

**AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE**



**ANNUAL
REPORT
2017–2018**

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LETTER OF TRANSMITTAL

The Honourable Greg Hunt MP
Minister for Health
Parliament House
Canberra ACT 2600

Dear Minister

On behalf of the Board of the Australian Commission on Safety and Quality in Health Care (the Commission), I am pleased to submit our Annual Report for the financial year ending 30 June 2018.

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

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

The Commission's annual performance statements were prepared in accordance with the requirements of section 39 of the Public Governance, Performance and Accountability Act and accurately present the Commission's performance from 1 July 2017 to 30 June 2018.

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

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

This report was approved for presentation to you in accordance with a resolution of the Board on 11 September 2018.

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
11 September 2018



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OVERVIEW

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

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ABOUT THE COMMISSION

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

OUR PURPOSE

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

The functions of the Commission are specified in section 9 of the *National Health Reform Act 2011*, and include:

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



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

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.

OUR ACCOUNTABILITY

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



REPORT FROM THE CHAIR

Professor Villis Marshall AC



We are fortunate in Australia to have a healthcare system that delivers high-quality and safe care. We are even more fortunate that the Commonwealth and all states and territories are committed to continuously improving the safety and quality of our healthcare system, and pursuing innovative means of achieving this, through their support of the Commission.

The Commission has continued its national leadership of healthcare safety and quality throughout 2017–18 and this report demonstrates its achievements. The Commission has demonstrated its leadership by providing expert advice to ministers and senior policy makers in the Australian Government and state and territory departments of health, and by facilitating consensus between all jurisdictions. The Commission has also demonstrated a strong commitment to engaging consumers and frontline health professionals as well as the private sector to create a common safety and quality agenda.

In 2017–18, the Commission made significant progress against its nationally agreed work plan, and its contribution to provision of safe and high quality health care can be seen through the many successful projects that were completed throughout the year.

The National Safety and Quality Health Service (NSQHS) Standards is the Commission's flagship program. The primary aims of the NSQHS Standards are to protect the public from harm and improve the quality of health service provision. Importantly, the

release of the second edition of the NSQHS Standards demonstrates the Commission's commitment to some important safety and quality issues that did not feature in the first edition.

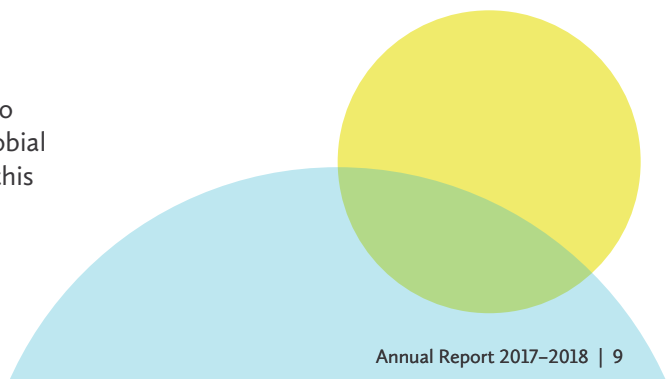
For the first time the NSQHS Standards include mental health and cognitive impairment, health literacy, end-of-life care and Aboriginal and Torres Strait Islander health. The Commission's efforts in developing tools and resources to support the implementation of the second edition have been substantial, and I thank the staff and stakeholders that contributed to their development for this achievement.

Moreover, the release of the second edition of the NSQHS Standards alongside the *National Model Clinical Governance Framework* provides health services with a clear understanding of their governance roles and responsibilities and its relationship to the safety and quality of the services they provide. The Framework is a significant enabler of safety and quality improvement in health services.

Another important achievement for the Commission this year was the release of the second edition of *Antimicrobial Stewardship in Australian Health Care 2018*, which was written by leading Australian medical, scientific, pharmacy, nursing and infection control experts to support improved prescribing of antimicrobials and patient care, and support strategies to contain the growing problem of antimicrobial resistance (AMR). The second edition of this

resource will provide Australian hospitals with world leading guidance and support that will ensure patients receive appropriate antibiotic treatment.

I would like to extend my thanks to the members of the Commission's Board for their advice and guidance throughout 2017–18. On behalf of the Board, I would also like to thank Minister Hunt for his leadership and support of the Commission's work. Finally, I would like to thank the Commission's staff for their continued commitment to improving the safety and quality of health care in Australia.



REPORT FROM THE CEO

Adjunct Professor Debora Picone AM



This has been a year of significant achievements for the Commission and the many public and private sector organisations and individuals that contribute to its work. This annual report highlights the Commission's work and achievements in collaboration with the Australian Government and state and territory governments, clinicians, consumer and patient groups, and the private sector in improving the safety and quality of the Australian healthcare system.

The release of the second edition of the NSQHS Standards in November 2017 was a highlight of the year. The development of the second edition was made successful through extensive consultation and collaboration with a large range of stakeholders and the application of new evidence and feedback from across the hospital sector.

The second edition has expanded the NSQHS Standards to include safety and quality issues that were not covered in the first edition, including Aboriginal and Torres Strait Islander health, mental health and cognitive impairment, health literacy, and end-of-life care.

The Commission has developed a suite of resources to provide implementation support and advice for the second edition, and continues to provide support via the NSQHS Standards Advice Centre.

Work on the *Australian Atlas of Healthcare Variation* series continued throughout the year. Notably, findings from the first Atlas showing a 30-fold variation in colonoscopy rates across the country have resulted in a change to the Medicare Benefits Schedule colonoscopy items, designed to address significant unwarranted variation.



With the launch of the second Atlas in June 2017, we saw the impact of publishing data at every level across the health system, and the power of data to drive change. In late 2017, the Queensland Clinical Senate used the findings on potentially preventable hospitalisations in the second Atlas as a prompt to explore ways to reduce unwarranted clinical variation. We are very pleased that other states and territories have plans to undertake similar work using the Atlas data.

Following a request from state and territory health department representatives to look at safety and quality issues regarding the use of transvaginal mesh, the Commission developed resources to assist women considering treatment options for pelvic organ prolapse and stress urinary incontinence, and to provide support in discussions with their health care professionals.

The Commission is very grateful to the many women who contributed to the development of the resources through a number of workshops held across the country. The women brought a range of experiences and important advice to inform the resources, and the personal information that they were willing to share was extremely valuable and appreciated.

The Commission has continued its work with the Australian Government and state and territory partners to incorporate quality and safety into hospital pricing and funding to improve patient health outcomes. As part of this work, and in partnership

with Commonwealth, state and territory healthcare safety and quality experts, clinicians, consumers and technical experts, the Commission revised the national sentinel events list, developed a series of fact sheets to assist interpretation of the hospital-acquired complications (HACs) list, and finalised a list of conditions considered to be avoidable hospital readmissions. The COAG Health Council will continue to oversee the development, implementation and ongoing refinement of reforms to integrate safety and quality into the pricing and funding of public hospital services.

In late 2017, the COAG Health Council also asked the Commission to develop options to align standards of public reporting of safety and quality data across public and private hospitals. The Commission is undertaking this work in close collaboration with its state and territory colleagues, private health sector representatives, consumers and clinicians. As part of this work, the Commission held focus groups in May 2018 to understand the type and format of safety and quality information that consumers and clinicians would find meaningful if publicly reported.

Finally, I would like to thank the Commission Board, health ministers, and health chief executive officers for their leadership and contribution to improving the safety and quality of health care nationally. My thanks also go to our Australian Government and state and territory partners, private sector colleagues, clinical and consumer advisors, and the outstanding staff of the Commission for our achievements this year.

STRATEGIC PLAN 2016–19

SAFETY. QUALITY. EVERY PERSON.

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

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

REPORT ON PERFORMANCE

This section details the Commission's achievements against its four priority areas. It also provides a snapshot of the state of safety and quality in Australian health care focusing on hospital-acquired complications.

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PRIORITY 1: PATIENT SAFETY

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

IMPLEMENTATION OF THE NATIONAL SAFETY AND QUALITY HEALTH SERVICE STANDARDS

The primary aim of the NSQHS Standards is to protect the public from harm and to improve the quality of health service provision. They outline safety and quality outcomes that a health service organisation must achieve, while allowing health service organisations the flexibility to decide how to achieve these outcomes in a way that is appropriate for their context. The first edition of the NSQHS Standards was endorsed in 2011.

All hospitals and day procedure services are required to implement the NSQHS Standards. They must implement organisation-wide safety and quality processes and a comprehensive clinical governance framework. With the NSQHS Standards and a clinical governance framework in place, health service organisations can reduce the risk of harm to patients from hospital-acquired infections, the wrong medicines, falls, pressure injuries or failures to communicate or identify and manage acute deterioration.

Nine independent accrediting agencies have approval from the Commission to assess health service organisations against the NSQHS Standards.

Health service organisations have to demonstrate they meet all of the requirements in the NSQHS Standards to achieve accreditation.

Since January 2013, all hospitals and day procedure services in Australia (1,312 organisations) have been assessed at least once, and 746 health service organisations have completed two assessment cycles. Of these organisations, 66% (489 organisations) met all core actions at initial assessment for their first accreditation cycle, compared to 73% (544 organisations) for the second accreditation cycle, demonstrating an improvement in accreditation results over time.

The Commission supports health service organisations to implement the NSQHS Standards in a number of ways. One such way is by providing an advice centre. In 2017–18, the Commission responded to 1,997 enquiries that included 244 telephone enquiries and 1,753 email enquiries. The Commission continues to meet its service targets, responding to 92% of email enquiries within five business days.

NATIONAL GENERAL PRACTICE ACCREDITATION SCHEME

The National General Practice Accreditation Scheme started operation on 1 January 2018. The four accrediting agencies approved

to assess general practices to the Royal Australian College of General Practitioners' *Standards for General Practice* are now reporting to the Commission on the outcome of accreditation assessments. Through the National General Practice Accreditation Scheme, de-identified data will be available nationally for the first time on performance at accreditation assessments.

HIGHLIGHTS

308 public hospitals, 162 private hospitals and 207 day procedure services assessed in 2017–18

Conducted annual performance review meetings with accrediting agencies and highlighted upcoming reform of the accreditation process

Achieved service targets for responding to 92% of email enquiries within five working days



FIGURE 1: HEALTH SERVICE ORGANISATION ACCREDITATION 2017–18

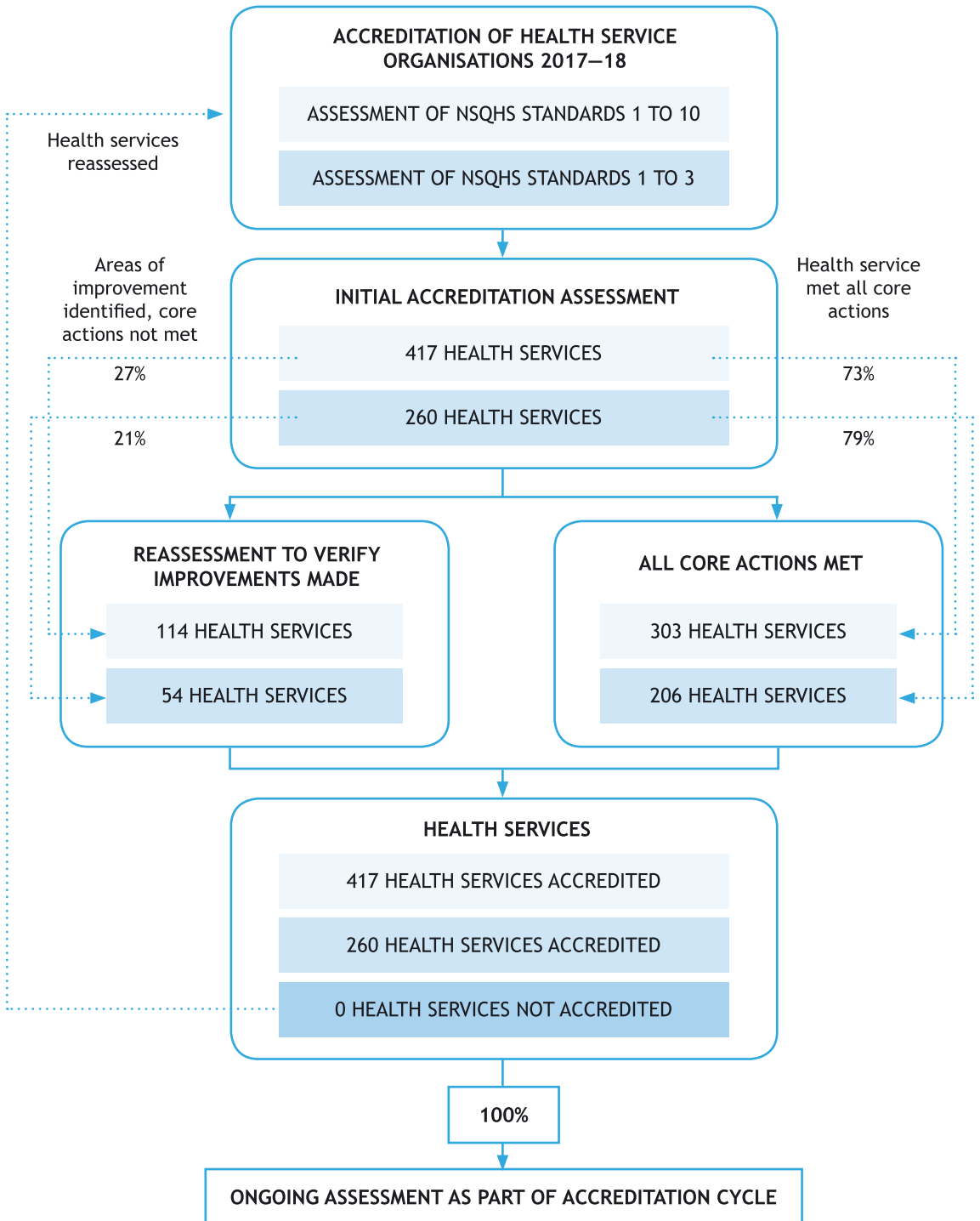


TABLE 1: TOP CORE NSQHS STANDARDS ACTIONS NOT MET AND MET WITH MERIT

Not met	
3.16.1	Compliance with relevant national or international standards and manufacturers' instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored
1.5.2	Actions are taken to minimise risks to patient safety and quality of care
3.14.4	Action is taken to improve effectiveness of antimicrobial stewardship
4.12.1	A system is in use that generates and distributes a current and comprehensive list of medicines and explanation of changes in medicines
1.1.1	An organisation-wide management system is in place for the development, implementation and regular review of policies, procedures and/or protocols
1.9.1	Accurate, integrated and readily acceptable patient clinical record allows for systematic audit of the contents against the requirements of these Standards
Met with merit	
1.6.2	Actions are taken to maximise patient quality of care
1.6.1	An organisation-wide quality management system is used and regularly monitored
1.2.2	Action is taken to improve the safety and quality of patient care
1.1.2	The impact on patient safety and quality of care is considered in business decision making
1.2.1	Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance

RELEASE OF THE SECOND EDITION OF THE NSQHS STANDARDS

The successful implementation of the first edition of the NSQHS Standards led to significant improvements in the safety and quality of care provided to patients and consumers across Australia. The NSQHS Standards have also had a significant impact on empowering patients and consumers in decision-making around the governance, design, and delivery of health services.

Following a comprehensive review of the first edition, the Commission developed a second edition in consultation and collaboration with the Australian Government, state and territory governments, private sector partners, clinicians, consumers, technical experts and a range of other interested parties. This second edition was released in November 2017.

The second edition addresses gaps in the first edition, updates the evidence for actions, and consolidates and streamlines standards and actions to make them clearer and easier to implement. The second edition embeds person-centred care and addresses the needs of people who may be at greater risk of harm. It sets requirements for providing comprehensive care for all patients and for actions related to health literacy, end-of-life care, care for Aboriginal and Torres Strait Islander people and care for people with lived experience of mental illness or cognitive impairment.

IMPLEMENTATION SUPPORT RESOURCES

The Commission is developing a suite of resources that describe how the NSQHS Standards can be used in different contexts. These resources take into account the

differing safety and quality risks within the health service organisation, the types of services that different types of health service organisations provide, and differences in terminology and approach used by these services. Hospitals, day procedure services, multi-purpose services and paediatric facilities each have a guide on the second edition of the NSQHS Standards. The Commission will develop further online resources in response to identified needs.

The NSQHS Standards Advice Centre allows health service organisations and others to seek guidance as they implement the NSQHS Standards.

HIGHLIGHTS

Released the second edition of the NSQHS Standards in November 2017

39,425 copies of the NSQHS Standards (2nd ed.) downloaded from the Commission website as at 30 June 2018

Developed implementation resources for hospitals, day procedure services, multi-purpose and small hospitals, and paediatric facilities

Released additional guidance to support Aboriginal and Torres Strait Islander health, partnering with consumers and clinical governance

IMPROVEMENT HIGHLIGHTS ASSOCIATED WITH IMPLEMENTATION OF THE FIRST EDITION OF THE NSQHS STANDARDS

- A decline in the *Staphylococcus aureus* bacteraemia rate per 10,000 patient days under surveillance between 2010 and 2014 from 1.1 to 0.87 cases
- A drop in the yearly number of methicillin-resistant *Staphylococcus aureus* bacteraemia cases between 2010 and 2014 from 505 to 389
- A decline of almost one-half in the national rate of central line-associated bloodstream infections between 2012–13 and 2013–14 from 1.02 to 0.6 per 1,000 line days
- The number of hospitals with antimicrobial stewardship increased from 36% in 2010 to 98% in 2015
- Formularies restricting use of broad-spectrum antimicrobials increased from 41% in 2010 to 86% in 2015
- Inappropriate use of antibacterials in Australian hospitals reduced by 12.6% from 2010 to 2016
- Better documentation of adverse drug reactions and medication history
- Reduction in yearly red blood cell issues by the National Blood Authority between mid-2010 and mid-2015 from about 800,000 units to 667,000 units
- Declining rates of in-hospital cardiac arrest and intensive care unit admissions following cardiac arrests:
 - NSW Between the Flags program report 51.5% decrease in cardiac arrest rates
 - Victorian hospitals report a 20% relative reduction in monthly cardiac arrest rates
- Early warning or track and trigger tools in 96% of recognition and response systems in 2015, compared with 35% in 2010
- The majority of hospital boards or their governance equivalent (84%) reported that as a result of the NSQHS Standards the board understood and enacted their roles and responsibilities concerning patient safety and quality.

REVISION OF THE AUSTRALIAN HEALTH SERVICE SAFETY AND QUALITY ACCREDITATION SCHEME

Under the National Health Reform Act, the Commission is responsible for formulating and coordinating national models of accreditation for health service organisations. An accreditation award provides assurance to the community that a health service organisation has the systems and processes in place to meet national standards for safety and quality.

