



Annual Report
2016–17

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Letter of transmittal

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

The Honourable Greg Hunt MP

Minister for Health

Parliament House

Canberra ACT 2600

Dear Minister

On behalf of the Board of the Australian Commission on Safety and Quality in Health Care (the Commission), I am pleased to submit our Annual Report for the financial year ending 30 June 2017.

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

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

The Commission's annual performance statements were prepared in accordance with the requirements of section 39 of the *Public Governance, Performance and Accountability Act* and accurately present the Commission's performance from 1 July 2016 to 30 June 2017.

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

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

This report was approved for presentation to you in accordance with a resolution of the Board on 13 September 2017.

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

Yours sincerely



Professor Willis Marshall AC

Chair

Australian Commission on Safety and Quality in Health Care

13 September 2017

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1



Overview

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

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About the Commission

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

Our mission

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

Our role and functions

The Commission provides health ministers with strategic advice on best practices to improve healthcare safety and quality, and makes recommendations about priority areas for action. The Commission also develops national initiatives to better inform, support and organise the delivery of safe and high-quality health care in Australia, contributing to improved health outcomes for patients, consumers and communities.

The Commission works in four priority areas:

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

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

Our accountability

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





Report from the Chair

Professor Villis Marshall AC

Millions of patient encounters take place across Australia's health system each year. Generally, patients receive an excellent standard of care during these interactions. Treatments and technologies have improved to the point where we have much better health outcomes than previous generations.

However, excellence in health care is relative, and is more akin to a process than a condition. Each success cannot be an end in itself, but rather a stepping stone to the next achievement. This is particularly apposite for the Commission's work. Better medicines and surgical techniques explain some of the health gains of recent decades, but better checks and balances, better systems, better partnerships and better ways of working are also fundamental.

In 2016–17, the Commission made a further significant contribution to these advances, covering safety perspectives, quality and appropriateness of care, support for practitioners and better resources for patients and consumers.

The Commission's foundational piece of work is the National Safety and Quality Health Service (NSQHS) Standards, which were introduced in 2011. The NSQHS Standards have had a very positive effect on the Australian health system and are responsible for a number of tangible and significant improvements nationally and at the local level. The Commission has built on this success by incorporating the lessons learnt from the NSQHS Standards into the development of the second edition of the NSQHS Standards, which have been approved by Australian health ministers. The second edition of the NSQHS Standards is due to be launched later this year and will consolidate and extend the positive impacts already seen.

Similarly, the launch of the *Australian Atlas of Healthcare Variation* in November 2015 proved a catalyst for focusing on appropriateness of care. Recommendations in the first Atlas prompted the Commission to start work on a number of new clinical care standards – including one on osteoarthritis of the knee, which was launched in May 2017. These recommendations helped shape the design of the *Second Australian Atlas of Healthcare Variation*, launched in June, so that key issues could be explored in greater detail.

Likewise, the Commission has built on its previous work in supporting healthcare professionals, and also consumers, with a range of new products, documents and other resources. These include a suite of documents designed to help clinicians identify and prevent hospital-acquired complications, as well as many other valuable tools in the areas of antimicrobial resistance, medication safety and e-health, cognitive impairment and mental health care. The Commission is also seeking to engage consumers more than ever before: this year the Commission has released decision-support aids for consumers, a revised list of healthcare ‘top tips’, and an innovative online ‘question builder’ designed to help members of the public navigate their healthcare journey more confidently.

Each of these examples shows the Commission becoming more sophisticated in delivering on its mission to lead national improvements in the safety and quality of health care. The huge improvements already seen in health care mean that the nature of the improvement challenge is changing: new and more complex approaches must be developed to ensure further improvements can be made. The Commission is ready for this challenge, and I look forward to its progress and its success in the coming year.

My thanks go to the members of the Commission’s Board for their advice throughout 2016–17. On behalf of Board members, I would also like to thank Minister Hunt, the Commission’s executive team and employees for their continued commitment to delivering our work priorities. Their significant achievements are described in detail throughout this report.



Report from the CEO

Adjunct Professor Debora Picone AM

This has been a year of outstanding achievement for the Commission and its partners. This annual report is a snapshot of the Commission's work in collaboration with the Australian Government and state and territory governments, clinicians, consumer and patient groups, and the private sector in improving the safety and quality of the Australian healthcare system.

I am pleased to report that the implementation of the National Safety and Quality Health Service (NSQHS) Standards continues to be a success, with 100% of health services assessed against the NSQHS Standards at least once, and a number having undergone a second assessment.

After extensive consultation, the second edition of the NSQHS Standards has been completed and approved by the COAG Health Council. The Commission has also undertaken significant consultation on supporting documentation including an NSQHS Standards user guide for Aboriginal and Torres Strait Islander services, resources for hospitals, multipurpose services and day procedure services, and fact sheets for consumer organisations. The Commission continues to provide implementation support and advice via the NSQHS Standards Advice Centre.

