AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

Annual Report
2014/15

Erica Hall
A/g Communications Manager
Australian Commission on Safety and Quality in Health Care
GPO Box 5480
Sydney NSW 2001

Or email mail@safetyandquality.gov.au

Suggested citation:
Australian Commission on Safety and Quality in Health Care (2015), Australian Commission on Safety and Quality in Health Care Annual Report 2014/15, Sydney. ACSQHC, 2015.

An online version of this report can be accessed at www.safetyandquality.gov.au.

ISSN 2200-3126 (print)
ISSN 2202-7777 (online)

ABN 97 250 687 371

Letter of transmittal

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

The Honourable Sussan Ley MP
Minister for Health
Parliament House
Canberra ACT 2600

Dear Minister

On behalf of the board of the Australian Commission on Safety and Quality in Health Care (the Commission), I am pleased to submit our annual report for the financial year ending 30 June 2015.

The report reflects the requirements of the *National Health Reform Act 2011* and section 46 of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act).

The audited financial statements were prepared in accordance with the Public Governance, Performance and Accountability (Financial Reporting) Rule 2015, made by the Finance Minister under the authority of the PGPA Act.

This report was approved for presentation to you in accordance with a resolution of the board on 17 September 2015.

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
17 September 2015

Contents

This annual report was prepared and submitted in accordance with parliamentary reporting and legislative requirements. It provides an overview of the Australian Commission on Safety and Quality in Health Care's operations and performance for the financial year ending 30 June 2015.

01
Overview

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

About the Commission

The Australian Commission on Safety and Quality in Health Care (the Commission) commenced as a corporate Commonwealth entity on 1 July 2011. The Australian, state and territory governments initially established the Commission in 2006 to lead and coordinate national improvements in healthcare safety and quality. The Commission's permanent status was confirmed with the assent of the *National Health and Hospitals Network Act 2011*. The Commission was subsequently included within the *National Health Reform Act 2011* (NHR Act).

Our mission

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

Our role and functions

The Commission's role is to provide health ministers with strategic advice on best practices to improve the safety and quality of health care.

The Commission develops and supports national safety and clinical standards; formulates and implements national accreditation schemes; and develops national health-related data sets. The Commission is also working to reduce unwarranted variations in practice and outcomes for individuals and populations, and coordinating national action to address healthcare-associated infections and antimicrobial resistance.

The NHR Act specifies the Commission's roles and responsibilities as a corporate Commonwealth entity under the PGPA Act. For details of the Commission's specific functions under the NHR Act see page 9.

Our accountability

As a corporate Commonwealth entity of the Australian Government, the Commission is accountable to the Parliament and the Minister for Health for achieving the outcomes of the Commission's agreed work plan and priorities. The Honourable Sussan Ley MP is the Minister for Health and has been the responsible minister since 23 December 2014. The Honourable Peter Dutton MP was the Minister for Health and the Commission's responsible minister from 1 July 2014 to 22 December 2014.

Report from the Chair

Professor Villis Marshall AC

The health care in Australia is generally of high quality, providing the best possible health outcomes for patients. However, health care is a complex process that requires much planning and coordination, and sometimes things can go wrong.

Throughout 2014/15, the Commission made significant progress towards its vision for a health system that is better informed, supported and organised to deliver safe and high-quality care.

In 2014/15, the Commission released Clinical Care Standards for antimicrobial stewardship, acute coronary syndromes and acute stroke. These standards will play an important role in delivering appropriate care and reducing unwarranted healthcare variation for these specific clinical conditions. They identify and define the care people should expect to be offered regardless of where they are treated.

Each of the Clinical Care Standards has been endorsed by all Australian health ministers as the national approach to improving the appropriateness of care in these areas.

During 2014/15, the Commission also commenced work on the Clinical Care Standards for delirium and hip fracture care.

A report by the Organisation for Economic Co-operation and Development's (OECD) 2014, *Geographic variations in health care*, generated valuable discussion on the extent of healthcare variation in Australia.

Among the findings for Australia, the report observed we have high knee replacement rates compared to other OECD countries, with more than 200 per 100 000 population. In 2014/15, the Commission began to explore the management of knee pain to determine how to identify and address any unwarranted variation in knee arthroscopy and replacement rates. This work is being led by an expert advisory group made up of consumers and clinicians representing orthopaedics, rheumatology, physiotherapy and general practice.

During the year, the Commission has also been mapping healthcare variation for selected medical interventions and procedures. The detailed *Australian atlas of healthcare variation* will be released later in 2015.

Antimicrobial resistance is a global public health issue and continues to be one of the major threats to human health. A number of initiatives are underway to combat antimicrobial resistance, including the World Health Organisation's (WHO's) development of a global action plan providing a framework of interventions to slow its emergence and reduce its spread. In June 2015, the Australian Antimicrobial Resistance Prevention and Containment Steering Group released the National Antimicrobial Resistance Strategy 2015–19 focusing on a 'One Health' approach to addressing the issue.

The Commission has continued to be heavily involved in addressing antimicrobial use and resistance at the clinical and national levels.

The Commission promotes appropriate prescribing and administration of antibiotics through a number of programs including the National Safety and Quality Health Service (NSQHS) Standards and the Antimicrobial Stewardship Clinical Care Standard. At the national level, the Commission is coordinating development of a national antimicrobial resistance surveillance system as a significant platform for reducing the impact of antimicrobial resistance.

I would like to express my thanks to Jane Halton PSM and the Honourable Verity Firth, two long-standing members of the Board who retired in 2014/15. Both have made significant contributions to the Commission over the years of their appointments.

On behalf of the Commission's board members, I would also like to thank the Standing Council on Health, the executive management team and staff for their continued commitment to delivering our work priorities. The achievements presented in this report reflect their hard work and dedication to the safety and quality of health care in Australia.

Report from the CEO

Adjunct Professor Debora Picone AM

It is with great pleasure that I present the Commission's Annual Report 2014/15 and reflect on our many achievements throughout the year in leading and coordinating national improvements in the safety and quality of health care provided in Australia.

It has been another busy and productive year for the Commission. One of the most significant areas of work during the past 12 months has been the review of the NSQHS Standards. While it is known from early reporting and anecdotal feedback from health service organisations that the NSQHS Standards and accreditation scheme are having a positive impact on patient care, it's important that we continue to monitor their effectiveness and efficiency.

The review of the NSQHS Standards aims to reduce duplication and the overall number of actions and individual standards, to improve the clarity of language used and to ensure the NSQHS Standards are applicable across healthcare settings. The review will also seek to address areas of risk to consumers not covered in the original NSQHS Standards. This will incorporate the Commission's recent work on mental health, cognitive impairment, health literacy, end-of-life care and Aboriginal and Torres Strait Islander health.

The review has involved a series of consultation sessions with health service organisations and accrediting agencies across the country. A public consultation on the draft version 2 of the NSQHS Standards will be conducted during 2015/16.

Cognitive impairment (dementia and delirium) is common among older people admitted to hospital. These patients are at greater risk of preventable complications, and adverse outcomes, including falls, pressure injuries, functional decline and mortality. They are more likely to stay in hospital longer, be re-admitted or enter residential care. Cognitive impairment is under-recognised in Australian hospitals, leading to significant safety and quality issues. However, harm can be minimised if cognitive impairment is recognised and care is tailored to the needs of the patient.

In November 2014, the Commission released a set of resources, called *A better way to care*, that describe a pathway to improve the early recognition and response to patients with cognitive impairment. The resources include guides for health service managers, clinicians and consumers which outline the care patients with cognitive impairment should receive when they are in hospital.

Hospitals are designed for rapid assessment, treatment and discharge of patients. In Australia, more than 50% of deaths occur in hospitals, despite surveys reporting that most people would prefer to die at home. In May 2015, the health ministers endorsed a consensus statement describing the essential elements for providing safe and high-quality care at the end of life. Developed by the Commission, the purpose of the consensus statement is to set out the principles and elements that shape the delivery of safe and high-quality end-of-life care in hospitals and other acute health services.

Over the coming year, the Commission will continue to support health service organisations in meeting the requirements of the NSQHS Standards, as well as promoting and supporting the uptake of the Clinical Care Standards for antimicrobial stewardship, acute coronary syndromes and acute stroke.

The release of the *Australian atlas of healthcare variation* will highlight medical procedures and interventions where notable variation in health care is occurring. This will inform the areas for further investigation and future priorities for the Commission.

In delivering on our healthcare safety and quality priorities, I wish to acknowledge and thank the board of the Commission, the Standing Council on Health, jurisdictional chief executives, the Australian Government Department of Health, the Inter-jurisdictional Committee and our many advisory groups who have contributed significantly to the Commission's successes throughout the year.

Finally, I would like to acknowledge the dedication and significant efforts of the Commission's staff in delivering our extensive work plan during 2014/15. Their commitment to improving the safety and quality of the health care provided in Australia is unfaltering. Their many achievements are described in detail throughout this report.

02
Report on performance

This section details the Commission's highlights for the year and achievements against four priority areas: patient safety; partnering with patients, consumers and communities; quality, cost and value; and supporting health professionals to provide safe and high-quality care.

Our work priorities

The Commission leads and coordinates safety and quality improvements nationally. The functions of the Commission are specified in the NHR 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 these standards
- Promoting, supporting and encouraging the implementation of programs and initiatives relating to healthcare safety and quality matters
- Formulating model national schemes that provide for the accreditation of organisations that provide healthcare services and relate to healthcare safety and quality matters
- Collecting analysing, interpreting and disseminating information relating to healthcare safety and quality matters
- Publishing reports and papers relating to healthcare safety and quality matters.

Under the NHR Act, the Commission is required to prepare a work plan that sets out the priorities for work to be undertaken during the next three financial years.

The priorities for 2014–17 are:

1. Patient safety
2. Partnering with patients, consumers and communities
3. Quality, cost and value
4. Supporting health professionals to provide safe and high-quality care.

SAFETY AND QUALITY

1

PATIENT SAFETY

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

2

PARTNERING WITH PATIENTS, CONSUMERS AND COMMUNITIES

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

3

QUALITY, COST AND VALUE

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

4

SUPPORTING HEALTH PROFESSIONALS TO PROVIDE SAFE AND HIGH-QUALITY CARE

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

STRATEGIC PLAN 2014–2019

EVERY PERSON. EVERYWHERE. EVERY TIME.

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

Highlights 2014/15

Priority 1: Patient safety

- As of 30 June 2015, 977 hospitals and day procedure services had been assessed against the NSQHS Standards since 1 July 2014. To support health service organisations to implement the NSQHS Standards, the Commission held network meetings, conducted mediations and answered more than 1350 queries through the Accreditation Advice Centre during 2014/15.
- In late 2014, the Commission began a review of the NSQHS Standards to improve the effectiveness and efficiency of the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme and to develop version 2 of the NSQHS Standards and the resources to support their implementation.
- A collaborative project with the Aboriginal and Torres Strait Islander community, jurisdictions, health services and others commenced in July 2014 with the aim of improving the safety of care provided to Aboriginal and Torres Strait Islander peoples in mainstream health services.
- The Commission released revised national quality use of medicines indicators for Australian hospitals in November 2014. The indicator set enables hospitals to monitor the safety and appropriateness of medicines use and includes antithrombotic, antibiotic, pain management and acute mental healthcare prescribing indicators.
- In November 2014, the Commission launched new resources for improving the safety and quality of care for patients with cognitive impairment (dementia and delirium) in hospital. The resources, titled *A better way to care*, provide actions for clinicians, health service managers and consumers. An app for mobile devices was released in April 2015 to provide clinicians with quick access to the key actions. **Image 1**
- As part of Antibiotic Awareness Week in November 2014, the Commission and partner organisations released a national report on antibiotic prescribing practices in 151 Australian hospitals. The report, *National Antimicrobial Prescribing Practice: Results of the 2013 National Antimicrobial Prescribing Survey (NAPS)*, was released by the Melbourne Health National Health and Medical Research Council (NHMRC) Centre for Antimicrobial Stewardship and the Commission.

1

Priority 2: Partnering with patients, consumers and communities

- In August 2014, the Commission released the *National statement on health literacy.* Developed in collaboration with healthcare professionals, consumers, policy makers and researchers, the national statement explores the role health literacy plays in the provision of safe and high-quality care and provides the basis for a national approach to coordinated and collaborative action. All Australian health ministers endorsed the *National statement on health literacy.*
- In October 2014, the Commission hosted a program of workshops, meetings and a symposium to promote shared decision making and the use of patient decision aids. Over 400 clinicians, consumer representatives, policy makers and researchers attended these events.
- As part of National Palliative Care Week in May 2015, the Commission launched the *National consensus statement: essential elements for safe and high-quality end-of-life care* in collaboration with Palliative Care Australia. The consensus statement was endorsed by all Australian health ministers as the national approach to the delivery of end-of-life care in Australian hospitals. **Image 2**

2

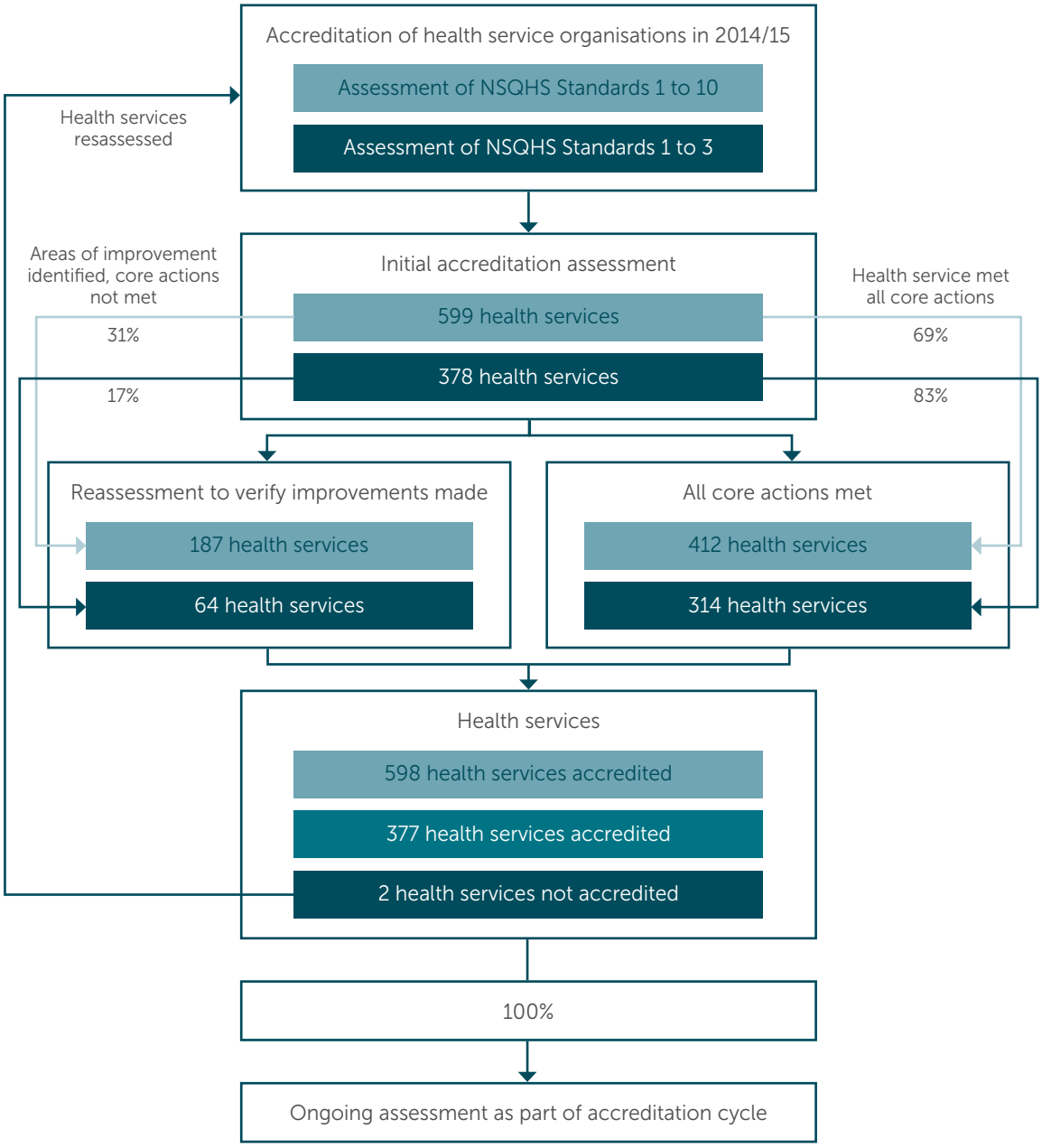
Priority 3: Quality, cost and value

- Throughout 2014/15, the Commission has worked with the National Health Performance Authority (NHPA), and specialist clinical and epidemiology advisors to identify and map areas of variation in care for a range of healthcare topics. The first *Australian Atlas of Healthcare Variation* will be released later in 2015.
- In November 2014, the Commission launched the first Australian standard that applies to clinical practice, the Antimicrobial Stewardship Clinical Care Standard. This Clinical Care Standard aims to ensure every use of an antibiotic is targeted and appropriate to effectively treat patients, while limiting the rise of resistant bacteria that could harm the whole community and has been endorsed by all Australian health ministers. **Image 3**
- The Commission launched a second Clinical Care Standard for acute coronary syndromes, in December 2014, in collaboration with the National Heart Foundation. The Acute Coronary Syndromes Clinical Care Standard has been endorsed by all Australian health ministers. **Image 4**
- In June 2015, the Minister for Health, the Honourable Sussan Ley MP, and NSW Minister for Health, the Honourable Jillian Skinner MP, launched the Acute Stroke Clinical Care Standard in collaboration with the Commission and the National Stroke Foundation. This Clinical Care Standard has been endorsed by all Australian health ministers. **Image 5**