Health service organisations must show that they have strategies in place to minimise patient harm in each of the areas covered, to be accredited against the NSQHS Standards. Such harm can be associated with hospital-acquired infections, medication errors, communication failures, and lack of comprehensive care or clinical deterioration, among others.

To become accredited, health service organisations must pass assessment showing they have implemented the NSQHS Standards. Assessments are conducted by any of nine independent accrediting agencies approved by the Commission as part of the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme, which provides for the national coordination of accreditation processes.

State and territory health departments and chief executives of health service organisations have raised concerns about the reliability of the accreditation process. To address these concerns, the Commission has agreed with states and territories on a suite of strategies that improve the rigour of the assessment process; improve the effectiveness and expertise of the assessment

team; better inform assessment processes through the use of data; improve regulatory oversight; improve communication about the assessments and their outcomes, particularly to consumers; and provide targeted resources to support health service organisations to implement the NSQHS Standards and prepare for assessment.

Implementation of these reforms will commence with the introduction of the second edition of the NSQHS Standards in January 2019. The key reforms will see:

- Introduction of standard three-year cycles
- A new rating scale identifying areas where improvements are recommended
- Repeat assessment after six months for health service organisations that have a large number of actions that are not met
- Governing bodies attesting to their compliance with key actions required of them
- Assessors testing high-risk scenarios to ensure health services are prepared
- Voluntary short-notice assessments to shift the effort from preparation for assessment to long-term improvement in care
- Use of a structured assessment process to ensure all components of safety and quality systems are comprehensively evaluated
- Greater involvement of patients and consumers in assessment processes
- Assessors completing a 40-hour online orientation program before carrying out their first assessment.

In 2018–19 the Commission will work with relevant parties to introduce standardised assessment reporting that can lead to public reporting on accreditation outcomes.

HIGHLIGHTS

Agreed on six strategies to improve the rigour of accreditation with states and territories

Commenced implementation of reforms to the AHSSQA Scheme

ANTIMICROBIAL RESISTANCE, ANTIMICROBIAL USE, SURVEILLANCE AND HEALTHCARE-ASSOCIATED INFECTIONS

The Antimicrobial Use and Resistance in Australia (AURA) Surveillance System is now well established. It has enabled enhanced national coordination and integration of more comprehensive data on antimicrobial resistance (AMR), antimicrobial use and the appropriateness of prescribing in Australia. The AURA program analyses and reports on AMR and antimicrobial use in hospitals, aged care homes, and the community more generally, through a range of surveillance programs. In 2017–18 the Australian Government and states and territories contributed funding for the operation of AURA.

AURA 2017: Second Australian report on antimicrobial use and resistance in human health was released in August 2017.

The report included analyses of trends where possible, and highlighted a number of areas for action to prevent and control AMR and improve antimicrobial prescribing, such as:

- Improving the appropriateness of antimicrobial use for surgical prophylaxis
- Intensifying efforts to reduce unnecessary prescribing of antimicrobials in the community
- Strengthening infection control practices to minimise the spread of vancomycin-resistant enterococci.

The AURA Surveillance System involves strategic partnerships with the Australian Group on Antimicrobial Resistance, the National Antimicrobial Prescribing Survey and the National Antimicrobial Utilisation Surveillance Program. Data from the National Antimicrobial Prescribing Survey and the National Antimicrobial Utilisation Surveillance Program support local antimicrobial stewardship programs and help health service organisations meet the requirements of the Preventing and Controlling Healthcare-Associate Infection Standard in the NSQHS Standards.

Data are also included in the AURA Surveillance System from the National Alert System for Critical Antimicrobial Resistances and Australian Passive AMR Surveillance (APAS), a surveillance program established by the Commission in 2015 with the support of Queensland Health to provide access to its OrgTRx system as the base infrastructure. APAS data are used to generate antibiograms, which are tables showing how susceptible organisms are to different antimicrobials, to inform local antimicrobial therapy recommendations and formulary management.

In 2017–18, APAS was enhanced by progressively incorporating data from 2006 to 2015 from a number of the participating pathology services. The APAS database now contains more than 50 million records,

increasing the capacity for trend analysis. The Commission published the first APAS report on multi-resistant organisms in June 2018. The report includes analyses of data for three important types of resistance – methicillin resistance in *Staphylococcus aureus*, fluoroquinolone resistance in *Escherichia coli* and vancomycin resistance in *Enterococcus faecium*.

In May 2018, the Commission published *Antimicrobial Stewardship in Australian Health Care 2018*, which provides clinicians and health service managers with the evidence and practical strategies to support implementation of antimicrobial stewardship programs that meet the requirements of the Preventing and Controlling Healthcare Associated Infection Standard. Prudent use of antimicrobials as part of antimicrobial stewardship improves patient safety and reduces the development of AMR.

The Commission has a well-established national healthcare-associated infection (HAI) program which supports prevention and containment of AMR through evidence-based infection control practice. In 2017–18, the Commission continued its support of the national hand hygiene program, which focused attention on improved compliance in emergency departments.

The Commission analysed administrative and surveillance data on *Clostridium difficile* infection (CDI) and developed a model to improve prevention and control of CDI. The model is designed to enhance understanding of the burden of CDI in Australian health service organisations and support implementation of targeted infection prevention and control and antimicrobial stewardship strategies to address CDI.

HIGHLIGHTS

Published *AURA 2017: Second Australian report on antimicrobial use and resistance in human health*

Enhanced APAS to include 10 years of historical data (2006 to 2015) for selected services

Published detailed reports on each of the AURA Surveillance System programs, including the first APAS report on multi-resistant organisms

Published *Antimicrobial Stewardship in Australian Health Care 2018*

Published an analysis of *Clostridium difficile* data and a model for monitoring, preventing and controlling *Clostridium difficile* infection

SAFETY IN DIGITAL HEALTH

Since July 2012, the Commission has conducted a clinical safety program for the My Health Record system. In July 2016, the system operator, the Australian Digital Health Agency (the Agency), appointed the Commission to operate the program for a further two years. The program aims to provide quality assurance and to enhance the clinical safety of the My Health Record system and of other national digital health infrastructure.

Program activities in 2017–18 included three clinical safety reviews which analysed:

- Reported incidents in states and territories pertaining to allergies and adverse drug reactions where clinical information systems are used to support clinical care
- Healthcare identifier allocation processes for pathology, diagnostic imaging and community pharmacies, which aimed to support the connection of these healthcare providers to the My Health Record system during 2017–18
- The costs, benefits, enablers and barriers relating to Australian paramedics accessing additional medical information via the My Health Record system.

The Commission also completed an analysis of vendor calls to the My Health Record helpline and a ‘deep dive’ analysis of health identifier issues at the interface between the My Health Record system and the clinical systems that connect to it.

In early 2018, the Commission established the My Health Record External Assurance Committee. The committee provides ongoing independent external assurance to the Agency’s My Health Record system clinical incident management and clinical safety risk-management systems. The Commission also provided representatives and expert advice for the following Agency committees:

- Medication Safety Program Steering Group
- Diagnostic Imaging Program Steering Group
- Digital Health Safety and Quality Governance Committee
- Pathology Program Steering Group
- Australian Medicines Terminology Support Group
- Australian Clinical Terminology Group

The Agency, in partnership with the Commission, is conducting a project to establish routine use of the My Health Record system by clinicians in hospital emergency departments. A draft framework has been developed based on the My Health Record participation trials conducted in the primary health networks of Nepean Blue Mountains and Northern Queensland, as well as on international experience and the literature. The framework will be piloted in late 2018.

In addition to its work with the Agency, the Commission published two reports on health IT safety in 2017–18:

- *The impact of digital health on the safety and quality in health care*
- *Safety issues at transitions of care.*

The most recent editions of the Commission’s *National guidelines for on-screen display of medicines information* and *National guidelines for on-screen presentation of discharge summaries* were approved by the Australian Health Ministers Advisory Council (AHMAC) in December 2017. States and territories are expected to incorporate the guidelines for on-screen presentation of medicines information and discharge summaries into their procurement, implementation and maintenance programs to enhance the safety of clinical information systems.

The Commission also released a new edition of *Electronic Medication Management Systems: A guide to safe implementation (3rd edition)* in December 2017. The guide aims to improve the planning for and implementation of electronic management (EMM) systems in Australian hospitals. The third edition focuses on EMM system governance and optimisation. The Commission convened a national roundtable in December 2017 to share lessons from the ongoing safety assessment of EMM systems in hospitals.

HIGHLIGHTS

Conducted three clinical safety reviews of the My Health Record system and national digital health infrastructure

Conducted an analysis of 50 vendor calls to the My Health Record helpline

Established the My Health Record External Assurance Committee to provide ongoing independent external assurance to the Agency's My Health Record clinical incident management and clinical safety risk-management systems

Started a project to establish routine use of the My Health Record system by clinicians in hospital emergency departments

Released revised editions of the *National guidelines for on-screen display of medicines information* and *National guidelines for on-screen presentation of discharge summaries*

Released *Electronic Medication Management Systems: A guide to safe implementation (3rd edition)*

Convened a national roundtable to support the ongoing safety assessment of EMM in hospitals

MEDICATION SAFETY

The Commission is responsible for the ongoing stewardship of nationally standardised tools used in Australian hospitals to prescribe, dispense and administer medicines safely. The Commission maintains a suite of standardised national medication charts, incorporating feedback and guidance provided by clinicians and medication safety experts. This standardised presentation of medication information for a patient reduces the risk of medication prescribing, dispensing and administration errors.

In January 2018, the Commission began an evaluation of the Pharmaceutical Benefits Scheme (PBS) hospital medication chart (HMC) which was approved for use in public and private hospitals in July 2016. The PBS HMC enables the prescribing, administering, supply and claiming of PBS eligible medicines without the need for a conventional prescription. The PBS HMC has been implemented in more than 100 public and private hospitals. The national subcutaneous insulin chart for use in subacute and mental health facilities was published in October 2017. A trial of the chart in hospitals showed improved management of blood glucose levels and insulin prescribing for patients with diabetes.

The Commission hosts the National Inpatient Medication Chart (NIMC) audit system for local and national audits. The objectives of NIMC audits are to evaluate the effect of standardised medication charts on the safety and quality of prescribing and medication documentation and identify further areas for improvement in medication management.

The Commission has coordinated national audits of the NIMC through the NIMC Audit

system. The introduction of the PBS HMC prompted a review of the audit questions and system. The outcomes of the review are a streamlined set of indicators and reporting on the safety and quality of the National Standard Medication Chart (NSMC). The new module will be called the NSMC Audit System and was made available in August 2018. A national audit will take place in October 2018. In addition to this work on nationally standardised medication charts, the Commission has undertaken a number of other medication safety projects in 2017–18, including:

- User testing of dispensed prescription medicine labels to inform development of a national standard
- Development of a position statement to promote best practice in prescribing, dispensing and administering of medicines for paediatric patients
- Development of a joint statement with the Australian and New Zealand College of Anaesthetists on the topical application of chlorhexidine to mitigate the risks of accidental injection
- Establishment of a secure clearing house portal for states and territories to share alerts and advisories pertaining to medicines and medical devices.

HIGHLIGHTS

Conducted an evaluation on the uptake and use of the PBS HMC

Released the national subcutaneous insulin chart for subacute and mental health facilities

Updated the NIMC audit system to include the PBS HMC and to incorporate new technology, questions and reporting functions

Completed user testing of dispensed prescription medicine labels

Developed a position statement to promote best practice in prescribing, dispensing and administering of medicines for paediatric patients

Published a joint safety statement with the Australian and New Zealand College of Anaesthetists on topical application of chlorhexidine to mitigate the risks of accidental injection

Coordinated the establishment of a secure clearing house portal for states and territories to share alerts and advisories pertaining to medicines and medical devices

MENTAL HEALTH

In July 2017 the Commission released the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*. The consensus statement provides guidance to health service organisations to ensure they have the capacity to safely, collaboratively and effectively recognise and respond to deterioration in a person's mental state.

During consultation for the consensus statement, the Commission identified the need to develop consensus on a set of signs that can be used for monitoring deterioration in a person's mental state and engaged Gaskin Research to conduct a study on this topic. The research involved a rigorous process of sequential surveys with people with lived experience of deterioration in mental state, their family members and clinicians. The findings of the study include a framework for recognising signs of deterioration, and highlight the need to closely attend the reports of the person themselves and the people that know them. These signs of deterioration can be used by local health service organisations developing their own escalation protocols. The findings will also be used by the Commission in the future development of resources to support actions in the Recognising and Responding to Acute Deterioration Standard in the NSQHS Standards.

The Commission also developed a consultation draft of the *NSQHS Standards user guide for health services providing care to people with mental health issues* (the user guide). This complements existing resources such as the *Guide for Hospitals* and the *Accreditation Workbook*. It provides additional information about how specific actions in the NSQHS Standards address

issues identified by people with mental health issues that affect their experience of health care. The user guide provides many practical examples, demonstrating how health services in Australia and internationally have developed innovations that improve the delivery of care. A national consultation will be conducted on the draft user guide, and the final version will be released later in 2018.

HIGHLIGHTS

Released the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*

Released report by Gaskin Research: *Recognising signs of deterioration in a person's mental state*

Developed consultation draft of *NSQHS Standards user guide for health services providing care to people with mental health issues*

COGNITIVE IMPAIRMENT

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

In 2017–18, the Commission continued the Caring for Cognitive Impairment campaign to assist health service organisations to improve care and prepare for assessment of the new cognitive impairment items in the second edition of the NSQHS Standards.

An updated campaign website was launched in November 2017, with additional educational videos and messages from individual champions. As at 30 June 2018, 2,060 individuals and 218 hospitals had joined the campaign. Thirty five supporting organisations are assisting with the campaign's promotion. The campaign website has an average 1,150 users every month. Webinars continue to be popular, as an example the *Safer use of medicines for cognitive impairment* webinar drew more than 300 participants. Hospitals are beginning to share their initiatives, with 31 summaries uploaded to the website. Nominated cognitive champions have started to learn from each other through the 'Chat with the Champions' sessions. The campaign will continue in 2018–19.

As part of the campaign, the Commission has coordinated and participated in a number of educational events. For example, in October 2017 the delirium expert Professor Sharon Inouye from Harvard Medical School visited Australia, and the Commission sponsored a masterclass for the Australasian Delirium Association, attracting more than 400 participants. Professor Inouye also recorded an interview, which is available on the campaign website. In March 2018, the

Commission participated in and supported SA Health's Sharing, Preparing and Caring for Cognitive Impairment conference where representatives from three local health networks showcased their work.

The campaign complements work already completed to include cognitive impairment material in the implementation resources that support the second edition of the NSQHS Standards. Resources released in 2014 to support better care for people in hospital with dementia and delirium will also be updated to reflect new evidence and to map actions to the second edition.

The Commission's work to reduce inappropriate use of antipsychotics continued in 2017–18. Knowledge gained from the previous year's roundtables provided a solid base for strategic discussions and briefings with regard to the review of national aged care quality regulatory processes.

HIGHLIGHTS

Updated and enhanced the Caring for Cognitive Impairment Campaign website

Continued the Caring for Cognitive Impairment campaign, with 218 hospitals, 2,060 individuals and 35 supporting organisations participating in the campaign

Provided input to the review of national aged care quality regulatory processes regarding use of antipsychotics

COMMUNICATING FOR SAFETY

Communication is a key safety and quality issue and plays a vital role in several aspects of care delivery. Risks to patient safety occur when clinical information about care is not adequately communicated, documented or shared between healthcare teams and the patient and their support people. In recognition that communication is essential to safe, high-quality care, the Commission has a program dedicated to improving clinical communications.

Revision of the NSQHS Standards provided an opportunity to identify and address clinical communication gaps from the feedback provided by consumers, healthcare providers, experts and health service managers. In the first edition of the NSQHS Standards the focus of clinical communication was on clinical handover; in the second edition this has been replaced by a new Communicating for Safety Standard. This standard strengthens clinical communications beyond clinical handover, focusing on governance, leadership and systems that support a broader safety culture by incorporating actions related to teamwork, collaboration and effective communication.

To support this, the Commission developed a Communicating for Safety resource portal. The Communication for Safety resource portal provides clinicians and health service managers with an easily navigable repository of tools and guides to support improvements in clinical communications and implementing the actions required to meet the NSQHS Standards. The design architecture of the resource portal reflects the Communicating for Safety framework which identifies key stages in the patient journey when they are at greater risk of communication failures.

The Commission has contracted Curtin University to undertake a translational research project to develop a practical education resource based on the iCare¹ conceptual communication model. The resource is specifically targeted to junior medical officers and junior nurses to improve their communications at transitions of care in an acute care setting and to assist communication between clinicians and across multidisciplinary teams.

HIGHLIGHTS

Established Communicating for Safety resource portal

Worked with Curtin University to develop a communication tool prototype and education resource package

COMPREHENSIVE CARE

Comprehensive care is the coordinated delivery of the total health care required or requested by the patient. This care is aligned with the patient's expressed preferences and healthcare needs, considers a patient's health issues in their life and wellbeing, and is clinically appropriate regardless of whether the care trajectory is focused on recovery or end of life.

The second edition of the NSQHS Standards includes a new standard aimed at supporting the delivery of comprehensive care for patients. The Comprehensive Care Standard addresses a range of cross-cutting issues that underlie many adverse events, and aims to

optimise health care while considering how risk and harm can be minimised along each patient journey.

In 2018, the Commission published a conceptual model for supporting comprehensive care delivery. The model was informed by literature reviews, scoping interviews and consultations, and provides a starting point for health service organisations and the Commission to consider the features that influence how comprehensive care is delivered and where change may lead to improvement.

The Commission is also developing a series of practical resources on how the conceptual model applies to the day-to-day business of healthcare delivery. This includes considering essential elements of comprehensive care delivery throughout the patient journey, guidance on screening and assessment, and resources to support implementation of the Comprehensive Care Standard. These resources will be available in 2018–19.

HIGHLIGHTS

Published a conceptual model for supporting comprehensive care delivery

Developed practical guidance and resources to support comprehensive care delivery, including resources for screening and assessment



PATIENT SAFETY IN PRIMARY HEALTHCARE

For most Australians primary care is the first point of contact within the health system, and provides a range of services for the diagnosis and management of acute and chronic conditions.² Primary care represents a significant proportion of all health care provided in Australia.

While the current primary care system performs well and most health care is associated with good clinical outcomes, some people do not receive the care that is recommended to them, and others are inadvertently harmed by the care they receive.³

Internationally, evidence about the nature and magnitude of patient harm in primary care settings is scarce but growing. To date, a majority of the work on patient safety has focused on the acute hospital sector and, to a lesser extent, general practice settings.⁴ There is also limited evidence available about effective and sustainable patient safety solutions in primary care.

This has led to a global call for action to better understand the nature and number of adverse patient outcomes in primary care and how they can be addressed in these settings.

