



Annual Report 2015–16

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

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Letter of transmittal

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

The Honourable Sussan Ley 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 2016.

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 34(1) of the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*.

The Commission's annual performance statements were prepared in compliance with the requirements of section 39 of the *Public Governance, Performance and Accountability Act* and accurately present the Commission's performance for the period 1 July 2015 to 30 June 2016.

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 to appropriately deal with fraud relating to the Commission have been taken.

This report was approved for presentation to you in accordance with a resolution of the Commission's Board on 14 September 2016.

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

Yours sincerely



Professor Villis Marshall AC

Chair
Australian Commission on Safety and Quality in Health Care
14 September 2016

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01 OVERVIEW

This section provides an overview of the Commission and its mission, role, functions and accountability, and reports from the Commission's Chair and Chief Executive Officer.

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About the Commission

In 2006 the Australian, state and territory governments established the Commission to lead and coordinate national improvements in safety and quality in health care. Its permanent status was confirmed with the passage of the *National Health and Hospitals Network Act 2011* and its role 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, state and territory governments.

Our mission

The Commission's mission is to lead and coordinate national improvements in the safety and quality of health care.

Our role and functions

The Council of Australian Governments established the Commission to lead and coordinate national improvements in the safety and quality of health care. The Commission provides strategic advice to health ministers on best practices to improve healthcare safety and quality and makes recommendations about priority areas for action. The Commission develops national initiatives that promote an Australian healthcare system that is informed, supported and organised to deliver safe and high-quality health care that contributes to better health outcomes for patients, consumers and communities.

The Commission works in four priority areas:

1. patient safety
2. partnering with patients, consumers and communities
3. quality, cost and value
4. supporting health professionals to provide safe and high-quality care.

The National Health Reform Act specifies the Commission's roles and responsibilities as a corporate Commonwealth entity under the *Public Governance, Performance and Accountability Act 2013*.

Our accountability

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, the Honourable Sussan Ley.



Professor Willis Marshall presents the AURA 2016: first Australian report on antimicrobial use and resistance in human health in June 2016



Professor Willis Marshall launches the Caring for Cognitive Impairment Campaign in January 2016



Professor Willis Marshall and the Minister for Health, the Honourable Sussan Ley, launch the *Australian Atlas of Healthcare Variation* in November 2015

Report from the Chair



Professor
Villis Marshall AC

The Commission has once again, with its partner organisations, been industrious and innovative in delivering against its extensive work plan. Australia is recognised internationally as having one of the safest health systems in the world. The Commission continues to work in partnership with patients, consumers, carers, clinicians, managers and healthcare organisations to improve the reliability, safety and quality of health care in Australia.

This year the Minister for Health, the Honourable Sussan Ley, launched the first *Australian Atlas of Healthcare Variation*. The atlas presents a clear picture of substantial variation in health care services across areas such as antibiotic prescribing, surgery, mental health and diagnostic services. The atlas is a catalyst for generating action to improve people's health outcomes and to improve the effectiveness of the healthcare system.

The Commission has also worked closely with partners to commence the revision of the National Safety and Quality Health Service (NSQHS) Standards. The purpose of the review is to reduce duplication in the standards, reduce red tape, and incorporate actions to improve

patient safety in mental health, cognitive impairment, health literacy, end-of-life care and Aboriginal and Torres Strait Islander health.

Turning to more specific topics, the Commission released a landmark report outlining the most comprehensive picture of antimicrobial resistance, antimicrobial use and appropriateness of prescribing in Australia to date. *Antimicrobial Use and Resistance in Australia 2016: First Australian report of antimicrobial use and resistance in human health* (AURA 2016) highlights antimicrobial use and resistance as a critical and immediate challenge to health systems in Australia and around the world. AURA 2016 contains valuable data on antimicrobial use in hospitals, residential aged-care

facilities and the community; key emerging issues for antimicrobial resistance; and a comparison of Australia's situation with other countries.

Through the National Patient Blood Management Collaborative, improved perioperative anaemia management has resulted in more appropriate use of blood and blood products.

The success of the Caring for Cognitive Impairment campaign has also been wonderful. The response from hospitals, staff, patients and carers has been very encouraging in demonstrating a commitment to provide high-quality care for people with cognitive impairment, including dementia and delirium.

Other major projects that were successfully delivered in 2015–16 included the Reduction in unwarranted radiation exposure from computed tomography (CT) scans for children and young people, the *Guide to the NSQHS Standards for Health Service Organisation Boards*, the *National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines*, and the launch of the National Alert System for Critical Antimicrobial Resistance (CARAlert).

10 years of operation

I am proud to say that the Commission is recognising 10 years of operation in 2016. The Council of Australian Governments established the Commission to lead and coordinate national improvements in the safety and quality of health care provided in Australia, which has been the basis for the vast array of projects, initiatives and solutions that have been the responsibility of the Commission since its creation.

While the Commission's flagship is the NSQHS Standards, the Commission works across the range of priorities in safety and quality in health care in supporting, sharing, valuing and informing improvements.

Significant achievements over the last 10 years include:

- Clinical care standards for acute coronary syndromes, acute stroke and antimicrobial stewardship
- Antimicrobial Stewardship in Australian Hospitals
- *Australian Atlas of Healthcare Variation*
- *Australian Charter of Healthcare Rights*
- National Inpatient Medication Chart
- Education modules for healthcare-associated infection
- Core hospital-based outcome indicators
- *Australian Open Disclosure Framework*
- *Framework for Australian clinical quality registries*
- *National Consensus Statement: Essential elements for safe and high-quality end-of-life care.*

Acknowledgements

My thanks to the members of the Commission's Board for their advice throughout the year.

On behalf of the Commission's Board, I would also like to thank Minister Ley, and the Commission's executive team and employees, for their continued commitment to delivering our work priorities. Their significant achievements are described in detail throughout this report.

Report from the CEO



Adjunct Professor
Debora Picone AM

This year has been another year of significant achievements for the Commission and its national and state-based partners. I am pleased to present this annual report as a snapshot of the work undertaken by the Commission in collaboration with the Australian, state and territory governments, patients, consumers and clinician partners and our private-sector colleagues across Australia.

The revision of the NSQHS Standards has made substantial progress in 2015–16 with valuable feedback received through consultation and piloting processes. Version 2 of the NSQHS Standards remains focused on improving safety systems for patients with an improved focus on mental health and cognitive impairment safety requirements. New adaptive and digital resources are planned to support version 2, in addition to the development of a framework for universities to include version 2 in medical, nursing, midwifery and allied health curricula. Version 2 of the NSQHS Standards is expected to be finalised in mid-2017 and implemented in 2018–19.

Following the release of the first *Australian Atlas of Healthcare Variation* an implementation plan has been developed to progress its recommendations and activity has been stimulated across the health system to understand and reduce unwarranted variation.

I am pleased to report that the Commission is developing an online interactive version of the atlas that will support users in interrogating local variation findings and enable users to control the data displayed, including overlays of boundaries of primary health networks. Additional interactive functions for the online atlas are planned, with atlas 2.0 set for release in early 2017.

Progress in digital health continues to grow at a rapid and interesting rate. The Commission maintains its responsibility for the clinical safety program for the My Health Record and continues to work closely with the Australian Digital Health Agency (formerly the National E-Health Transition Authority).

We have continued our work on improving care of people with cognitive impairment, through the successful launch of our campaign, Caring for Cognitive Impairment (cognitivecare.gov.au).

A new national model clinical governance framework will describe how leaders of health service organisations implement integrated corporate and clinical governance systems through which organisations and individuals are accountable to the community for continuously improving the safety and quality of their services. The framework is scheduled for release in 2016–17.

Other key areas of focus included the development of a draft safety and quality model for colonoscopy services and clinical care standards for osteoarthritis of the knee, cataract surgery and management of menorrhagia.

I would like to reiterate the message from the Chair in recognising the 10 years of excellent work demonstrated by the Commission and its employees. I also emphasise the importance of the key relationships with stakeholders, strength in partnerships and the passion of all those involved in working with the Commission in continuing to lead safety and quality innovations and practices in the Australian health sector.

The breadth of projects and initiatives managed by the Commission continues to challenge, engage and inspire health sector workers across Australia. I commend the Commission's employees, our Australian Government and state and territory partners, our private sector colleagues and, advisory groups and stakeholders alike for our joint achievements this year.

Strategic Plan 2014–19

SAFETY AND QUALITY

1

PATIENT SAFETY

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

2

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

3

QUALITY, COST AND VALUE

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

4

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

EVERY PERSON. EVERYWHERE. EVERY TIME.



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, policy makers and healthcare organisations to achieve a sustainable, safe and high-quality health system.



REPORT ON PERFORMANCE

This section details the Commission's highlights for the year and achievements against the Commission's four priority areas:

1. patient safety
2. partnering with patients, consumers and communities
3. quality, cost and value
4. supporting health professionals to provide safe and high-quality care.

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Priority 1: Patient safety

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



National implementation of the National Safety and Quality Health Service Standards

The primary aims of the NSQHS Standards are to protect the public from harm and to improve the quality of health service provision.

They require the implementation of an organisational-wide safety and quality framework to ensure that clinical risk mitigation strategies are in place to reduce adverse events associated with hospital-acquired infection, medication errors, patient falls, errors at transfer of care, and the prevention of clinical deterioration and pressure injuries.

Independent accrediting agencies assess health service organisations to confirm they have implemented the NSQHS Standards. Accreditation to the NSQHS Standards is awarded to facilities that have met all of the requirements of the NSQHS Standards.

Throughout Australia, hospital and day procedure services have successfully implemented the NSQHS Standards. Preliminary evaluation shows national improvements in safety and quality between 2010 and 2014, including:

- a decrease in the *Staphylococcus aureus* bacteraemia rate per 10 000 patient days under surveillance, from 1.1 to 0.87 cases
- a decrease in the yearly number of methicillin-resistant *Staphylococcus aureus* bacteraemia cases, from 505 to 389

- a decline in the national rate of central-line-associated bloodstream infections of almost one-half, from 1.02 to 0.6 per 1000 line days from 2012–13 to 2013–14
- greater prioritisation of antimicrobial stewardship activities in hospitals
- better documentation of adverse drug reactions and medication history
- reduction in the yearly red blood cell issues by the National Blood Authority between mid-2010 and mid-2015, from approximately 800 000 units to 667 000 units
- declining rates of intensive care unit admissions following cardiac arrests. In-hospital cardiac arrests in Victoria and New South Wales have also declined.

At a state level, South Australia has reduced the number of extreme harm incidents involving falls. Since 2011, the proportion of extreme harm (SAC1) incidents involving falls has decreased by more than 50%, from 0.31 per 10 000 occupied bed days in 2011–12 to 0.11 per 10 000 occupied bed days in 2014–15. In Queensland, hospital-acquired pressure injuries have continued to decline and Western Australia has maintained its previous improvements in the same area.

Since assessment to the NSQHS Standards commenced in 2013, 1310* hospitals and day procedure services have implemented the NSQHS Standards. As of 30 June 2016, 98%* of all hospitals and day procedure services in Australia have been assessed to the NSQHS Standards.

During the year the Commission undertook a comprehensive review of accrediting agencies, including a review of the approval process and held performance meetings with all agencies. There are now nine accrediting agencies approved to assess health service organisations to the NSQHS Standards.

In 2015–16, the Commission assumed responsibility for granting approval to accrediting agencies seeking to accredit health service organisations to the Department of Veterans' Affairs Trauma Recovery Programme Standards.

The Commission's review of accrediting agencies is ongoing, as is support for health service organisations through the NSQHS Standards Advice Centre.

The Commission, in collaboration with the Royal Australian College of General Practitioners (RACGP), have developed the National General Practice Accreditation Scheme.

The National General Practice Accreditation Scheme will support consistent assessment of Australian general practices against the RACGP *Standards for general practice*.

The National General Practice Accreditation Scheme will commence on 1 January 2017.

The National General Practice Accreditation Scheme will:

- provide greater choice for general practices seeking accreditation
- improve support programs for implementation of accreditation
- provide practices with access to national data on accreditation performance and enable benchmarking.

* Information on other services not included. Figures are for hospitals and day procedure services only.

2015–16 HIGHLIGHTS

- Assessed 98%* of Australian health service organisations (1310* hospitals and day procedure services) against the NSQHS Standards.
- Answered more than 1396 enquiries through the NSQHS Standards Advice Centre, with an average response time of two business days.
- Reviewed, updated or released 18 advisories to support accrediting agencies and health service organisations.
- Conducted 17 accrediting agency training sessions with 508 surveyors.
- Undertook a comprehensive review of accrediting agencies and nine observations of assessments.
- Published the NSQHS Standards guide for dental practices and services, *Credentialing health practitioners and defining their scope of clinical practice – A guide for managers and practitioners* and *Guide to the NSQHS Standards for community health services*.

Version 2 of the National Safety and Quality Health Service Standards

The Commission commenced its review of the NSQHS Standards in 2015. This is the first review following the endorsement of the NSQHS Standards by health ministers in 2011.

The review has involved extensive consultation with clinicians, consumers and content experts. Version 2 of the NSQHS Standards is the key deliverable for this project.

The review of the NSQHS Standards is focused on reducing duplication, addressing implementation issues, and incorporating actions to address safety issues in mental health, cognitive impairment, health literacy, end-of-life care, and Aboriginal and Torres Strait Islander health.

During 2015–16, the Commission piloted and widely consulted on the revised NSQHS Standards and, based on feedback, developed version 2 of the NSQHS Standards.

The Commission will launch version 2 of the NSQHS Standards in 2017 with supporting resources and measures. Assessment against version 2 of the NSQHS Standards will commence from January 2019.

2015–16 HIGHLIGHTS

- Revised and released the draft version 2 of the NSQHS Standards for public consultation and piloting.
- Facilitated 135 health service organisations to pilot version 2 of the NSQHS Standards.
- Analysed 162 written responses and 283 surveys from the health system and over 200 surveys from consumers as part of the consultation process for the NSQHS Standards.
- Refined the draft version 2 of the NSQHS Standards based on feedback from almost 500 clinicians and consumers.

Medication safety

The Commission's Medication Safety program continues to improve the safety and quality of medication management in acute and primary health care settings across Australia.

The Commission published the *National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines* in December 2015. The labelling standard applies to all clinical areas in Australian health services where injectable medicines and fluids are administered and implementation is a mandatory requirement for meeting NSQHS Standard 4: Medication Safety. Incomplete or inaccurate labelling of injectable medicines and fluids (and the devices used to deliver them) is a recognised risk to the safe administration of medicines and is potentially preventable. Improved labelling can reduce the risk of error and harm by safely communicating the contents of injectable medicines containers and the patients for whom they are intended.

In March 2016, the Commission published the *National Guidelines for On-Screen Display of Clinical Medicines Information*. The guidelines provide an evidence-based approach to on-screen presentation of medicines information, incorporate Australia's National Tall Man Lettering, and build on recommendations for terminology, abbreviations and symbols used in the prescribing and administration of medicines.