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

- The Commission's Maternal Sentinel Event and Post-Partum Haemorrhage Working Group developed clinical definitions to support the routine review and reporting of severe acute maternal morbidity. These definitions were endorsed by relevant clinical colleges in December 2014.
- The Commission has led work to provide public health service organisations with access to a common national set of patient experience questions. The Australian Health Ministers' Advisory Council (AHMAC) purchased a two-year national patient experience licence allowing health service organisations to administer validated patient experience surveys from July 2014.
- In September 2014, the Commission released the *Framework for Australian clinical quality registries*, following endorsement by AHMAC. The framework specifies national arrangements under which peak clinical groups and health service organisations can partner with governments to monitor and report on the quality (appropriateness and effectiveness) of health care.
- In July 2014, the Commission was appointed by the Australian Government Department of Health to conduct two clinical safety reviews of the Personally Controlled Electronic Health Record (PCEHR) and a set of incident analyses, with the oversight of the PCEHR Clinical Governance Advisory Group.

Health service accreditation 2014/15



Priority 1: Patient safety

This priority area aims to ensure patients and consumers are kept safe from preventable harm. The main areas of activity within this priority area during 2014/15 were:

- NSQHS Standards
- national coordination of health services accreditation
- medication safety
- mental health
- cognitive impairment
- patient safety in primary care
- nationally coordinated action to address
- healthcare-associated infections and antimicrobial resistance.

NSQHS Standards

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

Under the AHSSQA Scheme, the Commission is responsible for maintaining and implementing the NSQHS Standards.

The Commission's Accreditation Advice Centre continued to provide support for health service organisations implementing the NSQHS Standards. During 2014/15, the Commission responded to more than 1350 phone and email enquiries.

To support health service organisation boards to understand their role and responsibilities for ensuring patient safety, the Commission released a *Guide to the NSQHS Standards for health service organisation boards* in April 2015.

The Commission is also developing a guide to support community health services with implementation of the NSQHS Standards. This guide was released for consultation in May 2015 and is expected to be published later in 2015.

The Commission is currently undertaking a review of the NSQHS Standards. The aim of the review is to improve the effectiveness and efficiency of the AHSSQA Scheme and to develop version 2 of the NSQHS Standards and the resources to support their implementation. In the first half of 2015, the Commission held a series of consultation workshops across Australia. A draft of version 2 of the NSQHS Standards will be released in 2015/16 for public consultation and piloting by health service organisations and accrediting agencies. The Commission has further work planned on revising resources and training throughout 2016 and 2017.

In July 2014, the Commission commenced a collaborative project with the Aboriginal and Torres Strait Islander community, jurisdictions, health services and others with the aim of improving the safety of care provided to Aboriginal and Torres Strait Islander peoples in mainstream health services.

The project will consider safety and quality issues typically affecting Indigenous Australians in hospitals and will include:

- consultation with key stakeholders to consider elements of safe and high-quality care for Indigenous Australians
- an analysis of the safety and quality issues commonly associated with health care for Indigenous Australians
- a report mapping these safety and quality issues to the NSQHS Standards

- a literature scan of relevant evidence-based strategies for safety and quality
- a resource that aims to drive best practice care for Indigenous Australians in hospitals using the current version of the NSQHS Standards
- a report to jurisdictions with recommendations for progressing safety and quality in a systemic way in hospitals.

2014/15 KEY ACHIEVEMENTS

More than 500 health professionals provided feedback as part of consultation workshops for the review of the NSQHS Standards

The Commission and the jurisdictions received a joint award for *National partnership in the implementation of improved safety systems for patients* for implementation of the NSQHS Standards at the 3rd APAC Forum

The Commission consulted with approximately 230 participants from government and non-government agencies, Aboriginal and non-Aboriginal people, health services and policy professionals on issues typically affecting Indigenous Australians in hospitals

A survey focusing on factors that impact on the health outcomes of Aboriginal health received 876 responses with national representation

National coordination of accreditation of health services

The AHSSQA Scheme coordinates accreditation to the NSQHS Standards nationally and monitors safety and quality improvements across the health system. All Australian hospitals and day procedure services must be accredited. Other health services, such as community health and dental services, are increasingly using the accreditation scheme to ensure they provide safe and high-quality care.

The Commission coordinates the AHSSQA Scheme and provides support to state and territory health departments that regulate the scheme, health services undergoing accreditation and the accrediting agencies that assess health services.

Accrediting agencies provide the Commission and the regulators with data that show whether health services comply with the NSQHS Standards. There are 10 accrediting agencies approved to assess health services, these are:

- Australian Council on Healthcare Standards
- BSI Group ANZ Pty Ltd
- Global Mark Pty Ltd
- HDAA Pty Ltd
- Institute for Healthy Communities
- International Standards Certifications
- National Association of Testing Authorities (NATA), Australia
- Quality Innovation Performance Pty Ltd
- SAI Global
- TQCS International Pty Ltd.

Approved accrediting agencies have participated in training sessions and a review of performance conducted by the Commission to improve coordination of accreditation nationally.

In October 2014, the Commission released a literature review considering evidence and strategies to improve inter-assessor reliability. A greater focus will be placed on surveyor training to address issues with inter-assessor reliability with the current version of the NSQHS Standards and in preparation for the introduction of version 2 of the NSQHS Standards.

A review of the AHSSQA Scheme will be completed before the introduction of version 2 of the NSQHS Standards.

2014/15 KEY ACHIEVEMENTS

59% of health services are now accredited against all 10 NSQHS Standards

39% of health services have been assessed against NSQHS Standards 1, 2 and 3

2% of health services were newly established and underwent interim accreditation to the NSQHS Standards

13 training sessions for accrediting agencies have been held to ensure a consistent understanding of the NSQHS Standards by those surveyors assessing health services to the NSQHS Standards

Medication safety

Adverse drug events are responsible for a large number of hospital admissions. Patients in hospital also continue to experience adverse drug events. The Commission supports the use of a number of tools including medication charts that reduce adverse drug events in hospitals.

The World Health Organization's (WHO) project to ensure medication accuracy at transitions of care, 'High 5s', concluded during 2014. The Commission coordinated Australia's participation in this five-year project. In November 2014, the Commission held a seminar for the lead hospitals to report on their testing of the standard operating protocol for medication reconciliation and to showcase how electronic medication management systems can enhance medication reconciliation.

In November 2014, the Commission jointly published a set of 37 quality-use-of-medicines indicators for Australian hospitals with the NSW Therapeutic Advisory Group – the *National quality use of medicines indicators for Australian hospitals*. This indicator set enables hospitals to monitor the safety and appropriateness of medicines use and includes antithrombotic, antibiotic, pain management and acute mental healthcare prescribing indicators.

During 2014/15, the Commission developed a draft national standard for user-applied labeling of injectable medicines, fluids and lines which aims to promote safer use of injectable medicines. A public consultation on the draft national standard ended in April 2015.

The Commission also developed draft national guidelines for on-screen display of clinical medicines information. Feedback on the draft guidelines was sought via a public consultation process which commenced in April 2015. The final guidelines will be released during 2015/16.

In June 2014, the Commission commenced development of a Pharmaceutical Benefits Scheme (PBS) hospital medication chart with the aim of providing a standardised chart to reduce the regulatory and administrative burden of supplying eligible PBS medicines. Throughout 2014/15, the Commission has consulted with the states and territories, peak bodies and healthcare providers to develop a chart suitable for trial. A trial has been designed to assess the usability and effectiveness of the chart in a number of clinical settings. The trial is due for completion by the end of 2015.

Insulin is a high-risk medicine, and its administration in the acute care setting is not supported by the National Inpatient Medication Chart (NIMC). To improve the safety and quality of insulin prescribing and administration in acute care, the Commission has been developing a standardised subcutaneous insulin chart which is based on human factors design principles. The chart will be piloted in a range of hospitals in the second half of 2015.

The NIMC GP 'eVersion' is a printable form of the NIMC. It uses a combination of electronic and non-electronic mechanisms to populate medicine orders for administration to patients. During 2014/15, the Commission began an evaluation of this chart and how it is used in practice to identify the benefits and risks of its use. The evaluation is due for completion early in 2016.

2014/15 KEY ACHIEVEMENTS

Revised *National quality use of medicines indicators for Australian hospitals* released

Developed a draft national standard for user-applied labeling of injectable medicines, fluids and lines

Developed PBS hospital medication chart for trial

Commenced development of a standardised subcutaneous insulin chart for trial

Mental health

In July 2014, the Commission released *Recognising and responding to deterioration in mental state: A scoping review.* The review explores the current knowledge base for recognising and responding to deterioration in the mental state of inpatients in acute settings, gaps in safety and quality, and how the Commission's existing *National consensus statement: essential elements for recognising and responding to clinical deterioration* could be applied to deterioration in a person's mental state. During 2014/15, the Commission has consulted with members of the Safety and Quality Partnership Standing Committee to address the findings of the review.

In August 2014, the Commission released the *Scoping study on the implementation of national standards in mental health services*. More than 500 stakeholders across Australia contributed to the project, which was undertaken in collaboration with the National Mental Health Commission. The study identified a number of gaps in the framework that supports people who live with mental illness to experience safe and quality health care. One of the recommendations was that NSQHS Standards should include items that will address the specific safety issues faced by people with lived experience of mental health issues accessing all health services.

The Commission is undertaking work in response to this recommendation including identifying ways to include mental health safety issues across Version 2 of the NSQHS Standards.

During 2014/15, the Commission also commenced a scoping study on medication safety in mental health services.

2014/15 KEY ACHIEVEMENT

Two scoping reviews were published on recognising and responding to deterioration in mental state and implementation of national standards in mental health services

Cognitive impairment

To improve the safety and quality of care for patients with cognitive impairment, the Department of Social Services funded the Commission to undertake a project to use the NSQHS Standards and other potential mechanisms to improve national coordination of care for patients with cognitive impairment in hospitals.

In November 2014, the Commission released three resources targeting health service managers, clinicians and consumers, titled *A better way to care: safe and high-quality care for patients with cognitive impairment (dementia and delirium) in hospital*. An app for mobile devices was released in April 2015 to provide clinicians with quick access to the key actions and strategies.

The second phase of this project involves developing solutions for safety and quality issues that have been identified since implementation of the NSQHS Standards. The Commission is considering the incorporating cognitive impairment in version 2 of the NSQHS Standards as part of the review process.

'Across Australia there is action to create dementia-friendly communities – places where people living with dementia are supported to live a high quality of life. As so many older people with dementia are admitted to hospital, it's crucial we ensure our hospitals are also dementia-friendly.'

President of Alzheimer's Australia, Graeme Samuel AC, at the launch of the *A better way to care* resources, 5 November 2014.

2014/15 KEY ACHIEVEMENTS

The *A better way to care* resources were launched in collaboration with Alzheimer's Australia

Over 10 000 copies of the *A better way to care* resources were distributed to hospitals, health services and health professionals Australia-wide

The *A better way to care* app for clinicians has been downloaded more than 850 times since its release in April 2015

Patient safety in primary health care

The Commission continued work on general practice accreditation in partnership with the Royal Australian College of General Practitioners (RACGP). The project aims to ensure the quality of accreditation in general practice by:

- developing a governance framework for accreditation
- establishing mechanisms for coordinating accrediting agencies
- describing processes for collecting accreditation data.

The Commission released a literature review on general practice accreditation in November 2014 which identified:

- the key components of international general practice accreditation models that support improvement in the quality of care
- an evidence base to implement changes to the current general practice accreditation scheme.

Between July and October 2014, the Commission received feedback from more than 300 general practitioners, general practice staff, Medicare Local representatives, consumers, accreditation agencies and professional organisations as part of a consultation process to identify the barriers and enablers associated with accreditation in general practice and opportunities for improvement.

Agreement has been reached with the RACGP on a draft model of the General Practice Accreditation Scheme that includes processes for coordinating accrediting agencies and collecting data on accreditation outcomes. The Commission will continue to consult with key stakeholders on the draft model and commence implementation during 2015/16. Systems for collecting and reporting data will be operational from January 2016.

The majority of public dental practices in Australia are required to be accredited to the NSQHS Standards. While accreditation for private dental practices is voluntary, the Australian Dental Association supports their participation. In March 2015, the Commission released a draft guide to the NSQHS Standards for dental services and private dental practices for public consultation. The final guide will be released later in 2015.

During 2014/15, the Commission continued to support the community health sector with implementation of the NSQHS Standards through the development of sector-specific resources. A draft guide to the NSQHS Standards and an electronic monitoring tool were piloted with community health service organisations in the second half of 2014. The draft guide was released for public consultation in May 2015. Both resources will be released later in 2015.

2014/15 KEY ACHIEVEMENTS

The Commission and RACGP reached agreement on a draft model for an accreditation scheme for general practice

Draft guides to the NSQHS Standards have been developed for dental practices and community health services

Nationally coordinated action to address healthcare-associated infections and antimicrobial resistance

Antimicrobial resistance is a serious threat to the effective prevention and treatment of healthcare-associated infections. Antimicrobial resistance is not only a challenge for the delivery of effective health care in Australia, but it is a global issue identified by the WHO.[1]

The Commission is working to address the prevalence of healthcare-associated infections and antimicrobial resistance across Australia through a range of integrated strategies.

Throughout 2014/15, the National Hand Hygiene Initiative, run by Hand Hygiene Australia, continued to promote effective hand hygiene as the single most important, and cost effective, strategy for preventing healthcare-associated infections.

During 2014/15, the Commission also continued to promote antimicrobial stewardship programs and appropriate antimicrobial usage in hospitals and health services by supporting the implementation of *NSQHS Standard 3: Preventing and Controlling Healthcare Associated Infections* and via Antibiotic Awareness Week activities. Antimicrobial stewardship and appropriate antimicrobial usage are key safety and quality intervention strategies to reduce the spread of antimicrobial resistance.

As part of Antibiotic Awareness Week in November 2014, the Commission released the *National Antimicrobial Prescribing Practice: Results of the 2013 National Antimicrobial Prescribing Survey* in partnership with the NHMRC Melbourne Health. This report summarises the antimicrobial prescribing practices in 151 hospitals across Australia and highlights areas for improvement, such as reducing unnecessary use of broad spectrum antimicrobials and the need for more appropriate use for surgical prophylaxis.

This work is part of the Commission's larger project on Antimicrobial Use and Resistance in Australia (AURA). During 2014/15, the AURA project continued work on establishing a national surveillance system to monitor antimicrobial resistance and antimicrobial usage to support the achievements of the objectives of the National Antimicrobial Resistance Strategy 2015–19. The AURA Surveillance System will involve expanding both passive and targeted antimicrobial resistance and antimicrobial usage surveillance across Australia, and enable detection of critical antimicrobial resistance through the National Alert System for Critical Antimicrobial Resistances (NASCAR), which will inform clinicians and policy makers of emerging and re-emerging highly resistant bacteria.

