2018–19. There were no notifiable incidents in 2018–19. No notices were issued to the Commission and no investigations were initiated in 2018–19 under the Work Health and Safety Act.

Learning and development

The Commission values the talents and contributions of its staff members and recognises the importance of building expertise and capability within the organisation.

Learning and development needs and opportunities are primarily identified through the performance development scheme. The Commission promotes learning and development by delivering regular continuing professional development sessions to all staff members.

During 2018–19, the Commission's study support and training arrangements ensured the ongoing development of staff members' skills and capabilities. Participation in study and training included 12 staff members accessing study support assistance and 30 staff members completing 20 external training courses. Commission staff members are currently undertaking a range of tertiary courses, including Master of Public Health, Master of Health Service Management, and various graduate certificates in health-related fields.

Workplace diversity

The Commission's workplace diversity program supports the **Commission's ongoing commitment** to recognising and fostering diversity in the workplace.

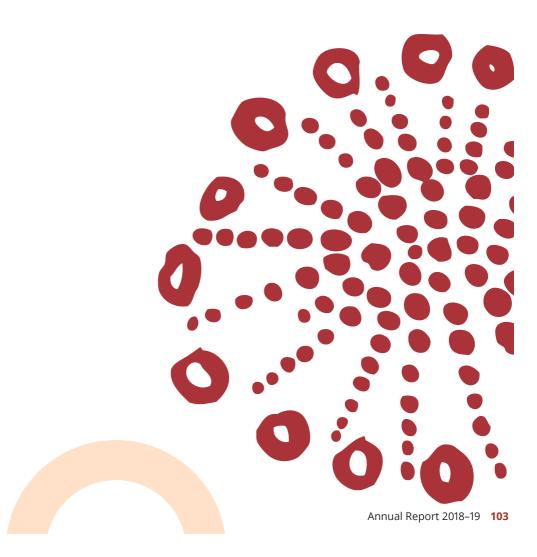
Commission staff participated in NAIDOC (National Aborigines and Islanders Day Observance Committee) Week activities in July 2018 and celebrated Harmony Day, a day celebrated around Australia on 21 March each year to promote cultural diversity.

The Commission is committed to increasing opportunities for people with a disability to participate in employment. The Commission complies with the Australian Government accessibility requirements for online access and publishing. Additionally, employees with a disability are provided with reasonable adjustments to help them perform their duties.

During 2018–19, the Commission participated in the Australian Public Service Disability Champions Network.

Aboriginal and Torres Strait Islander employment

The Commission has no staff members who identify as being Aboriginal or Torres Strait Islander.



Financial Statements



Independent auditors report	106
Financial Statements	108
Notes to and forming part of the Financial	
Statements for the period ended 30 June 2019	114





INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Australian Commission on Safety and Quality in Health Care ('the Entity') for the year ended 30 June 2019:

- (a) comply with Australian Accounting Standards Reduced Disclosure Requirements and the Public Governance, Performance and Accountability (Financial Reporting) Rule 2015; and
- (b) present fairly the financial position of the Entity as at 30 June 2019 and its financial performance and cash flows for the year then ended.

The financial statements of the Entity, which I have audited, comprise the following statements as at 30 June 2019 and for the year then ended:

- Statement by the Directors, Chief Executive and Chief Financial Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Cash Flow Statement; and
- Overview and Notes to the Financial Statements, comprising a summary of significant accounting policies and other explanatory information.

Basis for opinion

I conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. My responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of my report. I am independent of the Entity in accordance with the relevant ethical requirements for financial statement audits conducted by the Auditor-General and his delegates. These include the relevant independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 Code of Ethics for Professional Accountants (the Code) to the extent that they are not in conflict with the Auditor-General Act 1997. I have also fulfilled my other responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Accountable Authority's responsibility for the financial statements

As the Accountable Authority of the Entity, the Directors are responsible under the Public Governance, Performance and Accountability Act 2013 (the Act) for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards – Reduced Disclosure Requirements and the rules made under the Act. The Directors are also responsible for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for assessing the ability of the Entity to continue as a going concern, taking into account whether the Entity's operations will cease as a result of an administrative restructure or for any other reason. The Directors are also responsible for disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the assessment indicates that it is not appropriate.

> GPO Box 707 CANBERRA ACT 2601 19 National Circuit BARTON ACT Phone (02) 6203 7300 Fax (02) 6203 7777

Auditor's responsibilities for the audit of the financial statements

My objective is to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian National Audit Office Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

As part of an audit in accordance with the Australian National Audit Office Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- · identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control;
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Entity's internal control;
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Accountable Authority;
- conclude on the appropriateness of the Accountable Authority's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Entity's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Entity to cease to continue as a going concern; and
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Accountable Authority regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

Australian National Audit Office

Colin Bienke Senior Director

Delegate of the Auditor-General

Canberra

11 September 2019

Financial Statements

Australian Commission on Safety and Quality in Health Care

Statement by the Directors, Chief Executive and Chief Financial Officer

In our opinion, the attached financial statements for the year ended 30 June 2019 comply with subsection 42(2) of the Public Governance, Performance and Accountability Act 2013 (PGPA Act), and are based on properly maintained financial records as per subsection 41(2) of the PGPA Act.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the Australian Commission on Safety and Quality in Health Care will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the directors.

Chair

Adi, Professor Debora Picone AO

Chief Executive Officer

A/g Chief Operating Officer/

Chief Financial Officer

Date: 10 Sy who 2019 Date: 10 Sytuche, 2019 Date: 10 September 2019

Statement of Comprehensive Income for the period ended 30 June 2019

		2019	2018	Original	
	Notes	\$'000	\$'000	Budget \$'000	
NET COST OF SERVICES	Notes	\$ 000	\$ 000	\$ 000	
Expenses					
Employee benefits	1.1A	11,841	11,499	11,880	
Suppliers	1.1B	14,099	13.009	9,232	1
Depreciation and amortisation	2.2A	132	177	502	1
Finance costs		-	-	-	
Total expenses	=	26,072	24,685	21,614	
·	=	20,012	24,000	21,014	
Own-source income					
Rendering of services	1.2A	7,125	5,856	2,209	1
Interest	1.2B	261	157	120	1
State and Territory Government contributions	_	7,857	7,628	7,857	
Total own-source income	-	15,243	13,641	10,186	
Net cost of services	-	10,829	11,044	11,428	
Revenue from Commonwealth Government	1.2C	11,419	11,166	11,428	
Operating surplus	-	590	122		1
OTHER COMPREHENSIVE INCOME Items not subject to subsequent reclassification to net cost of services					
Changes in asset revaluation surplus	_	293	-		1
Total other comprehensive income	-	293			
Total comprehensive income	_	883	122		1

¹ Explanations for major variances to budget are made in note 5.2.

Statement of Financial Position

as at 30 June 2019

ac at 00 04110 20 10	Notes	2019 \$'000	2018 \$'000	Original Budget \$'000	
ASSETS		+ 000	ΨΟΟΟ	φσσσ	
Financial Assets					
Cash		12,785	9,740	4,363	1
Trade and other receivables	2.1A	3,160	1,808	110	1
Total financial assets	_	15,945	11,548	4,473	
Non-Financial Assets					
Property, plant and equipment	2.2A	1,173	584	1,706	1
Prepayments	_	73	186	300	1
Total non-financial assets		1,246	770	2,006	
Total assets		17,191	12,318	6,479	
LIABILITIES					
Payables					
Trade creditors and accruals		1,445	1,282	939	1
Unearned income		9,144	5,504	314	1
Other payables	2.3A _	183	125	86	1
Total payables	_	10,772	6,911	1,339	
Provisions					
Employee provisions	3.1	2,700	2,571	2,426	1
Total provisions		2,700	2,571	2,426	
Total liabilities		13,472	9,482	3,765	
Net assets		3,719	2,836	2,714	
EQUITY					
Contributed equity		1,836	1,836	1,836	
Reserves		298	5	5	1
Retained surplus	_	1,585	995	873	1
Total equity	_	3,719	2,836	2,714	
-					

¹ Explanations for major variances to budget are made in note 5.2.