In October 2017, the Commission released a consultation paper, *Patient safety and quality improvement in primary care*. The purpose of the consultation was to better understand the safety and quality issues affecting primary care services and seek feedback about safety and quality strategies, tools and resources that could be developed by the Commission to support improvements in this sector.

Respondents suggested a range of strategies, tools and resources. The Commission will work in partnership with primary care partners and consumers to develop and implement these strategies, tools and resources, which will include national safety and quality health service standards for primary care.

HIGHLIGHTS

Released the consultation paper: *Patient safety and quality improvement in primary care*

Completed a public consultation process on patient safety and quality improvement in primary care, receiving 53 submissions

TRANSVAGINAL MESH

Following a request from state and territory health department representatives, the Commission has responded to safety issues raised in relation to the use of transvaginal mesh devices. This work has been undertaken in collaboration with the Therapeutic Goods Administration (TGA) and the states and territories.

The objective was to develop guidance for consumers, clinicians and health services on the use of transvaginal mesh devices for the treatment of pelvic organ prolapse and stress urinary incontinence. The Commission reviewed the evidence on the use of transvaginal mesh and worked with a reference group that included consumers,

states, territories, the TGA, and clinical experts nominated by relevant colleges and surgical specialty organisations.

Consultations were also held with consumers, clinicians, the Australian Government Department of Health and state and territory health departments.

Following detailed consideration, the Commission released guidance documents in relation to hospital credentialing of senior medical practitioners to undertake transvaginal mesh surgery for stress urinary incontinence, pelvic organ prolapse and the removal of mesh. Each credentialing guidance document took into account the detailed discussion of transvaginal mesh undertaken to date and the available literature, both in Australia and internationally, in seeking to define an appropriate approach to skills, training and the experience required to support the safe and effective performance of transvaginal mesh surgery.

The Commission also developed three patient information resources to assist women to discuss treatment options regarding pelvic organ prolapse, stress urinary incontinence and (where appropriate) mesh removal with their doctor and other health professionals, and to assist women to share decision-making about care. The Commission wishes to recognise the contribution of many women who had mesh procedures in the development of these resources.

The Commission has sought to ensure that the range of guidance documents support access to safe, quality treatment through appropriate patient selection, informed consent, care pathways and a service model framework. The guidance documents will be reviewed periodically to ensure they are consistent with the latest evidence.

The work undertaken by the Commission complements that of a number of other organisations to improve outcomes for women treated with transvaginal mesh devices, including the TGA, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Urological Society of Australia and New Zealand and the states and territories.

HIGHLIGHTS

Released guidance documents in relation to hospital credentialing of senior medical practitioners to undertake transvaginal mesh surgery for stress urinary incontinence and pelvic organ prolapse and removal of mesh

Released information for consumers on treatment options for stress urinary incontinence and pelvic organ prolapse and mesh removal

PRIORITY 2: PARTNERING WITH PATIENTS, CONSUMERS AND COMMUNITIES

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

PERSON-CENTRED HEALTHCARE ORGANISATIONS

Person-centred care, where patients, consumers and members of the community are treated as partners in all aspects of healthcare planning, design, delivery and evaluation, is the foundation for achieving safe, high-quality care. Delivering person-centred care, and doing it well, will enable health service organisations to achieve better outcomes and experiences for their patients and workforce, and better value care. Person-centred care and partnering with consumers is a key feature of the NSQHS Standards.

In 2018, the Commission published a review identifying the key attributes shared by high-performing person-centred healthcare organisations. Seven attributes were identified, and collectively they provide an ideal organisational model for supporting consistent and excellent person-centred care. The Commission has released a series of resources providing information about these attributes and how they may look in practice.

The Commission will continue to examine different ways to support the health system move towards a more consistently person-centred approach, using the findings of this project to inform future work to foster partnerships with consumers and to support implementation of the NSQHS Standards.

HIGHLIGHTS

Published a review identifying key attributes of high-performing person-centred healthcare organisations

Released resources to support health service organisations to foster person-centred care attributes in the context of their organisation

SHARED DECISION MAKING AND HEALTH INFORMATION

Shared decision making is a core part of enabling meaningful partnerships with consumers in their own care. It is a way to discuss and plan care that brings the consumers' values, goals and concerns together with the best available evidence about treatment options, including benefits, risks and uncertainties. Shared decision making involves clinicians and consumers putting all considerations on the table and making decisions about healthcare management together.

The Commission, in partnership with four Australian specialist colleges, has adapted its online education module on risk communication and shared decision making for specialists. The module, originally developed for general practitioners, contains additional case studies relevant to specialist colleges. The module is available to college members through their learning management systems, and to increase availability to a broader range of Australian clinicians the Commission released an open access version late in 2017. Early in 2018, the Commission licensed the module to the Academy of Medical Royal Colleges (United Kingdom) which will adapt the module to the UK context.

Three short videos for clinicians on shared decision making were also released in late 2017. These videos address what shared decision making is; why it is important; myths associated with shared decision making; and information on patient decision aids.

Following the release of a clinical care standard on osteoarthritis of the knee in 2016–17, the Commission also developed

a draft decision support tool for patients with osteoarthritis of the knee. The tool provides a summary of the main treatment options and can be used by patients to help them discuss options, consider what matters most to them, share in decisions and be involved in planning care. The tool has been tested by consumers and clinicians and will be released in 2018–19.

HIGHLIGHTS

Developed and licensed an online education module on risk communication and shared decision making for specialist colleges

Released an open access version of an online education module on risk communication and shared decision making available to all clinicians

Released three short videos on shared decision making for clinicians

Developed and tested a draft decision support tool for patients for osteoarthritis of the knee

END-OF-LIFE CARE

The health care that people receive in the last years, months and weeks of their lives can minimise the distress and grief associated with death and dying for the individual and for their family, friends and carers. The Commission supports healthcare organisations, clinicians and consumers to deliver safe and high-quality end-of-life care that meets the needs and preferences of the dying person.

In 2017–18, the Commission completed a study of the use of an end-of-life care audit tool and a staff survey in nine hospitals across Australia. The audit and survey tools provide data on the delivery of end-of-life care in hospitals and on clinician perceptions on how it is delivered.

The Commission presented the findings of the study at the Australian and New Zealand Intensive Care Society/Australian College of Critical Care Nurses Annual Scientific Meeting in October 2017, and will publish a summary of the findings in 2018–19. Data from the

study indicates that a substantial proportion of dying patients did not have end-of-life care that was consistent with the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*.

Following the completion of the study, the Commission released an *End-of-life Care Audit Toolkit*, which provides guidance to hospitals on creating and completing an audit on the end-of-life care they provide, as well as free access to the tools. This allows hospitals to review how care is being delivered and identify opportunities for better alignment with the national consensus statement. It also supports health service organisations to meet the NSQHS Standards.

To further support health service organisations in improving end-of-life care, the Commission is working with Palliative Care Australia to map the different standards and guidelines that govern the provision of end-of-life and palliative care in Australia. This will be released in 2018–19.

HIGHLIGHTS

Completed a study of the end-of-life care audit tool and survey in nine hospitals across Australia

Released an *End-of-life Care Audit Toolkit* for health service organisations

PRIORITY 3: QUALITY, COST AND VALUE

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

IDENTIFYING HEALTHCARE VARIATION

Mapping variation in the use of healthcare services is a valuable tool for understanding how the health system provides care. Some geographic variation is expected, and can reflect differences in the health of specific populations or in personal preferences. Differences that do not reflect these factors indicate what is known as 'unwarranted variation' and may signal inappropriate care. Unwarranted variation provides opportunities for health service organisations to improve patient care by promoting the use of evidence-based treatment options that produce best outcomes, and by reducing treatment options with little or uncertain benefit.

The Commission released the *First Australian Atlas of Healthcare Variation* in November 2015 and a second Atlas covering different topics in June 2017. Findings from the Atlas series prompted state and territory governments to further investigate healthcare variation and address unwarranted variation. Medical colleges and societies are also examining clinical variation within their specialties and investigating opportunities to promote best practice.

For example, the Queensland Clinical Senate used the findings on potentially preventable hospitalisations in the second Atlas to explore ways to reduce unwarranted clinical variation. The Senate convened a meeting in late 2017 with more than 130 delegates, representing consumers, carers and a wide range of professions and specialties across the public, private, primary and acute care health sectors. The Senate made recommendations about sharing data and sharing accountability across acute, community and primary health sectors with the intent of improving service integration, identifying strategies to address reasons for unwarranted variation, and sharing learnings of successful interventions.

The Atlas series is a key part of the Commission's work to improve patient care while ensuring value for Australia's healthcare spending. To promote and embed best practice in patient care, the Commission incorporated an action about variation in clinical practice and health outcomes into the Clinical Governance Standard of the second edition of the NSQHS Standards. This action requires health service organisations to demonstrate that they have systems in place to monitor, identify and implement strategies to reduce unwarranted variation and improve appropriateness of care.

An interactive online version of the Atlas series is available on the Commission's website at www.safetyandquality.gov.au/atlas/. This interactive version enables users to explore local area data and now includes rates of healthcare use in primary health network areas to further assist users investigate variation.

Building on the success of the Atlas series, the Commission is developing the *Third Australian Atlas of Healthcare Variation*, due for release late 2018. The third Atlas will focus on:

- Appropriateness of care in primary and acute care settings, examining 13 new data items largely using the Pharmaceutical Benefits Scheme and Medicare Benefits Scheme as data sources
- Reporting rates over time for seven data items from the first Atlas to maintain the focus on variation in high-volume prescribing behaviour – this repeat analysis will include the antimicrobial, opioid and psychotropic medicines data items
- Responses across the healthcare system to variation in healthcare use following the release of the first and second Atlases.

HIGHLIGHTS

Included an action about variation in clinical practice and health outcomes in the second edition of the NSQHS Standards

Added rates of healthcare use in primary health networks on the interactive online version of the Atlas series

Prepared the third Atlas for release in late 2018



IMPROVING APPROPRIATENESS OF CARE

Clinical care standards aim to support the delivery of appropriate care, reduce unwarranted variation in care and promote shared decision making between patients, carers and clinicians. Clinical care standards target key areas where opportunities exist to better align clinical practice with the best available evidence. They identify and define the care people can expect to be offered or receive, regardless of where they are treated in Australia. They also include clinical indicators to help health service organisations and clinicians monitor and evaluate the care they provide.

In 2017–18, the Commission released the *Heavy Menstrual Bleeding Clinical Care Standard*. This clinical care standard was developed in response to findings of national variation in hysterectomy and endometrial ablation rates in the First Australian Atlas of Healthcare Variation. The Commission also released *Heavy Menstrual Bleeding: The case for improvement*, which is an educational resource designed to support implementation at the local level, as well as highlight opportunities for system-wide collaborative action.

The Commission developed a clinical care standard on colonoscopy as a component of a national safety and quality model for colonoscopy, which had been developed by the Commission in 2016 with funding support from the Department of Health. The clinical care standard is expected to be released in late 2018.

Responding to feedback from state and territory health departments, the Commission also developed the *Venous Thromboembolism Prevention Clinical Care Standard*, with a

view to reducing these hospital-acquired complications. This clinical care standard will be released in late 2018.

Based on findings from the first two editions of the Atlas, work has begun on the development of a clinical care standard for cataract surgery. An expert topic working group comprising consumers, clinicians, researchers, representatives from key health organisations and relevant technical experts is informing the development of this standard, which is expected to be released in 2018–19.

The Commission has also started data collection to support an evaluation of the processes used to develop clinical care standards and the effectiveness of those processes. This will be progressed in the coming years.

HIGHLIGHTS

Released the *Heavy Menstrual Bleeding Clinical Care Standard* and *Case for improvement* educational resource

Developed clinical care standards on colonoscopy and venous thromboembolism for release in 2018–19, and commenced a clinical care standard on cataract surgery

Started evaluating the processes used to develop clinical care standards

PRIORITY 4: SUPPORTING HEALTH PROFESSIONALS TO PROVIDE SAFE AND HIGH-QUALITY CARE

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

INDICATORS AND DATA SET SPECIFICATIONS

In 2017–18, the Commission continued to develop and maintain indicators and data set specifications that help to improve the safety and quality of health care.

CLINICAL CARE STANDARD INDICATORS

The Commission has continued to develop and specify indicators to support the implementation of clinical care standards on venous thromboembolism and colonoscopy. Work to refine and develop the indicator set to support the cataract clinical care standard continues.

ACCREDITATION

In 2017–18, the Commission developed data set specifications and a dictionary to support the second edition of the NSQHS Standards. The purpose of the data collection tool is to increase the transparency of accreditation processes and outcomes. Work will continue

in 2018–19 to develop this tool to support the second edition of the NSQHS Standards.

CORE HOSPITAL-BASED OUTCOME INDICATORS

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

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

In 2017–18, the Commission made the toolkit available on its website, allowing streamlined and timely access for users. The Commission also updated the nationally generated coefficients and reference sets in the *CHBOI Toolkit*. This update incorporated changes to ICD-10AM (the coding set used in admitted patient data in Australia) and admitted patient data for the years 2013–14 to 2015–16.

The Commission continued development work on the Australian Composite Model Hospital Standardised Mortality Ratio, which is a revised mortality outcome indicator. This included working with the Australian Institute of Health and Welfare to explore state and territory variations in palliative care coding. The mortality outcome indicator has been made available in prototype format to those states and territories who expressed interest.

HIGHLIGHTS

Developed indicators to support venous thromboembolism and colonoscopy clinical care standards

Developed data specifications to support the second edition of the NSQHS Standards

Updated the *CHBOI Toolkit* and made it available on the Commission's website



PATIENT-REPORTED OUTCOME MEASURES

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

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

However, current work in PROMs in Australia is scattered and uncoordinated. The Commission is developing a national work program to lead PROMs. The goal of this work is to maximise the benefits of PROMs without getting in the way of local innovation and existing initiatives.

In 2017–18, the Commission completed a literature review, environmental scan and stakeholder interview report to shape the work of PROMs in Australia. The Commission also established an expert advisory group to this national work program.

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

HIGHLIGHTS

Published a literature review, environmental scan and stakeholder interview report about PROMs research and practice internationally and in Australia

MEASURING PATIENT EXPERIENCE

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

The *Australian Hospital Patient Experience Question Set* (AHPEQS) is a tool developed to assess the person-centredness of health service organisations. It was originally commissioned by AHMAC to be a data source for the nationally consistent measurement of patients' healthcare experience. The questions were developed over a two-year period using a patient-centred methodology based on qualitative research about the good and bad experiences of patients in health service organisations.

The AHPEQS (formerly known as CorePEQs) is a non-proprietary 12 question survey instrument which assesses core aspects of patient experience without placing undue time burdens on the consumer. The short, generic and simple nature of the tool will enable systematic and routine capture and use of patients' perspectives on the quality and safety of their health care in a way that

is efficient for funders, providers and patients. The AHPEQS was released in early 2018 for local implementation.

There are two planned phases of implementation for the AHPEQS. The first phase focuses on implementation at a local level – it is currently being used to aid local safety and quality improvement and to measure progress towards person-centred care. In the second phase, the Commission is working with states, territories and the private sector to determine the feasibility of detailed specifications to enable nationally consistent and comparable measurement of patient experience.

HIGHLIGHTS

Released the *Australian Hospital Patient Experience Question Set* (AHPEQS) as a new national tool to assess the person-centredness of health services



MINIMISING HARM

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

AUSTRALIAN GOVERNMENTS AGREE TO IMPLEMENT REFORMS TO IMPROVE SAFETY AND QUALITY IN OUR HOSPITALS

On 1 April 2016, the COAG signed a Heads of Agreement as the basis of an addendum to amend elements of the National Health Reform Agreement (NHRA Addendum) for three years, until 30 June 2020. As part of this agreement, COAG resolved, among other things, to develop and begin to implement reforms to improve Australians' health outcomes and decrease avoidable demand for public hospital services.

In June 2017, all Australian Governments committed to develop and implement reforms to improve health outcomes for patients and decrease potentially avoidable demand for public hospital services through the NHRA Addendum. This Addendum sets out governments' intent to 'develop and implement reforms to:

- Improve patient outcomes
- Provide an incentive to the system to provide the right care, in the right place, at the right time
- Decrease avoidable demand for public hospital services

- Signal to the health system the need to reduce instances of preventable poor quality patient care, while supporting improvements in data quality and information available to inform clinicians' practice.'

In February 2018, Commonwealth and state and territory governments executed the Heads of Agreement. The Commonwealth and States and Territories Heads of Agreement will form the basis of negotiations for a new five-year national health agreement (NHA), to commence on 1 July 2020 and conclude on 30 June 2025.

The Commonwealth and States and Territories Heads of Agreement reaffirm a commitment to the reforms outlined under the NHRA Addendum. Specifically, it includes a focus on 'delivering safe, high quality care in the right place at the right time'. It also outlines that the NHA will include 'funding and pricing for safety and quality, to avoid funding unnecessary or unsafe care, and reducing avoidable readmissions to hospital'.

Specific to the work of the Commission, the NHA outlines requirements to incorporate quality and safety into hospital pricing and funding. This includes work on:

- Hospital-acquired complications
- Sentinel events
- Avoidable hospital readmissions.

HOSPITAL-ACQUIRED COMPLICATIONS LIST

The National Health Reform Agreement Addendum outlines that the Commission will 'curate the ...hospital-acquired complications for the purposes of ensuring they remain robust and relevant for clinical improvement purposes'.



A hospital-acquired complication is a complication for which clinical risk-mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. The hospital-acquired complications list (Table 2) was released in 2015. The list was refined and final specifications were released in October 2016. In 2017 the Commission established the Hospital-Acquired Complications Curation Clinical Advisory Group (HACs CCAG).

In 2017–18, the Commission continued to develop and update resources for the hospital-acquired complications list with the aims of improving clinical documentation and of supporting local monitoring and quality improvement. This included the release of the *Hospital-Acquired Complications Information Kit*. This kit provides tools for clinicians, safety and quality professionals, managers, executives, members of governing bodies and others to minimise the occurrence of hospital-acquired complications in their health service organisation.

In 2018–19, the HACs CCAG will focus on developing HACs for admitted mental health patients and evaluating the implementation of the HACs.