The Commission, in conjunction with an expert reference group, developed, trialled and evaluated a national Pharmaceutical Benefits Scheme hospital medication chart (PBS HMC). This is a national standardised medication chart that allows the prescribing, administration, claiming and supply of PBS and non-PBS medicines directly from the chart without the need for a separate paper prescription. The PBS HMC was widely trialled in public and private hospitals across the country throughout 2015. The chart was released on 1 July 2016, and is available for implementation in private and eligible public hospitals.

General practitioners who prescribe for inpatients need to issue medicine orders in National Inpatient Medication Chart compliant formats. To accommodate this requirement, the National Inpatient Medication Chart General Practitioner (NIMC GP) e-version was developed for incorporation in general practice electronic prescribing software. In 2015, an evaluation of the risks and benefits of the NIMC GP e-version was completed. As a result, guidance for safe use of the NIMC GP e-version was issued to vendors of GP software and to health services.

2015–16 HIGHLIGHTS

Developed, piloted and released the PBS hospital medication chart.

Published the *National Standard for User-applied Labelling of Injectable Medicines, Fluids and Lines*.

Published the *National Guidelines for On-Screen Display of Clinical Medicines Information*.

Safety in digital health

In 2015–16, the Commission continued to provide independent clinical safety oversight and advice to the My Health Record system (formerly Personally Controlled Electronic Health Record).

The Commission undertook two clinical safety reviews of the My Health Record system during 2015–16. The reviews examined the management of system down time, presentation of medications information, the impact of the system on emergency department workflows and system design processes.

The Commission also worked closely with states and territories, clinicians and the Australian Digital Health Agency (formerly the National E-Health Transition Authority), to develop guidelines to improve the on-screen presentation of discharge summaries across clinical information systems. Other activities include coordinating the provision of clinical safety input into new system functionality. In addition, a clinical incident management framework was delivered for the My Health Record system. Based on the framework, the Commission established a clinical incident management unit to provide round-the-clock availability for the My Health Record System Operator to manage and investigate clinical incidents reported by users.

The Clinical Safety Oversight Committee, chaired by the then Australian Chief Medical Officer, Professor Chris Baggoley AO, and comprising health care professionals, clinical safety and health information technology experts oversaw the program. The committee met quarterly during 2015–16.

On 1 July 2016, the Australian Digital Health Agency assumed the function of system operator. As part of this handover a new, two-year agreement was established between the Commission and the agency to continue to provide clinical safety review and support functions for the My Health Record and the broader digital health agenda.

2015–16 HIGHLIGHTS

Conducted two clinical safety reviews of the My Health Record System

Coordinated the provision of clinical safety advice on new system functionality

Delivered a clinical incident management framework for the My Health Record system

Established a round-the-clock clinical incident management unit for the system

Antimicrobial resistance, antimicrobial use surveillance and healthcare-associated infections

The Australian Government provided additional funding to the Commission to develop a national surveillance system for antimicrobial use (AU) and antimicrobial resistance (AMR), called the Antimicrobial Use and Resistance in Australia (AURA) Surveillance System. AURA analyses and reports on the passive and targeted surveillance of AMR and AU in hospitals and the community to inform strategies to prevent and contain AMR in Australia and ensure the rapid detection and response to critical and emerging AMR.

Surveillance is essential to understand the magnitude, distribution and impact of resistant organisms and antimicrobial usage, as well as to identify emerging issues and trends. It informs early detection of infection and antimicrobial resistances to promote timely, effective prevention and response strategies. The establishment of the AURA system will enable more targeted and effective strategy development.

The Commission's Healthcare-Associated Infection (HAI) program supports states, territories, and the private sector in preventing and containing AMR and promoting vital infection control.

This year the Commission reviewed *Clostridium difficile* infections (CDI) in Australia following reports of increased incidences of CDI in Australian hospitals. The Commission developed a number of recommendations for action, which are targeted at infection prevention and control.

Following an outbreak of carbapenemase-producing *Enterobacteriaceae* (CPE) in 2015, the Commission released a guide on its control. The guide includes information on planning and preparation for outbreak management, information on screening, management and laboratory identification, and recommendations for states and territories to assist in responding to an outbreak.

The Australian Health Ministers' Advisory Council supported an increase in the hand hygiene benchmark from 70% in 2015–16 to 75% from 2016–17, and 80% in 2017–18.

The Commission, in partnership with the National Health and Medical Research Council, is reviewing the Australian guidelines for the prevention and control of infections in health care to ensure current evidence informs clinical practice.

2015–16 HIGHLIGHTS

Established a nationally coordinated surveillance system for AU and AMR.

Published *Antimicrobial Use and Resistance in Australia 2016: First Australian Report on Antimicrobial use and resistance in human health* along with a range of specialised reports from partner programs.

Reduction in radiation exposure to children and young people from CT scans

This year the Commission, with funding support from the Australian Government Department of Health, developed and released a suite of resources to support a reduction in potential harm to children and young people from unnecessary radiation exposure from CT scans.

CT scans are a valuable diagnostic tool, of benefit in a wide range of clinical situations. However, the use of CT scans on children has been linked to a slight increase in developing cancer later in life.¹

In partnership with the Western Australian Department of Health, the Australian Institute of Radiography, and the Australian Radiation Protection and Nuclear Safety Agency, the Commission released:

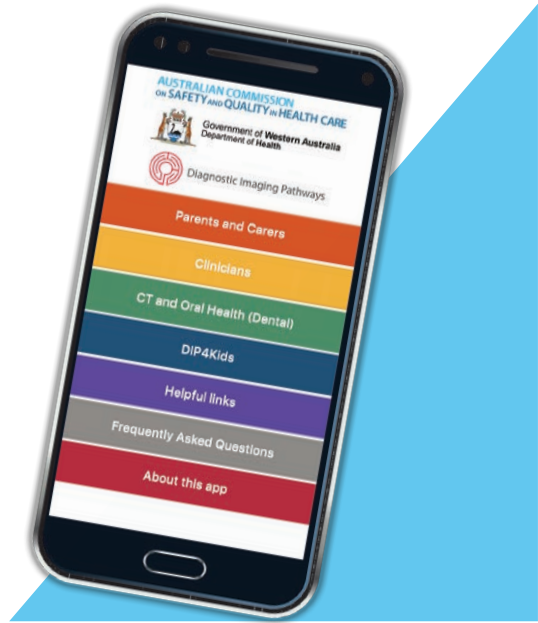
- DIP 4 Kids, a smartphone app that includes decision-making support for clinicians referring children and young people for medical imaging
- an online training module for radiographers undertaking CT scans for children and young people
- a series of brochures and posters for parents and carers outlining the benefits and risks of CT scans and useful questions to ask doctors and dentists about CT scans
- a fact sheet for referring clinicians that includes information on typical radiation doses and key issues to consider when deciding whether to refer a child for a CT scan.

¹ Mathews JD et al. Cancer risk in 680 000 people exposed to computed tomography scans in childhood or adolescence: data linkage study of 11 million Australians. *BMJ*.2013;346:2360

2015–16 HIGHLIGHTS

Released a suite of resources for clinicians, parents and carers to support a reduction in potential harm to children and young people from unnecessary radiation exposure from CT scans.

Released the DIP 4 Kids app.



Cognitive impairment

In January 2016, the Commission launched the Caring for Cognitive Impairment campaign to improve the care for people with cognitive impairment and those at risk of harm from delirium. In hospital, patients with cognitive impairment are at increased risk of adverse outcomes and preventable complications. The campaign aims to drive improvements in patient care at systems and individual levels.

The campaign also aims to improve clinician knowledge and care practices to provide better outcomes for patients in hospital with cognitive impairment or at risk of harm from delirium. It builds on other key initiatives, including the Commission's *A better way to care* resources, the development of a delirium clinical care standard and the incorporation of cognitive impairment into version 2 of the NSQHS Standards.

Following the successful launch, over 133 hospitals, 845 individuals and 26 supporting organisations joined the Caring for Cognitive Impairment

campaign. A dedicated website (cognitivecare.gov.au) supports the campaign and tracks the numbers of hospitals, supporting organisations and individuals. It provides a platform for information, collaboration and sharing of good practice.

2015–16 HIGHLIGHTS

Launched the Caring for Cognitive Impairment campaign, with more than 133 hospitals, 845 individuals and 26 supporting organisations joining.

Consulted with clinicians and consumers on the review and development of cognitive impairment actions in the draft version 2 of the NSQHS Standards.

Commissioned the documentary *On My Mind* for broadcast on ABC 24 and in general practices around Australia.

Mental health

This year the Commission, in consultation with the Mental Health Advisory Group, developed a number of new mental health specific actions for inclusion in version 2 of the NSQHS Standards. This work builds on that undertaken in the development of the *Accreditation Workbook for Mental Health Services* and the *Scoping Study on the Implementation of National Standards in Mental Health Services*.

The Commission also finalised a draft *National Consensus Statement: Essential Elements for Recognising and Responding to Deterioration in a Person's Mental State*. A national consultation on the Consensus Statement will commence in the second half of 2016.

2015–16 HIGHLIGHTS

Developed new mental health specific actions for inclusion in the draft version 2 of the NSQHS Standards.

Developed a draft *National Consensus Statement: Essential Elements for Recognising and Responding to Deterioration in a Person's Mental State* for consultation.

Communicating for safety

Communication is a key safety and quality issue and plays a vital role in several aspects of care delivery. Communication failures, lack of teamwork and inadequate documentation in health care are known to result in errors, misdiagnosis, inappropriate treatment and poor care outcomes. In 2015-16 the Commission established a Clinical Communications Advisory Group to provide strategic direction on clinical communications.

In 2015–16, the Commission commenced work in two areas critical to communicating for safety in health care: communication between multidisciplinary teams and documentation of clinical information to support communication at transitions of care.

The Commission incorporated actions in version 2 of the NSQHS Standards that address clinical communication more broadly. The aim of these inclusions is to ensure there is effective communication and documentation that supports continuous, coordinated and safe care for patients, particularly in high-risk situations where effective communication is critical for safe care.

The Commission undertook consultations with clinicians and researchers across Australia to gain an understanding of the key issues and challenges for improving communication between multidisciplinary teams to support the Commission's work in this area.

A research review on improving documentation at transitions of care for complex patients has also been undertaken.

2015–16 HIGHLIGHTS

Established the Clinical Communications Advisory Group to support the Commission's work and strategic direction on clinical communications.

Conducted a research review on improving documentation at transitions of care for complex patients.

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 with health professionals as partners in all aspects of health care.



Health literacy

Health literacy is a significant issue for Australia. Health information and systems have become increasingly complex and harder to understand. In Australia, almost 60 per cent of adults have low individual health literacy.

In 2015–16, the Commission actively promoted the concepts and actions identified in the *National statement on health literacy*, which proposes a coordinated approach based on:

- embedding health literacy into systems
- ensuring effective communication
- integrating health literacy into education.

The Commission contributed to a number of workshops, conferences and seminars to raise awareness of health literacy, how it affects the safety and quality of health care, and to provide leadership and guidance on action health services could take to reduce barriers to health literacy.

In 2015, the Commission published resources detailing how actions in the current version of the NSQHS Standards contribute to health literacy, and describing some of the health literacy strategies that health service organisations can use to meet the NSQHS Standards.

In addition, the Commission completed significant work to integrate health literacy into version 2 of the NSQHS Standards. This involved

extensive stakeholder consultation, and the redevelopment of NSQHS Standard 2: Partnering with Consumers to include actions to improve communication with consumers in a way that supports understanding and effective partnerships.

The Commission also continued to provide expert advice on health literacy to a variety of local, national and international organisations and individuals, including providing advice and guidance on research and quality improvement projects relevant to health literacy.

2015–16 HIGHLIGHTS

Published resources identifying how health service organisations can strategically address health literacy and meet the requirements of the NSQHS Standards.

Integrated health literacy into the draft version 2 of the NSQHS Standards.

Promoted health literacy and its role in partnering with consumers at a range of forums.

provides the Commission with links to networks of consumers and communities as well as advice and guidance on how to support partnerships with consumers in health care.

In 2015–16, work commenced on an online question prompt list for use by Australian healthcare consumers. The question prompt list is a decision support resource and a communication tool used to enhance patient participation in medical consultations. The list aids consumers in deciding what questions they should ask their healthcare provider about their care.

The Commission commenced a review into the *10 Tips for safer health care* consumer advisory resource that has been widely employed by states and territories since it was released in 2003. The advisory was developed to help consumers better understand what to expect when receiving health care, where they could find out more about their condition and medicines, and what they could do if they have concerns about their treatment. The Commission is utilising the perspectives and expertise of consumers throughout the process to strengthen the review and enhance the quality of the final resource, which will be released in 2016–17.

The Commission commenced research aimed at identifying consumer needs and preferences for healthcare safety and quality information. This work focuses on consumers' health information-seeking behaviours and their preferences regarding information content and presentation. The work will also involve a targeted consultation with Aboriginal and Torres Strait Islander peoples and culturally and linguistically diverse communities to ensure that the needs of less visible and hard-to-reach consumers are elicited in a culturally sensitive and collaborative way.

Partners for safety

This year the Commission engaged with a range of consumers and interest groups in order to promote a more patient-centred health system that will achieve better health outcomes and positive patient experiences.

In 2015, the Commission established a Partnering with Consumers Committee, which includes consumers, healthcare providers, managers and researchers. The committee

2015–16 HIGHLIGHTS

Established the Commission's first Partnering with Consumers Committee.

Commenced work on an online question prompt list for use by consumers.

Commenced the review of the *10 Tips for safer health care*.

Commenced research to identify the healthcare safety and quality information needs of consumers.

Shared decision-making

Shared decision-making involves a clinician and a patient jointly making a health care decision after considering the options and the evidence about potential benefits and harms and the patient's values and preferences.

In 2015–16, the Commission developed tools to support shared decision-making between clinicians and consumers. This is part of the Commission's commitment to supporting consumer-centred care and complements its work on exploring unwarranted healthcare variation and increasing appropriateness of care.

In collaboration with clinical, consumer and subject-matter experts, the Commission has developed an online training module for clinicians on communicating the risks and benefits of treatment options with patients. The two-hour interactive module explores statistical and communication principles that are required for effective risk communication.

The Commission is developing patient decision aids to support consumers in making informed

decisions about their health care. Decision aids on antibiotic use in sore throat, middle-ear infections and acute bronchitis are in development.

Over the next year, the Commission will develop patient decision aids on other topics featured in the *Australian Atlas of Healthcare Variation* as well as additional resources for the new clinical care standards.

2015–16 HIGHLIGHTS

Developed and piloted content for a training module on risk communication for clinicians.

Commissioned patient decision aids on antibiotic use in sore throat, middle ear infections and acute bronchitis.

Commenced the development of an online question-building tool for consumers.