Statement of Changes in Equity for the period ended 30 June 2019

ioi tile period erided 50 Julie 2019			Original	
	2019	2018	Budget	
	\$'000	\$'000	\$'000	
CONTRIBUTED EQUITY				
Opening balance	1,836	1,836	1,836	
Closing balance attributable to the Australian Government as at 30 June	1,836	1,836	1,836	
RETAINED EARNINGS				
Opening balance	995	873	873	1
Comprehensive income				
Surplus for the period	590	122		1
Total comprehensive income	590	122		
Closing balance attributable to the Australian Government as at 30 June	1,585	995	873	
ASSET REVALUATION RESERVE				
Opening balance	5	5	5	
Changes in asset revaluation surplus	293	-		1
Total comprehensive income	293	-		
Closing balance attributable to the Australian Government as at 30 June	298	5	5	
TOTAL EQUITY				
Opening balance	2,836	2,714	2,714	
Comprehensive income				
Surplus for the period	590	122	-	1
Other comprehensive income	293			1
Total comprehensive income	883	122	_	
Closing balance attributable to the Australian Government	3,719	2,836	2,714	

¹ Explanations for major variances to budget are made in note 5.2.

Cash Flow Statement

for the period ended 30 June 2019

	2019 \$'000	2018 \$'000	Original Budget \$'000	
OPERATING ACTIVITIES				
Cash received				
Receipts from Federal Government	11,419	11,166	11,428	
State and Territory contributions	7,857	7,628	7,857	
Rendering of services	9,528	9,552	2,459	1
Interest	258	142	120	1
GST received	773	1,011	900	1
Total cash received	29,835	29,499	22,764	
Cash used				
Employees	(11,705)	(11,507)	(11,832)	
Suppliers	(13,772)	(13,109)	(9,406)	1
GST paid	(885)	(853)	(900)	
Total cash used	(26,362)	(25,469)	(22,138)	
Net cash from (used by) operating activities	3,473	4,030	626	
INVESTING ACTIVITIES				
Cash used				
Purchase of property, plant and equipment	(428)	(623)	(349)	1
Total cash used	(428)	(623)	(349)	
Net cash used by investing activities	(428)	(623)	(349)	
Net increase (decrease) in cash held Cash and cash equivalents at the	3,045	3,407	277	
beginning of the reporting period	9,740	6,333	4,086	
Cash at the end of the reporting period	12,785	9,740	4,363	

¹ Explanations for major variances to budget are made in note 5.2.

Table of Contents - Overview and Notes to the **Financial Statements**

Overview

- 1. Financial Performance
 - 1.1. Expenses
 - 1.2. Income
- 2. Financial Position
 - 2.1. Financial Assets
 - 2.2. Non-Financial Assets
 - 2.3. Payables
- 3. People and Relationships
 - 3.1. Employee Provisions
 - 3.2. Key Management Personnel Remuneration
 - 3.3. Related Party Disclosures
- 4. Managing Uncertainties
 - 4.1. Contingent Assets and Liabilities
 - 4.2. Financial Instruments
 - 4.3. Fair Value Measurement
- 5. Other Information
 - 5.1. Aggregate assets and liabilities
 - 5.2. Budget Variances

Overview

Objectives of the Commission

The Australian Commission on Safety and Quality in Health Care (the Commission) is an Australian Government controlled entity. It is a not-for-profit entity. The objective of the Commission is to lead and coordinate health care safety and quality improvements in Australia.

Initially established in 2006 by the Australian, State and Territory governments to lead and coordinate national improvements in safety and quality, the Commission's permanent status was confirmed with the assent of the National Health Reform Act 2011 (NHR Act). It is a Commonwealth Authority operating under the requirements of the Public Governance, Performance and Accountability Act 2013. The Commission commenced as an independent, statutory authority on 1 July 2011, funded jointly by the Commonwealth. State and Territory governments.

The Commission is structured to meet a single outcome:

To improve safety and quality in healthcare across the health system, including through the development, support for implementation, and monitoring of national clinical safety and quality guidelines and standards.

The continued existence of the Commission in its present form and with its present programmes is dependent on Government policy and on continued funding from Parliament for the Commission's administration and programmes.

Basis of Preparation of the Financial Statements

The financial statements are general purpose financial statements and are required by section 42 of the Public Governance. Performance and Accountability Act 2013.

The financial statements have been prepared in accordance with:

- a) Public Governance, Performance and Accountability (Financial Reporting) Rule 2015 (FRR); and
- b) Australian Accounting Standards and Interpretations Reduced Reporting Requirements issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value. Except where stated, no allowance is made for the effect of changing prices on the results or the financial position. The financial statements are presented in Australian dollars.

New Accounting Standards

All new, revised, amending standards and interpretations that were issued prior to the signoff date, and are applicable to the current reporting period, did not have a material effect on the Commission's financial statements.

Taxation

The Commission is exempt from all forms of taxation, except for Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

1 Financial Performance

1.1 Expenses

	2019	2018
	\$'000	\$'000
1.1A: Employee Benefits		
Wages and salaries	8,342	8,318
Superannuation:	·	·
Defined contribution plans	1,319	1,315
Defined benefit plans	217	225
Leave and other entitlements	1,934	1,618
Other employee benefits	29	23
Total employee benefits	11,841	11,499

Accounting Policy

Accounting policies for employee related expenses are contained in Section 3 People and Relationships of the notes to the financial statements.

1.1B: Suppliers

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Good	ıs an	ıa se	rvices

00000 0.1000		
Contracts for services	8,672	7,673
Staff travel	399	292
Committee expenses	839	853
Information and communication	945	836
Printing and postage	512	874
Property outgoings	133	244
Other	667	561
Total goods and services	12,167	11,333
Goods and services are made up of:		
Goods supplied	505	904
Services rendered	11,662	10,429
Total goods and services	12,167	11,333
Other supplier expenses		

<u> </u>		
Operating	Lagea	rantale
Operation	ıcasc	ıcıılaıs

Minimum lease payments	1,723	1,514
Workers compensation expenses	209	162
Total other supplier expenses	1,932	1,676
Total supplier expenses	14,099	13,009

	2019	2018
Leasing commitments	\$'000	\$'000

The Commission entered into a lease in 2018 for Level 5 and part of Level 6 of 255 Elizabeth Street, Sydney. The lease is due to expire 31 December 2020.

Commitments for minimum lease payments in relation to noncancellable operating leases are payable as follows:

Within 1 year	1,723	1,723
Between 1 to 5 years	2,584	4,306
More than 5 years		-
Total operating lease commitments	4,307	6,029

Accounting Policy

Operating lease payments are expensed on a straight-line basis which is representative of the pattern of benefits derived from the leased assets.

1.2 Income

OWN-SOURCE REVENUE	2019 \$'000	2018 \$'000
1.2A: Rendering of Services		
Rendering of services	7,125	5,856
Total rendering of services	7,125	5,856

Accounting Policy

Revenue from rendering of services is recognised by reference to the stage of completion of contracts at the reporting date. The revenue is recognised when:

- the stage of completion and transaction costs incurred can be reliably measured; and
- b) the probable economic benefits associated with the transaction will flow to the Commission.

The stage of completion of contracts at the reporting date is determined by reference to the proportion that costs incurred to date bear to the estimated total costs of the transaction.

Receivables for goods and services, which have 30 day terms, are recognised at the nominal amounts due less any impairment allowance. Collectability of debts is reviewed at the end of the reporting period. Allowances are made when collectability of the debt is no longer probable.