'AMR [antimicrobial resistance] is a global public health issue and continues to be one of the major threats to human health. There is a real concern that without new antibiotics in the development pipeline some infections will be difficult or impossible to treat.'

Chief Medical Officer Professor Chris Baggoley, 17 November 2014.

2014/15 KEY ACHIEVEMENTS

Results from the 2013 National Prescribing Survey were published in partnership with the NHMRC and Melbourne Health

Over 70 interviews held for an AURA project scoping study and preliminary report

The Commission and key partners (NPS MedicineWise, the Australian Government Department of Health and Department of Agriculture, the Australian Veterinary Association, state and territory health departments and the private hospital sector) collaborated in the promotion of Antibiotic Awareness Week 2014

Priority 2: Partnering with patients, consumers and communities

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

This priority includes the Commission's work in the areas of:

- health literacy
- clinical communications
- shared decision making
- end-of-life care.

Health literacy

The healthcare system is complex and often hard to understand. Only about 40% of Australian adults have the level of health literacy needed to navigate their health care and the healthcare system.

Low health literacy costs individuals and the health system in terms of time, money, and quality of life and care. Low health literacy is associated with higher rates of hospitalisation and emergency care, and higher rates of adverse outcomes more generally.

In 2014/15, the Commission completed its first phase of work on health literacy, delivering the *Health literacy: taking action for safety and quality* background paper following extensive research, analysis, drafting and consultation. This background paper describes the concept of health literacy, the different approaches that can be taken to address health literacy and an overarching framework for coordinating action in Australia.

The background paper formed the basis of a shorter document, the *National statement on health literacy*, which was endorsed by health ministers in August 2014 as the national approach to health literacy.

In November 2014, the Commission held a national, multidisciplinary workshop with over 60 stakeholders to help identify and prioritise national action to address health literacy. A report on the workshop was published in January 2015.

To help consumers, clinicians, health service managers and health service organisations to understand their roles in addressing health literacy, the Commission released a series of tips sheets and promotional infographics in June 2015.

2014/15 KEY ACHIEVEMENTS

Health ministers endorsed the *National statement on health literacy*

More than 60 key stakeholders contributed to a national workshop on health literacy priorities

Resources for consumers, clinicians, and health executives and managers were released to increase understanding of health literacy

Clinical communications

Clinical communication problems are a major contributing factor in 70% of hospital sentinel events, with an increasing risk of harm occurring each time a patient is transferred between units, teams or clinicians.[2] Effective communication within clinical teams and between the patient and clinician is essential to providing safe patient care.[3-5]

The Commission is progressing work to improve patient-clinician communication across the patient journey. To inform this work, the Commission engaged a consortium of researchers to conduct an integrative review on engaging patients in transitions of care in acute care facilities. This involved a literature review and interviews with 62 key stakeholders across seven hospitals. Stakeholders included nurses, allied health professionals, doctors, patients, health advocates and family members.

The review was released in January 2015. The key findings included identification of facilitating factors and barriers to engaging patients in communication, and strategies and tools used by hospitals.

In 2015/16, the Commission will draw on research findings to develop resources focused on improving patient-clinician communication at transitions of care. This work supports the implementation of the NSQHS Standards and aligns with the Commission's work on health literacy, shared decision making, open disclosure and patient-centred care.

2014/15 KEY ACHIEVEMENT

The Commission released integrative review on engaging patients in transitions of care in acute care facilities

Shared decision making

Shared decision making involves the integration of a patient's values, goals and concerns with the best available evidence about treatment risks, benefits and uncertainties to achieve appropriate healthcare decisions.

During 2014/15, the Commission continued to promote shared decision making. This work is part of the Commission's commitment to support patient and consumer-centred care and complements work on exploring unwarranted healthcare variation and increasing appropriateness of care.

In October 2014, the Commission hosted a program of workshops, meetings and a symposium on shared decision making and the use of patient decision aids. The purpose of these events was to improve understanding of shared decision making, explore lessons from international experts, and to determine their relevance to policy and practice in Australia.

Professor Dawn Stacey from the University of Ottawa was the keynote speaker. Australian and international researchers also gave presentations. A live webcast of the symposium was broadcast and the recording is available on the Commission's web site.

During 2014/15, the Commission began developing patient decision aids for antibiotic use in three common conditions: sore throat, middle ear complaints, and acute bronchitis. These decision aids will provide patients with evidence to inform their healthcare choices and to reduce the overuse of antibiotics in routine care.

The Commission is also exploring simple tools to support consumers to be more involved in their own care. A literature review on question prompt lists (a specific type of decision support tool for consumers) was undertaken to investigate the possible benefits and limitations of these tools. This review, *Literature review: question prompt lists*, was released in October 2014.

2014/15 KEY ACHIEVEMENTS

Public meetings and by-invitation workshops hosted by the Commission to raise awareness about shared decision making and the use of patient decision aids, attended by over 400 clinicians, consumer representatives, policy makers and researchers

Literature review on the benefits and limitations of question prompt lists published

End-of-life care

The way that people who are dying are cared for is important. Good care in the last days, weeks and months of life can help to minimise the distress and grief associated with death and dying for the individual, and for their family, friends and carers.

The Commission developed the *National consensus statement: essential elements for safe and high-quality end-of-life care* to set out suggested practice for the provision of safe and high-quality end-of-life care in settings where acute care is provided.

This consensus statement reflects the views of health consumers and carers, experts in the field and the Commission. It was derived from expert experience and published evidence, and developed in partnership with carers and consumers, and representatives from public and private hospitals and health services, professional colleges, state and territory health departments and other government agencies.

The consensus statement was endorsed by health ministers and launched in partnership with Palliative Care Australia in May 2015.

A resource for patients, families and consumers was developed to accompany the consensus statement. This is based on the elements of the consensus statement and provides information about how care should be provided to hospitalised people who are at the end of life.

'It is important that clinicians work closely with patients, families and carers to understand a patient's wishes. This ensures making informed decisions about a person's end-of-life wishes is easier on all involved in a very sad time.'

Chief Executive of Palliative Care Australia, Liz Callaghan, at the launch of the consensus statement, 28 May 2015.

2014/15 KEY ACHIEVEMENTS

Health ministers endorsed the *National consensus statement: essential elements for safe and high-quality end-of-life care*

The consensus statement was launched as part of Palliative Care Week 2015 in partnership with Palliative Care Australia

Priority 3: Quality, cost and value

The Commission aims to have a health system that provides the right care, minimises waste and optimises value and productivity.

The Commission's work to improve quality, cost and value includes:

- improving appropriateness of care
- mapping healthcare variation
- developing Clinical Care Standards
- pricing for safety and quality.

Improving appropriateness of care

Appropriate health care optimises effectiveness, safety and efficiency and is based on the:

- needs and preferences of the patient, their family and carer
- best available evidence
- needs of the entire population, both clinically and in terms of best allocation of resources.

Appropriateness of care can be improved by examining healthcare variation and, specifically, unwarranted healthcare variation. Some variation is warranted and reflects innovation in practice, differences in population need, or cultural or patient preferences. However, much variation is unwarranted, and raises questions about quality, equity and efficiency in health care. This means that some patients are receiving unnecessary or potentially harmful care, while others are missing out on care that may be helpful.

In an earlier publication by the Commission, *Exploring healthcare variation in Australia*, procedures addressing knee pain were found to have high aggregate rates of variation across Australia. To determine how to identify and address any unwarranted variation in knee arthroscopy and replacement rates, the Commission established a Knee Pain Expert Advisory Group in October 2014. The group is made up of consumers and clinicians representing orthopaedics, rheumatology, physiotherapy and general practice.

During 2014/15, the Knee Pain Expert Advisory Group considered strategies to identify and address any unwarranted variation in knee arthroscopy and replacement rates, including consumer-oriented, clinician-oriented and organisation-oriented strategies. The Commission will release a report on the group's findings in 2015/16.

2014/15 KEY ACHIEVEMENT

The Knee Pain Expert Advisory Group was established to support the Commission's program of work to investigate and analyse healthcare variation

Mapping healthcare variation

Throughout 2014/15, the Commission continued the development of an Australian atlas of healthcare variation to map healthcare variation for selected medical interventions and procedures, and reflect areas that are national healthcare priorities. The first edition of the atlas will be released later in 2015 and will cover the following clinical themes:

- antimicrobial dispensing
- chronic diseases
- mental health and psychotropic medicines
- care of older people
- surgical interventions

- pathology and diagnostics
- pain management.

These clinical themes were selected and refined in close consultation with the Australian, state and territory health departments, clinical colleges, consumer organisations and other government agencies.

The atlas will guide activity aimed at investigating unwarranted healthcare variation and identifying options to reduce variation, and will be a valuable resource to improve appropriateness of care and patient safety outcomes.

The atlas will be relevant to all Australian healthcare settings, from acute to primary health care.

Clinical Care Standards

Ensuring consumers, clinicians and health services have the same understanding of the care that should be offered for a particular health condition is an important way to improve appropriateness of care.

Clinical Care Standards identify key components of care a patient should be offered for a specific clinical condition or a defined part of a clinical pathway. They are developed based on the most up-to-date clinical guidelines with consideration of what is important to clinicians and consumers.

The Commission has been working in collaboration with consumers, clinicians, researchers and health organisations to develop national Clinical Care Standards.

In 2014/15, the Commission launched the first three Clinical Care Standards to improve care in the areas of antimicrobial stewardship, acute coronary syndromes and acute stroke. Each Clinical Care Standard is accompanied by the following resources:

- indicator specifications to support local health services to identify areas for improvement
- clinician and consumer fact sheets
- promotional infographics.

The Commission is currently working with consumers, clinicians, researchers and health organisations to identify implementation strategies that will help local health services to embed these Clinical Care Standards into practice.

During 2014/15, the Commission commenced development of the two additional Clinical Care Standards for delirium and hip fracture care. Drafts of these Clinical Care Standards and accompanying resources were released for public consultation in May 2015.

'The Acute Stroke Clinical Care Standard will support the delivery of appropriate care to help ensure patients with stroke receive optimal treatment during the acute phase of management, regardless of where they live.'

The Honourable Sussan Ley MP at the launch of the Acute Stroke Clinical Care Standard, 10 June 2015.

2014/15 KEY ACHIEVEMENTS

The first Australian standard that applies to clinical practice, the *Antimicrobial Stewardship Clinical Care Standard,* was launched as part of Antibiotic Awareness Week

The *Acute Coronary Syndromes Clinical Care Standard* was launched in collaboration with the National Heart Foundation

The Minister for Health, the Honourable Sussan Ley MP, and NSW Minister for Health, the Honourable Jillian Skinner MP, launched the *Acute Stroke Clinical Care Standard*

Pricing for safety and quality

In 2014/15, the Commission continued its collaboration with the Independent Hospital Pricing Authority (IHPA) to examine ways to incorporate safety and quality in the pricing of Australian public hospital services. A joint working party, made up of clinicians, consumers and policy makers, continues to oversee this work and provide advice to both agencies.

Through the joint working group, the Commission and the IHPA are investigating how routinely collected hospital administrative data can be used to drive improvements in safety and quality. During 2014/15, this included developing:

- a proof of concept involving four Australian hospitals to test the draft national set of high-priority hospital complications
- new data item specifications for three complications indicating clinical deterioration (unplanned return to operating theatre, unplanned admission to intensive care unit and rapid response team call)
- a set of clinical documentation guidelines aimed at improving the recognition, documentation and data capture of high-priority complications that occur in hospital.

The joint working group has also established a sub-committee to investigate best-practice pricing schemes, supported by evidence, with a particular focus on hip fracture care. The sub-committee has:

- explored requirements and feasibility of introducing best-practice pricing for hip fracture care in Australian public hospitals
- investigated mechanisms for providing safety and quality data to clinical teams and hospital leaders to drive quality improvement, with a focus on hip fracture care
- consulted with national and international experts, the IHPA and clinical specialty groups across Australia for evidence-based pricing schemes and implementation strategies tailored to Australia.

The sub-committee finalised its recommendations in June 2015.

2014/15 KEY ACHIEVEMENTS

Completed a proof of concept involving four Australian hospitals to test the draft national set of high-priority hospital complications

Developed data item specifications for complications indicating clinical deterioration

Developed a draft report with recommendations on a best-practice pricing approach for hip fracture care in Australia

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

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

- developing and maintaining clinical measures to support safety and quality improvement
- developing and supporting a model for local monitoring of patient safety
- working with partners on national clinical quality registries
- embedding quality improvement in clinical information systems and ensuring safety in eHealth.

To achieve this, the Commission works closely with the NHPA, and other national partners including the Australian Institute of Health and Welfare and the Australian Bureau of Statistics.

Clinical measures to support safety and quality improvement

In 2014/15, the Commission continued to develop and maintain indicators and data set specifications to support safety and quality improvement.

The Commission's Maternal Sentinel Event and Post-Partum Haemorrhage Working Group developed clinical definitions to support the routine review and reporting of severe acute maternal morbidity. These definitions were endorsed by relevant clinical colleges in December 2014. The AHMAC agreed to the working group's recommendation to amend the national sentinel event definition on maternal death.

Work has commenced to develop robust measures for prospective monitoring and reporting of key aspects of health care relating to the revised NSQHS Standards.

A review of the surveillance of healthcare-associated *Staphylococcus aureus* bacteraemia data set specification was undertaken to ensure it continues to support surveillance in Australia. Indicators for day procedures were also reviewed.

The Commission continues to consult with the NHPA on the new Australian composite-model hospital-standardised mortality ratio.

2014/15 KEY ACHIEVEMENT

Clinical definitions for severe acute maternal morbidity were endorsed by clinical colleges

Patient safety monitoring models

The goal of improving patient safety is to minimise healthcare-related harm. However, it is difficult to measure the true rate of adverse events that occurs in hospitals. Obtaining a comprehensive and accurate picture of hospital patient safety requires a range of measures.

During 2014/15, the Commission continued development of a multi-faceted model to support local monitoring of hospital patient safety. This model includes:

- monitoring adherence to the NSQHS Standards
- the monitoring and routine review of a national set of core hospital-based outcome indicators (CHBOI)
- routine review of a national set of high-priority hospital complications
- routine monitoring and analysis of patient experiences of their hospital stay or patient-reported outcomes
- analysis of selected sets of incident categories, using information generated by incident reporting systems
- surveys of staff attitudes, behaviours and perceptions to understand the culture of safety in organisations.

To support local interpretation and use of hospital mortality indicators, the Commission developed a guide for board members and executives of hospitals and local health districts detailing how hospital mortality indicators can be used to screen for potential safety and quality issues through existing clinical governance processes. The guide was released in December 2014.

To accompany the guide, the Commission released an updated *CHBOI Toolkit*, which contains the specifications, coefficients and reference sets for mortality and readmission indicators. Together, the guide and toolkit will enable healthcare organisations, jurisdictions and private hospital groups to generate nationally consistent, risk-adjusted mortality and readmission indicators.

The Commission has led work to provide public health service organisations with access to a common national set of patient experience questions. The AHMAC purchased a two-year national patient experience licence allowing health service organisations to administer validated patient experience surveys from July 2014. The Commission has also commenced work to develop a set of non-proprietary patient experience questions for use in public and private hospitals and in non-general practice primary care settings.

Preliminary work has been undertaken to investigate the development of a national staff survey to assess staff attitudes, behaviours and perceptions in order to understand organisational patient safety culture. This work is scheduled for completion in late 2015.

During 2014/15, the Commission consulted with Australian and international experts on best-practice methodology for analysing selected datasets generated from incident reporting systems.

2014/15 KEY ACHIEVEMENTS

Guide on how to use existing clinical governance processes to screen for potential safety and quality issues released

National set of patient experience questions released for use in public health service organisations

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 September 2014, the Commission released the *Framework for Australian clinical quality registries*, following endorsement by AHMAC. This framework specifies national arrangements under which peak clinical groups and health service organisations can partner with governments to monitor and report on the quality (or appropriateness and effectiveness) of health care.

Under the framework, an organisation can systematically monitor the quality of health care, within specific clinical domains, by routinely collecting, analysing and reporting health-related information. The information is used to identify outcome benchmarks and significant outcome variance, and to make improvements in healthcare quality. By applying the framework, organisations can assure jurisdictions, private hospital groups, clinicians and patients that registry data and the systems that hold those data have satisfied minimum security, technical and operating standards.