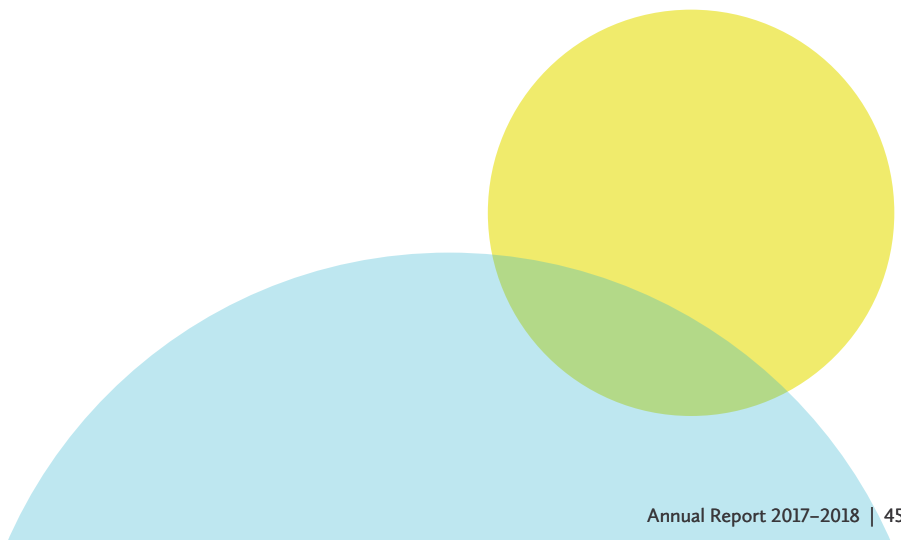


TABLE 2: HOSPITAL-ACQUIRED COMPLICATIONS LIST

Complication	Diagnosis
Pressure injury	<ul style="list-style-type: none"> • Stage III ulcer • Stage IV ulcer • Unspecified decubitus ulcer and pressure area
Falls resulting in fracture or intracranial injury	<ul style="list-style-type: none"> • Intracranial injury • Fractured neck of femur • Other fractures
Healthcare-associated infection	<ul style="list-style-type: none"> • Urinary tract infection • Surgical site infection • Pneumonia • Blood stream infection • Central line and peripheral line associated bloodstream infection • Multi-resistant organism • Infection associated with prosthetics/implantable devices • Gastrointestinal infections
Surgical complications requiring unplanned return to theatre	<ul style="list-style-type: none"> • Post-operative haemorrhage/haematoma requiring transfusion and/or return to theatre • Surgical wound dehiscence • Anastomotic leak • Vascular graft failure • Other surgical complications requiring unplanned return to theatre
Unplanned intensive care unit admission	<ul style="list-style-type: none"> • Unplanned admission to intensive care unit
Respiratory complications	<ul style="list-style-type: none"> • Respiratory failure including acute respiratory distress syndrome requiring ventilation • Aspiration pneumonia
Venous thromboembolism	<ul style="list-style-type: none"> • Respiratory failure including acute respiratory distress syndrome requiring ventilation • Aspiration pneumonia • Pulmonary embolism

TABLE 2: CONTINUED

Complication	Diagnosis
Renal failure	<ul style="list-style-type: none"> Renal failure requiring haemodialysis or continuous veno-venous haemodialysis
Gastrointestinal bleeding	<ul style="list-style-type: none"> Gastrointestinal bleeding
Medication complications	<ul style="list-style-type: none"> Drug related respiratory complications/depression Haemorrhagic disorder due to circulating anticoagulants Hypoglycaemia
Delirium	<ul style="list-style-type: none"> Delirium
Persistent incontinence	<ul style="list-style-type: none"> Urinary incontinence
Malnutrition	<ul style="list-style-type: none"> Malnutrition
Cardiac complications	<ul style="list-style-type: none"> Heart failure and pulmonary oedema Arrhythmias Cardiac arrest Acute coronary syndrome including unstable angina, STEMI and NSTEMI
Third and fourth degree perineal laceration during delivery	<ul style="list-style-type: none"> Third and fourth degree perineal laceration during delivery
Neonatal birth trauma	<ul style="list-style-type: none"> Neonatal birth trauma

NATIONAL SENTINEL EVENTS LIST

The National Health Reform Agreement Addendum outlines that the Commission will ‘curate the sentinel events list ...for the purposes of ensuring they remain robust and relevant for clinical improvement purposes.’ In line with this, in 2017 the Commission reviewed the Australian sentinel events list, based on significant national consultation.

On 8 December 2017, AHMAC noted the process undertaken to review the Australian sentinel events list and endorsed the revised list and associated definitions (Table 3).

AHMAC also agreed to forward an out of session paper to the COAG Health Council (CHC) seeking endorsement of this list. The revised list is being considered by all Australian governments through the CHC. Once finalised, the list will be released.

AHMAC has also requested that the Commission consider the development of a user guide for the sentinel events list. The Commission is currently preparing this user guide, which will include case studies relating to each of the sentinel events. If members wish to provide examples of sentinel events to inform the case studies, please contact the Commission’s secretariat.

TABLE 3: COMPARISON OF DRAFT AUSTRALIAN SENTINEL EVENTS LIST (VERSION 2) WITH ORIGINAL SENTINEL EVENTS LIST

The following provides a summary of the revised sentinel events list endorsed by AHMAC on 8 December 2017 compared to the original Australian list of sentinel events that was determined by Health Ministers in 2002.

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

AVOIDABLE HOSPITAL READMISSIONS

Under the National Health Reform Agreement Addendum, the Commission is responsible for developing a list of conditions that can be considered avoidable hospital readmissions. In 2017–18 the Commission worked with clinicians from across Australia to develop such a list, with timeframes for each condition within which a return to hospital would be deemed avoidable. AHMAC has agreed the list of conditions to be avoidable hospital readmissions (Table 4).

The list was informed by a review of international evidence, clinical consultations and interrogation of Australian health care data. In order to be included in the list, conditions had to be related to the index admission, avoidable by improved clinical management in the initial admission and/or appropriate discharge planning and follow up, and measurable through coded data generated from the patient medical record. The list is available on the Commission's website.

In 2018–19, in line with the National Health Reform Agreement Addendum, the Independent Hospital Pricing Authority will develop a pricing and funding approach for the list of avoidable hospital readmissions, for consideration by Health Ministers. This approach will be informed by public consultation to be led by the Independent Hospital Pricing Authority. The Commission will work closely with the Independent Hospital Pricing Authority to support this work.

In response to a request from AHMAC on 2 June 2017, the Commission will lead a process to develop a 'nationally consistent definition of avoidable hospital readmissions'. The outcome of this work will be provided to the CHC for advice.

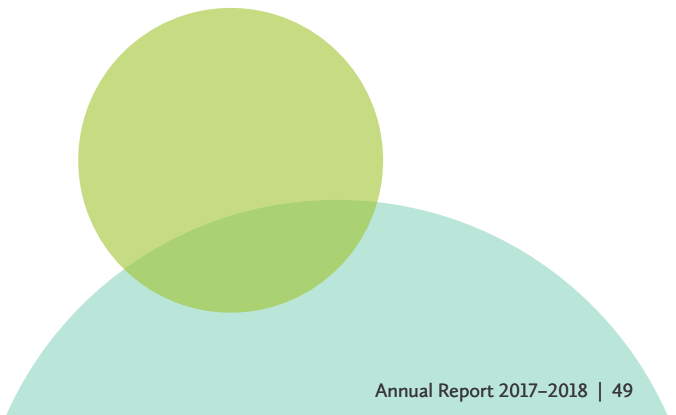


TABLE 4: LIST OF CONDITIONS AHMAC HAS AGREED ARE CONSIDERED TO BE AVOIDABLE HOSPITAL READMISSIONS AND ASSOCIATED READMISSION INTERVALS

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

TABLE 4: CONTINUED

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

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

ALIGNING PUBLIC REPORTING OF PUBLIC AND PRIVATE HOSPITALS

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

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

Current work across Australia supports both the need for aligning public and private reporting standards and improving the capacity to do so. Not only does increased transparency and public reporting improve consumer choice, but transparent use of data drives improvements in the performance of the health system and increases accountability to those who fund the services.

In August 2017, the COAG Health Council asked the Commission to identify options to align public reporting standards for safety and quality of health care across public and private hospitals nationally.

On finalisation, this work will be incorporated in the national work being progressed on Australia's health system and performance reporting frameworks (the new *Australian Health Performance Framework*).

The Commission has started a program of work to provide advice to the COAG Health Council and deliver key elements of the project by February 2019. A steering committee of consumer and

carer representatives, clinical experts, representatives from state and territory health departments, and representatives of the private sector and private health insurance sector has been established to provide high-level advice on the project.

The evidence collection phase was completed in June 2018. This included an environmental scan and literature review, expert interviews and focus groups of clinicians and consumers in major capital cities.

An options paper will be developed for public consultation in late 2018, with project finalisation planned for early 2019.

HIGHLIGHTS

Started project to identify options to align public reporting standards for safety and quality of health care across public and private hospitals nationally

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 2017–18, the Commission continued work to implement the Framework for Australian Clinical Quality Registries. The framework, endorsed by AHMAC in 2014, specifies national arrangements under which peak clinical groups and health service organisations can work with governments to monitor and report on the quality (or appropriateness and effectiveness)

of health care. Further, the Commission has contributed to a process to develop a national strategy for clinical quality registries, through involvement in an Expert Advisory Group of the Clinical Principal Committee.

CLINICAL TRIALS GOVERNANCE FRAMEWORK

In 2017–18, the Commission was engaged by the Australian Government Department of Health to undertake a project to develop the National Clinical Trials Governance Framework, as a first step toward a nationally consistent accreditation approach for health services undertaking clinical trials.

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

In 2017–18, the Commission established an expert Clinical Trials Governance Framework Steering Committee comprising clinical trial, consumer, government, health care and industry experts. It also undertook a review of the literature for evidence of clinical trials governance frameworks and commenced a mapping exercise to document the Australian clinical trials environment. The year ahead will involve further consultation, including consultation workshops that will be held across Australia, to deliver the National Clinical Trials Governance Framework by mid-2019.

HIGHLIGHTS

Commenced project to develop a clinical governance framework for clinical trials

THE STATE OF SAFETY AND QUALITY IN AUSTRALIAN HEALTH CARE

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

Safety and quality is a complex field that is integrated into all aspects of health care. There are many people and organisations involved in ensuring that people receive health care that is both safe and of high quality.

This complexity means that reporting on safety and quality is challenging. There is no single source of data that can provide comprehensive information about the safety and quality of the Australian healthcare system. Nor is there a single set of measures or indicators that could be taken to reflect the state of safety and quality in Australia. However Australia now has a health performance framework that provides a single and flexible approach for reporting on health and healthcare performance.⁵ Work is currently underway to develop the measures of safety and quality that sit within it.

Information about the state of safety and quality in Australia can be drawn from data about specific safety and quality issues, or from specific sources. One source of information is hospital-acquired complications (HACs). This section provides

more detail about HACs, and how they can help to improve safety and quality locally and nationally.

HOSPITAL-ACQUIRED COMPLICATIONS

Australia performs very well in international comparisons about health, including areas such as preventive care, provision of safe care, patient engagement, administrative efficiency and healthcare outcomes.⁶ Significant resources are deployed to ensure the health system supports the continued good health of Australians.⁷ Despite these efforts, an unacceptable proportion of Australian hospital admissions are associated with an adverse event.⁸ This means that more work is needed to reduce adverse events, and improve the safety and quality of care provided to patients.

A HAC refers to a complication for a patient in hospital for which clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.⁹ HACs are a problem as they affect a patient's recovery, overall outcome and can result in longer lengths of stay in



hospital.¹⁰ HACs are also a concern for health service organisations as a patient’s admission costs more if they have a HAC, potentially diverting resources away from other patient care activities.¹¹

All adverse events and complications in hospitals are important, and have an impact on patients and the health service organisations. A clinician-led process was used by the Commission to develop a list of 16 priority HACs* (Table 5) that clinicians can respond to, and whose occurrence can be reduced through clinical risk-mitigation strategies. These HACs were chosen based on their preventability, the severity of their impact on patients, their health service impact and their clinical priority.

These priority HACs can be used as a trigger for exploration of safety and quality within a health service, and as an indication of success of the health service.

HACs can be monitored using existing data sources (admitted patient data), meaning there is no additional burden associated with data collection. Private hospitals and insurance groups can currently monitor their own rates of complications using the Commission’s specifications. Potential future work could create the capacity for the Commission to monitor private hospitals as well.

* Each HAC has a number of associated diagnoses and codes, which define the HAC. Specifications for the list are available on the Commission’s website (<https://www.surveymonkey.com/r/HACsdownload>).

TABLE 5: RATES OF HOSPITAL-ACQUIRED COMPLICATIONS IN AUSTRALIAN PUBLIC HOSPITALS 2015–16

HAC		Rate*
1	Pressure injury	10
2	Falls resulting in fracture or other intracranial injury	4
3	Healthcare associated infection	135
4	Surgical complications requiring unplanned return to theatre	20
5	Unplanned intensive care unit (ICU) admission	N/A
6	Respiratory complications	24
7	Venous thromboembolism	8
8	Renal failure	2
9	Gastrointestinal bleeding	14
10	Medication complications	30
11	Delirium	51
12	Persistent incontinence	8
13	Malnutrition	12
14	Cardiac complications	69
15	Third and fourth degree perineal laceration during delivery (per 10,000 vaginal births)	358
16	Birth trauma (per 10,000 births)	49

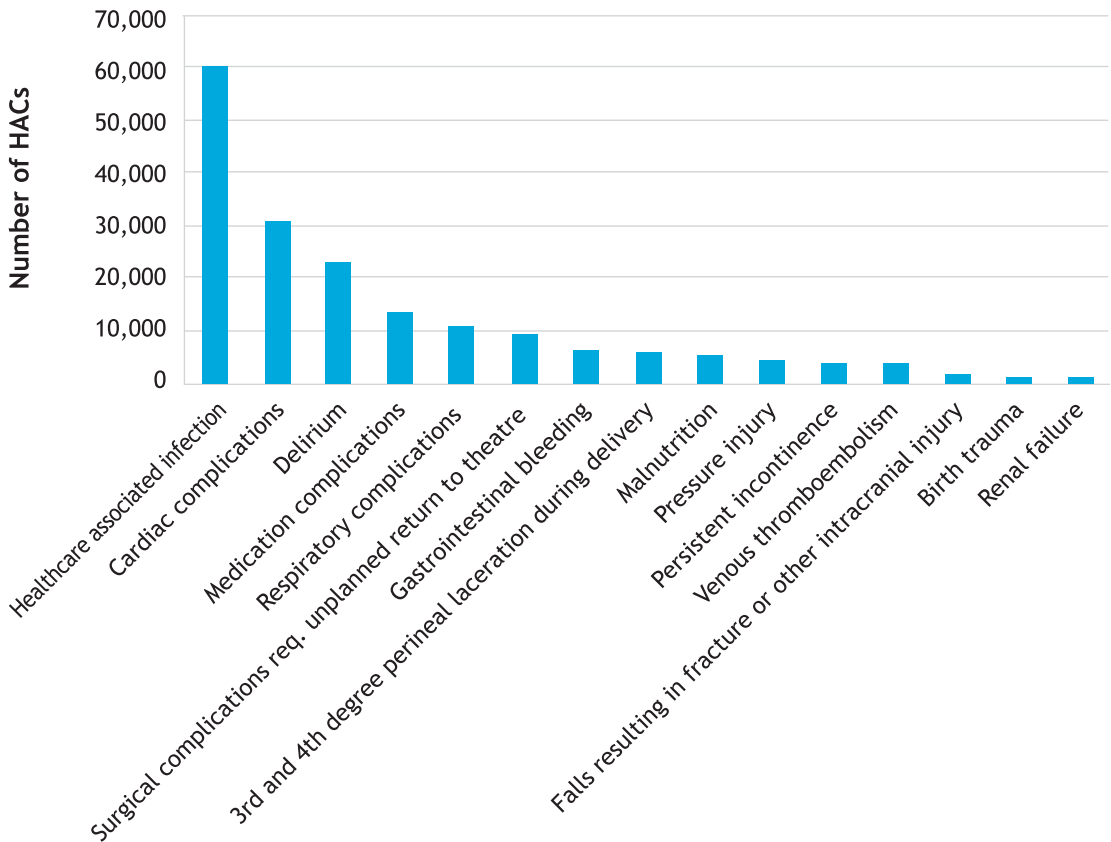
N/A = National data not currently available

* Rate per 10,000 admissions (apart from perineal tears and birth trauma where the denominator is vaginal births and all births respectively).

WHAT DO WE KNOW ABOUT HACs IN PUBLIC HOSPITALS?

In 2015–16, there were 179,354 HACs in Australian public hospitals (Figure 2). The most common HACs were healthcare-associated infections (34% of all HACs), cardiac complications (17%) and delirium (13%).

FIGURE 2: NUMBER OF HOSPITAL-ACQUIRED COMPLICATIONS IN AUSTRALIAN PUBLIC HOSPITALS 2015–16



Source: Australian Commission on Safety and Quality in Health Care, Internal analysis of Admitted Patient Care National Minimum Data Set, 2018.

HEALTHCARE-ASSOCIATED INFECTION HACs

By far the most common HACs in public hospitals relate to HAIs such as sepsis, surgical site infections and urinary tract infections. By looking in detail at these HACs we can learn about the impact of HAIs on patients, health service organisations and the health system. For example, we know that:

- 60,037 HAIs were identified in Australian public hospitals in 2015-16, affecting one in every 74 hospitalisations
- HAIs also increase the cost of admission incurred by the health service. This additional cost may be the result of an increased length of stay or more complex care requirements. While there is an increased financial cost, the most significant cost is the pain and discomfort experienced by the patient.¹²

Hospitals can be grouped into peer groups based on shared characteristics including their size and role. For principal referral hospitals the rate of HAIs in the peer group was 148 per 10,000 hospitalisations (Figure 3), with 36 hospitals being above this overall peer rate. If those 36 principal referral hospitals* reduced their rate to the peer rate, 7,165 HAIs could be prevented.

Exploring and understanding why differences in the rate of HACs exist will be an important focus for the Commission in 2018–19.