1.2B: Interest

Deposits	261	157
Total interest	261	157

Accounting Policy

Interest revenue is recognised using the effective interest method.

1.2C: Revenue from Government

Department of Health:

Total revenue from Government	11,419	11,166
government measures		0,000
Corporate Commonwealth entity payment item – Smaller	3.562	3.538
Ministers Advisory Council (AHMAC)		
Corporate Commonwealth entity payment item – Australian Health	7,857	7,628

Accounting Policy

Funding received or receivable from non-corporate Commonwealth entities (appropriated to the Department of Health as a corporate Commonwealth entity payment item for payment to the Commission) is recognised as Revenue from Government.

2 Financial Position

2.1 Financial Assets

	2019 \$'000	2018 \$'000
2.1A: Trade and Other Receivables		
Good and services receivables:		
Goods and services	2,845	1,556
Total goods and services receivable	2,845	1,556
Other receivables:		
Receivable from the Australian Taxation Office	283	223
Interest	32	29
Total other receivables	315	252
Total trade and other receivables (gross)	3,160	1,808
Total trade and other receivables (net)	3,160	1,808
No receivables were impaired at 30 June 2019 (2018: Nil).		

Accounting Policy

Financial Assets

Trade receivables and other receivables that are held for the purpose of collecting the contractual cash flows, where the cash flows are solely payments of principal, that are not provided at below-market interest rates, are measured at amortised cost using the effective interest method adjusted for any loss allowance.

2.2 Non-Financial Assets

2.2A: Reconciliation of the opening and closing balances of property, plant and equipment

Reconciliation of the opening and closing balances of property, plant and equipment for 2019

101 2019	Leasehold improvement \$'000	Plant and equipment \$'000	Intangible assets \$'000	Total \$'000
As at 1 July 2018		- + + + + + + + + + + + + + + + + + + +	+ + + + + + + + + + + + + + + + + + + 	+ + + + + + + + + + + + + + + + + + +
Gross book value Accumulated amortisation,	606	295	304	1,205
depreciation and impairment	(499)	(122)	-	(621)
Total as at 1 July 2018	107	173	304	584
Additions:				
By purchase	-	49	-	49
Internally developed	-	-	381	381
Work in progress	-	-	379	379
Revaluations recognised in other comprehensive income Depreciation and amortisation	293	-	-	293
expense	(42)	(47)	(43)	(132)
Transfer from work in progress	-	-	(381)	(381)
Total as at 30 June 2019	358	175	640	1,173
Total as of 30 June 2019 represented	bv:			
Gross book value Accumulated amortisation,	358	344	683	1,385
depreciation and impairment		(169)	(43)	(212)
	358	175	640	1,173

Leasehold improvements were revalued independently by Jones Lang Lasalle (JLL) as at 30 June for Level 5 and part of Level 6, 255 Elizabeth Street. Intangible assets include software assets under development and completed internally developed software assets.

Accounting Policy

Assets are recorded at cost on acquisition except as stated below. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken. Financial assets are initially measured at their fair value plus transaction costs where appropriate.

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the statement of financial position, except for purchases of leasehold improvements costing less than \$50,000, intangible assets costing less than \$75,000, and for all other purchased of property, plant and equipment costing less than \$4,500, which are expensed in the year of acquisition.

Accounting Policy continued

Revaluations

Following initial recognition at cost, property, plant and equipment are carried at fair value less subsequent accumulated depreciation and accumulated impairment losses. Valuations are conducted to ensure that the carrying amounts of assets do not differ materially from the assets' fair values as at the reporting date. The regularity of independent valuations will depend upon the volatility of movements in market values for the relevant assets.

Revaluation adjustments are made on a class basis. Any revaluation increment is credited to equity under the heading of asset revaluation reserve except to the extent that it reversed a previous revaluation decrement of the same asset class that was previously recognised in the surplus/deficit. Revaluation decrements for a class of assets are recognised directly in the surplus/deficit except to the extent that they reversed a previous revaluation increment for that class.

Any accumulated depreciation as at the revaluation date is eliminated against the gross carrying amount of the asset and the asset restated to the revalued amount.

Depreciation

Depreciable property, plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the Commission using, in all cases, the straight-line method of depreciation.

Depreciation rates (useful lives), residual values and methods are reviewed at each reporting date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate.

Depreciation rates applying to each class of depreciable asset are based on the following useful lives:

Asset Class 2019 2018 Leasehold improvements Lease term Lease term Plant and equipment 5 years 5 years

Impairment

All assets were assessed for impairment at 30 June 2019. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount. There were no indicators of impairment at 30 June 2019.

The recoverable amount of an asset is the higher of its fair value less costs to sell and its value in use. Value in use is the present value of the future cash flows expected to be derived from the asset. Where the future economic benefit of an asset is not primarily dependent on the asset's ability to generate future cash flows, and the asset would be replaced if the Commission were deprived of the asset, its value in use is taken to be its depreciated replacement costs.

Derecognition

An item of property, plant and equipment is derecognised upon disposal or when no further future economic benefits are expected from its use or disposal.

Accounting Policy continued

Intangibles

The entity's intangibles comprise internally developed software for operational use. These assets are carried at cost less accumulated amortisation and accumulated impairment losses.

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives of the entity's software is 5 years (2018: 5 years).

All software assets were assessed for indications of impairment as at 30 June 2019.

2.3: Payables

	2019	2018
2.3A: Other Payables	\$'000	\$'000
Salaries and wages	66	60
Superannuation	11	10
Rent payable	103	44
Other	3	11
Total other payables	183	125

3 People and Relationships

•		
	2019	2018
	\$'000	\$'000
3.1 Employee Provisions		
Leave	2,700	2,571
Total employee provisions	2,700	2,571

Accounting Policy

Liabilities for 'short-term employee benefits' and termination benefits expected within twelve months of the end of the reporting period are measured at their nominal amounts.

The liability for employee benefits includes provision for annual leave and long service leave. The leave liabilities are calculated on the basis of employees' remuneration at the estimated salary rates that will be applied at the time the leave is taken, including the Commission's employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination.

The liability for long service leave has been determined by the Department of Finance shorthand method as described under the FRR. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Superannuation

The Commission's staff are members of the Commonwealth Superannuation Scheme (CSS), the Public Sector Superannuation Scheme (PSS), the PSS accumulation plan (PSSap) or other superannuation funds held outside the Australian Government.

The CSS and PSS are defined benefit schemes for the Australian Government. The PSSap is a defined contribution scheme.

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported by the Department of Finance's administered schedules and notes.

The Commission makes employer contributions to the employees' defined benefit superannuation scheme at rates determined by an actuary to be sufficient to meet the current cost to the Government. The Commission accounts for the contributions as if they were contributions to defined contribution plans.

The liability for superannuation recognised as at 30 June represents outstanding contributions.

3.2 Key Management Personnel Remuneration

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Commission, directly or indirectly, including any director (whether executive or otherwise) of the Commission. The Commission has determined the key management personnel to be the Chief Executive, Chief Operating Officer and 12 Directors. Key management personnel remuneration is reported in the table below:

	2019	2018 ¹
	\$'000	\$'000
Short-term employee benefits	1,039	1,007
Post-employment benefits	94	91
Other long-term benefits	24	21
Termination benefits	-	-
Total key management remuneration expenses ²	1,157	1,119

The total number of key management personnel that are included in the above table are 14 (2018: 13)1. Two directors waived their right or were not eligible to receive remuneration during 2019 (2018: 1).

¹ The 2018 comparative figures have been restated to reflect an error in the classification between 'Short-term employee benefits and Other long-term benefits' of \$112,000. A reassessment of those holding key management personnel positions also resulted in the removal of 4 Senior Medical Officer roles that do not meet the definition of key management personnel. The impact of removing these positions reduced 'Short-term employee benefits (\$625,000), 'Post employee benefits (\$96,000) and 'Other long-term benefits' (\$24,000) to the prior year comparative figures.