Throughout 2014/15, the Commission progressed work on developing national clinical quality registries under the framework, including:

- identifying high-priority clinical domains for national registry development
- developing a registry governance framework
- undertaking a pilot of high-priority registries to:
  - test the governance framework
  - assess the value of national registries
  - assess the impact of registries on the appropriateness of care (according to clinical practice guidelines).

2014/15 KEY ACHIEVEMENT

Framework for Australian clinical quality registries released

Safety in eHealth

The Commission has run a clinical safety program for the PCEHR system since its inception in 2012.

In July 2014, the Commission was appointed by the Department of Health to conduct two clinical safety reviews of the PCEHR and a set of incident analyses, with the oversight of the PCEHR Clinical Governance Advisory Group. In addition, the Commission has drafted a clinical incident management framework to support the PCEHR in the future, as part of its transition to the My Health Record program.

During 2014/15, the advisory group met four times to advise on PCEHR safety issues, recommend areas for investigation through the PCEHR clinical safety reviews, and review reports and incident analyses conducted as part of the Commission's PCEHR safety program.

Two PCEHR clinical safety reviews were conducted during 2014/15 to address the usability and utility of shared health summaries and event summaries. In addition, the Commission reviewed the data quality of 500 de-identified PCEHRs and the identity management processes within the PCEHR system.

The Commission and the Australian Patient Safety Foundation reviewed 150 complaints to the PCEHR Helpline to screen for clinical safety issues. The review process further informed the consumer elements of the incident management framework.

The Commission convened a clinical expert team to investigate two PCEHR clinical safety incidents escalated to an advisory group, applying a safety review method called the London Protocol.

As part of the program, the Commission also developed a PCEHR clinical incident management framework based on a review of literature, extensive consultation and expert oversight by a sub-committee of the advisory group.

During 2014/15, the Commission held more than 30 interviews and meetings with clinical experts, academic experts, consumers and health organisations across Australia and conducted site visits to inform the development of the PCEHR safe use guides for clinicians and consumers. The safe use guides will be released later in 2015.

2014/15 KEY ACHIEVEMENT

Two clinical safety reviews of the PCEHR and analyses of clinical incidents and Helpline calls were completed. A clinical incident management framework was developed, and PCEHR safe use guides for clinicians and consumers were developed

The state of safety and quality in Australian health care

As part of its legislative functions, the Commission is required to report on the state of safety and quality in the Australian health system. This chapter provides an overview of key safety and quality themes. A full report can be found in the Commission's publication *Vital signs 2015: the state of safety and quality in Australian health care.*

Safety and quality in health care in Australia

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 safe and high-quality health care in Australia. This means there is no single source of data that can provide a comprehensive picture about the safety and quality of the Australian health system. It is necessary to draw on a range of data sources to understand whether and how things might be changing.

When such data are brought together it is possible to get a sense of the improvements that have been achieved and issues that need further examination.

Safety and quality are important for ensuring the health system is productive and sustainable

There is currently a significant focus on the productivity and sustainability of the health system in Australia. Australia spends about 10% of GDP on health care each year, and this is growing. In the decade to 2012/13, total spending grew by an average of 4.7% per year, which was faster than GDP growth in the same period. This growth means that it is important to look at ways of improving value to ensure the health system is sustainable.

Preventable healthcare complications and healthcare variation place a burden on the healthcare system in terms of financial cost and reduced capacity. In 2011/12, the total cost of a group of 'high-priority complications' considered by clinical experts to be preventable, and which have a significant impact of patients and health services, was estimated to be in excess of $973 million; over 4% of the total cost of separations in public hospitals for that year. Reducing these high-priority complications by 5%, 10% or 25% could lead to improved value worth $48.7 million, $97.3 million or $243.3 million respectively; or 34 500, 69 000, or 172 000 bed days. Compared to other countries, Australia has high rates of some common procedures. If treatment rates for these procedures were brought into line with international averages it is estimated that value could be improved by $1.63 billion.

There is also variation in the rates of these procedures within Australia. If regions with high variation were aligned with the average for that region, there would be potential improvements of $228.3 million.

These results indicate the importance of ensuring safe and high-quality care in Australia. Much work is underway to put in place systems that have the potential to reduce the occurrence of high-priority complications and healthcare variation, and thereby ensure ongoing productivity and sustainability.

Impact of the NSQHS Standards

One of the most important systems for supporting safe and high-quality care in Australia is the NSQHS Standards. By the end of 2015 all hospitals and day procedure services will have been assessed to the NSQHS Standards, and the use of these standards as a framework for quality improvement in other types of services is increasing. A comprehensive evaluation of the NSQHS Standards is underway, and early results indicate that they have had a positive impact on healthcare processes and patient outcomes.

Between 2013 and 2014, more health services were able to show that they met all of the requirements when they were first assessed, with fewer remedial actions being required. Feedback from healthcare providers and managers who have been responsible for implementing systems to meet the NSQHS Standards has been positive about the way that they have helped to transform the culture of health services to focus on patient safety. In addition, over 1300 dental practices have completed or enrolled in an accreditation program, and 43 community health services have been assessed.

Systems are also needed to meet emerging patient safety threats

Antimicrobial resistance has been identified as a challenge to the effectiveness of health care globally, including in Australia. In June 2015, the Australian Government released the National Antimicrobial Resistance Strategy 2015–19 to guide the response to the threat of antibiotic misuse and resistance.

Although antimicrobial resistance is a natural feature of bacterial evolution, inappropriate use of antimicrobials increases the potential for resistance. Inappropriate prescribing of antimicrobials continues to be an issue in Australia. In a 2014 national survey of 248 hospitals and almost 20 000 prescriptions, 23% of prescriptions for antimicrobials were found to be inappropriate. The most common types of inappropriate use were using an antimicrobial where none was indicated, and using an antimicrobial with an unnecessarily broad spectrum.

Inappropriate use contributes to the occurrence of bacteria that are resistant to multiple classes of antimicrobials, including those that are used as ‘last-line’ treatments. The proportion of these kinds of bacteria in Australia is currently low compared to other countries (less than 0.5% in Australia compared to between 2% and 11% in the United States depending on the species of bacteria). However, there is a growing trend that indicates they have the potential to become established here.

Information about magnitude, distribution and impact of resistant organisms, and the use of antimicrobials is essential for tackling antimicrobial resistance. Currently the surveillance framework in Australia is fragmented, leading to gaps in knowledge and limiting the ability for effective planning and priority setting. To address this gap, the Australian Government Department of Health has funded the Commission to work with the states and territories, the private hospital sector, and diagnostic and pathology organisations to establish a new, national surveillance network. Developed within the AURA project, this new system will support the achievement and objectives of the Government’s national strategy by collecting information about antimicrobial resistance and antibiotic usage in hospitals, the community and residential aged care settings. Information from the surveillance network will be reported publicly and inform clinical public health decision making.

New areas of focus for safety and quality

A focus on systems, particularly through the NSQHS Standards, has the potential to bring safety and quality improvements for people who face specific risks, or who are particularly vulnerable.

The gap between health outcomes for Aboriginal and Torres Strait Islander peoples and those of the general population is well known. The concept of 'racial bias' can be used to identify and describe groups of behaviours and processes that contribute to these health disparities. Racial bias can unintentionally influence the safety and quality of care, and people's experience of that care. For example, Indigenous people in public hospitals are 35% less likely than non-Indigenous people to receive a procedure. They are also eight times more likely to leave a hospital before their care or treatment plan is finished. This is known as discharge against medical advice, and provides an indirect indicator of the extent to which health services respond to an Indigenous patient's needs.

People with lived experience of mental illness also report that health services are not always responsive to their needs. People report that they do not feel safe in hospitals because of the way that services are designed and care is delivered. Emergency departments are often reported as being particularly problematic as they are typically noisy, crowded and bright, creating sensory overload, which can lead to increased agitation.

Although there has been significant investment in these and other areas, such as caring for people with cognitive impairment and for people at the end of life, the work of the Commission has identified that there are still gaps, and that people in these groups have particular safety and quality risks that are not always addressed. The review of the NSQHS Standards provides an opportunity to ensure there is ongoing focus on these issues, and that health services put in place systems to address the safety and quality risks that people in these groups face.

Safety and quality in primary care are increasing areas of focus, and systems are being put in place to ensure that people in these settings get the best possible care. Over one-third of the problems managed by general practitioners relate to chronic conditions, and 30% of the population who visit a general practice have more than one chronic condition. The most frequently managed chronic conditions in general practice are blood pressure, depression and diabetes; however, we also know that people do not always receive the right care for these conditions. Improvements in this area are being seen when general practices are supported to review data about their patient population and to put in place local initiatives to address the particular gaps they identify. This type of model, known as a collaborative, has been shown to lead to safety and quality improvements in a range of different settings and for a range of different topics.

Supporting ongoing safety and quality improvement

The work that is underway across Australia to improve healthcare safety and quality is being undertaken in an environment of fiscal restraint. The delivery of safe and high-quality care has the potential to address some of the issues that contribute to this environment by supporting a sustainable and productive health system.

The available information about safety and quality in Australia indicates that the efforts of a range of government, health service, non-government, consumer and other organisations are having an impact, leading to improved outcomes and experiences for patients. The introduction of systems such as the NSQHS Standards has already contributed to this, often by supporting existing work. The Commission will continue to work with its partners to improve the safety and quality of health care in Australia.

A full report on safety and quality of health care in Australia can be found in the Commission's publication *Vital signs 2015: the state of safety and quality in Australian health care.*

03
Corporate governance and accountability

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

Legislation and requirements

The Commission is a corporate Commonwealth entity of the Australian Government, accountable to the Parliament and the Australian Minister for Health. The Commission's principle legislative basis is the *National Health Reform Act 2011* (NHR Act), which sets out its purpose, powers, functions, and administrative and operational arrangements. The NHR Act also sets out the Commission's Constitution, the process for appointing members of the board and the Chief Executive Officer (CEO), and the operation of board meetings.

The Commission must fulfil the requirements of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), which regulates certain aspects of the financial affairs of Commonwealth entities; their reporting, accountability, banking and investment obligations; and the conduct of their accountable authorities and officials.

Strategic planning

In 2013/14, the Commission's board started work on a new strategic plan that would describe the high-level priorities for the Commission over the coming three to five years. The development of the strategic plan was based on wide-ranging research and consultation with consumers and consumer groups, health professionals, health services and national health organisations.

The strategic plan was endorsed by the board in August 2014, and guides the development of more detailed work plans.

Ministerial directions

Section 16 of the NHR 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 2014/15 reporting period.

Commission's board

The Commission's board governs the organisation and is responsible for the proper and efficient performance of its functions. The board establishes the Commission's strategic direction, including directing and approving its strategic plan and monitoring management's implementation of the plan. It also oversees the Commission's operations, and ensures that appropriate systems and processes are in place so that the Commission operates in a safe, responsible and ethical manner, consistent with its regulatory requirements.

The board is established and governed by the provisions of the NHR Act and the PGPA Act.

Board membership 2014/15

The board consists of a Chair and nine members, who among them have extensive experience in healthcare administration, the law, management and clinical work. The board also includes a patient and consumer representative. Women make up 50% of the board's membership.

Professor Villis Marshall AC (Chair)

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

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

Qualifications: MD, MBBS, FRACS

Board membership: First appointed on 1 April 2012; appointed as Chair on 1 April 2013.

Mr Martin Bowles PSM

Mr Martin Bowles was appointed as Secretary of the Australian Government Department of Health on 13 October 2014. Mr Bowles was previously the Secretary of the Department of Immigration and Border Protection. Prior to this he held the positions of Deputy Secretary in the Department of Climate Change and Energy Efficiency and the Department of Defence respectively. In 2012 he was awarded a Public Service Medal (PSM) for delivering highly successful energy efficiency policies and remediation programs for the Home Insulation and Green Loans programs. Prior to joining the Australian Government Mr Bowles held senior executive positions in the education and health portfolios in the Queensland and New South Wales public sectors. He is a Fellow of the Australian Society of Certified Practicing Accountants.

Qualifications: B.Bus, GCPubSecMgmnt

Board membership: First appointed on 14 May 2015.

Professor Christopher Brook PSM

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

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

Qualifications: MB, BS, FRACP (Gastroenterology), FAFPHM, FIPAA

Board membership: First appointed on 1 April 2012; reappointed on 1 April 2013.

Ms Sally Crossing AM

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

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

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

Qualifications: BEc (USyd)

Board membership: First appointed on 4 September 2014.

Professor Phillip Della

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

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

Qualifications: PhD, FACN

Board membership: First appointed on 1 April 2013.

The Honourable Verity Firth

The Honourable Verity Firth has legal expertise and experience in public healthcare administration.

Ms Firth served as a member of the New South Wales Legislative Assembly from 2007 to 2011. During this time, she served as Minister for Women, Minister for Science and Medical Research, Minister Assisting the Minister for Health (Cancer), Minister for Climate Change and the Environment, and Minister for Education and Training.

Qualifications: BA, LLB

Board membership: First appointed on 1 April 2013. Resigned from board effective 4 March 2015.

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 Hospitals 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, the Australian Government's Second Tier Advisory Committee, and the Minter Ellison Health and Ageing Industry Group Advisory Board.

Qualifications: MBA

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

Ms Jane Halton PSM

Ms Jane Halton was Secretary of the Australian Department of Health from 2002 until July 2014. She gained a wealth of experience through her roles with numerous leading national and international boards and committees.

Ms Halton was a board member of the Australian Institute of Health and Welfare and the National E-Health Transition Authority. She is also on the executive board of the Institute for Health Metrics and Evaluation at the University of Washington in the USA, and on the advisory boards of the Centre for Applied Philosophy and Public Ethics, and the Melbourne Institute.

Ms Halton was the Chair of the OECD Health Committee, and the WHO Executive Board. She was also previously an executive board member of WHO; President of the World Health Assembly; Vice-Chair of the WHO Executive Board; and Chair of the WHO Program, Budget and Administration Committee.

Prior to her appointment as Secretary of the Department of Health, Ms Halton was a Deputy Secretary in the Department of Prime Minister and Cabinet. Professor Halton was recently appointed Secretary of the Department of Finance.

Qualifications: BA (Hons) Psychology

Board membership: First appointed as Commission member in March 2006; appointed to the board, as established under the CAC Act, on 1 July 2011; term concluded on 5 March 2015.

Dr Shaun Larkin

Shaun was appointed Managing Director of the Hospitals Contribution Fund of Australia Limited (HCF), Australia's largest not-for-profit health fund, in July 2010.

After joining HCF as a General Manager in 1997 he served in a number of senior executive roles including Strategic Development, Benefits Management, Corporate Ventures and Operations.

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

Previously, he worked for nine years as an executive for Ramsay Health Care in Australia and the United States.

Qualifications: HlthScD, MHSc, MBA, BHA

Board membership: First appointed on 1 April 2013.

Mrs Cheryle Royle

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

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

Qualifications: RN, RM, BN, GDip Nursing Administration

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

Dr Helena Williams

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

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

Qualifications: MB, BS, FRACGP

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

Table 1: Board meetings and attendance

NAME	BOARD MEETING				
	7 August 2014	18 September 2014	30 October 2014	19 March 2015	14 May 2015
Prof. Villis Marshall (Chair)	✓	✓	✓	✓	✓
Martin Bowles*	–	–	–	–	×
Prof. Christopher Brook	✓	✓	✓	✓	✓
Sally Crossing**	–	–	✓	✓	✓
Prof. Phillip Della	✓	×	✓	✓	✓
The Hon. Verity Firth***	✓	✓	✓	×	–
Christine Gee	✓	✓	✓	✓	✓
Jane Halton***	×	×	×	–	–
Dr Shaun Larkin	✓	✓	×	✓	✓
Cheryle Royle**	–	–	✓	✓	✓
Dr Helena Williams	✓	✓	✓	✓	✓

✓ Present × Absent – Not a member at time of meeting

* Appointed 14 May 2015
** Appointed 4 September 2014
*** Term concluded 4 March 2015

Board development and review

New board members undertake a formal induction to their role, including a meeting with the Chair and CEO. They receive an *Induction manual* that includes details on the board governance charter. 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.

Two sitting members resigned from the board during 2014/15: Ms Jane Halton PSM and the Honourable Verity Firth. The terms of the remaining members were not due for review. See 'Board membership 2014/15' on pages 37–39 for dates of board member appointments.