In June, the Commission launched the *Second Australian Atlas of Healthcare Variation*. As with the first Atlas, the second Atlas demonstrates significant variations in treatment for the same conditions across Australia. The second Atlas has a focus on acute care, with indicators in the areas of surgical interventions, women's and maternity health, chronic disease and infection, and cardiovascular conditions. One of the innovations in the second Atlas is being able to look at data in new ways, including whether treatment was publicly or privately funded, and according to Aboriginal and Torres Strait Islander status.

The Atlas project is a key part of the Commission's priority to support the health system to reduce unwarranted clinical variation. This year we have released three clinical care standards – on hip fracture care, delirium, and most recently on appropriate treatment for osteoarthritis of the knee, one of the indicators featured in the first Atlas. We will be releasing more clinical care standards in the coming year, including one relating to treatment for heavy menstrual bleeding arising from data in both atlases on variation in rates of endometrial ablation and hysterectomy.

The Commission is the lead agency responsible for coordinating Australia's response to antimicrobial resistance, and our national Antimicrobial Use and Resistance in Australia (AURA) surveillance program continues to grow. There are now 159 hospitals across Australia participating in antibiotic usage monitoring and 281 are contributing information on appropriateness.

Supporting consumers to be partners in their own health care is critical to improving safety and quality. This year we have released a revised and updated version of one of our important resources for consumers and primary care practitioners, *Top Tips for Safe Health Care*. We also released the Question Builder, a web-based tool designed to help patients ask the questions that matter to them when visiting their doctor or specialist. The Commission is also working to support clinicians to work in partnership with their patients. In collaboration with four specialist clinical colleges, we have completed work on education modules to assist clinicians to better communicate risk to consumers. These were released in the second half of 2017.

The Commission has worked with the Australian Government and state and territory partners to incorporate quality and safety into hospital pricing and funding to improve patient health outcomes. The Commission, with clinicians,

consumers and technical experts, is revising the national sentinel events list, developed a list of hospital-acquired complications and clinical conditions that could be considered as avoidable hospital readmissions. The COAG Health Council will oversee the continuing development, implementation and ongoing refinement of reforms to integrate safety and quality into the pricing and funding of public hospital services.

On 1 January 2017 the National General Practice Accreditation Scheme commenced. Developed by the Commission in conjunction with the Royal Australian College of General Practitioners (RACGP), the scheme offers greater choice to general practices seeking accreditation.

Finally, my thanks go to the Commission Board, health ministers, and health chief executive officers for their leadership. Thanks also to our Australian Government and state and territory partners, private sector colleagues, clinical and consumer advisors, and the outstanding staff of the Commission for our achievements this year.

Strategic Plan 2016–2019

SAFETY. QUALITY. EVERY PERSON.

1

PATIENT SAFETY

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

2

PARTNERING WITH PATIENTS, CONSUMERS AND COMMUNITIES

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

3

QUALITY, COST AND VALUE

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

4

SUPPORTING HEALTH PROFESSIONALS TO PROVIDE SAFE AND HIGH-QUALITY CARE

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

EVERYWHERE. EVERY TIME.



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

2



Report on performance

This section details the Commission’s achievements against its four priority areas. It also includes an overview of the state of safety and quality in Australian health care.

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Priority 1: Patient safety

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

Implementation of the National Safety and Quality Health Service Standards

The primary aims of the National Safety and Quality Health Service (NSQHS) Standards are to protect the public from harm and to improve the quality of health service provision.

To meet the NSQHS Standards, health service organisations must implement organisation-wide safety and quality processes, along with a comprehensive clinical governance framework. This can reduce the risk of patient harm from hospital-acquired infections, medication errors, patient falls and errors at the transfer of care, and help prevent clinical deterioration and pressure injuries.

Health service organisations are currently assessed against the NSQHS Standards by any of nine approved accrediting agencies. Only health service organisations that demonstrate full compliance are awarded accreditation.

Assessment against the NSQHS Standards commenced in 2013. Since that time, 100% of Australian hospitals and day procedure services have implemented the NSQHS Standards and completed at least one accreditation cycle. As at 30 June 2017, 1,319 hospitals and day procedure services have been assessed to the NSQHS Standards.