² The above key management personnel remuneration excludes the remuneration and other benefits of the Portfolio Minister. The Portfolio Minister's remuneration and other benefits are set by the Remuneration Tribunal and are not paid by the Commission.

3.3 Related Party Disclosures

Related party relationships

The Commission is an Australian Government controlled entity. Related parties to this entity are Key Management Personnel including the Portfolio Minister and Executive, and other Australian Government entities.

Transactions with related parties

Given the breadth of Government activities, related parties may transact with the government sector in the same capacity as ordinary citizens. Such transactions include the payment or refund of taxes, receipt of a Medicare rebate or higher education loans. These transactions have not been separately disclosed in this note.

Several directors of the Commission hold directorships with other organisations. There were no transactions in 2018-19 between the Commission and organisations with a director common to the Commission.

4 Managing Uncertainties

4.1 Contingent Assets and Liabilities

As at 30 June 2019, the Commission had no quantifiable, unquantifiable or significant remote contingencies (2017-18: nil).

4.2 Financial Instruments

4.2A: Categories of financial instruments

	2019	2018
	\$'000	\$'000
Financial assets at amortised cost		
Cash on hand and at bank	12,785	9,740
Trade and other receivables	2,877	1,585
Total financial assets	15,662	11,325
Financial liabilities		
Financial liabilities measured at amortised cost:		
Trade creditors and accruals		
Suppliers	1,445	1,282
Total financial liabilities	1,445	1,282

4.2B: Net gains or losses on financial instruments

Financial assets at amortised cost

Interest revenue	261	157
Net gain from financial assets at amortised cost	261	157

The Commission holds only cash and receivables as financial assets and trade creditors and accruals as financial liabilities.

With the implementation of AASB 9 Financial Instruments for the first time in 2019, the Commission classifies all financial instruments at amortised cost (previously held-to-maturity under AASB 139 Financial Instruments: Recognition and Measurement). There have been no remeasurements due to the initial application of AASB 9. Amortised cost is determined using the effective interest rate method.

Effective Interest Method

Income is recognised on an effective interest rate basis for financial assets recognised at amortised cost.

4.3: Fair Value Measurement

Accounting Policy

The Commission seeks independent valuation for material non-financial assets on a triennial basis. The Commission procured the services of the Jones Lang Lasalle (JLL) to undertake a comprehensive revaluation of the leasehold improvement asset at 30 June 2019 and relied upon those outcomes to establish carrying amounts. JLL provided written assurance to the Commission that the models developed are in compliance with AASB 13 Fair Value Measurement.

	Fair value measurement at the end of the reporting period	
	2019 \$'000	2018 \$'000
Non-financial assets Leasehold improvements	358	107
Plant and Equipment	175	173
Total non-financial assets	533	280

5 Other information

5.1: Aggregate Assets and Liabilities

	2019	2018
	\$'000	\$'000
Assets expected to be recovered in:		
No more than 12 months	16,018	11,734
More than 12 months	1,173	584
Total assets	17,191	12,318
Liabilities expected to be settled in		
No more than 12 months	11,424	7,133
More than 12 months	2,048	2,349
Total liabilities	13,472	9,482

5.2: Budget Variances

The comparison of the unaudited original budget as presented in the 2018-19 Portfolio Budget Statements (PBS) to the 2018-19 final outcome as presented in accordance with Australian Accounting Standards is included in the Statement of comprehensive income, the Statement of financial position, Statement of changes in equity and Cash flow statement.

Major Variances

Line items impacted	Major variance explanations
Statement of comprehensive income Suppliers, Rendering of services,	The budget is prepared based on executed contracts for projects in April 2018.
Interest. Statement of financial position Cash, Trade and other receivables, Trade creditors and accruals, Unearned income. Cash flow statement	During the 2018-19 financial year additional projects were contracted resulting in higher payments received in advance of services being delivered. This led to an increase in unearned income.
Rendering of services, Interest and Suppliers.	The increase in receivables is due to projects being invoiced in June 2019 with the majority received in July 2019.
	The additional contracted projects resulted in increased project expenditure compared to budget.
Statement of comprehensive income Surplus, Total comprehensive income.	Budgets are prepared on a break even assumption for all projects. The timing of expenditure and delivery of workplan projects has resulted in a minor surplus.
Statement of financial position Retained earnings.	
Statement of changes in equity Surplus for the year.	
Statement of comprehensive income Changes in asset revaluation surplus.	The impact of the revaluation of leasehold improvements at 30 June 2019 was not incorporated into the budget.
Statement of financial position Reserves.	
Statement of changes in equity Asset revaluation reserve.	

Major Variances contd.

Statement of comprehensive income

Depreciation and amortisation.

Statement of financial position Property, plant and equipment.

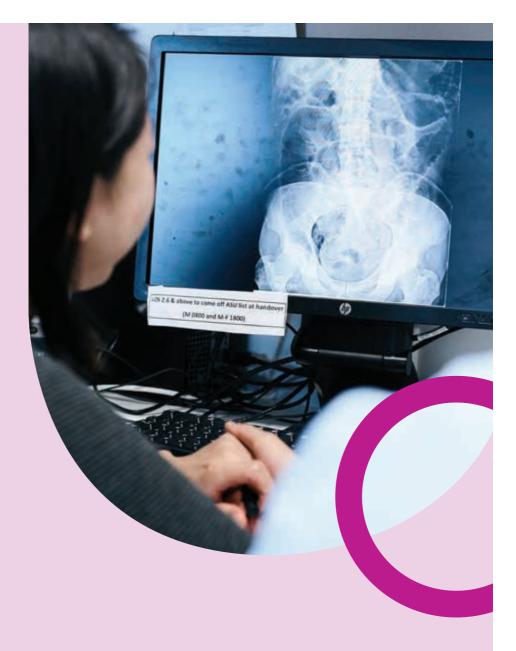
Cash flow statement

Purchase of property, plant and equipment.

The budget and timing for completion and delivery of projects developing intangible assets have changed since the budget was prepared.

Appendices

130



Appendix A: Freedom of information summary	132
Appendix B: Compliance to ecologically	
sustainable development	133
Appendix C: Related-entity transactions	135

Appendix A: Freedom of information summary

The following table summarises the year's freedom of information (FOI) requests and their outcomes, as discussed on page 90.

Table 11: Freedom of information summary, 2018–19

Activity	Number
Requests	
On hand at 1 July 2018	1*
New requests received	3
Total requests handled	4
Total requests completed as at 30 June 2019	2
Total requests on hand as at 30 June 2019	0
Action of request	
Access granted in full	2
Access granted in part	
Access refused	
Access transferred in full	
Request withdrawn	2
No records	
Response time	
0–30 days	
30-60 days	1

^{*} Information Commissioner review, resolved during 2018–19 but not included in the response time breakdown.

Appendix B: Compliance to ecologically sustainable development

The Commission is committed to making a positive contribution to ecological sustainability. Table 12 details the Commission's activities in accordance with section 516A(6) of the Environment Protection and Biodiversity Conservation Act 1999 (EPBC).

Table 12: Summary of the Commission's compliance with ecologically sustainable development, 2018-19

EPBC	Commission response
The activities of the Commission during 2018–19 accord with the principles of ecologically sustainable development.	The Commission ensures its decision-making and operational activities mitigate environmental impact, with the principles of ecologically sustainable development embedded in the Commission's approach to its work plan and corporate, purchasing and operational guidelines.
Outcomes specified for the Commission in an Appropriations Act for 2018– 19 contribute to ecologically sustainable development.	The Commission's single appropriations outcome focuses on improving safety and quality in health care across the Australian health system. As such, the Commission does not directly contribute to ecologically sustainable development.
Effects of the Commission's activities on the environment.	The Commission's offices are located in a 5-Star* (NABERS rating) building, with the Commission working proactively with the building management to achieve energy savings where possible. The Commission continues to improve its dissemination of publications, reports and written materials through electronic media to minimise printing output.