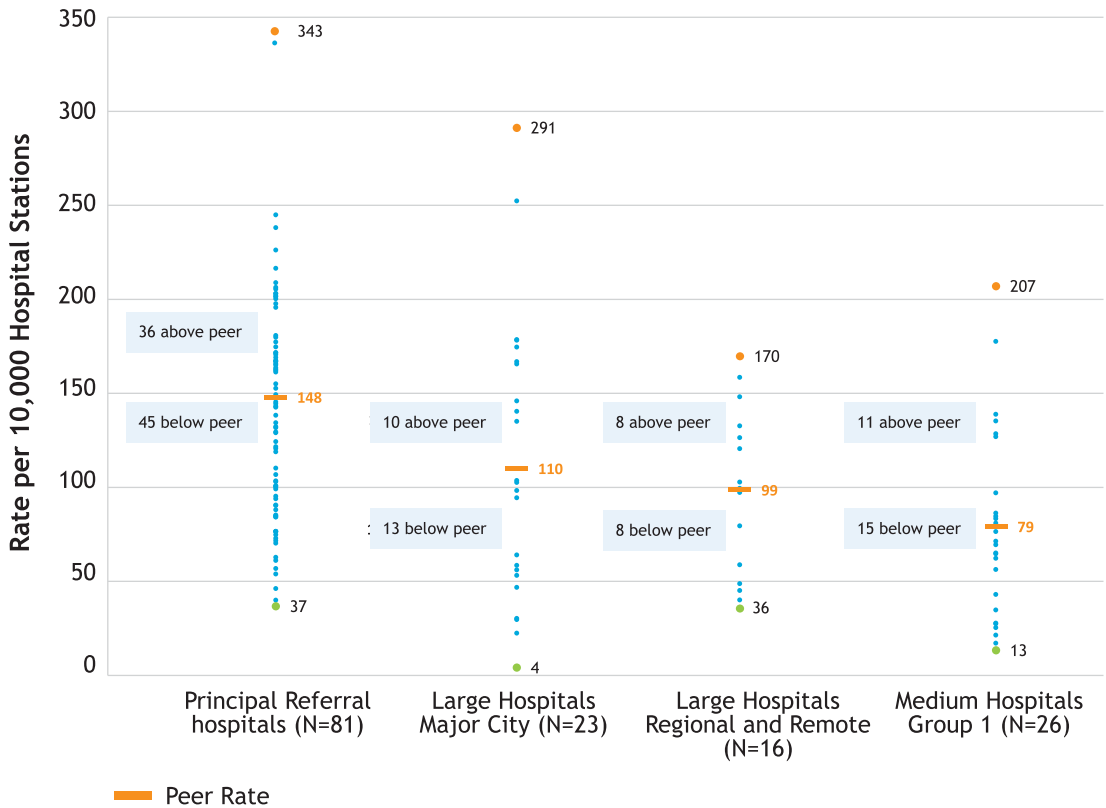
Principal referral hospitals generally treat sicker patients, and this is partly the reason that smaller hospitals have a lower rate of HAIs. However, the variation within each peer group warrants exploration. For example, in the peer group Medium Hospitals Group 1, the rate of HAIs ranged from 13 per 10,000 to 207 per 10,000. While this may partly be explained by the mix and acuity of patients, the Commission, via its advisory groups, clinical experts and jurisdictional safety and quality experts will monitor and investigate the observed variations to determine what other factors may be driving these disparities.

Reductions in HAI rates are already being achieved in some hospitals through prevention initiatives. The Commission will also seek to understand and share lessons learned from hospitals where reductions are achieved.

* *Principal referral hospitals* are public acute hospitals that provide a very broad range of services, have a range of highly specialised service units, and have large patient volumes. The term 'referral' recognises that these hospitals have specialist facilities not typically found in smaller hospitals.

FIGURE 3: HEALTHCARE-ASSOCIATED INFECTIONS BY HOSPITAL PEER GROUP, 2015–16

RATE OF HEALTHCARE-ASSOCIATED INFECTIONS BY PUBLIC HOSPITAL PEER GROUP 2015–16



Source: Australian Commission on Safety and Quality in Health Care, Internal analysis of Admitted Patient Care National Minimum Data Set.

Note: Each dot in the chart represents the rate of HAI infections for an individual hospital.

SUPPORTING USE OF THE HACs FOR LOCAL IMPROVEMENT

In 2017–18, the Commission developed the *Hospital-Acquired Complications Information Kit*, a series of comprehensive fact sheets for 15 HACs.* The information kit provides clinicians, safety and quality professionals, managers, executives, members of governing bodies and others with tools to minimise the occurrence of HACs in their health service. It draws on consultation with clinicians from across Australia and the latest evidence and clinical guidelines.

The information kit aims to:

- Provide strategies to prevent HACs, manage them should they occur and maintain low rates of HACs when they are achieved
- Support clinicians to include evidence based prevention strategies in their delivery of comprehensive patient care
- Assist health services to assess the quality and safety of clinical care by monitoring the incidence and prevalence of HACs and identifying opportunities for improvement
- Support the clinical governance of health services by helping governing bodies to review their structures, processes and clinical outcomes, to identify opportunities for improvement
- Support health services to evaluate the impact of quality improvement initiatives through clinical audit
- Link HACs reduction strategies to the NSQHS Standards and describe how monitoring and responding to HACs

can be used as evidence within the accreditation assessment process

- Provide insights for patients and carers as to the activities health services are undertaking to ensure safety and quality.

The information kit highlights the importance of the ongoing monitoring of HACs, as high or rising rates of HACs might be an indication of a broader safety issue within the service warranting investigation. Conversely, low and decreasing rates of HACs can signify success stories, which should be shared to support safety improvement.

THE POLICY CONTEXT

The HACs list was developed for local monitoring, reporting and improvement. The included HACs are easily and accurately monitored, relevant and actionable, and they are considered to improve the safety of health care if provided to and used by clinicians. Their value is in the fact that the HACs list is small, and therefore manageable, and clinically meaningful. This was supported by proof-of-concept testing during the development of the HACs list.

At the same time as the development of the HACs list, and for the first time, Australian governments have been looking at ways to incorporate safety and quality into the pricing and funding of public hospital services to improve patient outcomes. In 2016, governments agreed to use the Commission's HACs list, along with sentinel events and avoidable readmissions, as ways to encourage improvements in safety, reduce instances of preventable poor quality patient

* A fact sheet has not been prepared for HAC 'unplanned intensive care unit admission'. It is not currently possible nationally to identify patients who have had an unexpected admission to intensive care using the Admitted Patient Care National Minimum Data Set, which is used to monitor HACs.

care, and support improvements in data quality and information available to inform clinicians' practice. Governments committed to introduce a pricing and funding model for HACs from 1 July 2018, which incorporates a funding reduction for patient episodes that involve a HAC.

The Commission's policy objective is to enable both improvement through encouraging local monitoring and action, and improvement through national pricing and funding strategies, because the objectives are interdependent.

Evidence demonstrates that the provision of relevant and timely clinical information to clinicians and managers is an effective driver of safety and quality improvement.¹³ Pricing and funding adjustments at the national level should encourage, among other things, improvements in data quality, which in turn should increase clinical trust in the data. Already, the existence and advance notice of the national pricing and funding system has raised the profile of the prevalence of HACs at the local level, with some hospital groups or local health districts analysing their performance and suggesting innovative ways to improve.

Providing relevant local-level data to clinicians in a transparent and meaningful way (through dashboard type arrangements such as those instituted recently by Queensland Health), will encourage peer review, discussion and the implementation of innovative solutions to problems. Early successes are emerging. Reductions in HACs rates are being reported by some hospitals, local workshops are being held and system interest is increasing.

The Commission's future work is to evaluate the implementation of this complex system of innovation relating to the HACs, make changes where necessary, report on success, re-evaluate and make formative adjustments.



ANNUAL PERFORMANCE STATEMENTS

As the accountable authority of the Australian Commission on Safety and Quality in Health Care, the Board presents the 2017–18 annual performance statements of the Commission, as required under paragraph 39(1)(a) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act). In the opinion of the Board, based on advice from Commission management and the Audit and Risk Committee, these annual performance statements accurately reflect the performance of the Commission and comply with subsection 39(2) of the PGPA Act.



Professor Villis Marshall AC
Board Chair

ENTITY PURPOSE

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

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

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

PERFORMANCE AGAINST THE HEALTH PORTFOLIO BUDGET STATEMENTS AND CORPORATE PLAN 2017–18

The Commission's Corporate Plan 2017–18 was prepared under section 35(1) (a) of the PGPA Act, and published in accordance with section 16E (3) of the Public Governance, Performance and Accountability Rule 2014. The corporate plan describes the planned program of work for the four-year period to 2020–21 and specifies how the Commission will measure its performance during that period. The corporate plan can be accessed on the Commission's website: www.safetyandquality.gov.au/about-us/corporate-plan/

The Commission's performance measures for 2017–18 were published in the corporate plan and also formed the basis of the Commission's entry in the 2017–18 Health Portfolio Budget Statements. Table 6 provides a report against these performance measures.

TABLE 6: REPORT AGAINST PERFORMANCE MEASURES IN THE 2017–18 HEALTH PORTFOLIO BUDGET STATEMENTS

Performance criteria	Target 2017–18	Result against performance criteria
Successful implementation of the NSQHS Standards and ongoing monitoring of safety and quality performance of hospitals and day procedure services	Launch of the revised NSQHS Standards by the end of November 2017	Achieved The Commission released the second edition of the NSQHS Standards in November 2017
	Monitoring HACs for safety and quality	Ongoing The Commission is working with the Independent Hospital Pricing Authority regarding the use of HACs in national funding and pricing for safety and quality
	Tools in use for local monitoring	Achieved The Commission released the <i>Hospital-acquired complications kit</i> in April 2018
	Implementation Patient Experience measurement and pilot testing of Patient Reported Outcome Measures	Ongoing The Commission released the <i>Australian Hospital Patient Experience Question Set</i> in November 2017 The Commission is working with states, territories and individual hospitals to support implementation of the <i>Australian Hospital Patient Experience Question Set</i> Work is underway to identify options for the Commission’s role in supporting use of PROMs
Percentage of hospitals and day procedure services assessed to the NSQHS Standards	100%	Achieved 100%
Percentage of public hospitals meeting the benchmark for hand hygiene compliance	≥80%	Achieved 85% Note: This data is for the 12 month period 1 April 2017 to 31 March 2018 and is based on the latest information from Hand Hygiene Australia

TABLE 6: CONTINUED

Performance criteria	Target 2017–18	Result against performance criteria
Number of clinicians completing the healthcare-associated infection online education modules	≥14,000	<p>Achieved</p> <p>15,897 users registered and completed at least one of the 10 modules</p> <p>Note: This performance measure will be excluded from 2018–19 because it is not possible to distinguish between clinicians completing the online modules and other users.</p>
Provide safety and quality information to the general public	Reporting in the Annual Report on the state of safety and quality in health care for release by the end of October 2017	<p>Achieved</p> <p>The <i>2016–17 Annual Report</i> was published in October 2017 and included information about the state of safety and quality in Australia</p>
	Reporting for the general public – <i>Vital Signs</i> to be released by the end of November 2017	<p>Achieved</p> <p><i>Vital Signs</i> was published in October 2017 and includes information targeted at the general public</p>
	Reporting to the general public through regular ACSQHC newsletters and website publications	<p>Ongoing</p> <p>The Commission:</p> <ul style="list-style-type: none"> • Releases a quarterly electronic newsletter • Releases a weekly summary of safety and quality publications • Has an ongoing daily social media presence
Monitor quality, cost and value through mapping of healthcare variation and action to reduce unwarranted variation	Disseminate maps of healthcare variations in Australia for a set of topic areas	<p>Achieved</p> <p>The Commission released the <i>Second Australian Atlas of Healthcare Variation</i> in June 2017</p> <p>There is an interactive online version of the Atlas series that enables users to explore local area data</p>

TABLE 6: CONTINUED

Performance criteria	Target 2017–18	Result against performance criteria
		Work is underway to release the <i>Third Australian Atlas of Healthcare Variation</i> in late 2018
	Production of clinical resources focusing on high-impact, high-burden and high-variation areas of clinical care	<p>Achieved</p> <p>The Commission released reviews of consumer information about cataract surgery and tonsillectomy in January 2018</p> <p>Work is underway to develop a decision support tool for osteoarthritis of the knee</p> <p>See below for results regarding the clinical care standards</p>
	Develop clinical care standards for consultation, informed by outcomes from the work on healthcare variation	<p>Achieved</p> <p>The Commission released the <i>Heavy Menstrual Bleeding Clinical Care Standard</i> in October 2017</p> <p>Clinical care standards on venous thromboembolism and colonoscopy have been prepared and will be released later in 2018</p> <p>The development of a clinical care standard on cataract surgery has commenced</p>
Provide safety and quality information and resources to health professionals	Provide safety and quality information and resources to health professionals such as: clinical care standards, medication charts, antimicrobial use and resistance data and audit tools	<p>Achieved</p> <p>The Commission has an ongoing role maintaining medication charts and the National Inpatient Medication Chart audit system for national use</p> <p>The Commission released <i>AURA 2017: Second Australian report on antimicrobial use and resistance in human health</i> in July 2017</p> <p>See above for results regarding the clinical care standards</p>

TABLE 6: CONTINUED

Performance criteria	Target 2017–18	Result against performance criteria
Condition specific indicator sets	2	Achieved An indicator set for heavy menstrual bleeding was released in October 2017 An indicator set for venous thromboembolism has been prepared and will be released later in 2018 with the Venous Thromboembolism Clinical Care Standard

The Commission also identified a number of additional deliverables in the Corporate Plan 2017–18. Performance against these deliverables is in Table 7.

TABLE 7: PERFORMANCE AGAINST KEY DELIVERABLES SPECIFIED IN THE 2017–18 CORPORATE PLAN

Key deliverable	Result against key deliverable
<p>Release resources to support the implementation of the NSQHS Standards (2nd edition), with information sessions for health service organisations, training for accrediting agencies and assessors</p>	<p>Achieved</p> <p>The Commission released the first suite of resources in late 2017, with more resources released in April 2018. Available resources include:</p> <ul style="list-style-type: none"> • <i>Guide for Hospitals</i> • <i>Guide for Day Procedure Services</i> • <i>Guide for Multi-Purpose Services and Small Hospitals</i> • <i>Accreditation Workbook</i> • <i>User Guide for Aboriginal and Torres Strait Islander Health</i> • <i>User Guide for Measuring and Evaluating Partnering with Consumers</i> • <i>National Model Clinical Governance Framework</i> <p>Presentations to health service organisations were convened on a state by state basis</p> <p>Training program for accrediting agencies was developed and made available from April 2018</p>
<p>Develop an interactive online resource to provide information for clinicians and others on the NSQHS Standards (2nd edition)</p>	<p>Achieved</p> <p>The Commission released an online resource on the NSQHS Standards in May 2018</p>
<p>Consult with the primary care sector to introduce and support the application of the NSQHS Standards (2nd edition) into this sector</p>	<p>Ongoing</p> <p>Consultation took place between October 2017 and January 2018. Based on consultation feedback, an options paper for future action has been developed for consideration by the Commission’s Board</p>

TABLE 7: CONTINUED

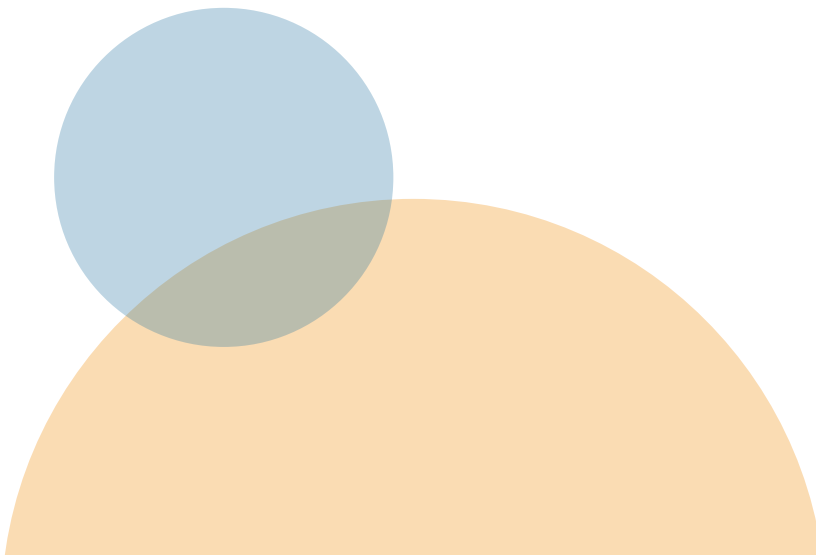
Key deliverable	Result against key deliverable
<p>Finalise the <i>National Model Clinical Governance Framework</i></p> <p>Develop resources for specialist settings and target groups supporting the <i>National Model Clinical Governance Framework</i></p> <p>Establish a consultative network of chairs of governing bodies in Australia</p>	<p>Achieved</p> <p><i>National Model Clinical Governance Framework</i> and supporting resources finalised and released November 2017</p> <p>Work is underway to establish the framework for a network to facilitate engagement with board chairs</p>
<p>Continue support for the National Antimicrobial Resistance Strategy and the dissemination of data and reports for jurisdictional and local AMR and antibiotic usage strategies</p>	<p>Ongoing</p> <p>Support for the National Antimicrobial Resistance Strategy through the AURA Surveillance System is ongoing. Reports published during 2017–18 include:</p> <ul style="list-style-type: none"> • <i>AURA 2017: Second Australian report on antimicrobial use and resistance in human health</i> • <i>National Alert System for Critical Antimicrobial Resistances: first annual report</i>, two 6-monthly summary reports and five bi-monthly data updates • <i>National Antimicrobial Utilisation Surveillance Program</i> annual reports – 2015 and 2016 • <i>Surgical National Antimicrobial Prescribing Survey: Results of the 2016 pilot</i> • <i>Aged Care National Antimicrobial Prescribing Survey 2016</i> • <i>AGAR Annual Sepsis Outcome Program</i> reports – 2015 and 2016
<p>Draft resources for consumers, clinicians, health services and policymakers on attributes of high-performing person-centred healthcare organisations</p> <p>Map these attributes against the requirements of the NSQHS Standards (2nd edition)</p>	<p>Achieved</p> <p>Report and associated fact sheets completed and released June 2018. The fact sheets include links to the NSQHS Standards</p>

TABLE 7: CONTINUED

Key deliverable	Result against key deliverable
Finalise, disseminate and distribute tools and resources to help primary care settings improve their health literacy environment	Achieved Fact sheets on improving the health literacy environment, including in primary care, were released in July 2017
Finalise report on validation study for end-of-life audit tool	Ongoing The report of the validation study has been drafted, and is undergoing a methodological review. It will be published in 2018–19
Finalise toolkit to support measurement of quality end-of-life care in hospitals	Ongoing The toolkit to support measurement of quality end-of-life care was published in June 2018
Draft and consult on indicators for measuring the safety and quality of end-of-life care	Ongoing Scoping regarding indicators for end-of-life care took place in 2017. A roundtable to examine potential for national approaches will take place in 2018–19
Implement a rolling program based on feedback from key users and health sector participants to publish further Atlases or similar reports, identify themes and clarify data items for further atlases and reports, undertake time series analysis of key data items	Ongoing This work is ongoing. In 2017–18 work has been underway to prepare the <i>Third Australian Atlas of Healthcare Variation</i> , which will be published in late 2018
National release of clinical care standards developed in 2016–17, including those on heavy menstrual bleeding and venous thromboembolism	Achieved <i>Heavy Menstrual Bleeding Clinical Care Standard</i> was released in October 2017 Clinical care standards on venous thromboembolism and colonoscopy in final stages of approval before release in late 2018
Progress the Patient Safety and Learning Model, including implementation of the set of hospital-acquired complications, AHPEQs and continuing the development of national core patient-reported outcome measures	Ongoing <i>The Australian Hospital Patient Experience Question Set</i> was released in November 2017 Options for national approaches to patient-reported outcome measures are currently being developed

TABLE 7: CONTINUED

Key deliverable	Result against key deliverable
Finalise development of a best-practice governance model for registry development	An information kit was released in March 2018 to support the use of the data on hospital-acquired complications for local improvement Ongoing This work is ongoing and expected to be completed later in 2018



ANALYSIS OF PERFORMANCE AGAINST PURPOSE

This year has been one of significant achievements for the Commission with the successful delivery of its targets and activities outlined in the *2017–18 Health Portfolio Budget Statements* and the *Corporate Plan 2017–18*.