Ethical standards

The board governance charter provides a *Directors' code of conduct.* The charter includes guidelines for managing conflicts of interest – including material personal interests – as required under section 29 of the PGPA Act.

Related-entity transactions

In accordance with subparagraph 7AB(4)(c) of the Public Governance, Performance and Accountability (Consequential and Transitional Provisions) Amendment (Annual Reports) Rule 2015, there were no related-entity transactions during 2014/15.

Remuneration and expenses

In accordance with section 23 of the NHR Act and the relevant determinations of the Remuneration Tribunal, the Commission's board members are entitled to remuneration and allowances. Details of board members' remuneration and interests are set out in note 12 of the financial statements on page 77.

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 2013/14 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 minimum period of cover available for business interruption is 36 months. Motor vehicle, third-party property damage and expatriate cover have not been taken out, as they don't apply to the Commission.

Committees

An Audit and Risk Committee advises the Commission and its board on audit, risk and finance. An Inter-Jurisdictional Committee (IJC) meets regularly to provide advice to the Commission and the board.

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

Audit and Risk Committee

The primary role of the Audit and Risk Committee, chaired by Ms Jennifer Clark, is to provide the board with assistance, advice and oversight on its financial reporting, corporate governance, risk and control, and internal and external audit functions. The Committee's core responsibilities include:

- monitoring the effectiveness of risk management and internal control frameworks, management policies and key governance processes
- monitoring the Commission's compliance with the PGPA Act provisions and requirements, and relevant regulations, and helping the Commission and its board comply with obligations under the PGPA Act
- monitoring cost forecasting and the collection of information for the annual report
- reviewing fraud prevention and security-related matters
- reviewing operational risks, internal control measures, and internal and external audits and reporting
- reviewing matters referred to it by the board or the CEO

- providing a forum for communications between board members, the Commission's senior managers, and the entity's internal and external auditors.

The Audit and Risk Committee met five times during the 2014/15 financial year. Ms Jennifer Clark attended all five meetings.

The Board members sitting on the Audit and Risk Committee from 1 July 2014 to 30 June 2015 were the Honourable Verity Firth (until 4 March 2015) and Dr Shaun Larkin (as of 15 August 2014). Mr Trevor Burgess held the position of the external member of the Audit and Risk Committee during 2014/15.

Inter-Jurisdictional Committee

The IJC is made up of healthcare safety and quality representatives from the Australian, state and territory governments. It is responsible for advising on policy development and facilitating jurisdictional engagement. The IJC's role is to:

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

The IJC met four times during the 2014/15 financial year.

Other committees and consultations

The Commission has two standing committees that provide specific advice and support across all relevant areas of its work. These are the:

- Private Hospital Sector Committee
- Primary Health Committee.

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

The Commission consults widely with subject-matter experts, peak bodies, jurisdictions, consumers and other relevant individuals and organisations. The consultation includes ongoing discussions with key national and other organisations, and with an extensive network of formal reference and advisory groups. These networks provide links with healthcare providers, consumers, subject-matter experts and jurisdictional representatives. The Commission also undertakes formal consultations on specific issues.

Internal governance arrangements

The CEO manages the Commission's day-to-day administration and is supported by an executive management team, internal management committees and staff members. 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 one committee:

- The Leadership Group and Business Group meet fortnightly to facilitate information sharing and help with decision making.
- The Work Health and Safety Committee develops and promotes strategies to support the health and safety of all staff members and visitors.

Risk management

Risk management is part of the Commission's strategy to promote accountability through good governance and robust business practices. The Commission is committed to embedding risk management principles and practices consistent with the *Australian standards for risk management – principles and guidelines* (AS/NZS ISO 31000:2009) and the *Commonwealth risk management policy* into its:

- organisational culture
- governance and accountability arrangements
- reporting, performance review, business transformation and improvement processes.

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

Fraud control

The Commission recognises the responsibility of all Australian Government entities to develop, encourage and implement sound financial, legal and ethical decision making. The Commission's *Fraud control and anti-corruption plan* complies with the Attorney General's *Commonwealth fraud control policy.* The *Fraud control and anti-corruption plan* minimises the potential for instances of fraud within the Commission's programs and activities, whether by employees or those 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.

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.

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

External scrutiny

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

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.

Freedom of information

Agencies subject to the *Freedom of Information Act 1982* (FOI Act) are required to publish information available to the public as part of the Information Publication Scheme (IPS). This requirement is in Part II of the FOI Act and has replaced the former requirement to publish a Section 8 statement in an annual report. The Commission displays a plan on its web site (www.safetyandquality.gov.au) showing which information it publishes in accordance with IPS requirements. See Appendix A on page 89 for a table summarising FOI activities for 2014/15.

Judicial decisions and reviews by external bodies

No judicial decisions or decisions of administrative tribunals had a significant effect on the Commission's operations during 2014/15.

Developments and significant events

The Commission is required under paragraph 19(1) of the PGPA Act to keep the Minister and the Finance Minister informed of any significant decisions of issues that have affected or may affect its operations. In 2014/15, there were no such decisions or issues. There have also been no such decisions or issues since 30 June 2015.

Environmental performance and ecologically sustainable development

Section 516A of the *Environment Protection and Biodiversity Conservation Act 1999* (EPBC Act) 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 on page 90.

National Health Reform Act amendments

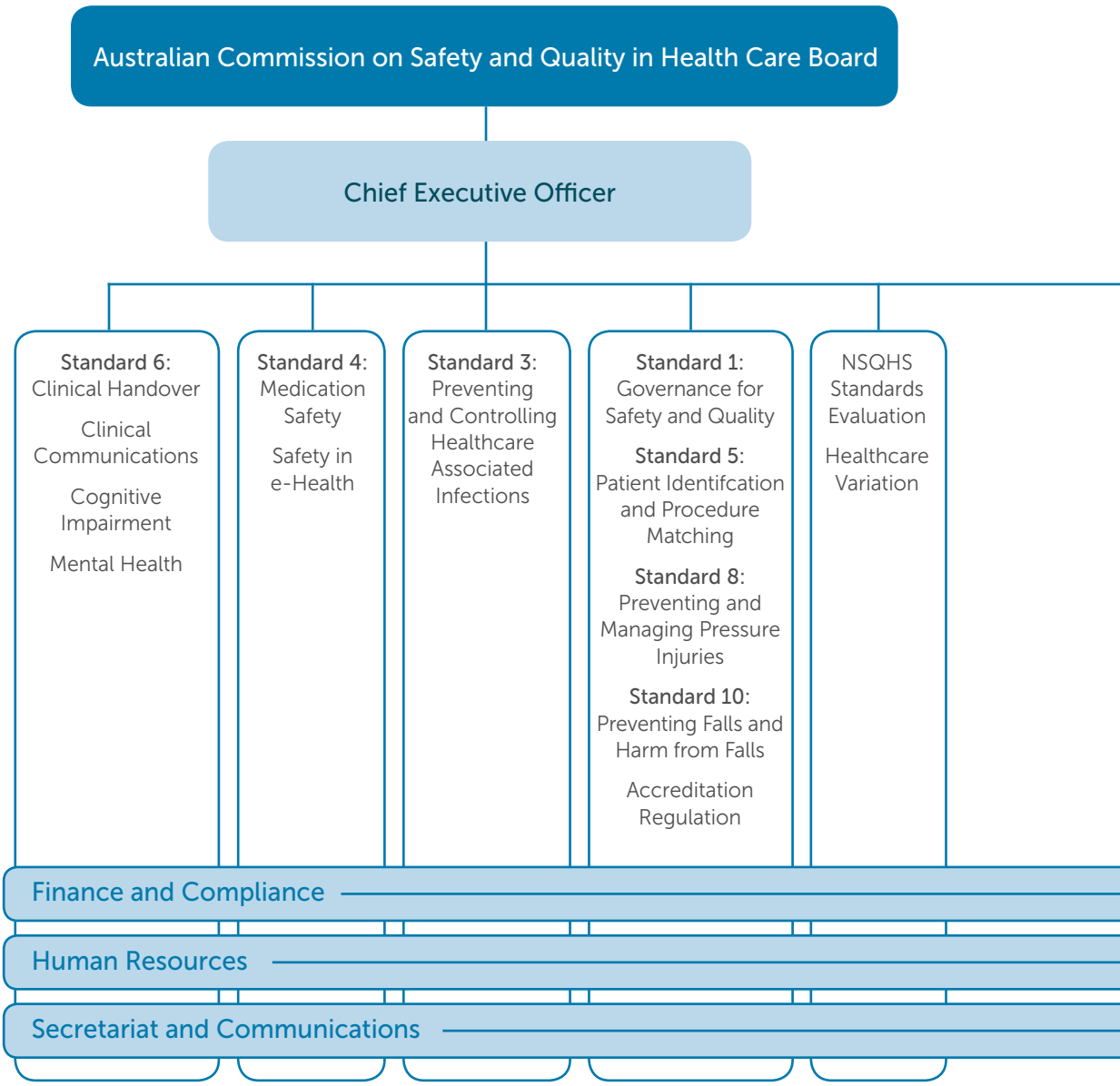
To support the introduction of the PGPA Act on 1 July 2014, the Australian Government introduced the *Public Governance, Performance and Accountability (Consequential and Transitional Provisions) Act 2014*, which came into effect at the beginning of the 2014/15 financial year. The Act introduced several minor amendments to the NHR Act, aligning the legislation with the terminology of the PGPA Act.

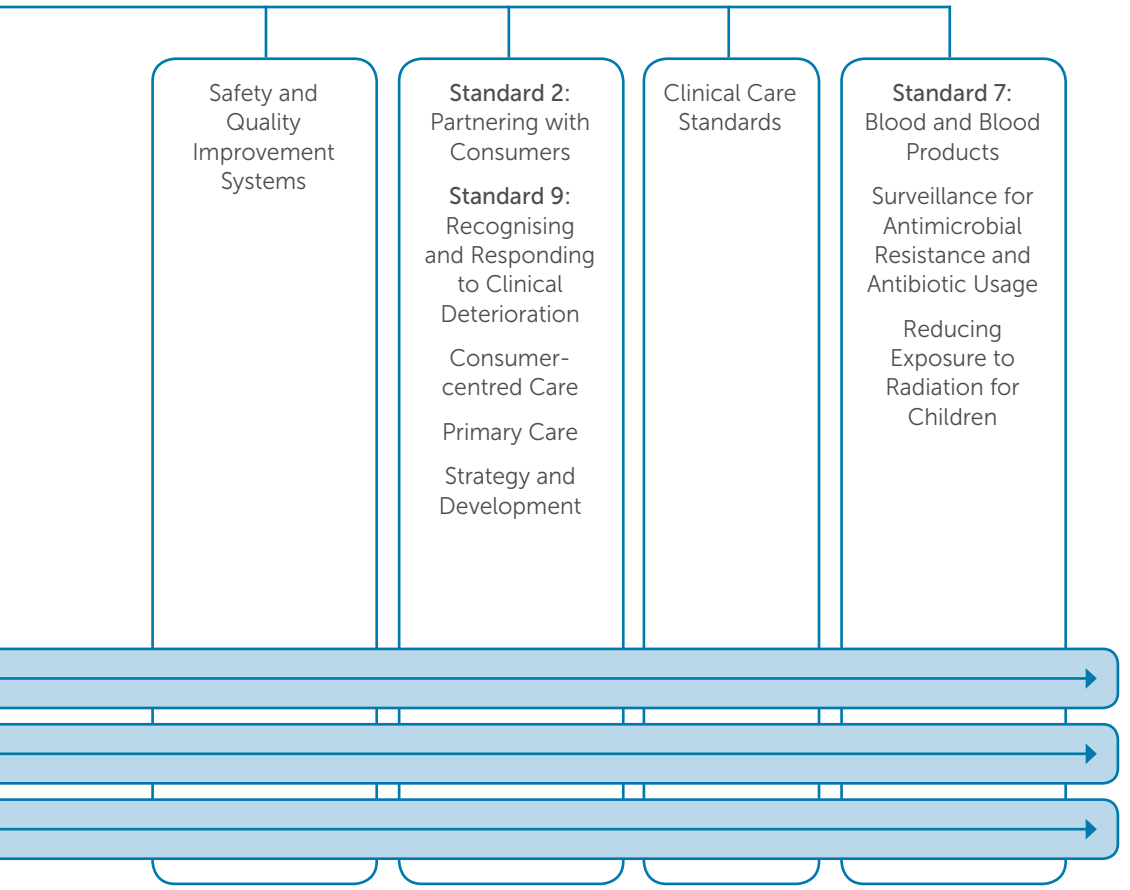
04
Our organisation

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

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

Organisational Structure




Safety and Quality Improvement Systems
Standard 2: Partnering with Consumers
Standard 9: Recognising and Responding to Clinical Deterioration
Consumer-centred Care
Primary Care
Strategy and Development
Clinical Care Standards
Standard 7: Blood and Blood Products
Surveillance for Antimicrobial Resistance and Antibiotic Usage
Reducing Exposure to Radiation for Children

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

In May 2015, all Commission staff were encouraged to participate in the APSC's census survey.

Staff profile

As of 30 June 2015, the Commission employed 82.1 full-time equivalent staff. The majority of staff are located in Sydney except for one staff member who works between Sydney and Melbourne and two others out-posted in Canberra and Perth. The following table provides a breakdown of the Commission's staffing by classification, gender, full-time or part-time status, and their ongoing or non-ongoing status.

Workplace health and safety

The Commission continues to promote a healthy and safe workplace and is committed to meeting its obligations under the *Work Health and Safety Act 2011* (WHS Act) and the *Safety, Rehabilitation and Compensation Act 1988 (*SRC Act).

All staff complete the Comcare *Work health and safety e-learning training module* on commencement with the Commission. The Commission has a suite of work health and safety policies and procedures to ensure its compliance with the WHS Act and to maintain the safety of its staff.

Commission workplace safety is monitored by the health and safety representatives and regular work health and safety committee meetings.

During 2014/15, the Commission undertook a number of activities aimed at preventing illness and injury in the workplace, including:

- conducting ergonomic workstation assessments for all staff
- appointing new Health and Safety Representatives and Workplace Harassment Contact Officers

Table 2: Staff numbers by classification as of 30 June 2015

	FEMALE				MALE				TOTAL
	Ongoing		Non-ongoing		Ongoing		Non-ongoing		
Classification	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	
CEO	1								**1**
MO6	1			0.2				1.6	**2.8**
MO4								0.2	**0.2**
EL 2	5	0.8	3		4		2		**14.8**
EL 1	11	5.4	14	4.3	3	0.8		0.2	**38.7**
APS 6	7		4	0.2	3		3		**17.2**
APS 5	1		3				2		**6.0**
APS 4	0		1					0.4	**1.4**
Total	**26.0**	**6.2**	**25.0**	**4.7**	**10.0**	**0.8**	**7.0**	**2.4**	**82.1**

- conducting bi-annual workplace inspections and encouraging all staff to report incidents, accidents or hazards in the workplace
- making influenza vaccinations available to all staff.

Five minor incidents were reported in 2014/15.

Learning and development

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

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

During 2014/15, the Commission's study support and training arrangements were updated to ensure the ongoing development of staff skills and capabilities. Accordingly, participation in study and training increased during the year with 15 staff accessing study support assistance and 24 employees completing training. Tertiary courses being undertaken include Masters of Public Health, PhD in nursing, Master of Health Service Management, Masters of Health Policy and various Graduate Certificates in health and human services related fields.

Training undertaken has included professional writing and project management courses.

Disability strategy

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

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

Indigenous employment

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

The proportion of Commission workforce who identify as being of Aboriginal and/or Torres Strait Islander origin is 1.1%. While this is below the Government's Indigenous employment target of 3% across the Commonwealth public sector by 2018, the Commission is exploring strategies to continue to increase the Indigenous workforce, with guidance by the Australian Public Sector's forthcoming *Indigenous recruitment and retention strategy.*

05
Financial statements

Australian National
Audit Office

INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

I have audited the accompanying annual financial statements of the Australian Commission on Safety and Quality in Health Care for the year ended 30 June 2015, which comprise:

- Statement by the Directors, Chief Executive and Chief Financial Officer;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Cash Flow Statement;
- Schedule of Commitments; and
- Notes to and forming part of the Financial Statements for the period ended 30 June 2015 comprising a Summary of Significant Accounting Policies and other explanatory information.