^{*} Based on the National Australian Built Environment Rating System.

Table 12: continued

EPBC Commission response Measures the Commission The Commission is improving its website functionality is taking to minimise its and increasing the use of multi-channel strategies to impact on the environment. distribute information electronically to further reduce its environmental impact. To reduce travel, the Commission uses remote meeting attendance options where feasible. The responsible use and disposal of materials, electricity and water is expected of all staff and visitors. Mechanisms for The Commission has a range of mechanisms established reviewing and increasing to review current practices and policies. In addition, the effectiveness of staff are encouraged to identify initiatives to change those measures. behaviours, procedures or policies that may reduce and/ or minimise their environmental impact, and that of their team and the Commission more broadly.

Appendix C: Related-entity transactions

Table 13: Related-entity transactions, 2018-19

Vendor no.	Commonwealth entity	Number of transactions	Transaction value	Description
100362	Department of Health	15	\$560,290.54	Payments processed in 2018–19 for corporate services received from the Department of Health under a shared services agreement between the Commission and the Department.

references



Acronyms	138
Glossary	140
Index of figures	145
Index of tables	146
Compliance index	147
Index	151
References	158

Acronyms

ACOP AHPEQS Implementers' Community of Practice ACM HSMR Australian Composite Model Hospital Standardised Mortality Ratio AGAR Australian Group on Antimicrobial Resistance AIHW Australian Institute of Health and Welfare AHMAC Australian Health Ministers' Advisory Council AHPEQS Australian Hospital Patient Experience Question Set AHSSQA Australian Health Service Safety and Quality Accreditation AM Member of the Order of Australia AMR antimicrobial resistance AO Officer of the Order of Australia APAS Australian Passive AMR Surveillance AU antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australias College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication HAI healthcare-associated infection	AC	Companion of the Order of Australia
AGAR Australian Group on Antimicrobial Resistance AIHW Australian Institute of Health and Welfare AHMAC Australian Health Ministers' Advisory Council AHPEQS Australian Hospital Patient Experience Question Set AHSSQA Australian Health Service Safety and Quality Accreditation AM Member of the Order of Australia AMR antimicrobial resistance AO Officer of the Order of Australia APAS Australian Passive AMR Surveillance AU antimicrobial use AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	ACOP	AHPEQS Implementers' Community of Practice
AIHW Australian Institute of Health and Welfare AHMAC Australian Health Ministers' Advisory Council AHPEQS Australian Hospital Patient Experience Question Set AHSSQA Australian Health Service Safety and Quality Accreditation AM Member of the Order of Australia AMR antimicrobial resistance AO Officer of the Order of Australia APAS Australian Passive AMR Surveillance AU antimicrobial use AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	ACM HSMR	Australian Composite Model Hospital Standardised Mortality Ratio
AHMAC Australian Health Ministers' Advisory Council AHPEQS Australian Hospital Patient Experience Question Set AHSSQA Australian Health Service Safety and Quality Accreditation AM Member of the Order of Australia AMR antimicrobial resistance AO Officer of the Order of Australia APAS Australian Passive AMR Surveillance AU antimicrobial use AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australasian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	AGAR	Australian Group on Antimicrobial Resistance
AHPEQS Australian Hospital Patient Experience Question Set AHSSQA Australian Health Service Safety and Quality Accreditation AM Member of the Order of Australia AMR antimicrobial resistance AO Officer of the Order of Australia APAS Australian Passive AMR Surveillance AU antimicrobial use AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	AIHW	Australian Institute of Health and Welfare
AHSSQA Australian Health Service Safety and Quality Accreditation AM Member of the Order of Australia AMR antimicrobial resistance AO Officer of the Order of Australia APAS Australian Passive AMR Surveillance AU antimicrobial use AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	AHMAC	Australian Health Ministers' Advisory Council
AMM Member of the Order of Australia AMR antimicrobial resistance AO Officer of the Order of Australia APAS Australian Passive AMR Surveillance AU antimicrobial use AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	AHPEQS	Australian Hospital Patient Experience Question Set
AMR antimicrobial resistance AO Officer of the Order of Australia APAS Australian Passive AMR Surveillance AU antimicrobial use AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australasian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	AHSSQA	Australian Health Service Safety and Quality Accreditation
APAS Australian Passive AMR Surveillance AU antimicrobial use AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	AM	Member of the Order of Australia
APAS Australian Passive AMR Surveillance AU antimicrobial use AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	AMR	antimicrobial resistance
AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	AO	Officer of the Order of Australia
AURA Antimicrobial Use and Resistance in Australia CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australasian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	APAS	Australian Passive AMR Surveillance
CARAlert National Alert System for Critical Antimicrobial Resistances CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australasian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	AU	antimicrobial use
CCAG Curation Clinical Advisory Group CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australasian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	AURA	Antimicrobial Use and Resistance in Australia
CHBOI core hospital-based outcome indicator COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	CARAlert	National Alert System for Critical Antimicrobial Resistances
COAG Council of Australian Governments CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	CCAG	Curation Clinical Advisory Group
CEO Chief Executive Officer CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	CHBOI	core hospital-based outcome indicator
CHC COAG Health Council COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	COAG	Council of Australian Governments
COPD chronic obstructive airways disease CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	CEO	Chief Executive Officer
CQR clinical quality registries CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	CHC	COAG Health Council
CSR clinical safety review ED Emergency Department EHR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	COPD	chronic obstructive airways disease
EMR electronic health record EMM Electronic Medication Management FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	CQR	clinical quality registries
EHRelectronic health recordEMMElectronic Medication ManagementFIAAFellow of the Institute of Actuaries of AustraliaFRACGPFellow of the Royal Australian College of General PractitionersFRACSFellow of the Royal Australasian College of SurgeonsEPBCEnvironment Protection and Biodiversity Conservation Act 1999HAChospital-acquired complication	CSR	clinical safety review
EMMElectronic Medication ManagementFIAAFellow of the Institute of Actuaries of AustraliaFRACGPFellow of the Royal Australian College of General PractitionersFRACSFellow of the Royal Australasian College of SurgeonsEPBCEnvironment Protection and Biodiversity Conservation Act 1999HAChospital-acquired complication	ED	Emergency Department
FIAA Fellow of the Institute of Actuaries of Australia FRACGP Fellow of the Royal Australian College of General Practitioners FRACS Fellow of the Royal Australasian College of Surgeons EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	EHR	electronic health record
FRACGPFellow of the Royal Australian College of General PractitionersFRACSFellow of the Royal Australasian College of SurgeonsEPBCEnvironment Protection and Biodiversity Conservation Act 1999HAChospital-acquired complication	EMM	Electronic Medication Management
FRACSFellow of the Royal Australasian College of SurgeonsEPBCEnvironment Protection and Biodiversity Conservation Act 1999HAChospital-acquired complication	FIAA	Fellow of the Institute of Actuaries of Australia
EPBC Environment Protection and Biodiversity Conservation Act 1999 HAC hospital-acquired complication	FRACGP	Fellow of the Royal Australian College of General Practitioners
HAC hospital-acquired complication	FRACS	Fellow of the Royal Australasian College of Surgeons
	EPBC	Environment Protection and Biodiversity Conservation Act 1999
HAI healthcare-associated infection	HAC	hospital-acquired complication
	HAI	healthcare-associated infection
HIT health information technology	HIT	health information technology