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

There was no change to the framework in which the Commission operated in 2017–18, and no change to the Commission's purpose, activities or organisational capability. The following examples highlight the Commission's key achievements in 2017–18 and demonstrate the benefits of its national approach:

- The implementation of the NSQHS Standards and the AHSSQA Scheme continues to be a success. As of 30 June 2018, all health service organisations in Australia have been assessed to the NSQHS Standards at least once, and an increasing number have received a second organisation-wide assessment.
- The second edition of the NSQHS Standards was released in November 2017 after being endorsed by health ministers. Assessment to the second edition will be mandatory from January 2019.
- Based on feedback received about the operation of the AHSSQA Scheme, the Commission has developed a package of reforms to improve the accreditation process. Consultation on the AHSSQA Scheme occurred in 2017–18, and work is currently underway to implement the reform strategies.
- The national AURA Surveillance System continues to expand, and involves strategic partnerships with the Australian Group on Antimicrobial Resistance, the National Antimicrobial Prescribing Survey and the National Antimicrobial Utilisation Surveillance Program. Data are also included from the National Alert System for Critical Antimicrobial Resistances and Australian Passive AMR Surveillance.
- The Commission continues to conduct a clinical safety program for the My Health Record system. The program aims to provide quality assurance and enhance clinical safety of the My Health Record system and other national digital health infrastructure.
- The *Second Australian Atlas of Healthcare Variation* was launched in June 2017. Work is underway to finalise the *Third Australian Atlas of Healthcare*

Variation that will be published in late 2018. The third Atlas will focus on appropriateness of care in primary and acute care settings, examining the topic areas of cardiac tests, thyroid investigations and treatments, gastrointestinal investigations and treatments and paediatric and neonatal health. The third Atlas will also look at changes over time from the first Atlas that indicated high-volume prescribing behaviour. This repeat analysis will include the antimicrobial, opioid and psychotropic medicines data items.

- The Commission released a clinical care standard on heavy menstrual bleeding, and developed clinical care standards on venous thromboembolism and colonoscopy that will be released later in 2018. Work on a clinical care standard on cataract surgery has also commenced. These clinical care standards identify and define the care people should expect to receive or be offered, and can play an important role in delivering appropriate care and reducing unwarranted variation.
- The Commission continues to undertake work that has been requested by the COAG Health Council and AHMAC. Of particular importance in 2017–18 was the work that has been done under the National Health Reform Agreement Addendum. This included incorporating the hospital-acquired complications and sentinel events into these national reforms, and extending the Commission's focus on indicators to avoidable hospital readmissions.
- In response to a request from state and territory health departments, the Commission has responded to a number of safety issues that have been raised in relation to the use of transvaginal

mesh devices. In collaboration with the TGA, states, territories, clinicians and consumers, the Commission has developed and released information for consumers about treatment options, and guidance documents regarding hospital credentialing processes for the use of mesh.

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 procedures for risk management and fraud control. It also includes profiles of the Commission's Board and committee members.

Legislation and requirements	76
The Commission's Board	78
Committees	85
Internal governance arrangements	87
External scrutiny	89



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, which sets out its purpose, powers, functions, and administrative and operational arrangements. The National Health Reform Act also sets out the Commission's Constitution, the process for appointing members of the Board and the CEO, and the operation of Board meetings.

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

COMPLIANCE WITH LEGISLATION

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

- Public Governance, Performance and Accountability Act
- 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 2017–18 reporting period.

STRATEGIC PLANNING

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

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.

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 2017–18 reporting period.

RELATED-ENTITY TRANSACTIONS

In accordance with the requirements prescribed by the Public Governance, Performance and Accountability Rule 2014 section 17BE and Department of Finance *Resource Management Guide 136 – Annual reports for corporate Commonwealth entities*, related-entity transactions for 2017–18 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 2017–18 to ensure the coverage was still appropriate for its operations.

During the year, no indemnity-related claims were made, and the Commission knows of no circumstances likely to lead to such claims being made. Many liability limits under the Commission's schedule of cover are standard Australian Government limits, such as \$100 million in cover for general liability and professional indemnity, as well as directors' and officers' liability. The Commission's business interruption indemnity cover is for a period of up to 24 months. Motor vehicle, third-party property damage and expatriate cover have not been taken out, as they do not apply to the Commission.

THE COMMISSION'S BOARD

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

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

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

BOARD MEMBERSHIP 2017–2018

The 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 Willis 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: Appointed to Board on 1 April 2012; appointed as Chair on 1 April 2013 and reappointed as Chair on 1 July 2017.

MR MARTIN BOWLES PSM

Mr Martin Bowles is the National Chief Executive Officer at Calvary Health Care.

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

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

Qualifications: BBus, GCPubSecMgmt

Board membership: Appointed on 14 May 2015.

DR DAVID FILBY PSM

Dr David Filby has worked extensively across the Australian health care landscape in a number of significant policy and executive roles. He has held senior national health policy roles and senior executive positions in Queensland and South Australia. In July 2016,

he completed a term of six and a half years as Executive Consultant for South Australia Health and the Australian Health Ministers' Advisory Council.

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

Qualifications: PhD

Board membership: Appointed on 29 July 2016.

ADJUNCT PROFESSOR JOHN WALSH AM

Professor John Walsh has expertise in the areas of social policy and funding across accident compensation, health and disability, with an Adjunct Professor appointment at the University of Sydney.

Professor Walsh is a board member of the National Disability Insurance Agency, having previously been a Productivity Commissioner. During 2010, he was part of the reference group which recommended a national disability insurance scheme.

Professor Walsh was also the Deputy Chair of the Board of the National Health Performance Authority until June 2016,

chaired the independent panel overseeing *Caring Together: A Health Action Plan for NSW* and has held memberships on several boards including the NSW Motor Accidents Authority and the NSW Home Care Service.

Professor Walsh was a partner at PricewaterhouseCoopers Australia, where he worked for 20 years. In 2011, Professor Walsh was appointed a Member of the Order of Australia and also received the Prime Minister's Award for outstanding service to the disability sector.

Qualifications: BSc, FIAA, FRACP (Hon)

Board membership: Appointed on 29 July 2016.

MS CHRISTINE GEE

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

Ms Gee is also involved in numerous national boards and committees, including the Australian Private Hospitals Association, the 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: Appointed as a Commission member in March 2006; appointed to the Board 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. Other past directorships include 10 years on the Board of Barristers' Chambers Limited, which is the repository of the substantial property assets of the Victorian Bar, and provider of chambers accommodation and ancillary services to its members.

Ms Harris chairs the National Model Clinical Governance Framework Advisory Panel, and is a member of the Bar Council of the Victorian Bar Inc.

Qualifications: LLB (Hons)

Board membership: Appointed on 1 July 2015.

PROFESSOR ALISON KITSON

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

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

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

Board membership: Appointed on 1 July 2017.

PROFESSOR SHAUN LARKIN

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

Prior to taking up his current role Professor Larkin worked at HCF for 20 years. After serving as a General Manager in a number of executive roles (Strategic Development; Benefits Management; Corporate Ventures; and Operations) in December 2009 he was selected to be the Managing Director and for seven years led an organisation with health funding responsibilities for more than 1.5 million Australians, revenues in excess of \$2.5 billion and over 1,300 staff.

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

Prior to joining HCF, Professor Larkin was based in Singapore for four years where he led the establishment of a chain of

ambulatory medical centres throughout Asia and the CIS. Before this he worked for eight years as an executive for a large private hospital operator (Ramsay Health Care) in Australia and the United States.

Qualifications: HlthScD, MHSc, MBA, BHA

Board membership: Appointed on 1 April 2013.

MRS CHERYLE ROYLE

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

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

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

Qualifications: RN, RM, BN, GDip Nursing Administration

Board membership: Appointed on 4 September 2014.



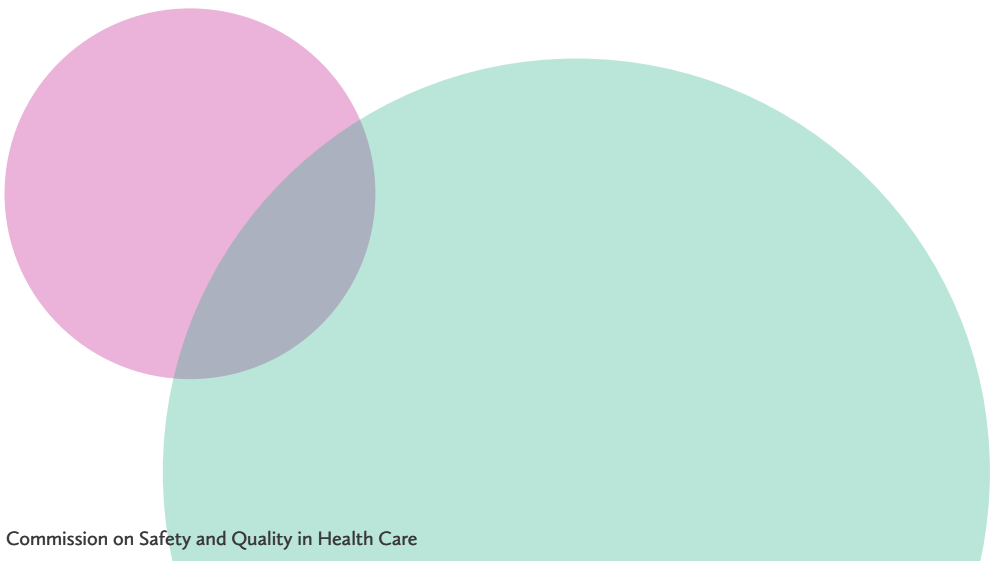
DR HELENA WILLIAMS

Dr Helena Williams brings to the Board active clinical expertise as a general practitioner and governance experience as a previous Clinical Director of the Southern Adelaide-Fleurieu-Kangaroo Island Medicare Local Ltd and a former Presiding Member of the Southern Adelaide Local Health Network Governing Council. She is also currently the GP Liaison Officer at the Adelaide Women's and Children's Hospital.

Dr Williams' other 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: Appointed as a Commission member in April 2008; appointed to the Board on 1 July 2011.



BOARD MEETINGS AND ATTENDANCE

TABLE 8: BOARD MEETINGS AND ATTENDANCE

Name	Board meeting				
	10 August 2017	13 September 2017	26 October 2017	22 February 2018	12 April 2018
Prof. Villis Marshall AC (Chair) ^a	✓	✓	✓	✓	✓
Mr Martin Bowles PSM	✓	×	✓	×	✓
Adj. Professor John Walsh AM ^b	✓	✓	✓	×	✓
Dr David Filby PSM	✓	✓	✓	×	✓
Ms Christine Gee ^c	✓	✓	✓	✓	✓
Professor Alison Kitson ^d	✓	✓	✓	✓	✓
Ms Wendy Harris QC ^e	✓	✓	×	✓	×
Dr Shaun Larkin ^b	✓	✓	✓	✓	✓
Mrs Cheryle Royle ^b	✓	✓	✓	✓	✓
Dr Helena Williams ^c	✓	✓	✓	✓	×

✓ Present

× Absent

^a Term concluded 30 June 2017 and reappointed on 1 July 2017

^b Reappointed 29 July 2016

^c Extended until 30 June 2018

^d Appointed 1 July 2017

^e Appointed 24 July 2015

BOARD DEVELOPMENTS AND REVIEW

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

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

ETHICAL STANDARDS

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



COMMITTEES

The Audit and Risk Committee advised the Commission and the Board on audit, risk and finance.

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

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

AUDIT AND RISK COMMITTEE

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

The Committee's responsibilities include:

- 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 PGPA Act and Rules

- Monitoring the preparation of the Commission's annual Financial Statements and recommending whether or not they be accepted by the Board
- Reviewing the appropriateness of the Commission's performance measures and how these are assessed and reported
- Assessing whether relevant policies are in place to maintain an effective internal control framework, including for security arrangements and business continuity
- Reviewing the work undertaken by the Commission's outsourced internal auditors, including approving the internal audit plan and reviewing all audit reports and issues identified in those reports.

The Audit and Risk Committee met five times during the 2017–18 financial year. Table 9 summarises members' attendance at the committee meetings.

Professor Larkin is a member of the Audit and Risk Committee representing the Board. Mr Trevor Burgess was an external member of the Audit and Risk Committee during 2017–18. Ms Dana Sutton was appointed as an additional external member of the Audit and Risk Committee in March 2018. 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.

TABLE 9: AUDIT AND RISK COMMITTEE ATTENDANCE

Jennifer Clark (Chair)	Trevor Burgess	Shaun Larkin	Dana Sutton
5/5	5/5	3/5	2/2

INTER-JURISDICTIONAL COMMITTEE

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

- Advise the Commission on the adequacy of the policy development process, particularly policy implementation
- Ensure health departments and ministries are aware of new policy directions and are able to review local systems accordingly
- Monitor national actions to improve patient safety, as approved by health ministers

- Help collect national data on safety and quality
- Build effective mechanisms within states and territories to enable national public reporting.

OTHER COMMITTEES AND CONSULTATIONS

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

- Private Sector Committee
- Primary Care Committee.

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

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

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

INTERNAL GOVERNANCE ARRANGEMENTS

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

INTERNAL MANAGEMENT

The Commission has two internal management groups and three committees.

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

RISK MANAGEMENT

Risk management is part of the Commission's strategy to promote accountability through good governance and robust business practices. The Commission is committed to embedding risk-management principles and practices consistent with the Australian standard of *Risk Management – Principles and Guidelines* (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 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 staff 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

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. 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 freedom of information activities for 2017–18.

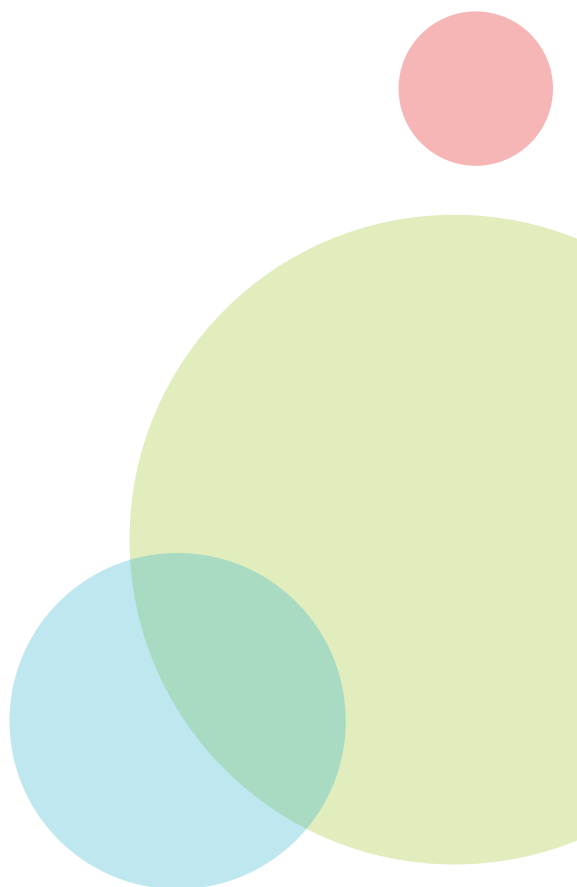
JUDICIAL DECISIONS AND REVIEWS BY EXTERNAL BODIES

No judicial decisions or external reviews significantly affected the Commission in 2017–18.

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 2017–18.

PARLIAMENTARY AND MINISTERIAL OVERSIGHT

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



EXECUTIVE REMUNERATION

TABLE 10: REMUNERATION PAID TO EXECUTIVES DURING THE REPORTING PERIOD IN 2017–18

Total remuneration	Executives no. \$	Average reportable salary \$	Average contributed superannuation \$	Average allowances \$	Average bonus paid \$	Average total remuneration \$
\$200,000 and less	1	30,855	3,835	–	–	34,690
\$200,001 to \$250,000	0	–	–	–	–	–
\$250,001 to \$300,000	0	–	–	–	–	–
\$300,001 to \$350,000	1	237,289	40,134	265	23,331	301,019
\$350,001 to \$400,000	0	–	–	–	–	–
\$400,001 to \$450,000	1	404,814	19,985	375	–	425,174
Total number of executives	3	–	–	–	–	–

Note: Data does not include two individuals as they have not provided consent to disclose.

TABLE 11: REMUNERATION PAID TO HIGHLY PAID STAFF DURING THE REPORTING PERIOD IN 2017–18

Total remuneration	Executives no. \$	Average reportable salary \$	Average contributed superannuation \$	Average allowances \$	Average bonus paid \$	Average total remuneration \$
\$200,001 to \$250,000	3	169,707	28,820	483	19,712	218,722
\$250,001 to \$300,000	2	226,713	38,090	–	24,892	289,695
\$300,001 to \$350,000	2	247,791	42,201	–	26,477	316,469

TABLE 11: CONTINUED

Total remuneration	Executives no.	Average reportable salary	Average contributed superannuation	Average allowances	Average bonus paid	Average total remuneration
	\$	\$	\$	\$	\$	\$
\$350,001 to \$400,000	0	-	-	-	-	-
Total number of executives	7	-	-	-	-	-

Note: Data does not include one individual as they have not provided consent to disclose.

DEVELOPMENTS AND SIGNIFICANT EVENTS

The Commission is required under paragraph 19(1) of the PGPA Act to keep the Health Minister and the Finance Minister informed of any significant decisions or issues that have affected or may affect its operations. In 2017–18, there were no such decisions or issues.

ENVIRONMENTAL PERFORMANCE AND ECOLOGICALLY SUSTAINABLE DEVELOPMENT

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

ADVERTISING AND MARKET RESEARCH

Section 331A of the *Commonwealth Electoral Act 1918* requires Australian Government departments and agencies to include particulars in their annual reports of amounts over \$13,200 that were paid to advertising agencies, market research organisations, polling organisations, direct mail organisations or media advertising organisations. In 2017–18, the Commission did not make any payments over \$13,200 to advertising or market research organisations.

NATIONAL HEALTH REFORM ACT AMENDMENTS

No amendments to the *National Health Reform Act* were made during the 2017–18 financial year.

GOVERNMENT POLICY ORDERS

No government policy orders applicable to the Commission were issued in 2017–18.