Fostering a person-centred healthcare system

Patient-centred care is health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers. The Commission's vision of a patient-centred healthcare system is one that is based on the principles of dignity and respect, information-sharing, participation and collaboration with patients and consumers, and results in safer, high-quality care.

There is demonstrated evidence that patient-centred care improves patient experience and creates public value for services. When health professionals, managers, patients, families and carers work in partnership, the

quality and safety of health care rises, costs decrease, provider satisfaction increases and patient experience improves.

The Commission actively supports a patient-centred approach to health care through the NSQHS Standards, *Australian Charter of Healthcare Rights*, and the *Australian Safety and Quality Framework for Health Care*. In 2015–16, the Commission commenced a series of reviews to explore new ways of fostering a person-centred healthcare system. Expert reviews on the concepts of person-centred care and advancements in these concepts within the health system and person-centred care in the context of complex adaptive systems and systems theory were completed.

The reviews will inform ongoing discussions on how systems thinking can be used to reorient the healthcare system to provide continuous and consistent delivery of a patient-centred care throughout a person's healthcare journey.

2015–16 HIGHLIGHTS

Completed an expert review into the concept of person-centred care.

Completed an expert review into person-centred care in the context of complex adaptive systems and systems theory.

End-of-life care

In 2015–16, the Commission developed guidance material about the care of children and young people at the end of life, and commenced the development of tools for hospitals to use to assess the quality and safety of the end-of-life care that they provide.

In 2015, an expert roundtable meeting was held to begin the process of drafting a consensus statement to guide the care of children and young people at the end of life. The draft *National Consensus Statement: Essential elements for safe and high-quality paediatric end-of-life care* describes the elements that are essential for delivering safe and high-quality end-of-life care to children in Australia. The paediatric consensus statement is based on the Commission's *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*, which sets out suggested practice for the provision of safe and high quality end-of-life care for adults and was endorsed by Health Ministers in 2015.

The Commission also piloted survey tools to investigate the perceptions of doctors, nurses and allied health practitioners about, and experiences of, end-of-life care provided in their workplaces. Alongside the survey tools, a patient record review tool was also tested. The tool collects data about the safety and quality of end-of-life care.

2015–16 HIGHLIGHTS

Held an expert roundtable meeting to develop guidance for the care of children and young people at the end of life.

Drafted the *National Consensus Statement: Essential elements for safe and high-quality paediatric end-of-life care* for consultation in 2016–17.

Developed and piloted survey and patient record review tools to assist health services to assess the safety and quality of the end-of-life care that they provide.

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.



The Australian Atlas of Healthcare Variation

The Minister for Health, the Honourable Sussan Ley, launched the first *Australian Atlas of Healthcare Variation* in November 2015. This was the first Australian atlas where healthcare variation across the country has been presented alongside national recommendations for action. The atlas presents a clear picture of substantial variation in health care services across Australia in areas such as antibiotic prescribing, surgery, mental health and diagnostic services. The atlas has identified opportunities for improving the health care that Australians receive and has been a catalyst for generating action to improve people's health outcomes and to increase the effectiveness of the healthcare system.

The Commission is collaborating with clinicians, health departments and consumer groups to act on the findings of the atlas, and implement recommendations to improve appropriateness of care.

Unwarranted variation in healthcare – that is, variation that is not related to patient need or preference – raises questions about healthcare quality and value. Unwarranted variation may reflect differences in clinicians' practices, in the organisation of health care, and in people's access to services. It may also reflect care that is not evidence-based.

The Commission's Healthcare Variation program aims to reduce unwarranted variation and improve patient care, while ensuring value for Australia's healthcare spending. Examining variation is an important first step.

The Commission developed the atlas in collaboration with the Australian, state and territory governments, specialist medical colleges, clinicians and consumer representatives.

This was the first time that data from the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme (PBS) and Admitted Patient Care National Minimum Data Set was used to explore variation across different healthcare settings in Australia.

The atlas reported variation in six clinical areas, covering prescribing, diagnostic, medical and surgical interventions. It identified many instances of large variation in healthcare practices, prompting further investigation and action to ensure appropriate health care for all Australians. Key findings included:

- very high overall rates of antimicrobial prescribing
- very high rates of colonoscopy with very large variation across the country – the area with the highest rate was 30 times higher than the area with the lowest rate
- high variation in rates of computed tomography scans of the lower back, with the highest rate 12 times higher than the lowest rate; inappropriate use of diagnostic imaging exposes patients to unnecessary radiation
- rates of knee arthroscopy in people aged 55 and over were seven times higher in some areas than others; knee arthroscopy is of little benefit for people with osteoarthritis and may cause harm
- women living in regional Australia were up to five times more likely to undergo a hysterectomy or endometrial ablation for abnormal uterine bleeding than those living in cities
- nearly 14 million prescriptions were dispensed through the PBS for opioid medicines in 2013–14, with the number of prescriptions 10 times higher in the area with the highest rate compared to the area with the lowest rate
- a very high rate of variation in PBS prescriptions for attention deficit hyperactivity disorder (ADHD) medicines for children and adolescents 17 years and under, with the highest rate 75 times higher than in the area with the lowest rate.

To address the high levels of variation reported in the atlas, the Commission is producing clinical care standards, patient decision aids and feedback to prescribers.

2015–16 HIGHLIGHTS

Launched the first *Australian Atlas of Healthcare Variation* with national recommendations for action.

Provided national, state and territory governments with an implementation strategy to ensure atlas recommendations are addressed.

Commenced work on the recommendations directed to the Commission to reduce unwarranted variation, including the development of new clinical care standards and shared decision making resources such as patient decision aids.

Clinical care standards

Clinical care standards can play an important role in delivering appropriate care and reducing unwarranted variation. They identify and define the care people should expect to be offered or receive, regardless of where they are treated in Australia.

During 2015–16, the Commission finalised clinical care standards for hip fracture care and for delirium in collaboration with consumers, clinicians, researchers and health organisations. Public consultation resulted in over 200 submissions for each standard, with strong overall support and agreement with the proposed recommendations (quality statements) for care described in each standard. The Commission will release these clinical care standards in 2016–17.

The development of a clinical care standard on osteoarthritis of the knee began in 2016 in response to preliminary recommendations of the Knee Pain Expert Working Group and findings of the atlas. This clinical care standard aims to improve the assessment and management of knee-related osteoarthritis with a view to improving a patient's symptom control and quality of life.

The Commission has also started preliminary work for clinical care standards on heavy menstrual bleeding (menorrhagia) and cataract surgery, based on the recommendations of the atlas.

In 2015, the Acute Stroke Clinical Care Standard was the focus of a national audit. The National Stroke Foundation published audit results against the indicators for this clinical care standard. Ongoing reporting of these indicators will help monitor progress in the care of patients with an acute stroke.

The Commission commenced the development of an evaluation framework that will review the uptake of the clinical care standards and supporting resources and will consider their effectiveness in improving the quality of patient care. The evaluation framework will be finalised in 2016–17 and will support ongoing evaluation activities and the evolution of the clinical care standards.

2015–16 HIGHLIGHTS

Finalised clinical care standards on hip fracture care and delirium.

Published *Acute Coronary Syndromes: Case for Improvement* and the *Acute Stroke: Case for Improvement* educational resources for clinicians and health services to support implementation of the clinical care standards on these topics.

Released clinical care standard on osteoarthritis of the knee for consultation.

Commenced development of new clinical care standards in the areas of heavy menstrual bleeding and cataract surgery.

Commenced the development of an evaluation framework that will consider the effectiveness of clinical care standards and guide their ongoing development, dissemination, uptake and implementation.

Pricing for safety and quality

In 2015–16, the Commission examined new ways to incorporate safety and quality into the pricing of Australian public hospital services in collaboration with the Independent Hospital Pricing Authority (IHPA).

The Commission and IHPA have been investigating how data that is routinely collected from patient medical records can be used to drive improvements in safety and quality.

During 2015–16, this involved:

- releasing the first ever national list of hospital-acquired complications
- identifying each complication in data that is routinely collected from patient medical records
- completing a proof-of-concept study of hospital-acquired complications.

In 2015–16, the Commission continued to explore how pricing can be used as a lever to encourage clinicians to follow best-practice care. A joint working party sub-committee investigated how pricing approaches can be used to improve best practice, specifically in hip fracture care, and published the report *Best-practice pricing and clinical quality information on hip fracture care*. This was the first report of its kind in Australia.

The Commission and IHPA subsequently worked together to implement recommendations from the report. Work started with the Australian and New Zealand Hip Fracture Registry to develop the capacity to measure and monitor hip fracture best practice care consistently, using indicators developed for the Commission's Hip Fracture Clinical Care Standard. This development is important for measuring and monitoring local quality improvement and as a potential best-practice pricing approach if IHPA implements one in future years.

In 2015–16, the Commission and IHPA also worked with key cardiology clinicians to explore best-practice pricing for acute coronary syndromes care. Development of an approach for this clinical area is following a process similar to the development of the hip fracture care best-practice pricing approach. The Commission has published an Acute Coronary Syndromes Clinical Care Standard. Indicators developed for this Standard can be used as the basis to measure and monitor best-practice acute coronary care. However, it is expected that development of an approach for acute coronary syndrome best-practice pricing will be more challenging than for hip fracture care, because there is currently no national data repository or registry that collects data about the indicators.

2015–16 HIGHLIGHT

Published *Best-practice pricing and clinical quality information on hip fracture care*.

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

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



Indicators and data set specifications

The Commission has continued working on resources outlining best practice for developing and reviewing safety and quality indicators. In 2015–16, the Commission continued to develop and maintain indicators and data set specifications to support safety and quality improvement alongside updating and managing the data governance and data-management policies.

In 2015–16, the Commission released version 2.0 of the *Core, Hospital-Based Outcome Indicators* (CHBOI) which contained

updated coefficients and reference sets.

To inform the review of the condition-specific indicators, the Commission finalised literature reviews on condition-specific mortality and same-hospital readmissions. Workshops in relation to condition-specific mortality indicators were subsequently conducted. The Commission's review of these indicators will continue in 2016–17.

This year the Commission also completed a review of the *Surveillance of healthcare-associated Staphylococcus aureus bacteraemia (SAB) data set specification* to ensure it continues to support surveillance of healthcare-associated SAB in Australian hospitals.

2015–16 HIGHLIGHTS

Undertook literature reviews for condition-specific mortality and same-hospital readmissions for condition-specific measures.

Released version 2.0 of the CHBOI Toolkit, including updated coefficients and reference sets.

Completed a review of the *Surveillance of healthcare-associated Staphylococcus aureus bacteraemia data set specification*.

A proof-of-concept study in seven public and eight private hospitals was also completed in 2015–16. The study confirmed that the concept of hospital-acquired complications is relevant for safety and quality improvement, and that the underlying data is useful and of a reasonable quality.

In 2016–17, the Commission will further refine the list and develop supporting resources for its use, with the aim of improving clinical documentation and supporting local monitoring.

National sentinel events list

In 2015–16, the Commission commenced a review of the national sentinel events list. The national sentinel events list is a list of adverse events that result in death or very serious harm to the patient, reported nationally through the Productivity Commission's *Report on Government Services*. The review is the first since Australian Health Ministers mandated the list of eight events in 2004. The review will consider the policy objectives and appropriateness of the list, the individual definitions and current national reporting requirements.

The first phase of the review will continue into 2016–17 and include:

- undertaking an environmental scan – through consultation with states and territories about current practice
- reviewing the literature to establish international best practice
- developing an options paper for consideration by states and territories.

Minimising healthcare-related 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 the identification of harm, the Commission's work includes the development of indicators for local monitoring of safety and quality.

Hospital-acquired complications list

Hospital-acquired complication refers to a complication for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. In 2015–16, the Commission released the hospital-acquired complications list. The list, developed by clinicians to support hospitals in monitoring patient safety, consists of 16 complications selected based on preventability, patient impact, health service impact and clinical priority.

2015–16 HIGHLIGHTS

- Released the national hospital-acquired complications list.
- Completed a proof-of-concept study of hospital-acquired complications.
- Held a jurisdictional roundtable on sentinel events.
- Commissioned a literature review exploring current sentinel event practices in Australia and internationally.

National clinical quality registries

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

In 2015–16, the Commission undertook work to support the implementation of the *Framework for Australian clinical quality registries* that was endorsed by the Australian Health Ministers’ Advisory Council in 2014. The framework specifies national arrangements under which peak clinical groups and health service organisations can partner with governments to monitor and report on the quality (or appropriateness and effectiveness) of health care.

In 2015–16 the Commission:

- completed an economic evaluation of five clinical quality registries in Australia to determine whether the registries provide a return on investment
- progressed work on the identification of high-priority clinical domains for clinical quality registry development to determine investment priorities.

2015–16 HIGHLIGHTS

- Completed economic evaluations of clinical quality registries.
- Consulted on high-priority clinical domains for national clinical quality development.

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. Below is an overview of the process by which the Commission assesses the safety and quality of health care services provided and uses this information to inform its strategic planning and forward work program. A full report on key safety and quality themes can be found in the Commission's publication *Vital signs 2016: the state of safety and quality in Australian health care*.

Safety and quality in the Australian health system is complex given it is integrated across all aspects of health care. The introduction of the National Safety and Quality Health Service Standards gave a nationally consistent approach to safety and quality in Australia's hospitals for the first time. The NSQHS Standards have contributed significantly to improvements in patient safety by providing a focused framework for safety and quality activities at the national level, and enabling better collaboration within the health sector, including within and between hospitals and across states and territories. There has also been greater attention to, and leadership for, safety and quality and increased clinical engagement in safety and quality activities.

The Commission assesses the safety and quality of health care services provided in Australia through the implementation of the NSQHS Standards and the ongoing monitoring of their impact on health services, staff and patients. The information, feedback and areas for improvement identified through the accreditation process are shared with the Commission's Board and standing committees, where issues highlighted are considered in context and solutions identified which inform the Commission's work plan and future activities.

Projects such as evaluating the use of clinical quality registries, the evaluation and review of the NSQHS Standards, considering the appropriateness of care, and developing standards to identify the expected level of care for different conditions that consumers should receive across Australia, demonstrate some of the ongoing improvements in the safety and quality of health care services provided in Australia led by the Commission.

Throughout 2015-16 the Commission has worked towards the development of better ways to provide information to governments, public and private sector health services, the health insurance industry and the public on the state of safety and quality in health care in Australia. This work has seen the development of the set of hospital-acquired complications which can be used to report on the incidents and, in time, prevalence of patient safety events that may be prevented.

The Commission published its first *Australian Atlas of Healthcare Variation* in November 2015 which reported on variations in healthcare provision and use across Australia. Some of this variation is unwarranted and as such, identifies care that hasn't been provided in line with best practice. The Commission continues to work collaboratively with its partners and stakeholders in providing a comprehensive picture of safety and quality in Australian health care.

Annual performance statements

As the accountable authority of the Australian Commission on Safety and Quality in Health Care (the Commission), the Board presents the 2015–16 annual performance statements of the Commission, as required under paragraph 39(1)(a) of the *Public Governance, Performance and Accountability Act 2013*. 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 *Public Governance, Performance and Accountability Act*.