НМС	Hospital Medication Chart
HSO	health service organisation
ICU	intensive care unit
IHPA	Independent Hospital Pricing Authority
MD	Doctor of Medicine
MHISSC	Mental Health Information Strategy Standing Committee
NAIDOC	National Aborigines and Islanders Day Observance Committee
NAPS	National Antimicrobial Prescribing Survey
NHA	National Health Agreement
NHRA	National Health Reform Agreement
NSMC	National Standard Medication Chart
NSMHS	National Standards for Mental Health Services
NSQHS	National Safety and Quality Health Service
NSTEMI	non-ST-myocardial infarction
OECD	Organisation for Economic Cooperation and Development
PBS	Pharmaceutical Benefits Scheme
PGPA Act	Public Governance, Performance and Accountability Act 2013
PIVC	peripheral intravenous catheter
POP	pelvic organ prolapse
PPI	proton pump inhibitor
PREM	patient-reported experience measure
PROM	patient-reported outcome measure
RACF	residential aged care facility
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RM	Registered Midwife
RN	Registered Nurse
SAT	self-assessment tool
SQPSC	Safety and Quality Partnership Standing Committee
STEMI	ST-elevation myocardial infarction
SUI	stress urinary incontinence
TGA	Therapeutic Goods Administration
VRE	Vancomycin-resistant Enterococcus faecium
VTE	venous thromboembolism

Glossary

Accreditation	A status that is conferred on an organisation or individual when they have been assessed as having met particular standards. The two conditions for accreditation are compliance with an explicit definition of quality (that is, a standard) and passing an independent review process aimed at identifying the level of congruence between practices and quality standards.
Adverse event	An incident that results in harm to a patient or consumer.
Antimicrobial	A chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts and moulds. ¹¹
Antimicrobial resistance	A property of organisms – including bacteria, viruses, fungi and parasites – that allows them to grow or survive in the presence of antimicrobial levels that would normally suppress growth or kill susceptible organisms.
Antimicrobial stewardship	A program implemented in a health service organisation to reduce the risks associated with increasing antimicrobial resistance, and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies, including monitoring and reviewing antimicrobial use.
Clinical care standards	Standards developed by the Commission and endorsed by health ministers that identify and define the care people should expect to be offered or receive for specific conditions.
Clinical communication	The exchange of information about a person's care that occurs between treating clinicians, the patient and members of a multidisciplinary team. Communication can take different forms, including face-to-face or electronic communication, or communication via telephone, written notes or other documentation.

Clinical governance	The set of relationships and responsibilities established by a health service organisation between its department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care and continuously improve services.
Clinical handover	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. ¹²
Clinician	A healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or teams of health professionals, who spend the majority of their time delivering direct clinical care.
Cognitive impairment	Deficits in one or more of the areas of memory, communication, attention, thinking and judgement. Cognitive impairment can be temporary or permanent, and can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Dementia and delirium are common forms of cognitive impairment seen in hospitalised older patients. Cognitive impairment can also be caused by a range of other conditions, such as an acquired brain injury, a stroke, intellectual disability or drug use.
Consumers	A person who has used, or may potentially use, health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes. ¹⁴
Core hospital-based outcome indicators (CHBOI)	A succinct set of indicators that hospitals routinely monitor and review. These hospital-based outcome indicators can be generated by state or territory health authorities or private hospital owners that hold the source data and reported back to the facilities that provide healthcare services.

Delirium	An acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the course of the day. Delirium is a serious condition that can be prevented in 30–40% of cases, and should be treated promptly and appropriately. Hospitalised older people with existing dementia are at the greatest risk of developing delirium. Delirium can be hyperactive (the person has heightened arousal, or can be restless, agitated and aggressive) or hypoactive (the person is withdrawn, quiet and sleepy). ¹⁵
Electronic medication management (EMM) system	Enables medicines to be prescribed, dispensed, administered and reconciled electronically.
End of life	The period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events such as sepsis, stroke or trauma. ¹⁶
Hand hygiene	A general term referring to any hand-cleansing action.
Healthcare variation	This occurs where patients with the same condition receive different types of care. For example, among a group of patients with the same condition, some may have no active treatment, some may be treated in the community and others in hospital, and some may have surgery while others receive medication. Some variation in how health care is provided is desirable because of differences in patients' needs, wants and preferences (see 'unwarranted healthcare variation').
Healthcare- associated infections	Infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare-associated infections may manifest after people leave healthcare facilities. ¹⁷
Hospital-acquired complications (HACs)	A complication for which clinical risk-mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.

Medication chart	A chart used by an authorised prescriber to record medication and treatment orders, as well as by nursing staff to record and monitor the administration of such medicines and treatment.
My Health Record	A secure online summary of a consumer's health information, managed by the System Operator of the national e-health record system (the Secretary to the Australian Government Department of Health). Healthcare providers are able to share health records to a consumer's My Health Record, in accordance with the consumer's access controls. This may include information such as medical history and treatments, diagnoses, medications and allergies. Also known as a 'Personally Controlled Electronic Health Record'.
National Safety and Quality Health Service (NSQHS) Standards	Standards developed by the Commission in consultation and collaboration with states and territories, technical experts, health service organisations and patients. The NSQHS Standards aim to protect the public from harm, and to improve the quality of health services. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum safety and quality standards are met, and a quality improvement mechanism that allows health service organisations to realise aspirational or developmental goals.
Partnering with consumers	Treating consumers and/or carers with dignity and respect, communicating and sharing information between consumers and/or carers and health service organisations, encouraging and supporting consumers' participation in decision-making, and fostering collaboration between consumers and/or carers and health service organisations in planning, designing, delivering and evaluating health care. Other terms are used internationally, such as patient-based, consumer-centred, personcentred, relationship-based, patient-centred, and patient-and-family-centred care.
Patient	A person receiving health care. Synonyms for 'patient' include 'consumer' and 'client'.
Patient safety	Reducing the risk of unnecessary harm associated with health care to an acceptable minimum.
Patient safety incident	An event or circumstance that could have resulted, or did result in, unnecessary harm to a patient.

Person-centred care	Where patients, consumers and members of the community are treated as partners in all aspects of healthcare planning, design, delivery and evaluation; and is the foundation for achieving safe, high-quality care.
Shared decision making	The integration of a patient's values, goals and concerns with the best available evidence about the benefits, risks and uncertainties of treatment to achieve appropriate healthcare decisions. ¹⁸
Standard	Agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.
Unwarranted healthcare variation	Variation not attributed to a patient's needs, wants or preferences. It may reflect differences in clinicians' practices, the organisation of health care or people's access to services. It may also reflect poor-quality care that is not in accordance with evidence-based practice.

Index of figures

Figure	Title	Page no.
Figure 1	The Australian Commission on Safety and Quality in Health Care's Strategic Plan 2014–2019	12–13
Figure 2	Health service organisation accreditation, 2018–19	18
Figure 3	Organisational structure	96-97

Index of tables

Table	Title	Page no.
Table 1	Hospital-acquired complications list	51–52
Table 2	Comparison of revised Australian sentinel events list (Version 2) with original sentinel events list	54
Table 3	List of conditions AHMAC has agreed are considered to be avoidable hospital readmissions and associated readmission intervals	56-57
Table 4	Report against performance measures in the Corporate Plan and Health Portfolio Budget Statements, 2018–19	66-69
Table 5	Board meetings and attendance	83
Table 6	Audit and Risk Committee attendance, 2018–19	86
Table 7	Remuneration paid to key management personnel, 2018–19	91
Table 8	Remuneration paid to executives, 2018–19	92
Table 9	Remuneration paid to other highly paid staff, 2018–19	92
Table 10	Employee profile as of 30 June 2019	99
Table 11	Freedom of information summary, 2018–19	132
Table 12	Summary of the Commission's compliance with ecologically sustainable development, 2018–19	133–134
Table 13	Related-entity transactions, 2018–19	135
Table 14	Mandatory reporting orders as required under legislation	147–150

Compliance index

The Commission is bound by various legislative requirements to disclose certain information in this annual report. The operative provisions of the Public Governance, Performance and Accountability Act came into effect on 1 July 2014. The Public Governance, Performance and Accountability **Amendment (Corporate Commonwealth Entity Annual Reporting) Rule** 2016 prescribes the reporting requirements for the Commission.