OUR ORGANISATION

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

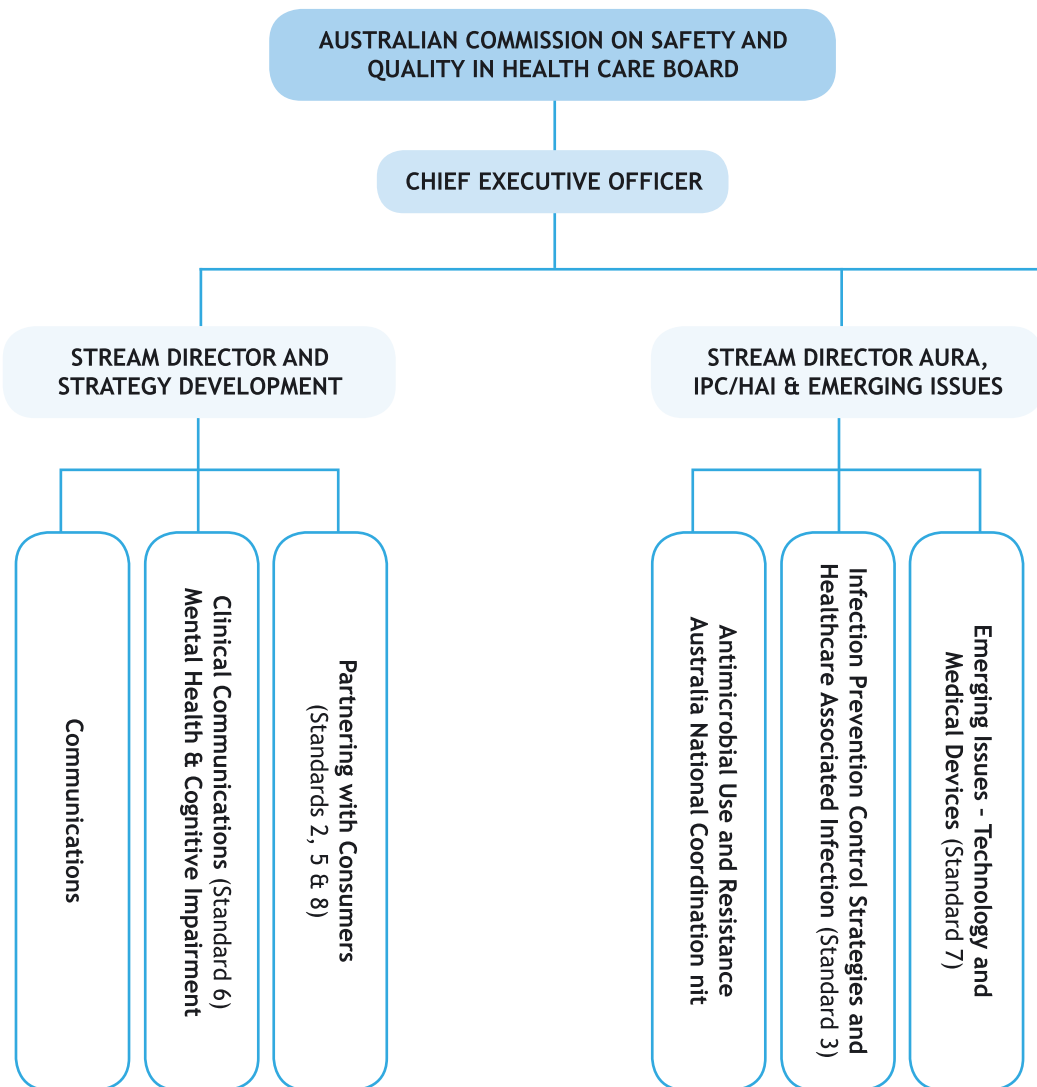
The Commission is committed to managing and developing its employees to achieve the objectives and outcomes contained in its work plan.

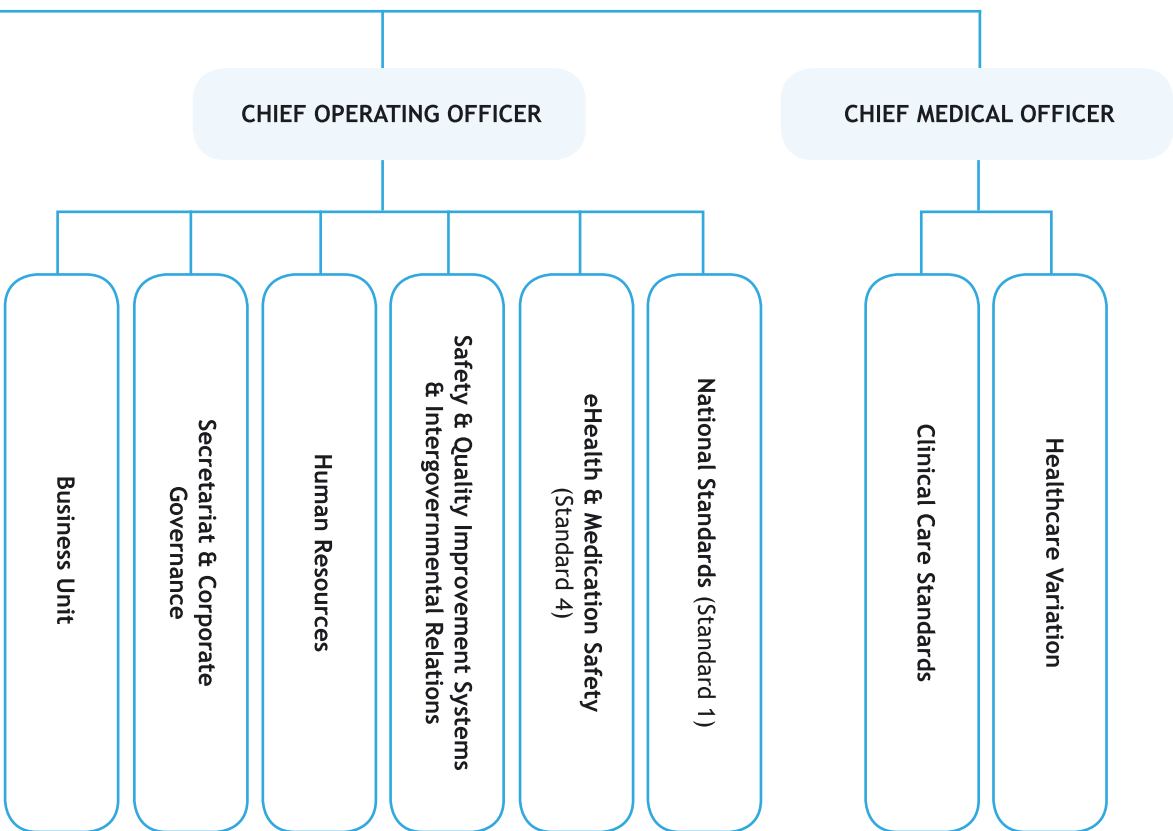
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ORGANISATIONAL STRUCTURE

FIGURE 4: ORGANISATIONAL STRUCTURE





PEOPLE MANAGEMENT

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

The Commission implemented a new performance development scheme in 2017–18, adopting an approach that places greater emphasis on employees and managers having regular, meaningful performance discussions. All employees are required to have an individual performance and development plan in place, and managers and employees have joint accountability for capability and career development.

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

In May 2018, the Commission encouraged all staff members to participate in the Public Service Commission’s employee census survey.



STAFF PROFILE

As of 30 June 2018, the Commission employed 72.2 full-time equivalent employees. Most employees are located in Sydney. Table 12 provides a breakdown of the Commission's employee profile by classification, gender, full-time or part-time status, and ongoing or non-ongoing status.

TABLE 12: EMPLOYEE PROFILE AS OF 30 JUNE 2018

Classification	Female				Male				Total
	Ongoing		Non-ongoing		Ongoing		Non-ongoing		
	Full time	Part time	Full time	Part time	Full time	Part time	Full time	Part time	
CEO			1.0						1.0
MO6	1.0					0.8		0.4	2.2
EL 2	8.0	2.3	1.0		6.0	0.8			18.1
EL 1	14.6	5.7	2.2	2.3	7.0		1.0		32.8
APS 6	5.0	2.1	2.0	0.6	1.8				11.5
APS 5	1.0				4.2				5.2
APS 4	1.0								1.0
APS 2								0.4	0.4
Total	30.6	10.1	6.2	2.9	19.0	1.6	1.0	0.8	72.2



WORKPLACE HEALTH AND SAFETY

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

The Commission undertook a number of activities during 2017–18 to encourage employees to adopt healthy work and lifestyle practices, including:

- Conducting ergonomic workstation assessments as required and providing access to standing desks
- Conducting biannual workplace inspections and encouraging all staff members to report incidents, accidents or hazards in the workplace
- Appointing a new work health and safety representative
- Providing access to an employee assistance program
- Providing an ‘R U OK’ training session for all staff members
- Making influenza vaccinations available to all staff members
- Providing access to reimbursement of eyewear costs for use with screen-based equipment.

Two minor incidents were reported in 2017–18. There were no notifiable incidents in 2017–18. No notices were issued to the Commission and no investigations were initiated in 2017–18 under the *Work Health and Safety Act*.

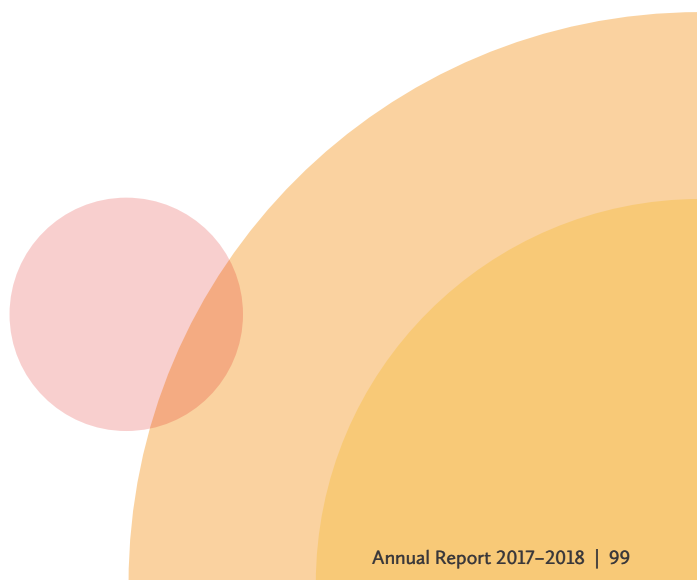
LEARNING AND DEVELOPMENT

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

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

During 2017–18, the Commission’s study support and training arrangements ensured the ongoing development of staff members’

skills and capabilities. Participation in study and training included 12 staff members accessing study support assistance and 25 staff members completing 30 external training courses. Commission staff members are currently undertaking a range of tertiary courses, including Master of Public Health, Master of Health Service Management and Master of Health Policy courses, and various graduate certificates in health-related fields.



WORKPLACE DIVERSITY

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

Commission staff participated in NAIDOC Week activities in July 2017 and celebrated Harmony Day, a day celebrated around Australia on 21 March each year to promote cultural diversity.

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

During 2017–18, the Commission participated in the Australian Public Service Disability Champions Network.

ABORIGINAL AND TORRES STRAIT ISLANDER EMPLOYMENT

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



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INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Australian Commission on Safety and Quality in Health Care for the year ended 30 June 2018:

- (a) comply with Australian Accounting Standards – Reduced Disclosure Requirements and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and
- (b) present fairly the financial position of the Australian Commission on Safety and Quality in Health Care as at 30 June 2018 and its financial performance and cash flows for the year then ended.

The financial statements of the Australian Commission on Safety and Quality in Health Care, which I have audited, comprise the following statements as at 30 June 2018 and for the year then ended:

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

Basis for Opinion

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

Accountable Authority's Responsibility for the Financial Statements

As the Accountable Authority of the Australian Commission on Safety and Quality in Health Care the Directors 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 – Reduced Disclosure Requirements and the rules made under that Act. The Directors are also responsible for such internal control as the Directors determine are necessary to enable the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

Australian National Audit Office



Colin Bienke
Senior Director

Delegate of the Auditor-General

Canberra
12 September 2018

FINANCIAL STATEMENTS


Australian Commission on Safety and Quality in Health Care


Statement by the Directors, Chief Executive and Chief Financial Officer


In our opinion, the attached financial statements for the year ended 30 June 2018 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


.....
Adj. Professor Debora Picone AM
Chief Executive Officer


.....
Mike Wallace
Chief Operating Officer /
Chief Financial Officer

Date: 11.09.18

Date: 11.09.18

Date: 11.9.18

Statement of Comprehensive Income

for the period ended 30 June 2018

	Notes	2018 \$'000	2017 \$'000	Original Budget \$'000	
EXPENSES					
Employee benefits	1.1A	11,499	12,206	12,941	A
Suppliers	1.1B	13,009	16,577	8,606	B
Depreciation and amortisation	2.2A	177	260	100	C
Finance costs		-	-	-	
Total expenses		24,685	29,043	21,647	
LESS:					
OWN-SOURCE INCOME					
Own-source revenue					
Rendering of services	1.2A	5,856	10,789	2,643	B
Interest	1.2B	157	216	200	D
External contributions	1.2C	7,628	7,406	7,628	
Total own-source revenue		13,641	18,411	10,471	
Net cost of services		11,044	10,632	11,176	E
Revenue from Government	1.2D	11,166	10,920	11,176	
Surplus		122	288	-	
Total comprehensive income		122	288	-	E

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

Original Budget Compared to 2018 Actual Variance Commentary

Statement of Comprehensive Income

^A Variance arises due to a lower average staffing level than was forecast when the budget was prepared.

^B A portion of the variance arises due to additional funding for projects in 2017-18 that were not contracted when the budget was prepared.

^C Additional asset acquisitions of leasehold improvements and intangible assets were not forecast when the budget was prepared.

^D Interest rates received were lower than anticipated when the budget was prepared.

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

Statement of Financial Position

as at 30 June 2018

	Notes	2018 \$'000	2017 \$'000	Original Budget \$'000	
ASSETS					
Financial Assets					
Cash and cash equivalents	2.1A	9,740	6,333	6,851	A
Trade and other receivables	2.1B	1,808	1,858	2,182	B
Total financial assets		11,548	8,191	9,033	
Non-Financial Assets					
Property, plant and equipment	2.2A	584	138	38	C
Other non-financial assets	2.2B	186	530	391	D
Total non-financial assets		770	668	429	
Total assets		12,318	8,859	9,462	
LIABILITIES					
Payables					
Suppliers	2.3A	1,282	1,796	3,023	E
Other payables	2.3B	5,629	1,773	1,789	A
Total payables		6,911	3,569	4,812	
Provisions					
Employee provisions	3.1	2,571	2,576	2,224	F
Total provisions		2,571	2,576	2,224	
Total liabilities		9,482	6,145	7,036	
Net assets		2,836	2,714	2,426	
EQUITY					
Contributed equity		1,836	1,836	1,836	
Reserves		5	5	484	G
Retained surplus		995	873	106	H
Total equity		2,836	2,714	2,426	

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

Original Budget Compared to 2018 Actual Variance Commentary - Statement of Financial Position

^A The budget reflects only contracted projects when the budget was prepared. The variance arises due to funding received in advance of project expenditure. This affects the balances disclosed for Cash and Other Payables (deferred revenue).

^B The budget is prepared based on past experience. Actual outstanding invoices were less than anticipated.

^C Variance arises due to acquisitions made for the lease of level 6, 255 Elizabeth Street that commenced at 1 January 2018. Development of intangible software assets was also not forecast.

^D The budget is prepared based on past experience. Prepayments were lower than anticipated.

^E The payables balance reflects the unpaid supplier invoices at year end that are a result of timing of work on projects.

^F The impact of low staff turnover on the employee provision calculation has increased the long service leave liability due to an increased probability staff will receive their entitlement.

^G The original budget allocated a balance to reserves that should have been reflected within the retained surplus.

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

Statement of Changes in Equity

for the period ended 30 June 2018

	2018	2017	Original Budget
	\$'000	\$'000	\$'000
CONTRIBUTED EQUITY			
Opening balance	1,836	1,836	1,836
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			
Opening balance	873	585	106 A
Comprehensive income			
Surplus for the period	122	288	- A
Total comprehensive income	122	288	- A
Closing balance as at 30 June	995	873	106 A
Closing balance attributable to the Australian Government	995	873	106 A
ASSET REVALUATION RESERVE			
Opening balance	5	5	484 B
Total comprehensive income	-	-	-
Closing balance as at 30 June	5	5	484
Closing balance attributable to the Australian Government	5	5	484
TOTAL EQUITY			
Opening balance	2,714	2,426	2,426 A
Comprehensive income			
Surplus for the period	122	288	- A
Total comprehensive income	122	288	-
Closing balance attributable to the Australian Government	2,836	2,714	2,426 A

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

Original Budget Compared to 2018 Actual Variance Commentary Statement of Changes in Equity

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

^B The original budget allocated a balance to reserves that should have been reflected within the retained surplus.

Cash Flow Statement

for the period ended 30 June 2018

	Notes	2018 \$'000	2017 \$'000	Original Budget \$'000
OPERATING ACTIVITIES				
Cash received				
Receipts from Government		11,166	10,920	11,176
State and Territory contributions		7,628	7,406	7,628
Rendering of services		9,552	7,078	2,493 A
Interest		142	249	200 B
Net GST received		1,011	1,076	500 C
Total cash received		29,499	26,729	21,997
Cash used				
Employees		(11,507)	(12,137)	(12,941) D
Suppliers		(13,962)	(19,110)	(11,056) E
Total cash used		(25,469)	(31,247)	(23,997)
Net cash from (used by) operating activities		4,030	(4,518)	(2,000)
INVESTING ACTIVITIES				
Cash used				
Purchase of property, plant and equipment		(623)	-	-
Total cash used		(623)	-	-
Net cash used by investing activities		(623)	-	-
Net increase (decrease) in cash held		3,407	(4,518)	(2,000)
Cash and cash equivalents at the beginning of the reporting period		6,333	10,851	8,851
Cash and cash equivalents at the end of the reporting period	2.1A	9,740	6,333	6,851

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

Original Budget Compared to 2018 Actual Variance Commentary Cash Flow Statement

^A The budget reflects only contracted projects when the budget was prepared. The variance is due to funding for projects in 2017-18 that were not contracted when the budget was prepared.

^B Interest rates received were lower than anticipated when the budget was prepared.

^C The balance was underestimated when the budget was prepared in line with other line items relating to supplier expenditure within the statements.

^D Variance arises due to a lower average staffing level than was forecast when the budget was prepared.

^E Variance arises due to increased project activity with project funding received and increased expenditure on projects than was forecast when the budget was prepared.

^F Variance arises due to acquisitions made for the lease of level 6, 255 Elizabeth Street that commenced at 1 January 2018 and equipment upgrades not forecast. Development of intangible software assets were also not forecast.