Professor Villis Marshall AC
Board Chair

Entity purpose

The Commission was established in 2006 to lead and coordinate safety and quality improvements in health care nationally. The Commission contributes to better outcomes and experiences for patients, clients and their carers, and improves productivity and sustainability of the Australian health system. The Commission has legislative responsibility for the National Safety and Quality Health Service (NSQHS) Standards, which are a major driver of safety and quality improvements within the health system.

The functions of the Commission are specified in the *National Health Reform Act 2011* and are summarised as follows:

- 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 these 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
- collecting, analysing, interpreting and disseminating information relating to healthcare safety and quality matters
- publishing reports and papers relating to healthcare safety and quality matters.

Corporate plan 2015–19

The Commission's *Corporate plan 2015–19* was prepared under paragraph 35(1) (a) of the *Public Governance, Performance Accountability Act*, and published in accordance with paragraph 16E (3) of the *Public Governance, Performance and Accountability Rule 2014*. The *Corporate plan 2015–19* describes the planned program of work for the four-year period and specifies how the Commission will measure its performance during that period. The *Corporate plan 2015–19* can be accessed on the Commission's website: <http://www.safetyandquality.gov.au/about-us/corporate-plan/>

Results

The Commission developed key performance indicators (KPIs) for the 2015–19 period. These KPIs were published in the *2015–16 Health Portfolio Budget Statements* and the Commission's *Corporate plan 2015–19*. Below is a report on the Commission's performance against the KPIs in the 2015–16 reporting period.

Performance criterion

Successful implementation of the National Safety and Quality Health Service (NSQHS) Standards.

Criterion source

Program 1.1, *2015–16 Portfolio Budget Statements*, p.192; Commission *Corporate plan 2015–19* p.11.

Result against performance criterion

The Commission successfully negotiated with states and territories on ongoing arrangements to support implementation of the NSQHS Standards in hospitals and day procedure services, community and other health services.

Performance criterion

100% of hospitals and day procedure services assessed to the NSQHS Standards.

Criterion source

Program 1.1, *2015–16 Portfolio Budget Statements*, p.192; Commission *Corporate plan 2015–19* p.11.

Result against performance criterion

98% of all hospitals and day procedure services in Australia have been assessed to the NSQHS Standards.

Performance criterion

Public hospitals meeting the benchmark of $\geq 70\%$ for hand hygiene compliance.

Criterion source

Program 1.1, *2015–16 Portfolio Budget Statements*, p.192; Commission *Corporate plan 2015–19* p.11.

Result against performance criterion

Data reported by Hand Hygiene Australia confirms that public hospitals have met the benchmark hand hygiene compliance rates for the 2015–16 reporting period.

The overall compliance rates for each audit were as follows:
 Audit Period 3 — 2015 (October): 82.7%
 Audit Period 1 — 2016 (March): 83.7%
 Audit Period 2 — 2016 (June): 83.7%

Further information can be found at <http://www.hha.org.au>

Performance criterion

$\geq 12\,000$ clinicians completing the healthcare-associated infection online education modules.

Criterion source

Program 1.1, *2015–16 Portfolio Budget Statements*, p.192; Commission *Corporate plan 2015–19* p.11.

Result against performance criterion

E3learning hosts the Commission's healthcare-associated infection online education modules. Clinicians register for the online modules using an email address, which identifies them within the system.

In the 2015–16 financial year, 13 103 clinicians completed the online education modules.

2015–16 Work plan performance

The Commission measured its work plan performance in 2015–16 within its comprehensive project management system, which monitors budgets, timeframes, deliverables and risks for each project. Project reports were actively managed by the Commission’s executive group and provided to the Audit and Risk Committee and the Commission’s Board at each meeting. The Commission’s work plan objectives are developed in partnership with the Australian Government and the states and territories. The Commission successfully met its work plan objectives for 2015–16.

Key deliverables

In addition to its key performance indicators, the Commission measured its performance against some key planned deliverables which were described in the Commission’s *Corporate Plan 2015–19* and were achieved over the 2015–16 reporting period.

Performance criterion

Pilot version 2 of NSQHS Standards in health services.

Criterion source

Commission *Corporate Plan 2015–19*, p.12

Result against performance criterion

In 2015–16, the Commission successfully piloted version 2 of NSQHS Standards; 132 sites were involved in piloting the NSQHS Standards, as were seven accrediting agencies.

Performance criterion

Review of the Australian Health Service Safety Quality Accreditation (AHSSQA) Scheme to align with version 2 of the NSQHS Standards.

Criterion source

Commission *Corporate Plan 2015–19*, p.12

Result against performance criterion

In 2015–16 the Commission successfully reviewed the AHSSQA Scheme to align with version 2 of the NSQHS Standards. Activities undertaken as part of the review were as follows:

- 37 focus groups were conducted nationally on the NSQHS Standards and AHSSQA scheme, involving over 480 clinicians.
- 162 written submissions were received – 43% from public sector, 42% from private sector and 15% from others.
- 206 health service representatives responded to a survey on the NSQHS Standards.
- 71 consumers responded to a consumer survey.

Performance criterion

Establish a national surveillance system for antimicrobial use and resistance in Australia.

Criterion source

Commission *Corporate Plan 2015–19*, p.13

Result against performance criterion

In 2015–16 the Commission successfully established the Antimicrobial Use and Resistance in Australia (AURA) Surveillance System to coordinate surveillance activities to facilitate analysis and antimicrobial use (AU) and antimicrobial resistance (AMR) reporting at a national level. AURA provides surveillance data from the hospital and community sectors.

The Commission established the system in partnership with Australian Group on Antimicrobial Resistance, National Antimicrobial Prescribing Survey, the National Antimicrobial Utilisations Surveillance Program and the Queensland Health's OrgTRx system. Data is also sourced from the Pharmaceutical Benefit Scheme/ Repatriation Benefit Scheme, NPS MedicineWise, the National Neisseria Network, and the National Notifiable Diseases Surveillance System.

Surveillance is essential to understand the magnitude, distribution and impact of resistant organisms and antimicrobial usage, as well as to identify emerging issues and trends. As part of the system, a new system for the early detection of critical antimicrobial resistances has been developed which provides alerts to ensure effective action can be taken.

AURA will provide critical information needed by clinicians, policy makers, researchers and health system managers to target efforts to inform antimicrobial stewardship and antimicrobial resistance policy and program development.

AURA will support the objectives of the National Antimicrobial Resistance Strategy.

Performance criterion

Draft consensus statement about essential elements for a person-centred healthcare system.

Criterion source

Commission *Corporate Plan 2015–19*, p.13

Result against performance criterion

During this reporting period, the Commission progressed work on exploring new ways of fostering a person-centred healthcare system. After consultation with key stakeholders, it was agreed that an important first step would be for the Commission to carry out expert reviews to inform the scope and content of a national document on person-centred healthcare.

In 2015–16 the Commission undertook the following reviews:

- an expert commentary on person-centred care, which explored the concept, how it has changed and progress towards person-centred care
- a review of person-centred care in the context of complex adaptive systems and systems theory.

The findings of these reviews will form the basis of a discussion paper on how systems thinking can be used to foster a person-centred healthcare system. The Commission will then explore, and provide guidance on the actions that are needed across the system to achieve this goal.

Performance criterion

Produce patient decision aids on antibiotic use and knee pain.

Criterion source

Commission *Corporate Plan 2015–19*, p.13

Result against performance criterion

In 2015–16 the Commission developed and finalised three patient decision aids on antibiotic use. In addition, preliminary work on the development of a patient decision aid on knee pain commenced.

Performance criterion

Publish the first *Australian Atlas of Healthcare Variation*.

Criterion source

Commission *Corporate Plan 2015–19*, p.14

Result against performance criterion

The Commission published the first *Australian Atlas of Healthcare Variation* in 2015, in collaboration with the Australian, state and territory governments, specialist medical colleges, clinicians and consumer representatives. This was the first time that data from the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and Admitted Patient Care National Minimum Data Set were all used to explore variation across different healthcare settings.

The successful launch of the atlas produced 67 recommendations that suggest ways in which coordinated action can be taken at all levels of the healthcare system. These are expected to be implemented across the Australian healthcare system over the coming years.

Performance criterion

Development of clinical care standards on hip fracture care and delirium, and resources to consumers and clinicians to support implementation.

Criterion source

Commission *Corporate Plan 2015–19*, p.14

Result against performance criterion

In 2015–16 the Commission successfully completed clinical care standards on hip fracture care and delirium. The formal launch of both standards is scheduled for the 2016–17 financial year.

Hard copy resources will be made available to health services across Australia, professional colleges and organisations, and relevant consumer groups.

Analysis of performance against purpose

This year has been one of significant achievements for the Commission with the successful delivery of its work plan activities and achievement of all KPIs for this period.

The Commission continues to focus its work on areas that can best be improved through national action. Improvements to healthcare safety and quality are best achieved through national partnerships that are supported by local activities and implementation. The Commission achieves this through the maintenance of strong, positive relationships with its partners, including patients and consumers, consumer groups, healthcare providers, public and private healthcare organisations, governments and other healthcare organisations and agencies. The Commission works in partnership with its stakeholders to support the implementation of safety and quality initiatives through the development of guidance, resources, tools and educational material. The Commission supports the evaluation of its activities and measurement of the impact on the health system of safety and quality improvement initiatives. The Commission continually scans the horizon to identify new and emerging issues regarding safety and quality, while being responsive to the evolving needs of its stakeholders.

There was no change to the framework in which the Commission operated in the 2015–16 reporting period, and no change to the Commission's purposes, activities or organisational capability.



CORPORATE GOVERNANCE AND ACCOUNTABILITY

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

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Legislation and requirements

The Commission is a corporate Commonwealth entity of the Australian Government, accountable to the Parliament and the Australian Minister for Health. The Commission's principle legislative basis is the *National Health Reform Act 2011*, 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 Chief Executive Officer (CEO), and the operation of board meetings.

The Commission must fulfil the requirements of the *Public Governance, Performance and Accountability Act 2013*, 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.

Strategic planning

The Commission's strategic plan describes the high-level priorities for the Commission over three to five years and guides the development of detailed work plans.

The strategic plan covers four priority areas:

1. Patient safety: the aim of this priority area is to have a safe health system that minimises harm to patients and consumers, and reduces costs associated with preventable adverse events.
2. Partnering with patients, consumers and communities: the aim of this priority area is to have a health system that maximises the potential for safe and high-quality care by supporting and encouraging patients, consumers and members of the community to participate as equal partners in health care.
3. Quality, value and cost: the aim of this priority area is to have a health system that provides the right care to patients and consumers, improves health outcomes for patients and optimises the value of the healthcare system by improving productivity.
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 having robust and sustainable improvement systems.

Ministerial directions

Section 16 of the National Health Reform Act empowers the Minister for Health to make directions with which the Commission must comply. The Minister for Health made no such directions during the 2015–16 reporting period.

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, and
- 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 reporting period. Where immaterial non-compliances were identified they were managed in accordance with our policies and procedures, including analysis to detect and rectify any breakdowns of internal controls.

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.

It also oversees the Commission's 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 Public Governance, Performance Accountability Act.

Board membership 2015–16

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 pre-hospital 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: First appointed on 1 April 2012; appointed as Chair on 1 April 2013.

Mr Martin Bowles PSM

Mr Martin Bowles was appointed as Secretary of the Australian Government Department of Health on 13 October 2014.

Mr Bowles was previously the Secretary of the Department of Immigration and Border Protection. Prior to this, he held the positions of Deputy Secretary in the Department of Climate Change and Energy Efficiency and the Department of Defence respectively. In 2012, he was awarded a Public Service Medal (PSM) for delivering highly successful energy efficiency policies and remediation programs for the Home Insulation and Green Loans programs.

Prior to 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: B.Bus, GCPubSecMgmt

Board membership: First appointed on 14 May 2015.

Professor Christopher Brook PSM

Professor Christopher Brook has experience in public healthcare administration and improving the safety and quality of health care. He is currently an independent health policy consultant, previously the Chief Advisor for Innovation, Safety and Quality for the Department of Health, Victoria.

As a personal appointment, Professor Brook is also the State Health and Medical Commander (Emergency Management) for Victoria. He also sits on the Clinical Trials Advisory Committee auspiced by the Australian Government Department of Industry, and on the Advisory Board of the National Blood Authority.

Qualifications: MBBS, FRACP
(Gastroenterology), FAFPHM, FIPAA

Board membership: First appointed on 1 April 2012; reappointed on 1 April 2013; term concluded on 31 March 2016.

Ms Sally Crossing AM

Initially trained as an economist, and after a career in banking and government, Ms Crossing has worked in a voluntary capacity to represent and advocate for health consumers, especially those affected by cancer, for the last 18 years.

Following diagnosis and ongoing treatment for cancer, Ms Crossing established and led the well-known consumer advocacy groups Breast Cancer Action Group NSW (1997) and Cancer Voices (2000). She was pivotal in the establishment of Health Consumers NSW (HCNSW), the peak independent voice for the consumers of health services in NSW, and became its first Chair in 2011. At national level, Ms Crossing has served on the board of the Consumers' Health Forum of Australia. She also acts as consumer representative on a number of committees – research, clinical and policy – and at both state and national levels.

In 2005, Ms Crossing was appointed a Member of the Order of Australia (AM) for services to the community through cancer consumer advocacy. In 2014, Ms Crossing was awarded an Honorary Doctorate (Health Sciences) by her alma mater, the University of Sydney.

Qualifications: BEd (USyd)

Board membership: First appointed on 4 September 2014; term concluded on 31 March 2016.

Professor Phillip Della

Professor Phillip Della has experience in public administration (health care), providing professional healthcare services, and improving safety and quality. Previously Deputy Pro Vice-Chancellor of Health Science at Curtin University, Professor Della continues to hold a number of positions at the university, including Professor and Head of the School of Nursing, Midwifery and Paramedicine.

Previous roles also include Chief Nursing Officer and Principal Nursing Advisor for the Western Australian Department of Health.

Qualifications: PhD, FACN

Board membership: First appointed on 1 April 2013.

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 Chief Executive Officer 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 Private Hospitals Association of Queensland, the Queensland board of the Medical Board of Australia, and the Australian Government's Second Tier Advisory Committee.

Qualifications: MBA

Board membership: First appointed as a Commission member in March 2006; appointed to the board, as established under the National Health Reform Act, on 1 July 2011.

Ms Wendy Harris QC

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. In addition to her membership of the Board of the Commission, she chairs the National Model Clinical Governance Framework Advisory Panel.

Other previous 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. She is currently a member of the Bar Council of the Victorian Bar Inc.

Qualifications: LLB (Hons)

Board membership: First appointed July 2015.

Dr Shaun Larkin

Dr Shaun Larkin joined The Hospitals Contribution Fund of Australia (HCF), Australia's largest not-for-profit health fund, in 1997.