Accountable Authority's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An

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

audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Accountable Authority of the entity, as well as evaluating the overall presentation of the financial statements.

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

Independence

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

Opinion

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

(a) comply with Australian Accounting Standards and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and

(b) present fairly the financial position of the Australian Commission on Safety and Quality in Health Care as at 30 June 2015 and its financial performance and cash flows for the year then ended.

Australian National Audit Office

Brandon Jarrett

Executive Director

Delegate of the Auditor-General

Canberra

17 September 2015

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 2015 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
Accountable Authority

Date: 17/9/2015

Adj. Professor Debora Picone AM
Chief Executive Officer

Date: 17/9/2015

Mike Wallace
Chief Operating Officer /
Chief Financial Officer

Date: 17/9/15

Statement of Comprehensive Income

for the period ended 30 June 2015

	Notes	2015 $'000	2014 $'000
EXPENSES			
Employee benefits	3A	**10,981**	8,600
Suppliers	3B	**12,300**	9,977
Depreciation and amortisation	3C	**18**	87
Finance costs	3D	**1**	6
Impairment of assets	3E	**-**	56
Total expenses		**23,300**	18,726
LESS:			
OWN-SOURCE INCOME			
Own-source revenue			
Rendering of services	4A	**9,729**	6,104
Interest	4B	**476**	312
External contributions	4C	**6,760**	6,335
Total own-source revenue		**16,965**	12,751
Net cost of services		**6,335**	5,975
Revenue from Government	4D	**6,760**	6,335
Surplus		**425**	360
OTHER COMPREHENSIVE INCOME			
Changes in asset revaluation reserves		**-**	-
Total other comprehensive income (loss)		**-**	-
Total comprehensive income (loss)		**425**	360
Total comprehensive income (loss)		**425**	360

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

Statement of Financial Position

as at 30 June 2015

	Notes	2015 $'000	2014 $'000
ASSETS			
Financial Assets			
Cash and cash equivalents	6A	**14,254**	13,159
Trade and other receivables	6B	**2,744**	2,214
Total financial assets		**16,998**	15,373
Non-Financial Assets			
Property, plant and equipment	7A,B	**44**	56
Other non-financial assets	7C	**107**	155
Total non-financial assets		**151**	211
Total assets		**17,149**	15,584
LIABILITIES			
Payables			
Suppliers	8A	**3,479**	2,233
Other payables	8B	**9,637**	10,135
Total payables		**13,116**	12,368
Provisions			
Employee provisions	9A	**2,035**	1,504
Other provisions	9B	**250**	389
Total provisions		**2,285**	1,893
Total liabilities		**15,401**	14,261
Net assets		**1,748**	1,323
EQUITY			
Contributed equity		**1,836**	1,836
Reserves		**5**	5
Accumulated deficit		**(93)**	(518)
Total equity		**1,748**	1,323

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

Statement of Changes in Equity

for the period ended 30 June 2015

	Retained earnings		Asset revaluation Reserve		Contributed equity		Total equity	
	2015	2014	**2015**	2014	**2015**	2014	**2015**	2014
	$'000	$'000	**$'000**	$'000	**$'000**	$'000	**$'000**	$'000
Opening balance	**(518)**	(878)	**5**	5	**1,836**	1,836	**1,323**	963
Comprehensive income								
Other comprehensive income	**-**	-	**-**	-	**-**	-	**-**	-
Surplus (Deficit) for the period	**425**	360	**-**	-	**-**	-	**425**	360
Total comprehensive income	**425**	360	**-**	-	**-**	-	**425**	360
Transactions with owners								
Contributions by owners								
Equity injection	**-**	-	**-**	-	**-**	-	**-**	-
Sub-total transactions with owners	**-**	-	**-**	-	**-**	-	**-**	-
Closing balance as at 30 June	**(93)**	(518)	**5**	5	**1,836**	1,836	**1,748**	1,323
Closing balance attributable to the Australian Government	**(93)**	(518)	**5**	5	**1,836**	1,836	**1,748**	1,323

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

Cash Flow Statement

for the period ended 30 June 2015

	Notes	2015 $'000	2014 $'000
OPERATING ACTIVITIES			
Cash received			
Receipts from Government		**6,760**	6,335
State and Territory contributions		**6,760**	6,335
Rendering of services		**9,222**	10,796
Interest		**455**	301
Net GST received		**650**	529
Lease incentive received		**-**	1,180
Total cash received		**23,847**	25,476
Cash used			
Employees		**(10,358)**	(8,250)
Suppliers		**(12,388)**	(11,117)
Total cash used		**(22,746)**	(19,367)
Net cash from (used by) operating activities	10	**1,101**	6,109
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		**(6)**	-
Total cash used		**(6)**	-
Net cash from (used by) investing activities		**(6)**	-
Net increase (decrease) in cash held		**1,095**	6,109
Cash and cash equivalents at the beginning of the reporting period		**13,159**	7,050
Cash and cash equivalents at the end of the reporting period	6A	**14,254**	13,159

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

Schedule of Commitments

as at 30 June 2015

	2015	2014
BY TYPE	**$'000**	$'000
Commitments receivable		
Project Commitments[1]	**7,378**	15,056
Net GST recoverable on commitments	**182**	298
Total commitments receivable	**7,560**	15,354
Commitments payable		
Operating lease[2]	**497**	1,636
Other Commitments[3]	**2,756**	1,955
Total commitments payable	**3,253**	3,591
Net commitments by type	**4,307**	11,763
BY MATURITY		
Commitments receivable		
One year or less	**7,148**	10,216
From one to five years	**412**	5,138
Total receivable on commitments	**7,560**	15,354
Commitments payable		
Operating lease		
One year or less	**497**	1,091
From one to five years	**-**	545
Total operating lease commitments payable	**497**	1,636
Other commitments		
One year or less	**2,679**	1,784
From one to five years	**77**	171
Total other commitments payable	**2,756**	1,955
Total commitments payable	**3,253**	3,591
Net commitments by maturity	**4,307**	11,763

Note: Commitments are GST inclusive where relevant.

1. Project commitments: services committed to be provided by the Commission, under signed agreements, where the Commission has yet to perform the services required.
2. Operating lease commitments: the Commission has committed to a 2 year lease term agreement which commenced in December 2013. The lease is effectively non-cancellable. Lease payments are subject to annual increases or reviews until the end of the lease.
3. Other commitments: amounts committed under signed agreements where the contracted organisation has yet to perform the services required.

This schedule should be read in conjunction with the accompanying notes.

Table of Contents – Notes

Notes to and forming part of the Financial Statements for the period ended 30 June 2015

Note 1: Summary of Significant Accounting Policies

1.1 Objectives of the entity

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

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

The Commission is structured to meet a single outcome:

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

1.2 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) Financial Reporting Rule (FRR) for reporting periods ending on or after 1 July 2014; and

b) Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

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

The financial statements are presented in Australian dollars and values are rounded to the nearest thousand dollars.

Assets and liabilities are recognised in the statement of financial position when and only when it is probable that future economic benefits will flow to the Commission or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. Liabilities and assets that are unrecognised are reported in the schedule of commitments or the contingencies note.

Income and expenses are recognised in the statement of comprehensive income when and only when the flow, consumption or loss of economic benefits has occurred and can be reliably measured.

1.3 Significant Accounting Judgements and Estimates

No accounting assumptions or estimates have been identified that have a significant risk of causing a material adjustment to the carrying amounts of assets or liabilities within the next reporting period.

1.4 New Australian Accounting Standards

Adoption of New Australian Accounting Standard Requirements

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

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

Future Australian Accounting Standard Requirements

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

1.5 Revenue

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 amount of revenue, 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 surveys of work performed.

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

Interest revenue is recognised using the effective interest method as set out in AASB 139 *Financial Instruments: Recognition and Measurement*.

Revenue from Government

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.

1.6 Employee Benefits

Liabilities for 'short-term employee benefits' (as defined in AASB 119 *Employee Benefits*) and termination benefits due within twelve months of the end of the reporting period are measured at their nominal amounts.

The nominal amount is calculated with regard to the rates expected to be paid on settlement of the liability.

Leave

The liability for employee benefits includes provision for annual leave and long service leave. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years by employees of the Commission is estimated to be less than the annual entitlement for sick 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 is measured at the present value of the estimated future cash flows to be made in respect of all employees at year end. 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 funds.

The CSS and PSS are defined benefit schemes for the Australian Government. The PSSap and other funds are defined contribution schemes.

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' 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 for the final fortnight of the year.

1.7 Leases

A distinction is made between finance leases and operating leases. Finance leases effectively transfer from the lessor to the lessee substantially all the risks and rewards incidental to ownership of leased assets. An operating lease is a lease that is not a finance lease. In operating leases, the lessor effectively retains substantially all such risks and benefits.

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

The Commission did not have any finance leases during the year.

1.8 Fair Value Measurement

The entity deems transfers between levels of the fair value hierarchy to have occurred at the end of the period.

1.9 Cash

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.

1.10 Financial Assets

The Commission classifies its financial assets as cash and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition. Financial assets are recognised and derecognised upon trade date. The Commission only held cash and receivables.

Effective Interest Method

The effective interest method is a method of calculating the amortised cost of a financial asset and of allocating interest income over the relevant period. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, or, where appropriate, a shorter period.

Income is recognised on an effective interest rate basis except for financial assets that are recognised at fair value through profit or loss.

Receivables

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

Impairment of Financial Assets

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

If there is objective evidence that an impairment loss has been incurred for receivables, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the asset's original effective interest rate. The carrying amount is reduced by way of an allowance account. The loss is recognised in the statement of comprehensive income.

1.11 Financial Liabilities

Financial liabilities are classified as either financial liabilities 'at fair value through profit or loss' or other financial liabilities. Financial liabilities are recognised and derecognised upon 'trade date'.

The Commission only incurred other financial liabilities. These consist of trade creditors and accruals and other payables. Other financial liabilities are recognised at their nominal amount, being the amounts the Commission expects the liabilities to be settled. Liabilities are recognised to the extent that the goods or services have been received (and irrespective of having been invoiced).

1.12 Acquisition of Assets

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.

1.13 Property, Plant and Equipment

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the statement of financial position, except for purchases of leasehold improvements costing less than $10,000 and for all other purchased of property, plant and equipment costing less than $2,500, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

The initial cost of an asset includes an estimate of the cost of dismantling and removing the item and restoring the site on which it is located. This is particularly relevant to 'make good' provisions in property taken up by the Commission where there exists an obligation to restore the leased premises to the condition they were in prior to fitout. These costs are included in the value of the Commission's leasehold improvements with a corresponding provision for the 'make good' recognised.

Revaluations

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

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

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

Depreciation

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

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

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

Asset Class	**2015**	**2014**
Leasehold improvements	Lease term	Lease term
Plant and equipment	5 years	5 years

Impairment

All assets were assessed for impairment at 30 June 2015. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

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

Derecognition

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

1.14 Taxation

The Commission is exempt from all forms of taxation, except for Fringe Benefits Tax and Goods and Services Tax.

Revenues, expenses, assets and liabilities are recognised net of GST except:
i) where the amount of GST incurred is not recoverable from the Australian Taxation Office; and
ii) for receivables and payables.

Note 2: Events After the Reporting Period

On 3 August 2015, the Commission was advised by the Minister for Health that from 1 July 2016 some of the functions of the National Health Performance Authority (NHPA) will be transferred to the Commission as part of machinery of government changes. It has yet to be defined what functions will be transferred and this will be finalised with the Department of Health over the coming 12 months.

Note 3: Expenses

	2015 $'000	2014 $'000
Note 3A: Employee Benefits		
Wages and salaries	**8,087**	6,428
Superannuation:		
Defined contribution plans	**1,160**	908
Defined benefit plans	**232**	195
Leave and other entitlements	**1,458**	1,033
Other employee benefits	**44**	36
Total employee benefits	**10,981**	8,600
Note 3B: Suppliers		
Goods and services		
Consultants	**-**	34
Contracts for services	**8,248**	5,820
Travel	**758**	723
Information and communication	**751**	693
Printing and postage	**280**	162
Property outgoings	**167**	447
Other	**1,091**	881
Total goods and services	**11,295**	8,760
Goods and services are made up of:		
Provision of goods – external parties	**269**	189
Rendering of services – related parties	**863**	1,054
Rendering of services – external parties	**10,163**	7,517
Total goods and services	**11,295**	8,760
Other supplier expenses		
Operating lease rentals		
Minimum lease payments – external parties	**-**	672
Sublease – related parties	**820**	452
Workers compensation expenses	**185**	93
Total other supplier expenses	**1,005**	1,217
Total supplier expenses	**12,300**	9,977

	2015 $'000	2014 $'000

Note 3C: Depreciation and Amortisation

Depreciation:		
Property, plant and equipment	**18**	87
Total depreciation	**18**	87

Note 3D: Finance Costs

Unwinding of discount	**1**	6
Total finance costs	**1**	6

The unwinding of discount relates to make good on lease.

Note 3E: Impairment of Assets

Impairment of property, plant and equipment	**-**	56
Total impairment of assets	**-**	56

During the 2013-14 period, the Commission relocated office premises. Leasehold improvements not transferrable to the new office premises were impaired.

Note 4: Income

	2015	2014
OWN-SOURCE REVENUE	**$'000**	$'000

Note 4A: Rendering of Services

Rendering of services – Commonwealth entities	**9,628**	6,104
Rendering of services – State and Territory government entities	**101**	-
Total sale of goods and rendering of services	**9,729**	6,104

Note 4B: Interest

Deposits	**476**	312
Total interest	**476**	312

Note 4C: External Contributions

States and Territories contributions	**6,760**	6,335
Total external contributions	**6,760**	6,335

Note 4D: Revenue from Government

Department of Health:		
Corporate Commonwealth entity payment item	**6,760**	6,335
Total revenue from Government	**6,760**	6,335

Note 5: Fair Value Measurement

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

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

Note 5A: Fair Value Measurements, valuation techniques and inputs used

Fair value measurements at the end of the reporting period by hierarchy for assets and liabilities in 2015:

	Fair value measurements at the end of the reporting period using			For Levels 2 and 3 fair value measurements	
	2015 $'000	2014 $'000	**Category (Level 1, 2 or 3)**	**Valuation technique**	**Inputs used**
Non-financial assets					
Recurring - Property, Plant and Equipment	**44**	56	Level 2	Cost approach	Replacement cost Remaining useful life
Total non-financial assets	**44**	56	-		
Total fair value measurements	**44**	56	-		

Note 6: Financial Assets

	2015 $'000	2014 $'000
Note 6A: Cash and Cash Equivalents		
Cash on hand and at bank	**14,254**	13,159
Total cash and cash equivalents	**14,254**	13,159
Note 6B: Trade and Other Receivables		
Good and Services:		
Department of Health	**2,120**	1,806
Related parties	**340**	170
Total receivables for goods and services	**2,460**	1,976
Other receivables:		
GST receivable from the Australian Taxation Office	**237**	212
Interest - related parties	**2**	4
Interest - external parties	**45**	22
Total other receivables	**284**	238
Total trade and other receivables (gross)	**2,744**	2,214
Less impairment allowance account:		
Goods and services	**-**	-
Total impairment allowance account	**-**	-
Total trade and other receivables (net)	**2,744**	2,214
Receivables are expected to be recovered in:		
No more than 12 months	**2,744**	2,214
Total trade and other receivables (net)	**2,744**	2,214
Receivables are aged as follows:		
Not overdue	**2,744**	2,214
Overdue by 61 to 90 days	**-**	-
Total trade and other receivables (net)	**2,744**	2,214

No receivables were impaired at 30 June 2015 (2014: Nil).

Note 7: Non-Financial Assets

	2015 $'000	2014 $'000
Note 7A: Property, Plant and Equipment		
Fair value	**89**	384
Accumulated depreciation	**(45)**	(272)
Accumulated impairment losses	**-**	(56)
Total property, plant and equipment	**44**	56

Leasehold improvements relating to the former Oxford Street premises were disposed of upon expiry of the lease in September 2014.

No property, plant or equipment is expected to be sold or disposed of within the next 12 months.

No indicators of impairment were found for property, plant and equipment.