Table 14: Mandatory reporting orders as required under legislation

Requirement	Reference	Page listing of compliant information
Accountable authority	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(j)	77–84
Amendments to the Commission's enabling legislation and to any other legislation directly relevant to its operation	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(a)	93
Approval by the accountable authority	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule section 17BB	1
Assessment of the impact of the performance of each of the Commission's functions	National Health Reform Act subsection 53(a)	14–71
Assessment of the safety of healthcare services provided	National Health Reform Act subsection 53(b)(i)	62-63

Table 14: continued

Requirement	Reference	Page listing of compliant information
Assessment of the quality of healthcare services provided	National Health Reform Act subsection 53(b)(ii)	62-63
Board committees	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(j)	85–87
Ecologically sustainable development and environmental performance	Environment Protection and Biodiversity Conservation Act, section 516A	93
Enabling legislation, functions and objectives	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(a)	6, 74
Financial Statements	Public Governance, Performance and Accountability Act subsection 43(4)	104–129
Financial Statements certification: a statement, signed by the accountable authority	Public Governance, Performance and Accountability Act subsection 43(4)	106
Financial Statements certification: Auditor- General's Report	Public Governance, Performance and Accountability Act subsection 43(4)	108
Government policy orders	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(e)	93
Indemnities and insurance premiums for officers	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(t)	76

Table 14: continued

Requirement	Reference	Page listing of compliant information
Judicial decisions and decisions by administrative tribunals	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(q)	90
Key activities and changes that have affected the Commission	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(p)	93
Location of major activities and facilities	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(I)	99
Ministerial directions	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(d)	75
Organisational structure	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(k)	96-99
Related-entity transactions	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsections 17BE(n) and (o)	135
Reporting of significant decisions or issues	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(f)	93

Table 14: continued

Requirement	Reference	Page listing of compliant information
Reports about the Commission by the Auditor-General, a parliamentary committee, the Commonwealth Ombudsman or the Office of the Australian Information Commissioner	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(r)	90
Responsible Minister	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(c)	7, 74
Review of performance	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(g)	64–71
Statement on governance	Public Governance, Performance and Accountability (Corporate Commonwealth Entity Annual Reporting) Rule subsection 17BE(m)	88-89

Index

Page range references in **bold** type refer to major discussions of a topic.

A

A Better Way to Care: Safe and high quality care for patients with cognitive impairment or at risk of delirium in acute health services (second edition), 30-31

abbreviations, 138-139

Aboriginal and Torres Strait Islander people, 8, 43, 66, **103**

accountability, 7, 73–93

legislation and requirements, 74–76

accreditation, 11, 16-20, 140

Australian Health Service Safety and Quality Accreditation Scheme (AHSSQA), 11, **71**, 138

improving reliability, 19-20

National General Practice Accreditation Scheme, 17, 46-47

acronyms, 138-139

advertising, 93

aged care, 22

AHMAC, see Australian Health Ministers **Advisory Council**

annual performance statements, 64-71

analysis of performance against

purpose, **70-71**

entity purpose, **65**

performance against the Health Portfolio Budget Statements and Corporate Plan 2018-19, 66-70

antimicrobial resistance (AMR), 9, **21–23**

Antimicrobial Stewardship in Australian Health Care 2018, 9, 24

Antimicrobial Use and Resistance in Australia (AURA) Surveillance System, **21–23**, 71

AURA 2017: Second Australian report on antimicrobial use and resistance in human health, 21

AURA 2019: Third Australian report on antimicrobial use and resistance in human health, 9, **21–23**

antipsychotic medication, 29, 30–31 Audits

Audit and Risk Committee, 64, 85-86 independent auditor's report, 106-107 internal, 85, 88, 89

Australian Atlas of Healthcare Variation, 9, 29-30, **40-43**, 44, 67-68

Australian Charter of Healthcare Rights (second edition), 36, 67

Australian Commission on Safety and Quality in Health Care, see also accountability; staff

purpose and role, 6-7

strategic plan, 77

Australian Composite Model Hospital Standardised Mortality Ratio, 47

Australian Digital Health Agency, 24–25

Australian Health Ministers Advisory Council (AHMAC), 48, 54, 55-57, 61

Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme, 11, 71

Australian Hospital Patient Experience Question Set (AHPEQS), 48–49

7. Indexes and references

Australian Institute of Health and Welfare. Third and Fourth Degree Perineal Tear, 45-46, 52, 69 9.47 Venous Thromboembolism Prevention, Australian Public Service Commission, 98 11, 44-45, 68-69, 71 Australian Public Service Disability Clinical governance framework, 16 Champions Network, 102 Australian sentinel events list, 11, 50, 53-54 Clinical Governance Standard, 36 avoidable hospital readmissions, 24, 50, clinical quality registries, 61 55-57 clinical trials governance framework, 61 COAG, see Council of Australian Governments R cognitive impairment, 16, 29-31 Beauchamp, Glenys, 81 colonoscopy, 11, 43-44, 68, 71 bleeding, menstrual, 38, 68 Communicating for Safety resources, 32 Board, 11, 77-84 compliance with legislation, 35, 74, 85 Board Operating Guidelines, 84 compliance index, 147-50 developments and review, 84 Comprehensive Care Standard, 16, 33, ethical standards, 84 36, 39 meetings and attendance, 83 core hospital-based outcome indicators membership, 77-82 (CHBOI), 46-47 Bowles, Martin, 78 Core PEQs, see Australian Hospital Patient Experience Question Set corporate governance, 73–93 C Board, 77-84 Caring for Cognitive Impairment campaign, 30-31 committees, 85-87 Casey, Adjunct Professor Veronica, 80 external scrutiny, 90-93 cataract surgery, 44-46, 71 internal governance arrangements, CEO Report, 10-11 legislation and requirements, **76–77** Chair, 1, 8-9, 77-78 Corporate Plan 2018-19, 65-71 Clinical Care Standards Corporate Plan, performance against Acute Coronary Syndromes, 46, 68-69, 71 deliverables, 66-71 Acute Stroke, 46, 68-69, 71 Council of Australian Governments, 61 Antimicrobial Stewardship, 26 Health Council (CHC), 11, 53, 55, 58, 61 Cataract, 44-46, 68-69, 71 NHRA Addendum, 50-57 Colonoscopy, 11, 43-46, 68-69, 71 cultural diversity, 102 Heavy Menstrual Bleeding, 38, 68

Peripheral Venous Access, 44–46, 69

Fraud Control and Anti-Corruption Plan, 89 D Fraud Control Policy, 89 delirium, 30-31, 52, 57 freedom of information, 90, 132 Department of Health, 11, 25, 27, 39, 44, 61 digital health, safety, 24-25 disability strategy, 102 G diversity, 102 Gee, Christine, 79, 87 Duty to Disclose Interests Policy for Board glossary, 140-144 Members, 84 н Е harm minimisation, 16, 31, 33, 49-57 ecologically sustainable development, Harris, Wendy, 79 **93**, **133-134**, 148 health and safety, **100**, see also patient safety electronic health records (EHR), 24-25 Health Portfolio Budget Statements 2018–19, electronic medication management 65-71 (EMM) systems, 26, 28 health professionals, see supporting end-of-life care, 39 health professionals to provide safe environmental performance, 93, 133-134 and high-quality care environmental scan, 50, 60 health care ethical standards, 84 appropriateness of, 22, 44-45 executive remuneration, 91-92 patient safety in primary healthcare, 6, 34 external scrutiny, 90-93 safety and quality in, 12–13, 16, 34, **62–63** advertising and market research, 93 variation, **44-45**, 67-68 environmental performance, 93 healthcare-associated infections, 21-23, 51 executive remuneration, 91-92 high-risk medicines, 27, 29 freedom of information, 90 hospital readmissions, avoidable, 24, 50, 55-57 government policy orders, 93 hospital-acquired complications (HACs), judicial decisions, 90 11, 50-52 parliamentary and ministerial healthcare-associated infections, 21-23, oversight, 90 Hospital-Acquired Complications F Curation Clinical Advisory Group (HACs CCAG), 50 Filby, Dr David, 78 list, 11, **50–52** Financial Statements, 1, 105–128 hospitals, reporting on, 58 Fraud control Hunt, Greg (Minister for Health), 7, 9 Audit and Risk Committee, 85