After serving as a General Manager in a number of executive roles (Strategic Development; Benefits Management; Corporate Ventures; and Operations) in 2009 he was selected to be the next Managing Director and now leads an organisation with healthcare responsibilities for more than 1½ million Australians, revenues in excess of A\$2½ billion, and over 1 100 staff.

Prior to joining HCF, Dr Larkin was based in Singapore for four years, where he led the establishment of a chain of ambulatory medical centres throughout Asia.

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: First appointed on 1 April 2013.

Mrs Cheryle Royle

Starting her career as a nurse, Mrs Cheryle Royle has had a long career in health service management in both Victoria and Queensland. Mrs Royle is currently the Chief Executive Officer of St Vincent's Private Hospital in Brisbane. She is a passionate advocate for quality care in hospitals and has been on a number of boards in Victoria.

In 1998, Mrs Royle was awarded the Victorian Telstra Business Woman of the Year for the private sector.

Qualifications: RN, RM, BN, GDip Nursing Administration

Board membership: First appointed to the board on 4 September 2014.

Dr Helena Williams

Dr Helena Williams brings to the board her clinical expertise as a general practitioner and as the previous Executive Clinical Director of the Southern Adelaide-Flourieu-Kangaroo Island Medicare Local Ltd. She is currently also the Presiding Member of the Southern Adelaide Local Health Network Governing Council.

Dr Williams' previous board directorships include the Cancer Council SA, Noarlunga Health Services, the South Australian Divisions of General Practice, the Australian General Practice Network and the Southern Adelaide Health Service.

Qualifications: MBBS, FRACGP

Board membership: First appointed as a Commission member in April 2008; appointed to the board, as established under the National Health Reform Act, on 1 July 2011.

Table 1: Board meetings and attendance

Name	Board meeting					
	20 August 2015	17 September 2015	12 November 2015	18 February 2016	29 March 2016	14 April 2016
Prof. Willis Marshall AC (Chair)						
Mr Martin Bowles PSM ²						
Prof. Christopher Brook ²						
Ms Sally Crossing AM ²						
Prof. Phillip Della						
Ms Christine Gee ²						
Ms Wendy Harris QC ^{1,2}						
Dr Shaun Larkin ²						
Mrs Cheryle Royle ²						
Dr Helena Williams ²						



Present



Absent



Not a member at the time of the meeting

1 Appointed 24 July 2015**2** Term concluded 31 March 2016**Note** The terms of eight Board members expired on 31 March 2016 and the appointments of eight new and re-appointed members took effect on 29 July 2016.

Board development 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 defines the function, duties and responsibilities of the board, and a code of conduct, which defines the standard of conduct required of board members and the ethics and values that they are bound to uphold. The *Duty to Disclose Interests Policy for Board Members* requires that board members recognise, declare and take reasonable steps to avoid or appropriately manage any conflict of interest. This includes the duty to disclose material personal interests as required under section 29 of the Public Governance Performance Accountability Act.

Related-entity transactions

In accordance with the requirements prescribed by Subdivision B of Division 3A of the Public Governance, Performance and Accountability Rule 2014 Section 17BE, and Department of Finance Resource Management Guide 136, related entity transactions for 2015–16 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 2015–16 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 60 months. Motor vehicle, third-party property damage and expatriate cover have not been taken out, as they don't apply to the Commission.

The Commission's Comcover premium for 2015–16 was \$31 569.24 (including GST).

Committees

An Audit and Risk Committee advises the Commission and its board on audit, risk and finance.

An Inter-Jurisdictional Committee meets regularly to provide advice to the Commission and the Board.

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 *Public Governance, Performance and Accountability Act 2013* and the Public Governance, Performance and Accountability Rule Section 17. The primary role of the committee, chaired by Ms Jennifer Clark, 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:

- monitoring the effectiveness 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 Public Governance, Performance Accountability Act and Rules
- 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 four times during the 2015–16 financial year. Ms Jennifer Clark attended all four meetings.

Board-appointed member Dr Shaun Larkin was a member of the Audit and Risk Committee from 1 July 2015 to 31 March 2016. Mr Trevor Burgess held the position of the external member of the Audit and Risk Committee during 2015–16. 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, state and territory governments. It is responsible for advising on policy development and facilitating jurisdictional engagement.

The role of committee members is to:

- advise the Commission on the adequacy of the policy development process, in particular policy implementation
- ensure health departments and ministries are aware of new policy directions and can review local systems accordingly
- monitor national actions to improve patient safety, as approved by health ministers
- participate in national data collections on safety and quality
- build effective mechanisms within jurisdictions to enable national public reporting.

The committee met five times during the 2015–16 financial year.

Other committees and consultations

The Board has established two sub-committees that provide specific advice and support across all relevant areas of its work. 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 in close partnership with a number of time-limited expert committees, working parties and reference groups to inform and support its work. These groups allow the Commission to draw on expert knowledge, consult with relevant key stakeholders and develop appropriate implementation strategies.

The Commission consults widely with subject-matter experts, peak bodies, jurisdictions, consumers, and other relevant individuals and organisations. The consultation includes ongoing discussions with key national and other organisations, and with an extensive network of formal reference and advisory groups. These networks provide links with healthcare providers, consumers, subject-matter experts and jurisdictional representatives. The Commission also undertakes formal consultations 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 Business Group meet fortnightly to facilitate information sharing and help with decision-making.

The Work Health and Safety Committee develops and promotes strategies to support the health and safety of all employees and visitors. In 2015–16, the Commission established a Workplace Consultative Committee to facilitate consultation and employee participation in the development and review of HR policies and procedures.

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 standards for risk management – principles and guidelines (AS/NZS ISO 31000:2009) 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, encourage and implement sound financial, legal and ethical decision-making. 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 fraud awareness training to all employees and contractors annually.

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

External scrutiny of the Commission includes parliamentary and ministerial oversight, freedom of information and judicial decisions, and reviews by outside bodies such as the Commonwealth Ombudsman.

Freedom of information

Agencies subject to the *Freedom of Information Act 1982* are required to publish information to the public as part of the Information Publication Scheme (IPS). 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: www.safetyandquality.gov.au.

See [Appendix A](#) for a table summarising FOI activities for 2015–16.

Judicial decisions and reviews by external bodies

There were no judicial decisions or external reviews significantly affecting the Commission in 2015–16.

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 2015–16.

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.

Developments and significant events

The Commission is required under paragraph 19(1) of the Public Governance, Performance and Accountability Act to keep the Minister and the Finance Minister informed of any significant decisions or issues that have affected or may affect its operations. In 2015–16, 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 \$12 700 that were paid to advertising agencies, market research organisations, polling organisations, direct mail organisations or media advertising organisations. In 2015–16, the Commission did not make any payments over \$12 700 to advertising or market research organisations.

National Health Reform Act amendments

No amendments to the National Health Reform Act were made during the 2015–16 financial year.





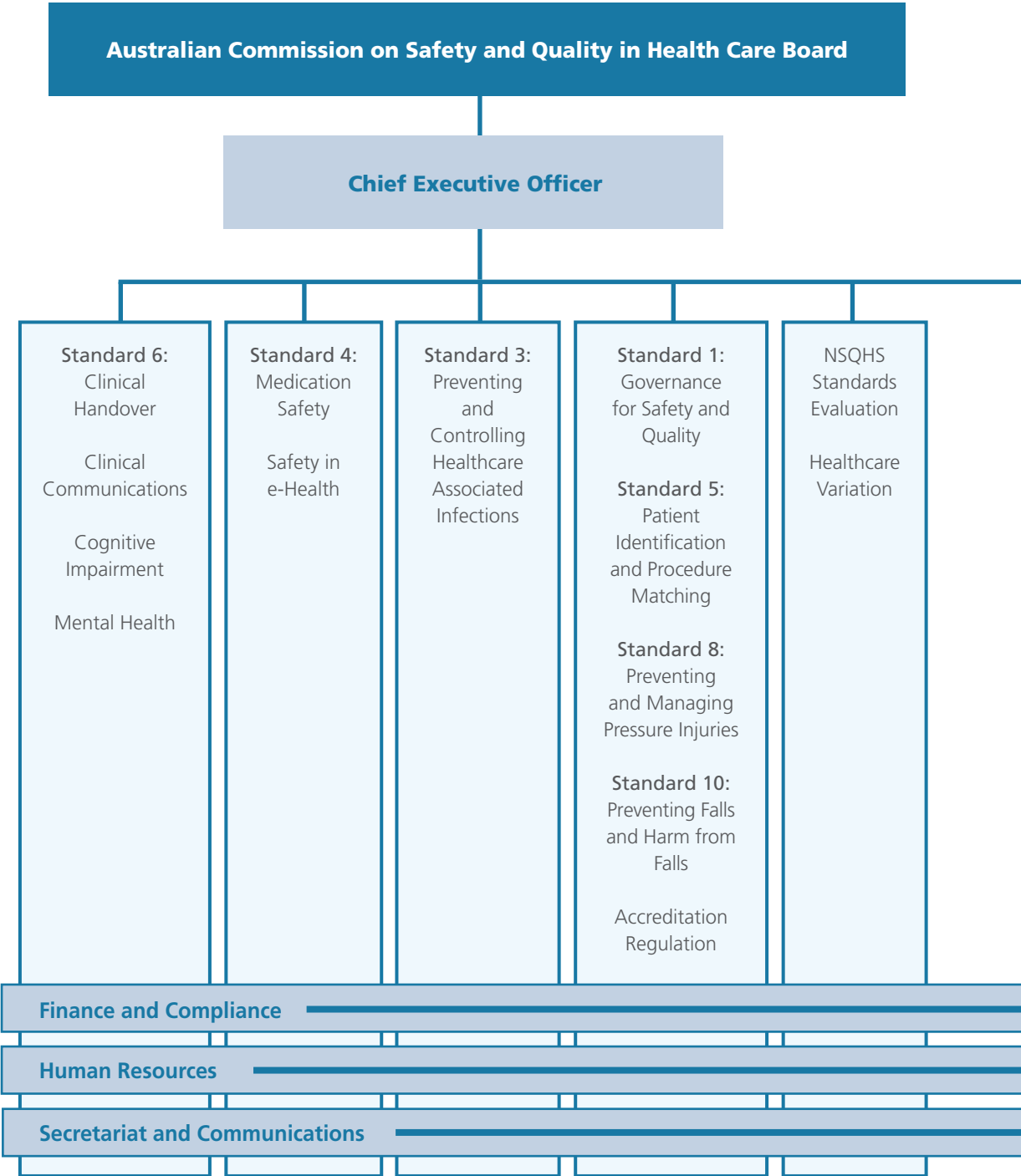
04 THE ORGANISATION

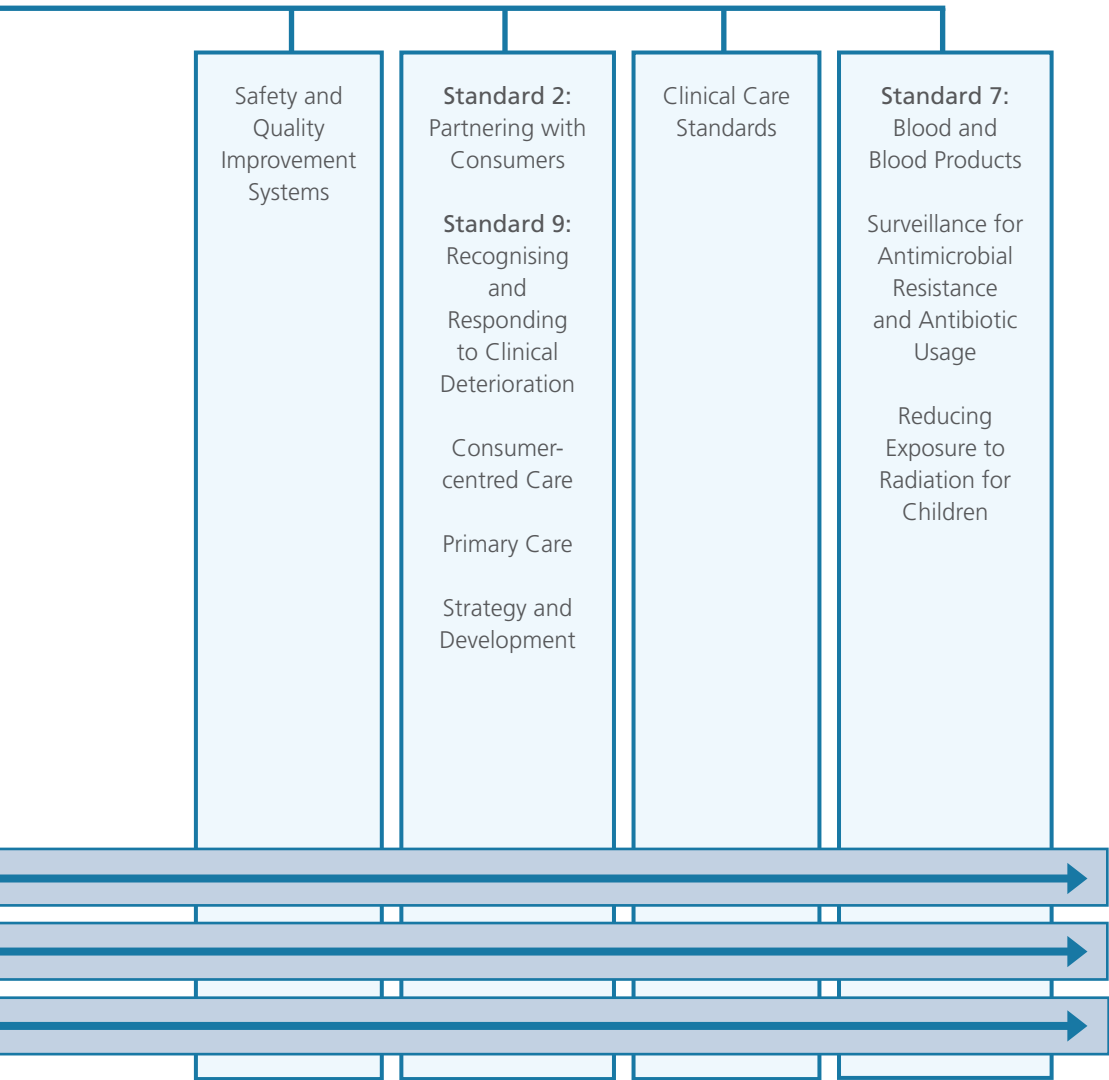
The Commission employs a diverse range of highly skilled professionals with experience across the healthcare industry. Because of the nature of the work, the Commission has a strong national presence in safety and quality in both the public and private sectors.

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

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Organisational structure





People management

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

The Commission participates in the Australian Public Service Commission (APSC) online induction program, giving all new employees the opportunity to learn how the Australian Public Service operates and the behaviours expected.

In May 2016, all Commission employees were encouraged to participate in the APSC's census survey.