Note 7B: Reconciliation of the opening and closing balances of property, plant and equipment

	2015 $'000	2014 $'000
As at 1 July		
Gross book value	**384**	384
Accumulated depreciation and impairment	**(328)**	(185)
Net book value 1 July	**56**	199
Additions:		
By purchase	**6**	-
Depreciation expense	**(18)**	(87)
Impairments recognised in other comprehensive income	**-**	(56)
Net book value 30 June	**44**	56
Net book value as of 30 June represented by:		
Gross book value	**90**	384
Accumulated depreciation and impairment	**(46)**	(328)
	44	56

	2015 $'000	2014 $'000
Note 7C: Other Non-Financial Assets		
Prepayments	**107**	155
Total other non-financial assets	**107**	155
Total other non-financial assets - are expected to be recovered in:		
No more than 12 months	**107**	155
Total other non-financial assets	**107**	155

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

Note 8: Payables

	2015 $'000	2014 $'000
Note 8A: Suppliers		
Trade creditors and accruals	**3,479**	2,233
Total supplier payables	**3,479**	2,233
Supplier payables expected to be settled within 12 months:		
Related entities - Department of Health	**-**	109
Related entities - Other	**87**	158
External parties	**3,392**	1,966
Total	**3,479**	2,233

Settlement is usually made within 30 days.

Note 8B: Other Payables		
Salaries and wages	**283**	204
Superannuation	**46**	33
Unearned income	**8,989**	9,025
Lease incentive	**283**	850
Other	**36**	23
Total other payables	**9,637**	10,135
Other payables expected to be settled:		
No more than 12 months	**8,721**	9,852
More than 12 months	**916**	283
Total other payables	**9,637**	10,135

Note 9: Provisions

	2015 $'000	2014 $'000
Note 9A: Employee Provisions		
Leave	**2,035**	1,504
Total employee provisions	**2,035**	1,504
Employee provisions are expected to be settled in:		
No more than 12 months	**1,468**	937
More than 12 months	**567**	567
Total employee provisions	**2,035**	1,504
Note 9B: Other Provisions		
Provision for relocation	**250**	-
Provision for restoration obligations	**-**	255
Provision for surplus lease space	**-**	134
Total other provisions	**250**	389
Other provisions are expected to be settled in:		
No more than 12 months	**250**	389
More than 12 months	**-**	-
Total other provisions	**250**	389

Reconciliation of the opening and closing balances of other provisions:

	Provision for relocation $'000	Provision for surplus lease space $'000	Provision for restoration $'000	Total $'000
Carrying amount at 1 July 2014	**-**	**134**	**255**	**389**
Provisions made	**250**	**-**	**-**	**250**
Amounts recognised in other comprehensive income	**-**	**(134)**	**(256)**	**(390)**
Unwinding of discount rate or change in discount rate	**-**	**-**	**1**	**1**
Closing balance at 30 June 2015	**250**	**-**	**-**	**250**

Provisions for the Oxford Street premises were all consumed during the period upon the end of the lease in September 2014.

The Commission has received advice that it will be required to vacate the current leased premises at the expiry of the lease on 31 December 2015. Given the recent experience of the cost of relocating premises in December 2013 a provision has been recognised.

Note 10: Cash Flow Reconciliation

	2015 $'000	2014 $'000
Reconciliation of net cost of services to net cash from operating activities:		
Net cost of services	**(6,335)**	(5,975)
Add revenue from Government	**6,760**	6,335
Adjustments for non-cash items		
Depreciation and amortisation	**18**	87
Impairment of assets	**-**	56
Movements in operating recognised in equity	**-**	-
Capitalisation of accruals not classified as operating	**-**	-
Changes in assets / liabilities		
(Increase) / decrease in net receivables	**(530)**	(1,053)
(Increase) / decrease in prepayments	**48**	(98)
Increase / (decrease) in employee provisions	**531**	275
Increase / (decrease) in supplier payables	**1,246**	(245)
Increase / (decrease) in other payables	**(498)**	6,587
Increase / (decrease) in other provisions	**(139)**	140
Net cash from (used by) operating activities	**1,101**	6,109

Note 11: Contingent Assets and Liabilities

Quantifiable Contingencies

As at 30 June 2015, the Commission had no quantifiable contingencies (2013-14: nil).

Unquantifiable Contingencies

As at 30 June 2015, the Commission had no unquantifiable contingencies (2013-14: nil).

Significant Remote Contingencies

As at 30 June 2015, the Commission had no material remote contingencies (2013-14: nil).

Note 12: Senior Management Personnel Remuneration

	2015 $	2014 $
Short-term employee benefits		
Salary	**1,396,606**	1,215,254
Performance bonuses	**76,841**	71,918
Total short-term employee benefits	**1,473,447**	1,287,172
Post-employment benefits		
Superannuation	**201,338**	151,218
Total post-employment benefits	**201,338**	151,218
Other long-term benefits		
Annual leave accrued	**102,048**	81,063
Long service leave	**39,092**	20,252
Total other long-term benefits	**141,140**	101,315
Termination benefits		
Termination benefits	**-**	-
Total termination benefits	-	-
Total senior management remuneration expenses	**1,815,925**	1,539,705

The total number of senior management personnel that are included in the above table are 18 (2014 : 16). 4 directors included in this number waived their right or were not eligible to receive remuneration during 2015 (2014: 4). The directors of the Commission, including appointments and cessations during the year are listed in note 13.

Note 13: Related Party Disclosures

The directors of the Commission during the year were:

	Commenced	Ceased
Professor Villis Marshall AC (Chair from 1 April 2013)	1/04/2012	
Mr Martin Bowles PSM	14/05/2015	
Professor Chris Brook PSM	1/04/2012	
Ms Sally Crossing AM	14/05/2015	
Professor Phillip Della	1/04/2013	
The Hon Verity Firth	1/04/2013	4/03/2015
Christine Gee	1/07/2011	
Jane Halton AO PSM	1/07/2011	4/12/2014
Dr Shaun Larkin	1/04/2013	
Mrs Cheryle Royle	14/05/2015	
Dr Helena Williams	1/07/2011	

Transactions with Directors of Director-Related Entities

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

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

During the year, Dr Helena Williams provided project support and expert advice to the Commission. Fees paid by the Commission for these services were $13,122 (2014: 10,226).

Note 14: Remuneration of Auditors

	2015 $'000	2014 $'000
Financial statement audit services were provided to the Commission by the Australian National Audit Office (ANAO).		
Cost of the services provided		
Financial statement audit services	**50**	50
Total	**50**	50

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

Note 15: Financial Instruments

Note 15A: Categories of financial instruments

	2015 $'000	2014 $'000
Financial assets		
Receivables:		
Cash on hand and at bank	**14,254**	13,159
Trade and other receivables	**2,507**	2,002
Total	**16,761**	15,161
Carrying amount of financial assets	**16,761**	15,161
Financial liabilities		
At amortised cost:		
Trade creditors and accruals		
Suppliers	**3,479**	2,233
Total	**3,479**	2,233
Carrying amount of financial liabilities	**3,479**	2,233

Note 15B: Net income and expense from financial assets

Receivables		
Interest revenue	**476**	312
Net gain/(loss) from receivables	**476**	312
Net gain/(loss) from financial assets	**476**	312

Note 15C: Fair value of financial instruments

	Carrying amount 2015 $'000	Carrying amount 2014 $'000
Financial assets		
Receivables:		
Cash and cash equivalents	**14,254**	13,159
Trade and other receivables	**2,507**	2,002
Total	**16,761**	15,161
Carrying amount of financial assets	**16,761**	15,161
Financial liabilities		
At amortised cost:		
Suppliers	**3,479**	2,233
Total	**3,479**	2,233
Carrying amount of financial liabilities	**3,479**	2,333

There are no potential differences between the carrying amounts and fair values of financial assets and liabilities.

Note 15D: Credit risk

The Commission was exposed to minimal credit risk as receivables were cash and trade receivables. The maximum exposure to credit risk was the risk that arises from potential default of a debtor. This amount was equal to the total amount of trade and other receivables at 30 June 2015: $2,507,000 (2014: $2,002,000).

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

The Commission holds no collateral to mitigate against credit risk.

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

	Not past due nor impaired		Past due or impaired	
	2015	2014	**2015**	2014
	$'000	$'000	**$'000**	$'000
Cash and cash equivalents	**14,254**	13,159	**-**	-
Trade and other receivables	**2,507**	2,002	**-**	-
Total	**16,761**	15,161	**-**	-

Note 15E: Liquidity risk

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

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

Maturities for financial liabilities 2015:

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

Maturities for financial liabilities 2014:

	On demand $'000	Within 1 year $'000	Total $'000
Other financial liabilities			
Suppliers	-	2,233	2,233
Total	-	2,233	2,233

Note 15F: Market risk

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

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

Note 16: Financial Assets Reconciliation

	Notes	2015 $'000	2014 $'000
Financial assets			
Total financial assets as per statement of financial position		**16,998**	15,373
Less: non-financial instrument components:			
Other receivables	6B	**237**	212
Total non-financial instruments components		**237**	212
Total non-financial assets as per financial instruments note		**16,761**	15,161

Note 17: Reporting of Outcomes

Note 17A: Net Cost of Outcome Delivery

The Commission is structured to meet one outcome:

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

	Outcome 1	
	2015	2014
	$'000	$'000
Expenses		
Departmental	**23,300**	18,726
Income from non-government sector		
Sale of goods and rendering of services	**9,729**	6,104
Interest	**476**	312
External contributions	**6,760**	6,335
Total income from non-government sector	**16,965**	12,751
Net cost of outcome delivery	**6,335**	5,975

The primary statements of these financial statements represent the Major Classes of Departmental Expense, Income, Assets and Liabilities by Outcome, as required by the FRR. Accordingly these tables are not repeated in note 17.

Note 18: Budgetary Reports and Explanations of Major Variances

The following tables provide a comparison of the original budget as presented in the 2014-15 Portfolio Budget Statements (PBS) to the 2014-15 final outcome as presented in accordance with Australian Accounting Standards for the entity. The Budget is not audited.

Note 18A: Agency Budgetary Reports

STATEMENT OF COMPREHENSIVE INCOME
for the period ended 30 June 2015

	Actual	Budget estimate Original[1]	Variance[2]
	2015	**2015**	2015
	$'000	**$'000**	$'000
EXPENSES			
Employee benefits	**10,981**	**10,336**	645
Suppliers	**12,300**	**9,903**	2,397
Depreciation and amortisation	**18**	**-**	18
Finance costs	**1**	**-**	1
Impairment of assets	**-**	**-**	-
Total expenses	**23,300**	**20,239**	3,061
LESS:			
OWN-SOURCE INCOME			
Own-source revenue			
Rendering of services	**9,729**	**7,082**	2,647
Interest	**476**	**200**	276
External contributions	**6,760**	**-**	6,760
Total own-source revenue	**16,965**	**7,282**	9,683
Net cost of services	**6,335**	**12,957**	(6,622)
Revenue from Government	**6,760**	**12,957**	(6,197)
Surplus (deficit)	**425**	**-**	425
OTHER COMPREHENSIVE INCOME			
Changes in asset revaluation reserves	**-**	**-**	-
Total other comprehensive income (loss)	**-**	**-**	-
Total comprehensive income (loss)	**425**	**-**	425
Total comprehensive income (loss)	**425**	**-**	425

[1]The Commission's original budgeted financial statement that was first presented to parliament in respect of the reporting period (i.e. from the Commission's 2014-15 Portfolio Budget Statements (PBS)).

[2]Between the actual and original budgeted amounts for 2015. Explanations of major variances are provided further below.

STATEMENT OF FINANCIAL POSITION

As at 30 June 2015

	Actual	Budget estimate Original[1]	Variance[2]
	2015	**2015**	2015
	$'000	**$'000**	$'000
ASSETS			
Financial Assets			
Cash and cash equivalents	**14,254**	**7,050**	7,204
Trade and other receivables	**2,746**	**1,341**	1,405
Total financial assets	**17,000**	**8,391**	8,609
Non-Financial Assets			
Property, plant and equipment	**44**	**-**	44
Other non-financial assets	**107**	**456**	(349)
Total non-financial assets	**151**	**456**	(305)
Total assets	**17,151**	**8,847**	8,304
LIABILITIES			
Payables			
Suppliers	**3,479**	**6,428**	(2,949)
Other payables	**9,639**	**-**	9,639
Total payables	**13,118**	**6,428**	6,690
Provisions			
Employee provisions	**2,035**	**1,456**	579
Other provisions	**250**	**-**	250
Total provisions	**2,285**	**1,456**	829
Total liabilities	**15,403**	**7,884**	7,519
Net assets	**1,748**	**963**	785
EQUITY			
Contributed equity	**1,836**	**1,844**	(8)
Reserves	**5**	**(3)**	8
Accumulated deficit	**(93)**	**(878)**	785
Total equity	**1,748**	**963**	785

[1]The Commission's original budgeted financial statement that was first presented to parliament in respect of the reporting period (i.e. from the Commission's 2014-15 Portfolio Budget Statements (PBS)).

[2]Between the actual and original budgeted amounts for 2015. Explanations of major variances are provided further below.

STATEMENT OF CHANGES IN EQUITY

For the period ended 30 June 2015

	Retained earnings			Asset revaluation reserve			Contributed equity			Total equity		
	Actual	Budget estimate Original[1]	Variance[2]	Actual	Budget estimate Original[1]	Variance[2]	Actual	Budget estimate Original[1]	Variance[2]	Actual	Budget estimate Original[1]	Variance[2]
	2015	2015	2014	2015	2015	2014	2015	2015	2014	2015	2015	2014
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Opening balance	**(518)**	**(878)**	360	**5**	**(3)**	8	**1,836**	**1,844**	(8)	**1,323**	**963**	360
Comprehensive income												
Other comprehensive income	-	-	-	-	-	-	-	-	-	-	-	-
Surplus (Deficit) for the period	**425**	**-**	425	**-**	**-**	-	**-**	**-**	-	**425**	**-**	425
Total comprehensive income	**425**	**-**	425	**-**	**-**	-	**-**	**-**	-	**425**	**-**	425
Transactions with owners												
Contributions by owners												
Equity injection	-	-	-	-	-	-	-	-	-	-	-	-
Sub-total transactions with owners	-	-	-	-	-	-	-	-	-	-	-	-
Closing balance as at 30 June	**(93)**	**(878)**	785	**5**	**(3)**	8	**1,836**	**1,844**	(8)	**1,748**	**963**	785
Closing balance attributable to the Australian Government	**(93)**	**(878)**	785	**5**	**(3)**	8	**1,836**	**1,844**	(8)	**1,748**	**963**	785

[1]The Commission's original budgeted financial statement that was first presented to parliament in respect of the reporting period (i.e. from the Commission's 2014-15 Portfolio Budget Statements (PBS)).

[2]Between the actual and original budgeted amounts for 2015. Explanations of major variances are provided further below.

CASH FLOW STATEMENT

For the period ended 30 June 2015

	Actual 2015 $'000	Budget estimate Original[1] 2015 $'000	Variance[2] 2014 $'000
OPERATING ACTIVITIES			
Cash received			
Receipts from Government	**6,760**	**12,957**	(6,197)
State and Territory contributions	**6,760**	**7,082**	(322)
Rendering of services	**9,222**	**-**	9,222
Interest	**455**	**200**	255
Net GST received	**650**	**500**	150
Lease incentive received	**-**	**-**	-
Total cash received	**23,847**	**20,739**	3,108
Cash used			
Employees	**(10,358)**	**(10,336)**	(22)
Suppliers	**(12,388)**	**(10,403)**	(1,985)
Total cash used	**(22,746)**	**(20,739)**	(2,007)
Net cash from (used by) operating activities	**1,101**	**-**	1,101
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment	**(6)**	**-**	(6)
Total cash used	**(6)**	**-**	(6)
Net cash from (used by) investing activities	**(6)**	**-**	(6)
Net increase (decrease) in cash held	**1,095**	**-**	1,095
Cash and cash equivalents at the beginning of the reporting period	**13,159**	**7,050**	6,109
Cash and cash equivalents at the end of the reporting period	**14,254**	**7,050**	7,204

[1]The Commission's original budgeted financial statement that was first presented to parliament in respect of the reporting period (i.e. from the Commission's 2014-15 Portfolio Budget Statements (PBS)).

[2]Between the actual and original budgeted amounts for 2015. Explanations of major variances are provided further below.