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Overview

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 - 1.2. Income
2. Financial Position
 - 2.1. Financial Assets
 - 2.2. Non-Financial Assets
 - 2.3. Payables
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 - 3.3. Related Party Disclosures
4. Managing Uncertainties
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Overview

Objectives of the Commission

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

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

The Commission is structured to meet a single outcome:

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

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

Basis of Preparation of the Financial Statements

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

The financial statements have been prepared in accordance with:

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

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

New Accounting Standards

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

Taxation

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

Budget Variances Commentary

The notes to each of the primary statements include a comparison of the original budget as presented in the 2017-18 Portfolio Budget Statements (PBS) to the Commission's 2017-18 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.

1 Financial Performance

1.1 Expenses

	2018	2017
	\$'000	\$'000
1.1A: Employee Benefits		
Wages and salaries	8,318	9,076
Superannuation:		
Defined contribution plans	1,315	1,363
Defined benefit plans	225	259
Leave and other entitlements	1,618	1,449
Other employee benefits	23	59
Total employee benefits	11,499	12,206

Accounting Policy

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

1.1B: Suppliers

Goods and services

Contracts for services	7,673	10,672
Staff travel	292	401
Committee expenses	853	1,041
Information and communication	836	950
Printing and postage	874	832
Property outgoings	244	424
Other	561	724
Total goods and services	11,333	15,044

Goods and services are made up of:

Goods supplied	904	857
Services rendered	10,429	14,187
Total goods and services	11,333	15,044

Other supplier expenses

Operating lease rentals		
Minimum lease payments	1,514	1,306
Workers compensation expenses	162	227
Total other supplier expenses	1,676	1,533
Total supplier expenses	13,009	16,577

	2018	2017
	\$'000	\$'000

Leasing commitments

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

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

Within 1 year	1,723	644
Between 1 to 5 years	4,306	-
More than 5 years	-	-
Total operating lease commitments	6,029	644

Accounting Policy

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

1.2 Income

	2018	2017
	\$'000	\$'000
OWN-SOURCE REVENUE		

1.2A: Rendering of Services

Rendering of services	<u>5,856</u>	10,789
Total sale of goods and rendering of services	<u>5,856</u>	10,789

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:

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

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

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

1.2B: Interest

Deposits	<u>157</u>	216
Total interest	<u>157</u>	216

Accounting Policy

Interest revenue is recognised using the effective interest method.

1.2C: External Contributions

States and Territories contributions	<u>7,628</u>	7,406
Total external contributions	<u>7,628</u>	7,406

1.2D: Revenue from Government

Department of Health:

Corporate Commonwealth entity payment item – Australian Health Ministers Advisory Council (AHMAC)	7,628	7,406
Corporate Commonwealth entity payment item – Smaller government measures	<u>3,538</u>	3,514
Total revenue from Government	<u>11,166</u>	10,920

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

	2018	2017
	\$'000	\$'000
2.1A: Cash and Cash Equivalents		
Cash on hand or on deposit	9,740	6,333
Total cash and cash equivalents	9,740	6,333

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 receivables:

Goods and services	1,556	1,434
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Total goods and services receivable	1,556	1,434
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Other receivables:

Receivable from the Australian Taxation Office	223	410
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Interest	29	14
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Total other receivables	252	424
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Total trade and other receivables (gross)	1,808	1,858
--	--------------	--------------

Total trade and other receivables (net)	1,808	1,858
--	--------------	--------------

No receivables were impaired at 30 June 2018 (2017: 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.

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 2018

	Leasehold improvement \$'000	Plant and equipment \$'000	Intangible assets \$'000	Total \$'000
As at 1 July 2017				
Gross book value	479	103	-	582
Accumulated amortisation, depreciation and impairment	(359)	(85)	-	(444)
Net book value 1 July 2017	120	18	-	138
Additions:				
By purchase	127	192	-	319
Work in progress	-	-	304	304
Depreciation and amortisation expense	(140)	(37)	-	(177)
Net book value 30 June 2018	107	173	304	584
Net book value as of 30 June 2018 represented by:				
Gross book value	606	295	304	1,205
Accumulated amortisation, depreciation and impairment	(499)	(122)	-	(621)
	107	173	304	584

Additions relate to leasehold improvements as part of the lease of part of Level 6, 255 Elizabeth Street and related plant and equipment installation. Intangible assets under development are internally developed software assets.

Accounting Policy

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

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the statement of financial position, except for purchases of leasehold improvements costing less than \$50,000, intangible assets costing less than \$100,000, and for all other purchased of property, plant and equipment costing less than \$4,500, 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.

Accounting Policy continued

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>2018</u>	<u>2017</u>
Leasehold improvements	Lease term	Lease term
Plant and equipment	5 years	5 years

Impairment

All assets were assessed for impairment at 30 June 2018. 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 costs.

Derecognition

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

Intangibles

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

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives of the entity's software is 5 years (2017: the Commission did not hold intangible assets).

All software assets were assessed for indications of impairment as at 30 June 2018.

2018 2017
\$'000 \$'000

2.2B: Other Non-Financial Assets

Prepayments	186	530
Total other non-financial assets	186	530

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

2.3: Payables

2.3A: Suppliers

Trade creditors and accruals	1,282	1,796
Total supplier payables	1,282	1,796

Settlement is usually made within 30 days.

2.3B: Other Payables

Salaries and wages	60	62
Superannuation	10	11
Unearned income	5,504	1,687
Other	55	13
Total other payables	5,629	1,773

3 People and Relationships

2018	2017
\$'000	\$'000

3.1 Employee Provisions

Leave	<u>2,571</u>	<u>2,576</u>
Total employee provisions	<u>2,571</u>	<u>2,576</u>

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 the Department of Finance shorthand method as described under the FRR. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Superannuation

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

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

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

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

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

3.2 Key Management Personnel Remuneration

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Commission, directly or indirectly, including any director (whether executive or otherwise) of the Commission. The Commission has determined the key management personnel to be the Chief Executive, Chief Operating Officer, 4 Senior Medical Officers and 10 Directors. Key management personnel remuneration is reported in the table below:

	2018	2017
	\$'000	\$'000
Short-term employee benefits	1,520	1,526
Post-employment benefits	187	201
Other long-term benefits ¹	157	172
Termination benefits	-	-
Total key management remuneration expenses²	1,864	1,899

The total number of key management personnel that are included in the above table are 16 (2017: 17). One director, for part of the period, waived their right or were not eligible to receive remuneration during 2018 (2017: 2).

¹ The 2017 comparative figure has been restated to reflect an adjustment to capture the accrual of all leave entitlements for the period.

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

3.3 Related Party Disclosures

Related party relationships

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

Transactions with related parties

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

Several directors of the Commission hold directorships with other organisations. 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.

The following transactions with related parties occurred during the financial year:

- Dr Helena Williams provided project support and expert advice to the Commission. Fees paid by the Commission for these services were \$1,978 (2017: \$5,339).
- The spouse of a director, through their employment, was involved in the provision of advice to the Commission regarding a project review. The value of the project review was \$248,600.

4 Managing Uncertainties

4.1 Contingent Assets and Liabilities

Quantifiable Contingencies

As at 30 June 2018, the Commission had no quantifiable contingencies (2016-17: nil).

Unquantifiable Contingencies

As at 30 June 2018, the Commission had no unquantifiable contingencies (2016-17: nil).

Significant Remote Contingencies

As at 30 June 2018, the Commission had no material remote contingencies (2016-17: nil).

4.2 Financial Instruments

4.2A: Categories of financial instruments

	2018 \$'000	2017 \$'000
Financial assets		
Cash on hand and at bank	9,740	6,333
Trade and other receivables	1,585	1,448
Total financial assets	11,325	7,781
Financial liabilities		
Financial liabilities measured at amortised cost:		
Trade creditors and accruals		
Suppliers	1,282	1,796
Total financial liabilities	1,282	1,796

4.2B: Net gains or losses on financial assets

Interest revenue	157	216
Net gain from financial assets	157	216

The Commission holds only cash and receivables as financial assets and trade creditors and accruals as financial liabilities. Financial assets are recognised and derecognised upon trade date. Supplier payables are recognised at amortised cost. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).

Effective Interest Method

Income is recognised on an effective interest rate basis.

4.3: Fair Value Measurement

Accounting Policy

The Commission seeks independent valuation for material non-financial assets on a triennial basis. The Commission procured the services of the 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.

	Fair value measurement at the end of the reporting period	
	2018 \$'000	2017 \$'000
Non-financial assets		
Leasehold improvements	107	120
Plant and Equipment	173	18
Total non-financial assets	280	138

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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 89.

TABLE 13: FREEDOM OF INFORMATION SUMMARY 2017–18

Activity	Number
Requests	
On hand at 1 July 2017	0
New requests received	2
Total requests handled	2
Total requests completed as at 30 June 2018	2
Total requests on hand as at 30 June 2018	0
Action of request	
Access granted in full	0
Access granted in part	0
Access refused	0
Access transferred in full	0
Request withdrawn	1
No records	1
Response times	
0–30 days	2
30–60 days	0

TABLE 13: CONTINUED

Activity	Number
Internal review	
On hand as at 1 July 2018	0
Requests received	0
Decision affirmed	0
Decision amended	0
Request withdrawn	0
Review by Administrative Appeals Tribunal	
Applications received	0
Review by the Office of the Australian Information Commissioner	
Applications received	1

APPENDIX B: COMPLIANCE TO 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* (EPBC) Act.

TABLE 14: SUMMARY OF THE COMMISSION’S COMPLIANCE WITH ECOLOGICALLY SUSTAINABLE DEVELOPMENT

EPBC Act requirement	Commission response
The activities of the Commission during 2017–18 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 2017–18 contribute to ecologically sustainable development	The Commission’s single appropriations outcome focuses on improving safety and quality in health care across the Australian health system. As such, the Commission does not directly contribute to ecologically sustainable development.
Effects of the Commission’s activities on the environment	The Commission’s offices are located in a 5-star* (NABERS rating) building, with the Commission working proactively with the building management to achieve energy savings where possible. The Commission continues to improve its dissemination of publications, reports and written materials through electronic media to minimise printing output.

* Based on the National Australian Built Environment Rating System

TABLE 14: CONTINUED

EPBC Act requirement	Commission response
Measures the Commission is taking to minimise its impact on the environment	<p>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.</p> <p>To reduce travel, the Commission uses remote meeting attendance options where feasible.</p> <p>The responsible use and disposal of materials, electricity and water is expected of all staff and visitors.</p>
Mechanisms for reviewing and increasing the effectiveness of those measures	<p>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.</p>

APPENDIX C: RELATED-ENTITY TRANSACTIONS

TABLE 15: RELATED-ENTITY TRANSACTIONS

Vendor No.	Commonwealth Entity	Number of Transactions	Transaction Value	Description
100362	Department of Health	12	\$564,706.88	Payments processes in 2017-18 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
AHMAC	Australian Health Ministers Advisory Council
AHPEQS	Australian Hospital Patient Experience Question Set
AHSSQA	Australian Health Service Safety and Quality Accreditation
AM	Member of the Order of Australia
AMR	Antimicrobial Resistance
APAS	Australian Passive AMR Surveillance
APS	Australian Public Service
AURA	Antimicrobial Use and Resistance in Australia
CHC	COAG Health Council
COAG	Council Of Australian Governments
CorePEQS	Australian Core Patient Experience Question Set
EMM	Electronic medication management
FIAA	Fellow of the Institute of Actuaries of Australia
FRACGP	Fellow of the Royal Australian College of General Practitioners
FRACS	Fellow of the Royal Australasian College of Surgeons
HAC	Hospital-acquired Complication
HACs CCAG	Hospital-acquired Complication Clinical Curation Advisory Group
HAI	Healthcare-Associated Infection
HCF	Hospitals Contribution Fund of Australia
HMC	Hospital Medication Chart
ICU	Intensive Care Unit
IHPA	Independent Hospital Pricing Authority
MD	Doctor of Medicine
NHA	National Health Agreement

NHRA	National Health Reform Act
NIMC	National Inpatient Medication Chart
NSMC	National Standard Medication Charts
NSQHS	National Safety and Quality Health Service
NSTEMI	Non-ST-Myocardial Infarction
PBS	Pharmaceutical Benefits Scheme
PBS HMC	Pharmaceutical Benefits Scheme Hospital Medication Chart
PSM	Public Service Medal
PROM	Patient-Reported Outcome Measure
RM	Registered Midwife
RN	Registered Nurse
STEMI	ST-Myocardial Infarction
TGA	Therapeutic Goods Administration

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. ¹⁴
Antimicrobial resistance	A property of organisms – including bacteria, viruses, fungi and parasites – that allows them to grow or survive in the presence of antimicrobial levels that would normally suppress growth or kill susceptible organisms.
Antimicrobial stewardship	A program implemented in a health service organisation to reduce the risks associated with increasing antimicrobial resistance, and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies, including monitoring and reviewing antimicrobial use. ¹⁴
Clinical care standards	Standards developed by the Commission and endorsed by health ministers that identify and define the care people should expect to be offered or receive for specific conditions.
Clinical communication	The exchange of information about a person’s care that occurs between treating clinicians, the patient and members of a multidisciplinary team. Communication can take different forms, including face-to-face or electronic communication, or communication via telephone, written notes or other documentation.
Clinical governance	The set of relationships and responsibilities established by a health service organisation between its department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care and continuously improve services.

Clinical handover	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. ¹⁵
Clinician	A healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or teams of health professionals, who spend the majority of their time delivering direct clinical care.
Cognitive impairment	Deficits in one or more of the areas of memory, communication, attention, thinking and judgement. Cognitive impairment can be temporary or permanent, and can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Dementia and delirium are common forms of cognitive impairment seen in hospitalised older patients. ¹⁶ Cognitive impairment can also be caused by a range of other conditions, such as an acquired brain injury, a stroke, intellectual disability or drug use.
Consumers	A person who has used, or may potentially use, health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes. ¹⁷
Core Hospital-Based Outcome Indicators (CHBOI)	A succinct set of indicators that hospitals routinely monitor and review. These hospital-based outcome indicators can be generated by state or territory health authorities or private hospital owners that hold the source data and reported back to the facilities that provide healthcare services.
Delirium	An acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the course of the day. Delirium is a serious condition that can be prevented in 30–40% of cases, and should be treated promptly and appropriately. Hospitalised older people with existing dementia are at the greatest risk of developing delirium. Delirium can be hyperactive (the person has heightened arousal, or can be restless, agitated and aggressive) or hypoactive (the person is withdrawn, quiet and sleepy). ¹⁸
Electronic medication management system	Enables medicines to be prescribed, dispensed, administered and reconciled electronically.

End of life	The period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events such as sepsis, stroke or trauma. ¹⁹
Hand hygiene	A general term referring to any hand-cleansing action.
Healthcare variation	This occurs where patients with the same condition receive different types of care. For example, among a group of patients with the same condition, some may have no active treatment, some may be treated in the community and others in hospital, and some may have surgery while others receive medication. Some variation in how health care is provided is desirable because of differences in patients' needs, wants and preferences (see 'unwarranted healthcare variation').
Healthcare-associated infections	Infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare-associated infections may manifest after people leave healthcare facilities. ²⁰
Hospital-acquired complications	A hospital-acquired complication is a complication for which clinical risk-mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring
Medication chart	A chart used by an authorised prescriber to record medication and treatment orders, as well as by nursing staff to record and monitor the administration of such medicines and treatment.
My Health Record	A secure online summary of a consumer's health information, managed by the System Operator of the national e-health record system (the Secretary to the Australian Government Department of Health). Healthcare providers are able to share health records to a consumer's My Health Record, in accordance with the consumer's access controls. This may include information such as medical history and treatments, diagnoses, medications and allergies. Also known as a Personally Controlled Electronic Health Record.
National Safety and Quality Health Service (NSQHS) Standards	Standards developed by the Commission in consultation and collaboration with states and territories, technical experts, health service organisations and patients. The NSQHS Standards aim to protect the public from harm, and to improve the quality of health services. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum safety and quality standards are met, and a quality improvement mechanism that allows health service organisations to realise aspirational or developmental goals.

Partnering with consumers	Treating consumers and/or carers with dignity and respect, communicating and sharing information between consumers and/or carers and health service organisations, encouraging and supporting consumers' participation in decision-making, and fostering collaboration between consumers and/or carers and health service organisations in planning, designing, delivering and evaluating health care. Other terms are used internationally, such as patient-based, consumer-centred, person-centred, relationship-based, patient-centred, and patient- and family-centred care.
Patient	A person receiving health care. Synonyms for 'patient' include 'consumer' and 'client'.
Patient safety	Reducing the risk of unnecessary harm associated with health care to an acceptable minimum.
Shared decision making	The integration of a patient's values, goals and concerns with the best available evidence about the benefits, risks and uncertainties of treatment to achieve appropriate healthcare decisions. ²¹
Standard	Agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.
Unwarranted healthcare variation	Variation not attributed to a patient's needs, wants or preferences. It may reflect differences in clinicians' practices, the organisation of health care or people's access to services. It may also reflect poor-quality care that is not in accordance with evidence-based practice.

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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 PGPA Act came into effect on 1 July 2014. The Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 prescribes the reporting requirements for the Commission.

TABLE 16: MANDATORY REPORTING ORDERS AS REQUIRED UNDER LEGISLATION

Requirement	Reference	Page listing of compliant information
Accountable authority	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(j)	78–83
Amendments to the Commission’s enabling legislation and to any other legislation directly relevant to its operation	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(a)	91
Approval by the accountable authority	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 section 17BB	1
Assessment of the impact of the performance of each of the Commission’s functions	National Health Reform Act subsection 53(a)	16–73
Assessment of the safety of health care services provided	National Health Reform Act subsection 53(b)(i)	54–55
Assessment of the quality of health care services provided	National Health Reform Act subsection 53(b)(ii)	54–55
Board committees	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(j)	85–86

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Requirement	Reference	Page listing of compliant information
Ecologically sustainable development and environmental performance	Environment Protection and Biodiversity Conservation Act, section 516A	91
Enabling legislation, functions and objectives	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(a)	6, 76
Financial statements	Public Governance, Performance and Accountability Act subsection 43(4)	106–125
Financial statements certification: a statement, signed by the accountable authority	Public Governance, Performance and Accountability Act subsection 43(4)	106
Financial statements certification: Auditor-General's Report	Public Governance, Performance and Accountability Act subsection 43(4)	104–105
Government policy orders	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(e)	91
Indemnities and insurance premiums for officers	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(t)	77
Judicial decisions and decisions by administrative tribunals	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(q)	89
Key activities and changes that have affected the Commission	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(p)	89
Location of major activities and facilities	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(l)	97

TABLE 15: CONTINUED

Requirement	Reference	Page listing of compliant information
Ministerial directions	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(d)	77
Organisational structure	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(k)	94–95
Related-entity transactions	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsections 17BE(n) and (o)	132
Reporting of significant decisions or issues	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(f)	89
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 Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(r)	89
Responsible Minister	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(c)	6, 76
Review of performance	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(g)	62–73
Statement on governance	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule 2016 subsection 17BE(m)	87–88

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