Employee profile

As of 30 June 2016, the Commission had 88.6 full-time equivalent employees. The average employment level for 2015–16 was 86. The majority of employees are located in Sydney. The following table provides a breakdown of the Commission's employment by classification, gender, full-time or part-time status, and their ongoing or non-ongoing status.

Workplace health and safety

The Commission continues to promote 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 employees complete the Comcare work health and safety e-learning training module

Table 2: Staff numbers by classifications as of 30 June 2016

FEMALE					MALE				TOTAL
Classification	Ongoing		Non-ongoing		Ongoing		Non-ongoing		
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	
CEO			1						1
MO6		0.4		0.2				1.8	2.4
MO4									0
EL 2	10.5	1.5	1		4				17.1
EL 1	21.6	6.2	2	0.1	8				42.5
APS 6	9.6	0.6	4	4.7	3.2		1		18.4
APS 5	2.4				2.7		0.1		5.2
APS 4	1				1				2
Total	45.1	8.7	8	5	18.9	0	1.1	1.8	88.6

on commencement with the Commission. The Commission has a suite of work health and safety policies and procedures to ensure its compliance with the Work Health and Safety Act and to maintain the safety of its employees.

During 2015–16, the Commission undertook a number of activities aimed at preventing illness and injury in the workplace, including:

- conducting ergonomic workstation assessments for all employees
- appointing new Health and Safety Representatives and Workplace Harassment Contact Officers
- conducting bi-annual workplace inspections and encouraging all employees to report incidents, accidents or hazards in the workplace
- making influenza vaccinations available to all employees.

Three minor incidents were reported in 2015–16.

Learning and development

The Commission values the talent and contribution of its employees and recognises the importance of building expertise within the organisation.

Learning and development needs and opportunities are primarily identified through the performance development scheme.

During 2015–16, the Commission's study support and training arrangements ensured the ongoing development of employee skills and capabilities. During the year, 18 employees accessed study support assistance undertaking tertiary courses such as a Masters of Public Health, Masters of Health Service Management, Masters of Health Policy and various Graduate Certificates in health-related fields. During the

year, 25 employees completed external training courses and training was conducted for all employees on workplace bullying and harassment, security awareness and fraud awareness.

Disability strategy

The Commission's workplace diversity program 2014–2016 provides a framework that enables the Commission to support and embrace diversity, including employees with a disability.

The workplace diversity program provides for the Commission to apply the principle of reasonable adjustment to remove barriers to employment for those with a disability. Accordingly, employees with a disability are provided with assistance to adjust to working arrangements, work methods, equipment or the work environment that is necessary, possible and reasonable, to reduce or eliminate the effects of disability on their work.

The Commission's disability champion continued to participate in the APS Disability Champions' Network and to drive action on disability employment issues within the Commission.

Indigenous employment

The Commission is committed to improving the recruitment, retention and career development of Indigenous employees.

The proportion of the Commission's workforce who identified as being of Aboriginal and/or Torres Strait Islander origin during 2015–16 was 0.5%. This is below the Commission's indigenous employment target of 2.5%. The Commission is undertaking to recruit an indigenous graduate through the APSC's 2017 Indigenous Graduate Program.

Remembering Rosio Cordova

Director, Clinical Care Standards, 2012–2015

Rosio Cordova began working at the Commission in December 2012 as the inaugural Director of the Clinical Care Standards program. Rosio brought with her a depth of experience in policy development. She had worked at NSW Health as the Associate Director of Clinical Governance in Western Sydney for over five years, and before that, as a project officer in health promotion, quality assurance and women's health. She also brought insights from her background in nursing.

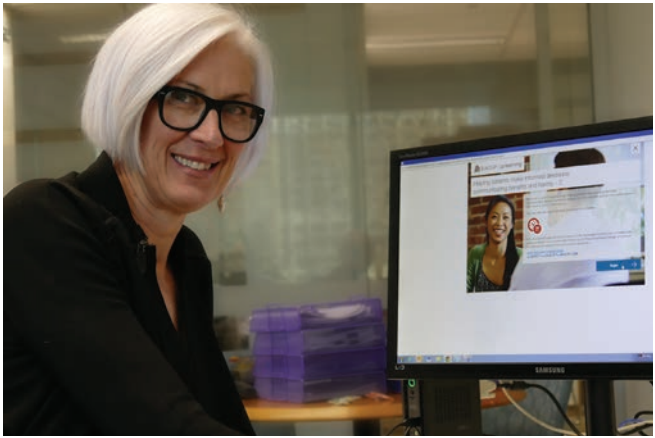
When Rosio arrived at the Commission, the Clinical Care Standards program was in its infancy. Without hesitation, Rosio embraced the opportunity of building a new program area. She loved the challenge of developing policy on the 'quality' of health care, which she considered a harder nut to crack than safety. Her passion for the clinical care standards and their potential to effect change, her unflinching determination, work ethic, fearlessness, and ability to engage others in the work, became the markers of her leadership style.

She greatly valued the importance of teamwork, and nurtured solid working relationships. She was an active listener, a keen observer of human triumphs and failures, and an astute analyst. She was also a mentor to many, and was strongly committed to supporting fellow migrants in the workplace. Given her own experience of migrating to Australia from Peru as an adult, she felt a strong responsibility to encourage other migrants, particularly those with English as a second language, to fulfil their potential in the workplace and overcome any barriers.



Rosio's leadership of the Clinical Care Standards program saw the successful launch of three clinical care standards, and the development of processes to support the future of the program. Rosio's positive outlook, strength, humour, and clear outlook on the big picture, stood her in good stead for the demands of the work, and became particularly valuable when she was faced with personal challenges.

Rosio is fondly remembered by her colleagues at the Commission for her considerable achievements, and her endearing qualities as a person, mother, wife, colleague and friend.



Dr Helena Williams tests the online risk communication module developed this year (see page 22).



Sydney Local Health District Management Trainee Imogen Hooper spent three months at the Commission learning about our work.



This year the Commission's nurses celebrated International Nurses Day on May 11.



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INDEPENDENT AUDITOR'S REPORT

To the Minister for Health and Aged Care

I have audited the accompanying annual financial statements of the Australian Commission on Safety and Quality in Health Care for the year ended 30 June 2016, which comprise:

- 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
- Notes comprising an Overview and other explanatory information.

Opinion

In my opinion, the financial statements of the Australian Commission on Safety and Quality in Health Care:

- (a) comply with Australian Accounting Standards and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and
- (b) present fairly the financial position of the Australian Commission on Safety and Quality in Health Care as at 30 June 2016 and its financial performance and cash flows for the year then ended.

Accountable Authority's Responsibility for the Financial Statements

The Members of the Board of the Australian Commission on Safety and Quality in Health Care are responsible under the *Public Governance, Performance and Accountability Act 2013* for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards and the rules made under that Act and are also responsible for such internal control as the Members determine is necessary to enable the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I have conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. These auditing standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor

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

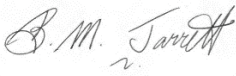
considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Accountable Authority of the entity, as well as evaluating the overall presentation of the financial statements.

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

Independence

In conducting my audit, I have followed the independence requirements of the Australian National Audit Office, which incorporate the requirements of the Australian accounting profession.

Australian National Audit Office



Brandon Jarrett
Executive Director

Delegate of the Auditor-General

Canberra
14 September 2016

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 2016 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.

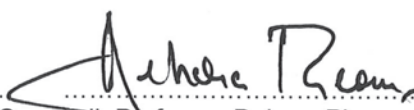
In our opinion, at the date of this statement, there are reasonable grounds to believe that the Australian Commission on Safety and Quality in Health Care will be able to pay its debts as and when they fall due.

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



Professor Villis Marshall AC
Chair

Date: 14.9.16



Adj. Professor Debora Picone AM
Chief Executive Officer

Date: 14.9.16



Mike Wallace
Chief Operating Officer /
Chief Financial Officer

Date: 14.9.16

Statement of Comprehensive Income

for the period ended 30 June 2016

		2016	2015	Original Budget
	Notes	\$'000	\$'000	\$'000
EXPENSES				
Employee benefits	1.1A	12,179	10,981	12,264
Suppliers	1.1B	14,875	12,300	14,440
Depreciation and amortisation	2.2A	138	18	-
Finance costs		-	1	-
Total expenses		27,192	23,300	26,704
LESS:				
OWN-SOURCE INCOME				
Own-source revenue				
Rendering of services	1.2A	12,408	9,729	12,048
Interest	1.2B	353	476	200
External contributions	1.2C	7,190	6,760	7,266
Total own-source revenue		19,951	16,965	19,514
Gains				
Reversal of provision	1.2D	250	-	-
Resources received free of charge	1.2E	479	-	-
Total gains		729	-	-
Total own-source income		20,680	16,965	19,514
Net cost of services		6,512	6,335	7,190
Revenue from Government	1.2F	7,190	6,760	7,190
Surplus		678	425	-
OTHER COMPREHENSIVE INCOME				
Total other comprehensive income (loss)		-	-	-
Total comprehensive income (loss)		678	425	-

The above statement should be read in conjunction with the accompanying notes.

Original Budget Compared to 2016 Actual Variance Commentary

Statement of Comprehensive Income

^A Variance arises due to depreciation for the fit-out asset that was not forecast when the budget was prepared.

^B Revenue from Government of \$7.19m is reflected within the disclosures of the Portfolio Budget Statements (PBS). For the purposes of comparison in the financial statements Revenue from Government has been restated from the Original Budget to reflect this.

^C The budget reflects only contracted projects when the budget was prepared. The variance arises due to additional new funded projects commencing in 2015-16 not contracted when the budget was prepared.

^D Variance arises as the budget is derived on a break even assumption.

^E Variance arises as the transaction was not expected at the time of preparing the budget.

^F Variance due to the fair value adjustment for the fitout asset that was received free of charge not anticipated when the budget was prepared.

Statement of Financial Position

as at 30 June 2016

	Notes	2016 \$'000	2015 \$'000	Original Budget \$'000	
ASSETS					
Financial Assets					
Cash and cash equivalents	2.1A	10,851	14,254	4,129	^A
Trade and other receivables	2.1B	2,182	2,744	2,399	
Total financial assets		13,033	16,998	6,528	
Non-Financial Assets					
Property, plant and equipment	2.2A	398	44	56	^B
Other non-financial assets	2.2B	391	107	355	
Total non-financial assets		789	151	411	
Total assets		13,822	17,149	6,939	
LIABILITIES					
Payables					
Suppliers	2.3A	3,031	3,479	2,037	^C
Other payables	2.3B	5,827	9,637	891	^A
Total payables		8,858	13,116	2,928	
Provisions					
Employee provisions	4.1	2,538	2,035	2,299	^D
Other provisions	2.4A	-	250	389	
Total provisions		2,538	2,285	2,688	
Total liabilities		11,396	15,401	5,616	
Net assets		2,426	1,748	1,323	
EQUITY					
Contributed equity		1,836	1,836	1,836	^B
Reserves		5	5	5	^E
Retained surplus / (Accumulated deficit)		585	(93)	(518)	
Total equity		2,426	1,748	1,323	

The above statement should be read in conjunction with the accompanying notes.

Original Budget Compared to 2016 Actual Variance Commentary

Statement of Financial Position

^A The budget reflects only contracted projects when the budget was prepared. The variance arises due to the rollover of projects funded but not completed in previous periods as well as additional new funded projects commencing in 2015-16 not contracted when the budget was prepared. This effects the balances disclosed for Cash and Other payables (deferred revenue).

^B Variance arises due to the take on of fit-out assets not forecast when the budget was prepared.

^C Variance arises due to increased project activity with additional projects commencing during the year than was forecast when the budget was prepared.

^D The variance arises due to provisions in place when the budget was prepared consumed or not required.

^E Variance arises as the budget is derived on a break even assumption.

Statement of Changes in Equity

for the period ended 30 June 2016

	2016 \$'000	2015 \$'000	Original Budget \$'000
CONTRIBUTED EQUITY			
Opening balance	1,836	1,836	1,836
Transactions with owners			
Contributions by owners			
Equity injection	-	-	-
Sub-total transactions with owners	-	-	-
Closing balance as at 30 June	1,836	1,836	1,836
Closing balance attributable to the Australian Government	1,836	1,836	1,836
RETAINED EARNINGS / (ACCUMULATED LOSSES)			
Opening balance	(93)	(518)	(518) ^A
Comprehensive income			
Other comprehensive income	-	-	-
Surplus (Deficit) for the period	678	425	- ^A
Total comprehensive income	585	(93)	(518) ^A
Closing balance as at 30 June	585	(93)	(518) ^A
Closing balance attributable to the Australian Government	585	(93)	(518) ^A
ASSET REVALUATION RESERVE			
Opening balance	5	5	5
Comprehensive income			
Other comprehensive income	-	-	-
Total comprehensive income	5	-	-
Closing balance as at 30 June	5	5	5
Closing balance attributable to the Australian Government	5	5	5

Statement of Changes in Equity (continued)

for the period ended 30 June 2016

	2016 \$'000	2015 \$'000	Original Budget \$'000	
TOTAL EQUITY				
Opening balance	1,748	1,323	1,323	^A
Comprehensive income				
Surplus for the period	678	425	-	^A
Total comprehensive income	<u>678</u>	<u>425</u>	<u>-</u>	
Transactions with owners				
Contributions by owners				
Equity injection	-	-	-	
Total transactions with owners	<u>-</u>	<u>-</u>	<u>-</u>	
Closing balance as at 30 June	<u>2,426</u>	<u>1,748</u>	<u>1,323</u>	^A
Closing balance attributable to the Australian Government	<u>2,426</u>	<u>1,748</u>	<u>1,323</u>	^A

The above statement should be read in conjunction with the accompanying notes.

Original Budget Compared to 2016 Actual Variance Commentary

Statement of Changes in Equity

^A Variance arises as the budget is derived on a break even assumption.

Cash Flow Statement

for the period ended 30 June 2016

	Notes	2016 \$'000	2015 \$'000	Original Budget \$'000	
OPERATING ACTIVITIES					
Cash received					
Receipts from Government		7,190	6,760	7,190	^A
State and Territory contributions		7,190	6,760	7,190	
Rendering of services		9,843	9,222	5,223	^{A,B}
Interest		353	455	200	
Net GST received		818	650	500	
Total cash received		25,394	23,847	20,303	
Cash used					
Employees		(11,972)	(10,358)	(12,260)	
Suppliers		(16,812)	(12,388)	(14,944)	^C
Total cash used		(28,784)	(22,746)	(27,204)	
Net cash from (used by) operating activities	3.1	(3,390)	1,101	(6,901)	
INVESTING ACTIVITIES					
Cash used					
Purchase of property, plant and equipment		(13)	(6)	-	
Total cash used		(13)	(6)	-	
Net cash from (used by) investing activities		(13)	(6)	-	
Net increase (decrease) in cash held		(3,403)	1,095	(6,901)	
Cash and cash equivalents at the beginning of the reporting period		14,254	13,159	11,030	
Cash and cash equivalents at the end of the reporting period	2.1A	10,851	14,254	4,129	

The above statement should be read in conjunction with the accompanying notes.