medication safety, 26-28, 97 П menstrual bleeding, 38, 68 incontinence, 35, 52 mental health, 25, 29-31, 50 indemnity, 76 minimising harm, 49-57 independent auditor's report, 106-107 Minister for Health (Greg Hunt), 7, 9, 74–75, Independent Hospital Pricing Authority, 106-107 10-11, 50, 55 mortality outcome indicators, 47 infections, healthcare-associated, 21-23, 51 My Health Record, 24-25, 71 Information and Records Management Steering Committee, 88 Information Publication Scheme, 90 Ν insurance, 76 National Clinical Trials Governance Inter-Jurisdictional Committee, 85-86 Framework, 11, 61 internal governance arrangements, 88-89 National Consensus Statement: Essential elements for delivering safe and high-quality Fraud Control and Anti-Corruption Plan, 89 end-of-life care, 39 internal audits, 89 national dispensed labelling standard, 28 internal management, 88 National General Practice Accreditation risk management, 88 Scheme, 17-20, 46 national health agreement (NHA), 50 K National Health and Hospitals Network Act 2011, 6 Kitson, Professor Alison, 80 National Health Reform Act 2011, 1, 6, 62, 65 knees, osteoarthritis of, 38 National Health Reform Agreement (NHRA), 50, 53, 55 L National Safety and Quality Health Service Larkin, Professor Shaun, 81-82, 86 (NSQHS) Standards Leadership Group, 88 Advice Centre, 17 learning and development, 101 aims, 143 legislation, compliance with, 74-76, 85 Clinical Governance Standard, 19, 36 compliance index, 147-150 cognitive impairment, 66, 30-31 letter of transmittal, 1 Communicating for Safety Standard, 32 Comprehensive Care Standard, 33 data set specifications, 46-47 М for primary care, 34 market research, 93 implementation of, 9, **16–20**, 39, 65–66 Marshall, Professor Villis (Chair), 1, 8-9, 77-78 in the AHSSQA Scheme, 11, 71

National General Practice Accreditation comprehensive care, 33 Scheme, 17-20 culture, 60 NSQHS Standards User Guide for Aboriginal High Risk Medicines education and Torres Strait Islanders, 8 courses, 27 NSQHS Standards User Guide for health incident. 59 service organisations providing care for in digital health, 24-25 patients with cognitive impairment or at risk of delirium, 30-31 in primary healthcare, 34 NSQHS Standards User Guide for health medication safety, 25-26 services providing care to people with mental health, 28 mental health issues, 29 national dispensed labelling standard, 28 Partnering with Consumers Standard, 66 NSQHS Standards and, 16-21 second edition, 9, 11, 16-18, 66, 71 Patient safety and quality improvement national standard medication chart in primary care, 32 (NSMC), 27 revision of the AHSSQA Scheme, 22-23 State of patient safety and quality in 0 Australian hospitals 2019, 10, 62 organisational culture, 60 Third World Health Organization Global Third World Patient Safety Challenge, 27 organisational structure, 96-97 transvaginal mesh, 35, 71 osteoarthritis of the knee, 38, 67 pelvic organ prolapse, 35 people management, 98 P performance statements, see annual palliative care, 47 performance statements partnering with patients, consumers person-centred healthcare, 36-37, 48 and communities, 28, 34, **36-39**, 66 Pharmaceutical Benefits Scheme (PBS), end-of-life care, 39 22-23, 42 person-centred healthcare organisations, Pharmaceutical Benefits Scheme Hospital 33, 36–37, 48 Medication Chart, 27, 28 shared decision making and health Picone, Adjunct Professor Debora, 10-11 information, 37-38 Primary Care Committee, 87 patient-reported outcome measures primary healthcare, patient safety in, 34, (PROMs), **48** 59-60 patient safety, 7, 12, **16–35**, 58 private hospitals, reporting of, 58 across public and private hospitals, 58 Private Sector Committee, 87 AMR. 21-23 psychotropic medications, 41, 50, 52, 58, 71 cognitive impairment, 30-31 communicating for, 32

7. Indexes and references

Public Governance, Performance and sentinel events, see Australian Sentinel Accountability (PGPA) Act 2013, 64, 65, 74, **Events List** 77, 84-85, 93 shared decision making and health Public Governance, Performance and information, 37 Accountability Rule 2014, 1, 74, 76, 85–86 staff, see also Board public hospitals, reporting of, 17, 58, 67 Chair, 1, 8–9, 77–78 public reporting, 19, 58, 86 diversity, **102**, 103 purpose and role, **6–7**, **70–71** learning and development, 101 organisational structure, 96-97 Q people management, 98 quality, cost and value, 7, **40–45**, 75 profile, 99 identifying healthcare variation, 40-43 remuneration of executives, 91 improving appropriateness of care, report from the CEO, 10-11 44-45 work health and safety, 100 standards, see National Safety and Quality Health Service (NSQHS) Standards; R Clinical Care Standards related-entity transactions, 76, 135 State of patient safety and quality in Australian remuneration hospitals 2019, 10, 62 executives, 92 strategic plan, 7, 12–13, **75**, see also key management personnel, 91 partnering with patients, consumers and communities; patient safety; quality, cost other highly paid staff, 92 and value; supporting health professionals reporting to provide safe and high-quality care aligning public reporting of public and stress urinary incontinence, 35 private hospitals, 58 supporting health professionals to provide annual performance statements, 62–71 safe and high-quality care, 7, 46-61, 75 mandatory reporting orders, 147–150 aligning public reporting of public and reports, 8-11, 21, 28, 32, 65 private hospitals, **58** risk management, 10, 24, 63, **65-66** clinical trials governance framework, 53 Royle, Cheryle, 82 indicators and data set specifications, 46-47 measuring patient experience, **42–43** S minimising harm, 49-57 safety, see patient safety; work health national clinical quality registries, 61 and safety National Clinical Trials Governance safety and quality in Australian healthcare, Framework, 61 HACs as a measure of, **50–52**

patient safety culture, 60 PROMs, 48 severe incident management, 59 surveillance, 21-22, 71 sustainability health system, 6, 65 environment, 93, 133-134

Т

Therapeutic Goods Administration (TGA), 35, 71 Third Australian Atlas of Healthcare Variation, 9, 29-30, **40-43**, 44, 67-68 Torres Strait Islanders, 8, 43, 66, 103 transition of care, 27 transvaginal mesh, 34-35, 71

U

urinary incontinence, 11, **35**, 52, 56

V

variation in healthcare, 9, **40-44**, 47, 62, 67-68 venous thromboembolism (VTE), 11, 44-45, 52, 57, 68, 71

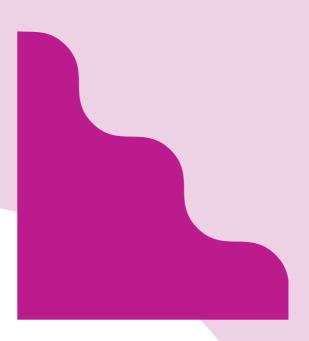
W

Walsh, Adjunct Professor John, 78–90, 86 Williams, Dr Helena, 79-80, 87 work health and safety, 100 Workplace Consultative Committee, 88 workplace diversity, 102, 103

References

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