Note 18B: Major Budget Variances for 2015

Explanations of major variances	Affected line items (and statements)
Arises from the rollover of projects funded but not completed in previous periods into the 2014-15 year as well as additional new funded projects commencing in 2014-15 that were not forecast at the time of preparing the budget statements.	Supplier expenses (Statement of comprehensive income) Rendering of services (Statement of comprehensive income) Cash and cash equivalents (Statement of financial position) Trade and other receivables (Statement of financial position) Other non-financial assets (Statement of financial position) Supplier payables (Statement of financial position) Other payables (Statement of financial position) Retained earnings (Statement of changes in equity) Receipts from Government, External Contributions, and Rendering of services (Cash flow statement) Suppliers (Cash flow statement) Interest (Cash flow statement) Net GST received (Cash flow statement)
Arises due to all Commonwealth funding, including revenue from 'other funded projects', being disclosed as a single line within the PBS. In the financial statements this revenue is split between Revenue from Government – for Workplan revenue jointly funded by the Commonwealth and States and Territories; and revenue from rendering of services – for revenue from 'other funded projects'.	External contributions (Statement of comprehensive income) Revenue from Government (Statement of comprehensive income) Receipts from Government (Cash flow statement) External contributions (Cash flow statement) Rendering of services (Cash flow statement)
Arises from a higher number of staff than expected at the time of preparing budget statements.	Employee benefits (Statement of comprehensive income) Employee provisions (Statement of financial position)

06
Appendices

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 43.

Table 3: Freedom of Information summary 2014/15

Activity	Number
Requests	
On hand as at 1 July 2014	0
New requests received	4
Total requests handled	3
Total requests completed as at 30 June 2015	2
Total requests on hand as at 30 June 2015	1
Action of request	
Access granted in full	0
Access granted in part	1
Access refused	1
Access transferred in full	0
Request withdrawn	1
No records	0
Response times	
0–30 days	0
30–60 days	2
Internal review	
On hand as at 1 July 2014	0
Requests received	1
Decision affirmed	1
Decision amended	0
Request withdrawn	0
Review by Administrative Appeals Tribunal	
Applications received	0
Review by the Officer of the Australian Information Commissioner	
Applications received	0

Appendix B

Compliance with ecologically sustainable development

The Commission is committed to making a positive contribution to ecological sustainability. The following table details the Commission's activities in accordance with section 156A(6) of the *Environment Protection and Biodiversity Conservation Act 1999* (EPBC Act).

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

EPBC Act requirement	Commission response
The activities of the Commission and its administration of legislation during 2014/15 accord with the principles of ecologically sustainable development	The Commission gives appropriate consideration to the effects its activities may have on the environment, including in terms of its work plan and corporate governance. Instances where the Commission's activities have environmental impacts are mitigated wherever possible. The Commission is not responsible for administering any legislation.
Outcomes specified for the Commission in an Appropriations Act for 2014/15 contribute to ecologically sustainable development	The Commission's single appropriations outcome focuses on improving safety and quality in health care across the health system rather than environmental outcomes and, as such, has no implications on environmental protection and biodiversity conservation.
Effects of the Commission's activities on the environment	The Commission's offices are located in a 5-star (NABERS rating) building and the Commission's staff works proactively with the building manager to achieve energy savings where possible. Office lighting is automated to power off outside business hours. The Commission encourages its staff members to view documents online where possible and print only when necessary. The Commission's waste practices are in accordance with the National Waste Policy.
Measures the Commission is taking to minimise its impact on the environment	The Commission is working hard to further reduce its environmental effects, particularly in the area of information and communication technology (ICT). In 2014/15, the Commission implemented a number of initiatives required by the *Australian Government ICT Sustainability Plan 2010–2015.* These initiatives included introducing and using 100% post-consumer recycled paper and modifying the Commission's ICT infrastructure, which will deliver desktop energy savings and reduce the Commission's carbon footprint. The Commission is also partnering with the City of Sydney's CitySwitch program to explore further environmental sustainability options.
Mechanisms for reviewing and increasing the effectiveness of those measures	The Commission is implementing a number of initiatives to reduce its environmental impact, with a view to introducing a formal environmental policy. Review mechanisms will be included in this policy.

07
Indexes and references

Acronyms and abbreviations

AHMAC	Australian Health Ministers' Advisory Council
AHSSQA Scheme	Australian Health Service Safety and Quality Accreditation Scheme
AURA Project	Antimicrobial Utilisation and Resistance in Australia Surveillance Project
CHBOI	core, hospital-based outcome indicators
Commission	Australian Commission on Safety and Quality in Health Care
EPBC Act	*Environment Protection and Biodiversity Conservation Act 1999*
FOI Act	*Freedom of Information Act 1982*
IHPA	Independent Hospital Pricing Authority
IJC	Inter-Jurisdictional Committee
IPS	Information Publication Scheme
NASCAR	National Alert System for Critical Antimicrobial Resistances
NHMRC	National Health and Medical Research Council
NHR Act	*National Health Reform Act 2011*
NSQHS Standards	National Safety and Quality Health Service Standards
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
PGPA Act	*Public Governance, Performance and Accountability Act 2013*
RACGP	Royal Australian College of General Practitioners
SRC Act	*Safety, Rehabilitation and Compensation Act 1988*
WHO	World Health Organization
WHS Act	*Work Health and Safety Act 2011*

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.[6]

Antimicrobial: A chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts and moulds.[7]

Antimicrobial stewardship: A program implemented in a health service organisation to reduce the risks associated with increasing microbial resistance, and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies, including monitoring and reviewing antimicrobial use.[7]

Clinical communication: An exchange of information that occurs between healthcare providers treating a patient. Communication can be formal (for example, when a message conforms to a predetermined structure in a health record or stored electronic data), or informal (when a message's structure is determined solely by the relevant parties; for example, in a face-to-face or telephone conversation).[8]

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.[9]

Clinical practice guidelines: Systematically developed statements to help practitioners and patients make decisions about appropriate health care for specific circumstances.[10]

Clinician: A healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or teams of health professionals providing health care who spend the majority of their time delivering direct clinical care.

Consumers: Patients and potential patients, carers and organisations representing consumers' interests.[11]

Consumer-centred care: Treating consumers and/or carers with dignity and respect; communicating and sharing information between consumers and/or carers and healthcare providers; encouraging and supporting consumers' participation in decision making; and fostering collaboration with consumers and/or carers and healthcare organisations in planning, designing, delivering and evaluating health care. Other terms are used internationally, such as patient-based, person-centred, relationship-based, patient-centred, and patient- and family-centred care.

Core, hospital-based outcome indicators (CHBOI): A succinct set of indicators that hospitals routinely monitor and review. These hospital-based outcome indicators can be generated by the jurisdictions or private hospital owners that hold the source data and reported back to the facilities that provide healthcare services.

Dataset: A collection of data elements that are collected as a set.

Electronic medication management system: Enables medicines to be prescribed, supplied, administered and reconciled electronically.

Hand hygiene: A general term referring to any hand-cleansing action.

Hand Hygiene Australia: An organisation engaged by the Commission to implement the National Hand Hygiene Initiative.

Health care: Services provided to individuals or communities to promote, maintain, monitor or restore health. Health care is not limited to medical care, and it includes self-care.

Health literacy: The skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and health care and take appropriate action.

Healthcare-associated infections: Infections that are acquired in healthcare facilities (nosocomial infections) or that occur as a result of healthcare interventions (iatrogenic infections). Healthcare-associated infections may manifest after people leave healthcare facilities.[12]

Healthcare provider: Any person working within the health sector (at the service or jurisdictional level) who is responsible for providing or organising the provision of care and/or treatment to patients.

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.[13]

Health service organisation: A separately constituted health service that is responsible for the clinical governance, administration and financial management of service units that provide health care. A service unit is a group of healthcare providers and others working in a systematic way to deliver health care to patients. This can take place in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, medical practices and healthcare providers' clinics.

Hospital: A healthcare facility licensed by the respective regulator as a hospital or declared as a hospital.

Infection: The invasion and reproduction of pathogenic or disease-causing organisms inside the body. This may cause tissue injury and disease.[7]

Jurisdictions: State and territory governments.

Medicare Locals: A nation-wide network of primary healthcare organisations to support health providers, to improve the delivery of primary care services at a local level and to improve access to after-hours primary care.

Medication: Using medicine for therapy or for diagnosis, its interaction with the patient and its effects.

Medication chart: A chart used by an authorised prescriber to record medication and treatment orders, as well as by nursing staff to record and monitor the administration of such medicines and treatment.

Medication reconciliation: The process of obtaining, verifying and documenting an accurate list of a patient's current medications on admission to a healthcare facility, and comparing this list to the admission, transfer and/or discharge medication orders to identify and resolve discrepancies. At the end of the period of care, the verified information is transferred to the next care provider.

Medicine: A chemical substance given to prevent, diagnose, cure, control or alleviate disease, or otherwise improve the physical or mental welfare of people. Prescription, non-prescription and complementary medicines, irrespective of their administration route, are included in this definition.[14]

Monitor: To check, supervise, observe critically or record the progress of an activity, action or system on a regular basis to identify and track change.

National Safety and Quality Health Service (NSQHS) Standards: Ten standards developed by the Commission in consultation and collaboration with jurisdictions, technical experts and healthcare providers and patients. The NSQHS Standards aim to protect the public from harm and to improve the quality of health services. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum safety and quality standards are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals.

Open disclosure: An open discussion with a patient about incidents that resulted in harm to that patient while they were receiving health care. The elements of open disclosure are an apology or expression of regret (including the word 'sorry'), a factual explanation of what happened, an opportunity for the patient to relate their experience, and an explanation of the steps being taken to manage the event and prevent recurrence. Open disclosure may take place over several meetings.

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.

Prophylaxis: A measure taken for the prevention of a disease.

Quality of care: The degree to which health services for individuals and populations increase the likelihood of desired health outcomes, and are consistent with current professional knowledge.

Residential aged-care facility: A facility that cares for older patients, operated by an approved provider. It replaces the older terms 'nursing home' and 'hostel'.

Sentinel event: An unexpected occurrence involving death or potential or actual serious physical or psychological injury. Eight specific types of clinical incident were endorsed by Australian health ministers in 2004 as fitting the definition of a sentinel event.

Severe adverse maternal morbidity: A woman who nearly dies but survived a complication that occurred during pregnancy, childbirth or within 42 days of termination of pregnancy.[15]

Shared decision making: The integration of a patient's values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment to achieve appropriate healthcare decisions.[16]

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 patients' needs, wants or preferences that cannot be explained on the basis of a patient's illness, medical evidence or preferences.[16] Unwarranted variation raises questions about quality, equity and efficiency in health care.[13]

Index of tables

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 from 1 July 2014. The *Public Governance, Performance and Accountability (Consequential and Transitional Provisions) Amendment (Annual Reports) Rule 2015* (PGPA Annual Report Rule) prescribes the reporting requirements for the 2014/15 reporting period.

Table 5: Mandatory reporting orders as required under legislation

Requirement	Reference	Page listing of compliant information
Amendments to the Commission's enabling legislation and to any other legislation directly relevant to its operation	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	43
Approval by the accountable authority	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	I
Assessment of the impact of the performance of each of the Commission's functions	NHR Act 2011 subsection 53(a)	8–34
Assessment of safety of health care services provided	NHR Act 2011 subsection 53(b)(i)	32–34
Assessment of quality of health care services provided	NHR Act 2011 subsection 53(b)(ii)	32–34
Board committees	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	40–41
Commonwealth disability strategy	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	49
Statement on governance	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	35–43
Accountable authority	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	36–39
Ecologically sustainable development and environmental performance	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c), ref *Environment Protection and Biodiversity Conservation Act 1999,* section 516A	43, 90
Education and performance review processes for the accountable authority	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	40
Enabling legislation, functions and objectives	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	2, 9, 36
Ethics and risk management policies	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	40, 41
Financial statements	PGPA Act subsection 43(4)	51–87
Financial statements certification: a statement, signed by the accountable authority	PGPA Act subsection 42(3)	54

Requirement	Reference	Page listing of compliant information
Financial statements certification: Auditor-General's Report	PGPA Act subsection 43(4)	52–53
Fraud risk assessment and control	Commonwealth Fraud Control Policy – Section 21	42
Government policy orders	PGPA Act section 22	n/a
Indemnities and insurance premiums for officers	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	40
Information Publication Scheme Statement	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	43, 89
Judicial decisions and decisions by administrative tribunals	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	43
Key activities and changes that have affected the Commission	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	43
Letter of transmittal detailing approval by accountable authority	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	I
Location of major activities and facilities	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	Inside cover, 48
Ministerial directions	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	36
Operational and financial results	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	51–87
Organisational structure	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	46
Other legislation	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	43
Related-entity transactions	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	40
Reporting of significant decisions or issues	PGPA Act subsection 46(3) Paragraph 19(1)(c), (d) or (e) of the PGPA Act	43
Reports about the Commission by the Auditor-General, a parliamentary committee, the Commonwealth Ombudsman or the Office of the Australian Information Commissioner	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	43
Responsible Minister	PGPA Act subsection 46(3) PGPA Annual Report Rule, subparagraph 7AB(4)(c)	2
Review of performance	PGPA Act PGPA Annual Report Rule, subparagraph 7AB(4)(c)	8–34
Work health and safety	PGPA Act PGPA Annual Report Rule, subparagraph 7AB(4)(c), ref *Work Health and Safety Act 2011*, Schedule 2, Part 4	48

Index

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

Index

Index

Index

Index

References

1. Duguid M and Cruickshank M. Antimicrobial Stewardship in Australian Hospitals. Sydney: Australian Commission on Safety and Quality in Health Care, 2011.

2. Australian Commission on Safety and Quality in Health Care. Implementation Toolkit for Clinical Handover Improvement. In: Care ACSQHC, (ed.). Sydney 2011.

3. Makoul G and Clayman ML. An integrative model of shared decision making in medical encounters. *Patient education and counseling*. 2006; 60: 301.

4. Rao JK, Anderson LA, Inui TS and Frankel RM. Communication interventions make a difference in conversations between physicians and patients: a systematic review of the evidence. *Medical care.* 2007; 45: 340-9.

5. *Rosen D. Vital Conversations: Improving communication between doctors and patients.* New York: Columbia University Press, 2014.

6. Australian Council for Safety and Quality in Health Care. Standard for Credentialling and Defining the Scope of Clinical Practice: A National Standard for credentialling and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals. 2004.

7. Cruickshank M and Ferguson J. Reducing Harm to Patients from Health Care Associated Infection: The Role of Surveillance. Sydney: Australian Commission on Safety and Quality in Health Care, 2008.

8. Coiera EW, Jayasuriya RA, Hardy J, Bannan A and Thorpe MEC. Communication loads on clinical staff in the emergency department. *Medical Journal of Australia.* 2002; 176: 415-8.

9. National Patient Safety Agency. Seven steps to patient safety. London: National Patient Safety Agency, 2004.

10. Field M and Lohr K. Guidelines for clinical practice: from development to use. Washington DC.: National Academy Press, 1992.

11. Consumers Health Forum of Australia. Consumer representative program policy. Consumers Health Forum of Australia, 2011.

12. National Health & Medical Research Council. Australian Guidelines for the Prevention and Control of Infection in Healthcare. Canberra: NHMRC, 2010, p. 260.

13. Australian Institute of Health and Welfare and Australian Commission on Safety and Quality in Health Care. Exploring Healthcare Variation in Australia: Analyses Resulting from an OECD Study. Sydney: ACSQHC, 2014, p. 2.

14. Australian Pharmaceutical Advisory Council. Guiding principles for medication management in the community. Canberra: Commonwealth of Australia, 2006.

15. Say L, Souza JP and Pattinson RC. Maternal near miss towards a standard tool for monitoring quality of maternal health care. *Best Practice & Research Clinical Obstetrics & Gynaecology*. 2009; 23: 287-96.

16. Légaré F, Ratté S, Stacey D, et al. Interventions for improving the adoption of shared decision making by healthcare professionals. *Cochrane Database Syst Rev.* 2010; 5.

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

ABN 97 250 687 371

Level 5, 255 Elizabeth Street
SYDNEY NSW 2000

Telephone: (02) 9126 3600

mail@safetyandquality.gov.au
www.safetyandquality.gov.au

Follow us on Twitter @ACSQHC