Original Budget Compared to 2016 Actual Variance Commentary

Cash Flow Statement

^A Receipts from Government of \$7.19m is reflected within the disclosures of the Portfolio Budget Statements (PBS). For the purposes of comparison in the financial statements Receipts from Government has been restated from the Original Budget to reflect this.

^B The budget reflects only contracted projects when the budget was prepared. The variance arises due to additional new funded projects commencing in 2015-16 not contracted when the budget was prepared.

^C Variance arises due to increased project activity with additional projects commencing during the year than was forecast when the budget was prepared.

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Overview

Objectives of the entity

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) for reporting periods ending on or after 1 July 2015; and
- b) Australian Accounting Standards and Interpretations 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

Adoption of New Australian Accounting Standard Requirements

No Accounting Standard has been adopted earlier than the application date as stated in the standard.

No new standards, revised standards, interpretations or amending standards that were issued prior to the sign off date and were applicable to the current reporting period had a financial impact on the Commission.

Future Australian Accounting Standard Requirements

New standards, revised standards and interpretations that were issued by the Australian Accounting Standards Board prior to the sign off date and are applicable to the future reporting period are not expected to have a material future financial impact on the Commission.

Taxation

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

Budget Variances Commentary

The notes to each of the primary statements include a comparison of the original budget as presented in the 2015-16 Portfolio Budget Statements (PBS) to the Commission's 2015-16 financial outcome in accordance with Australian Accounting Standards. The budget has not been subject to audit.

In accordance with guidance provided under the Public Governance, Performance and Accountability (Financial Reporting Rule) 2015 (the FRR) variances are considered to be major when:

- a) The variance between budget and actual for line items is greater than 10%; or
- b) The variance between budget and actual is greater than 2% of total expenses or total own source revenue, or
- c) A variance is below the threshold but is considered relevant to the reader's understanding of the Commission's performance.

Events After the Reporting Period

On 29 July 2016, six board members that ceased on 31 March 2016 were reappointed to the board. The reappointed members were:

- Mr Martin Bowles PSM
- Ms Christine Gee
- Ms Wendy Harris QC
- Mr Shaun Larkin
- Mrs Cheryle Royle
- Dr. Helena Williams

Two new board members were also appointed on 29 July 2016. These were:

- Dr David Filby
- Professor John Walsh AM

1 Financial Performance

1.1 Expenses

	2016	2015
	\$'000	\$'000

1.1A: Employee Benefits

Wages and salaries	9,020	8,087
Superannuation:		
Defined contribution plans	1,371	1,160
Defined benefit plans	241	232
Leave and other entitlements	1,442	1,458
Other employee benefits	105	44
Total employee benefits	12,179	10,981

1.1B: Suppliers

Goods and services

Contracts for services	10,238	8,248
Travel	956	758
Information and communication	683	751
Printing and postage	474	280
Property outgoings	162	167
Other	1,237	1,091
Total goods and services	13,750	11,295

Goods and services are made up of:

Goods supplied	542	269
Services rendered	13,208	11,026
Total goods and services	13,750	11,295

Other supplier expenses

Operating lease rentals		
Minimum lease payments	939	820
Workers compensation expenses	186	185
Total other supplier expenses	1,125	1,005
Total supplier expenses	14,875	12,300

Leasing commitments

The Commission has a lease for Level 5 of 255 Elizabeth Street, Sydney.
The lease is due to expire 31 December 2017.

2016	2015
\$'000	\$'000

Commitments for minimum lease payments in relation to non-cancellable operating leases are payable as follows:

Within 1 year	1,306	497
Between 1 to 5 years	664	-
More than 5 years	-	-
Total operating lease commitments	1,970	497

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.

1.1C: Remuneration of Auditors

2016	2015
\$'000	\$'000

Financial statement audit services were provided to the Commission by the Australian National Audit Office (ANAO).

Cost of the services provided

Financial statement audit services	50	50
Total	50	50

No other services were provided by the auditors of the financial statements.

1.2 Income

	2016	2015
	\$'000	\$'000
OWN-SOURCE REVENUE		

1.2A: Rendering of Services

Rendering of services	12,408	9,729
Total sale of goods and rendering of services	12,408	9,729

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 amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
- 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 surveys of work performed.

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	353	476
Total interest	353	476

Accounting Policy

Interest revenue is recognised using the effective interest method.

1.2C: External Contributions

States and Territories contributions	7,190	6,760
Total external contributions	7,190	6,760

1.2D: Reversal of provision

Reversal of provision	250	-
Total reversal of provision	250	-

A provision for relocation was raised in 2014-15 as a result of advice received that the Commission would be required to vacate the premises at the expiry of the lease on 31 December 2015. The Commission entered into a new lease arrangement on 1 January 2016 and the provision was not required.

1.2E: Resources received free of charge

	2016 \$'000	2015 \$'000
Resources received free of charge	479	-
Total other gains	479	-

Leasehold improvements (fit-out) at level 5, 255 Elizabeth Street were received free of charge when the Commission commenced the new lease agreement on 1 January 2016. The gain represents the fair value of the assets received.

Accounting Policy

Contributions of assets at no cost of acquisition or for nominal consideration are recognised as gains at their fair value when the asset qualifies for recognition.

1.2F: Revenue from Government

Department of Health:

Corporate Commonwealth entity payment item	7,190	6,760
Total revenue from Government	7,190	6,760

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

	2016 \$'000	2015 \$'000
2.1A: Cash and Cash Equivalents		
Cash on hand or on deposit	10,851	14,254
Total cash and cash equivalents	10,851	14,254

Accounting Policy

Cash is recognised at its nominal amount. Cash and cash equivalents includes:

- a) cash on hand; and
- b) demand deposits in bank accounts with an original maturity of 3 months or less that are readily convertible to known amounts of cash and subject to insignificant risk of changes in value.

2.1B: Trade and Other Receivables

Good and Services:

Department of Health	1,509	2,120
Related parties	297	340
Total goods and services receivable	1,806	2,460

Other receivables:

Receivable from the Australian Taxation Office	320	237
Interest - related parties	47	47
Other	9	-
Total other receivables	376	284
Total trade and other receivables (gross)	2,182	2,744

Receivables are expected to be recovered in:

No more than 12 months	2,182	2,744
Total trade and other receivables (net)	2,182	2,744

Receivables are aged as follows:

Not overdue	2,182	2,744
Overdue by 61 to 90 days	-	-
Total trade and other receivables (net)	2,182	2,744

No receivables were impaired at 30 June 2016 (2015: Nil).

Accounting Policy

Receivables

Trade receivables and other receivables that have fixed or determinable payments that are not quoted in an active market are classified as 'receivables'. Receivables are measured at amortised cost using the effective interest method less impairment. Interest is recognised by applying the effective interest rate.

Impairment of Financial Assets

Financial assets are assessed for impairment at the end of each reporting period.

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 2016

	Leasehold improvement \$'000	Plant and equipment \$'000	Total \$'000
As at 1 July			
Gross book value	-	90	90
Accumulated amortisation, depreciation and impairment	-	(46)	(46)
Net book value 1 July	-	44	44
Additions:			
By purchase	-	13	13
Received free of charge	479	-	479
Depreciation expense	(119)	(19)	(138)
Net book value 30 June	360	38	398
Net book value as of 30 June represented by:			
Gross book value	479	103	582
Accumulated amortisation, depreciation and impairment	(119)	(65)	(184)
	360	38	398

Leasehold improvements at Level 5, 255 Elizabeth Street previously belonging to the Office of the Fairwork Ombudsman were received free of charge to the Commission on 1 January 2016 and have been recognised at fair value.

Reconciliation of the opening and closing balances of property, plant and equipment for 2015

	Leasehold improvement \$'000	Plant and equipment \$'000	Total \$'000
As at 1 July			
Gross book value	-	384	384
Accumulated amortisation, depreciation and impairment	-	(328)	(328)
Net book value 1 July	-	56	56
Additions:			
By purchase	-	6	6
Depreciation expense	-	(18)	(18)
Net book value 30 June	-	44	44
Net book value as of 30 June represented by			
Gross book value	-	90	90
Accumulated depreciation and impairment	-	(46)	(46)
	-	44	44

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 \$10,000 and for all other purchased of property, plant and equipment costing less than \$2,800, which are expensed in the year of acquisition.

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:

<u>Asset Class</u>	<u>2016</u>	<u>2015</u>
Leasehold improvements	Lease term	Lease term
Plant and equipment	5 years	5 years

Impairment

All assets were assessed for impairment at 30 June 2016. 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.

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 cost.

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.

Assets acquired at no cost

Assets at no cost of acquisition or for nominal consideration are recognised at their fair value when the asset qualifies for recognition.

2016	2015
\$'000	\$'000

2.2B: Other Non-Financial Assets

Prepayments	391	107
Total other non-financial assets	391	107

Total other non-financial assets - are expected to be recovered in:

No more than 12 months	391	107
Total other non-financial assets	391	107

No indicators of impairment were found for other non-financial assets.

2.3: Payables

2016	2015
\$'000	\$'000

2.3A: Suppliers

Trade creditors and accruals	3,031	3,479
Total supplier payables	3,031	3,479

Supplier payables expected to be settled:

No more the 12 months	3,031	3,479
Total suppliers	3,031	3,479

Settlement is usually made within 30 days.

2.3B: Other Payables

Salaries and wages	36	283
Superannuation	6	46
Unearned income	5,770	8,989
Lease incentive	-	283
Other	15	36
Total other payables	5,827	9,637

Other payables expected to be settled:

No more than 12 months	4,980	8,721
More than 12 months	847	916
Total other payables	5,827	9,637

2.4: Other Provisions

2016	2015
\$'000	\$'000

2.4A: Other Provisions

Provision for relocation	-	250
Total other provisions	-	250

Other provisions are expected to be settled in:

No more than 12 months	-	250
More than 12 months	-	-
Total other provisions	-	250

Reconciliation of the opening and closing balances of other provisions:

	Provision for relocation \$'000	Total \$'000
Carrying amount at 1 July 2015	250	250
Provisions made	-	-
Amounts recognised in statement of comprehensive income	(250)	(250)
Unwinding of discount rate or change in discount rate	-	-
Closing balance at 30 June 2016	-	-

3 Funding

3.1 Cash Flow Reconciliation

	2016 \$'000	2015 \$'000
Reconciliation of net cost of services to net cash from operating activities:		
Net cost of services	(6,991)	(6,335)
Add revenue from Government	7,190	6,760
Adjustments for non-cash items		
Depreciation and amortisation	138	18
Changes in assets / liabilities		
(Increase) / decrease in net receivables	562	(530)
(Increase) / decrease in prepayments	(284)	48
Increase / (decrease) in employee provisions	503	531
Increase / (decrease) in supplier payables	(448)	1,246
Increase / (decrease) in other payables	(3,810)	(498)
Increase / (decrease) in other provisions	(250)	(139)
Net cash from (used by) operating activities	(3,390)	1,101

4 People and Relationships

2016	2015
\$'000	\$'000

4.1 Employee Provisions

Leave	2,538	2,035
Total employee provisions	2,538	2,035

Employee provisions are expected to be settled in:

No more than 12 months	1,532	1,468
More than 12 months	1,006	567
Total employee provisions	2,538	2,035

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.

Leave

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 reference to the work of an actuary as at 30 June 2016. 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.

4.2 Senior Management Personnel Remuneration

	2016	2015
	\$	\$
Short-term employee benefits		
Salary	1,363,572	1,396,606
Performance bonuses	104,259	76,841
Total short-term employee benefits	1,467,831	1,473,447
Post-employment benefits		
Superannuation	194,390	201,338
Total post-employment benefits	194,390	201,338
Other long-term benefits		
Annual leave accrued	95,935	102,048
Long service leave	25,191	39,092
Total other long-term benefits	121,126	141,140
Termination benefits		
Termination benefits	-	-
Total termination benefits	-	-
Total senior management remuneration expenses	1,783,347	1,815,925

The total number of senior management personnel that are included in the above table are 16 (2015 : 18). 3 directors included in this number waived their right or were not eligible to receive remuneration during 2016 (2015: 4). The directors of the Commission, including appointments and cessations during the year are listed in note 4.3.

4.3 Related Party Disclosures

The directors of the Commission during the year were:

	<u>Commenced</u>	<u>Ceased</u>
Professor Villis Marshall AC (Chair from 1 April 2013)	1/04/2012	
Mr Martin Bowles PSM	14/05/2015	31/03/2016
Professor Chris Brook PSM	1/04/2012	31/03/2016
Ms Sally Crossing AM	14/05/2015	31/03/2016
Professor Phillip Della	1/04/2013	
Christine Gee	1/07/2011	31/03/2016
Ms Wendy Harris QC	24/07/2015	31/03/2016
Dr Shaun Larkin	1/04/2013	31/03/2016
Mrs Cheryle Royle	14/05/2015	31/03/2016
Dr Helena Williams	1/07/2011	31/03/2016

Transactions with Directors of Director-Related Entities

There are no loans to the directors or director related entities.

Several directors of the Commission hold directorships with other organisations. All transactions between the Commission and organisations with a director common to the Commission, or any dealings between the Commission and directors individually, are conducted using commercial and arms-length principles.

During the year, Dr Helena Williams provided project support and expert advice to the Commission. Fees paid by the Commission for these services were \$1,881 (2015: \$13,122).

Following their cessation as a Director on 31 March 2016 several Directors have attended meetings on behalf of the Commission for which they have received fees and/or reimbursement of expenses. These included Dr. Helena Williams (\$653) and Christine Gee (\$1,089).

5 Managing Uncertainties

5.1 Contingent Assets and Liabilities

Quantifiable Contingencies

As at 30 June 2016, the Commission had no quantifiable contingencies (2014-15: nil).

Unquantifiable Contingencies

As at 30 June 2016, the Commission had no unquantifiable contingencies (2014-15: nil).

Significant Remote Contingencies

As at 30 June 2016, the Commission had no material remote contingencies (2014-15: nil).

5.2 Financial Instruments

5.2A: Categories of financial instruments

	2016 \$'000	2015 \$'000
Financial assets		
Cash on hand and at bank	10,851	14,254
Trade and other receivables	1,862	2,507
Total	12,713	16,761
Financial liabilities		
At amortised cost:		
Trade creditors and accruals		
Suppliers	3,031	3,479
Total	3,031	3,479

5.2B: Net income and expense from financial assets

Interest revenue	353	476
Net gain/(loss) from financial assets	353	476

5.2C: Fair value of financial instruments

	Carrying amount 2016 \$'000	Carrying amount 2015 \$'000
Financial assets		
Cash and cash equivalents	10,851	14,254
Trade and other receivables	1,862	2,507
Total	12,713	16,761
Carrying amount of financial assets	12,713	16,761
Financial liabilities		
At amortised cost:		
Suppliers	3,031	3,479
Total	3,031	3,479
Carrying amount of financial liabilities	3,031	3,479

Carrying amounts are equal to fair values of financial assets and liabilities.

5.2D: Credit risk

The Commission was exposed to minimal credit risk as receivables were cash and trade receivables. The maximum exposure to credit risk was the risk that arises from potential default of a debtor. This amount was equal to the total amount of trade and other receivables at 30 June 2016: \$1,862,000 (2015: \$2,507,000).

The Commission manages its debtors by undertaking recovery processes for those receivables which are considered to be overdue. The risk of overdue debts arising is minimised through the implementation of credit assessments on potential customers.

The Commission holds no collateral to mitigate against credit risk.

The credit quality of financial instruments not past due or individually determined as impaired:

	Not past due nor impaired		Past due or impaired	
	2016	2015	2016	2015
	\$'000	\$'000	\$'000	\$'000
Cash and cash equivalents	10,851	14,254	-	-
Trade and other receivables	1,862	2,507	-	-
Total	12,713	16,761	-	-

5.2E: Liquidity risk

The Commission's financial liabilities comprise trade creditors, research project creditors, and other payables. The exposure to liquidity risk is based on the notion that the Commission will encounter difficulty in meeting its obligations on its financial liabilities. This is highly unlikely due to Commonwealth, State and Territory government funding, the Commission's ability to draw down on cash reserves, and internal policies and procedures put in place to ensure there are appropriate resources to meet its financial obligations.

The Commission manages liquidity risk by ensuring all financial liabilities are paid in accordance with terms and conditions on demand. In addition, the Commission has no past experience of defaults in its current and prior forms.

Maturities for non-derivative financial liabilities 2016:

	On demand \$'000	Within 1 year \$'000	Total \$'000
Other financial liabilities			
Suppliers	-	3,031	3,031
Total	-	3,031	3,031

Maturities for non-derivative financial liabilities 2015:

	On demand \$'000	Within 1 year \$'000	Total \$'000
Other financial liabilities			
Suppliers	-	3,479	3,479
Total	-	3,479	3,479

5.2F: Market risk

The Commission holds basic financial instruments that do not expose the Commission to certain market risks, such as 'currency risk' or 'other price risk'.

The only interest-bearing items on the statement of financial position were the cash and cash equivalents, which bear interest at prevailing bank interest rates. Their values do not fluctuate due to changes in the market interest rate.

5.3 Financial Assets Reconciliation

	Notes	2016 \$'000	2015 \$'000
<u>Financial assets</u>			
Total financial assets as per statement of financial position		13,033	16,998
Less: non-financial instrument components:			
Other receivables	2.1B	320	237
Total non-financial instruments components		320	237
Total non-financial assets as per financial instruments note		12,713	16,761

5.4: Fair Value Measurement

The following table provides an analysis of assets and liabilities that are measured at fair value. The different levels of the fair value hierarchy are defined below:

- Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at measurement date.
- Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly.
- Level 3: Unobservable inputs for the asset or liability.

Accounting Policy

The Commission seeks independent valuation for material non-financial assets on a triennial basis. The Commission procured the services of the Australian Valuation Solutions (AVS) to undertake a comprehensive revaluation of the leasehold improvement asset at 30 June 2016 and relied upon those outcomes to establish carrying amounts. AVS provided written assurance to the Commission that the models developed are in compliance with AASB 13.

5.4A: Fair Value Measurements, valuation techniques and inputs used

	Fair value measurements at the end of the reporting period using		For Levels 2 and 3 fair value measurements	
	2016 \$'000	2015 \$'000	Category (Level 1, 2 or 3)	Valuation technique Inputs used
Non-financial assets				
Leasehold improvements	360	-	Level 3	The DRC approach reflects the amount a market participant would be prepared to pay to acquire or construct a substitute asset of comparable utility, adjusted for physical depreciation and obsolescence
Plant and Equipment	38	44	Level 2	Depreciated Replacement Cost (DRC) Cost approach Replacement cost Remaining useful life
Total non-financial assets	398	44		

The remaining assets and liabilities reported by the Commission are not measured at fair value in the statement of financial position.

6 Other Information

6.1 Reporting of Outcomes

6.1A: Net Cost of Outcome Delivery

The Commission is structured to meet one 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.

	Outcome 1	
	2016	2015
	\$'000	\$'000
Expenses		
Departmental	27,192	23,300
Income from non-government sector		
Sale of goods and rendering of services	12,408	9,729
Interest	353	476
External contributions	7,190	6,760
Gains	729	-
Total income from non-government sector	20,680	16,965
Net cost of outcome delivery	6,512	6,335

The primary statements of these financial statements represent the Major Classes of Expense, Income, Assets and Liabilities by Outcome, as required by the FRR. Accordingly these tables are not repeated in 6.1A.



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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 49](#).

Table 3: Freedom of Information summary 2015–16

Activity	Number
Requests	
On hand at 1 July 2015	1
New requests received	1
Total requests handled	2
Total requests completed as at 30 June 2016	2
Total requests on hand as at 30 June 2016	0
Action of request	
Access granted in full	0
Access granted in part	2
Access refused	0
Access transferred in full	0
Request withdrawn	0
No records	0
Response times	
0–30 days	1
30–60 days	1
Internal review	
On hand as at 1 July 2015	0
Requests received	0
Decision affirmed	0
Decision amended	0
Request withdrawn	0
Review by Administrative Appeals Tribunal	
Applications received	0
Review by the Officer of the Australian Information Commissioner	
Applications received	0

Appendix B: Compliance with ecologically sustainable development

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

Table 4: Summary of the Commission's compliance with ecologically sustainable development

EPBC Act requirement	Commission response
The activities of the Commission during 2015–16 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 2015–16 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 across two 5-star (NABERS rating) buildings, 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.
Measures the Commission is taking to minimise its impact on the environment	The Commission is improving its website functionality and increasing the use of multi-channel strategies to distribute information electronically to further reduce its environmental impact. To reduce travel, enhanced technological solutions are to be installed in all meeting rooms. The responsible use and disposal of materials, electricity and water is expected of all staff and visitors.
Mechanisms for reviewing and increasing the effectiveness of those measures	The Commission has a range of mechanisms established to review current practices and policies. In addition, staff are encouraged to identify initiatives to change 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

In accordance with Section 17BE of the Public Governance, Performance and Accountability Rule 2014, there were 14 transactions with a related entity during 2015–16.

Table 5: Related-entity transactions during 2015–16

Commonwealth entity	No. of transactions	Aggregate value	Process
Department of Health	14	\$ 738,239	Payments processed in 2015-16 for corporate services received from the Department of Health under a shared services agreement between the Commission and Health.



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Acronyms and abbreviations

AC	Companion of the Order of Australia
AM	Member of the Order of Australia
AMR	Antimicrobial Resistance
AO	Officer of the Order of Australia
APC NMDS	Admitted Patient Care National Minimum Data Set
APS	Australian Public Service
APSC	Australian Public Service Commission
AU	Antimicrobial Use
B Bus	Bachelor of Business
BA	Bachelor of Arts
BEc	Bachelor of Economics
BHA	Bachelor of Health Administration
BN	Bachelor of Nursing
BS	Bachelor of Science
CHBOI	Core, Hospital-Based Outcome Indicators
EL	Executive Level
FACN	Fellow of the Australian College of Nursing
FAFPHM	Fellow of the Australian Faculty of Public Health Medicine
FIPAA	Fellow of the Institute of Public Administration Australia
FRACP	Fellow of the Royal Australasian College of Physicians
FRACS	Fellow of the Royal Australasian College of Surgeons
FRACGP	Fellow of the Royal Australian College of General Practitioners
GCPubSecMgmt	Graduate Certificate in Public Sector Management
GDip	Graduate Diploma
GP	General Practitioner
HCF	Hospitals Contribution Fund of Australia
IHPA	Independent Hospital Pricing Authority
KPI	Key Performance Indicator
LLB	Bachelor of Laws

MB	Bachelor of Medicine
MBA	Master of Business Administration
MBBS	Bachelor of Medicine, Bachelor of Surgery
MBS	Medicare Benefits Schedule
MD	Doctor of Medicine
MHSc	Master of Health Science
MO	Medical Officer
PBS HMC	Pharmaceutical Benefits Scheme Hospital Medication Chart
PhD	Doctor of Philosophy
PSM	Public Service Medal
RM	Registered Midwife
RN	Registered Nurse
SAB	<i>Staphylococcus aureus</i> bacteraemia

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. ²
Antimicrobial resistance	A property of organisms, including bacteria, viruses, fungi and parasites, that confers the capacity to grow or survive in the presence of antimicrobial levels that would normally suppress growth or kill susceptible organisms. ⁷
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 the monitoring and review of antimicrobial use. ⁷
Clinical Care Standards	Standards endorsed by health ministers and developed by the Commission 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, patients and members of a multidisciplinary team. Communication can take on a number of different forms including face-to-face, via telephone, through written notes or other documentation and electronic formats.
Clinical governance	A system through which organisations and individuals are accountable to the community for continually improving the quality of services provided to patients and carers and safeguarding high standards of care, ensuring they are patient-centred, safe and effective.
Clinical governance framework	A document that describes the vision for safe and high-quality care for patients in a health service organisation, and sets out the actions needed to achieve this vision.
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. ³

Clinician	A healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or teams of health professionals providing health care 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 judgment. This 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. ⁴ Cognitive impairment can also be due to a range of other conditions such as 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. ⁵
Consumer-centred care	Treating consumers and/or carers with dignity and respect; communicating and sharing information between consumers and/or carers and healthcare providers; encouraging and supporting consumers' participation in decision-making; and fostering collaboration with consumers and/or carers and healthcare organisations in planning, designing, delivering and evaluating health care. Other terms are used internationally, such as patient-based, person-centred, relationship-based, patient-centred, and patient- and family-centred care.
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 the jurisdictions 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. It 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). ⁷
Electronic medication management system	Enables medicines to be prescribed, supplied, administered and reconciled electronically.

End of life	The period when a patient consumer 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. ⁸
Hand hygiene	A general term referring to any hand-cleansing action.
Hand Hygiene Australia	An organisation engaged by the Commission to implement the National Hand Hygiene Initiative.
Health care	Services provided to individuals or communities to promote, maintain, monitor or restore health. Health care is not limited to medical care, and it includes self-care.
Health literacy	The skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action.
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. ¹⁰
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).
Hospital	A healthcare facility licensed by the respective regulator as a hospital or declared as a hospital.
Infection	The invasion and reproduction of pathogenic or disease-causing organisms inside the body. This may cause tissue injury and disease. ¹¹
Medication	Using medicine for therapy or for diagnosis, its interaction with the patient and its effects.
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.
Medicine	A chemical substance given to prevent, diagnose, cure, control or alleviate disease, or otherwise improve the physical or mental welfare of people. Prescription, non-prescription and complementary medicines, irrespective of their administration route, are included in this definition. ¹²

Monitor	To check, supervise, observe critically or record the progress of an activity, action or system on a regular basis to identify and track change.
My Health Record	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	Ten standards developed by the Commission in consultation and collaboration with jurisdictions, technical experts and healthcare providers 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 services to realise aspirational or developmental goals.
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.
Shared decision-making	The integration of a patient's values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment to achieve appropriate healthcare decisions. ¹³
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, in the organisation of health care, and in people's access to services. It may also reflect poor-quality care that is not in accordance with evidence-based practice.

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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 2013* came into effect from 1 July 2014. The Public Governance, Performance and Accountability (Consequential and Transitional Provisions) Amendment (Annual Reports) Rule 2015 prescribes the reporting requirements for the 2015–16 reporting period.

Mandatory reporting orders as required under legislation

Requirement	Reference	Page listing of compliant information
Amendments to the Commission's enabling legislation and to any other legislation directly relevant to its operation	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	50
Approval by the accountable authority	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	i
Assessment of the impact of the performance of each of the Commission's functions	National Health Reform Act subsection 53(a)	11–37
Assessment of the safety of health care services provided	National Health Reform Act subsection 53(b)(i)	31
Assessment of the quality of health care services provided	National Health Reform Act subsection 53(b)(ii)	31
Board committees	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	46–47

Requirement	Reference	Page listing of compliant information
Commonwealth disability strategy	Public Governance, Performance and Accountability Act subsection 46(3)	57
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	
Statement on governance	Public Governance, Performance and Accountability Act subsection 46(3)	39–51
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	
Accountable authority	Public Governance, Performance and Accountability Act subsection 46(3)	41–45, 49
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	
Ecologically sustainable development and environmental performance	Public Governance, Performance and Accountability Act subsection 46(3)	49, 95, Appendix B
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c), reference <i>Environment Protection and Biodiversity Conservation Act 1999</i> , section 516A	
Education and performance review processes for the accountable authority	Public Governance, Performance and Accountability Act subsection 46(3)	45
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	
Enabling legislation, functions and objectives	Public Governance, Performance and Accountability Act subsection 46(3)	2, 40
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	
Ethics and risk management policies	Public Governance, Performance and Accountability Act subsection 46(3)	45–46
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	

Requirement	Reference	Page listing of compliant information
Financial statements	Public Governance, Performance and Accountability Act subsection 43(4)	61–91
Financial statements certification: a statement, signed by the accountable authority	Public Governance, Performance and Accountability Act subsection 42(3)	64
Financial statements certification: Auditor-General's Report	Public Governance, Performance and Accountability Act subsection 43(4)	62–63
Fraud risk assessment and control	Commonwealth Fraud Control Policy section 21	48
Government policy orders	Public Governance, Performance and Accountability Act section 22	N/A
Indemnities and insurance premiums for officers	Public Governance, Performance and Accountability Act subsection 46(3)	45
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	
Information Publication Scheme Statement	Public Governance, Performance and Accountability Act subsection 46(3)	49, 94–Appendix A
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	
Judicial decisions and decisions by administrative tribunals	Public Governance, Performance and Accountability Act subsection 46(3)	49
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	
Key activities and changes that have affected the Commission	Public Governance, Performance and Accountability Act subsection 46(3)	49
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	
Letter of transmittal detailing approval by Accountable authority	Public Governance, Performance and Accountability Act subsection 46(3)	i
	Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	

Requirement	Reference	Page listing of compliant information
Location of major activities and facilities	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	Inside cover, 56
Ministerial directions	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	40
Operational and financial results	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	61–91
Organisational structure	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	54–55
Other legislation	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	50
Related-entity transactions	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	45, Appendix C–96
Reporting of significant decisions or issues	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Act paragraph 19(1)(c), (d) or (e) of the	49

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 Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	49
Responsible Minister	Public Governance, Performance and Accountability Act subsection 46(3) Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	2, 49
Review of performance	Public Governance, Performance and Accountability Act Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c)	11–37
Work health and safety	Public Governance, Performance and Accountability Act Public Governance, Performance and Accountability Annual Report Rule, subparagraph 7AB(4)(c), reference Work Health and Safety Act 2011, Schedule 2, Part 4	56–57

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