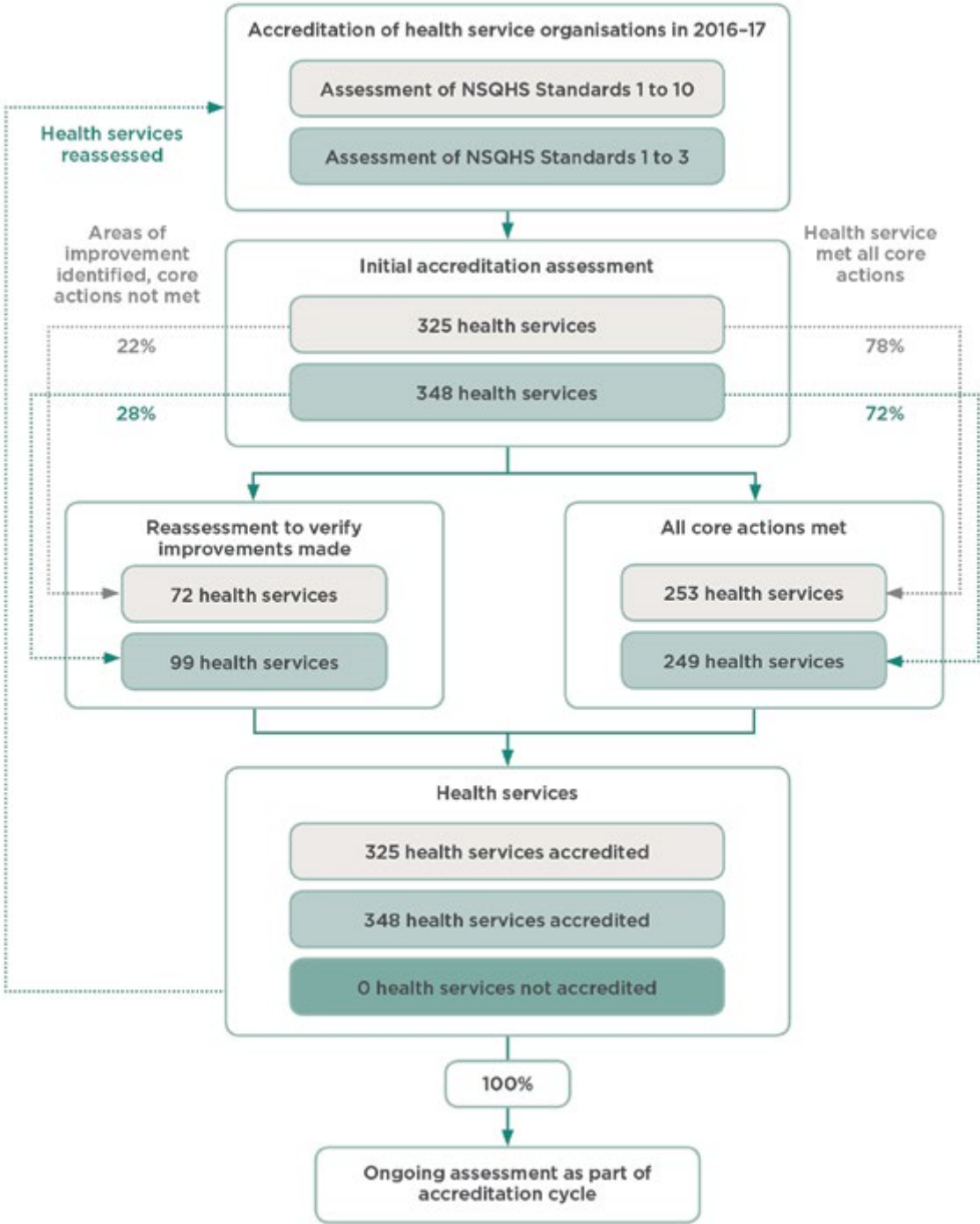
During 2016–17, the Commission completed its annual comprehensive review of accrediting agencies, which included performance review meetings with each of the nine approved accrediting agencies.

The Commission's Advice Centre provides health service organisations with support and guidance on the NSQHS Standards. In 2016–17, the Commission responded to 1,189 enquiries, including 986 email enquiries and 203 telephone enquiries. The Commission continued to meet its service delivery targets, responding to 95% of email enquiries within one business day and the remainder within five business days.

The National General Practice Accreditation Scheme, developed by the Commission in collaboration with the Royal Australian College of General Practitioners (RACGP), commenced on 1 January 2017. Four accrediting agencies were appointed by an industry-based approval panel in 2016 to assess general practices using the RACGP *Standards for general practices*.

The scheme offers general practices seeking accreditation greater choice of accrediting agency. It will also provide access to national de-identified data on the accreditation performance of general practices that are assessed.

Figure 1: Health service organisation accreditation 2016-17



2. Report on performance

Table 1: Top core NSQHS Standards actions not met or met with merit

Not met	
3.10.2	Compliance with aseptic technique is regularly audited
1.18.2	Mechanisms are in place to monitor and improve documentation of informed consent
2.4.2	Action is taken to incorporate consumers' and/or carers' feedback into publications prepared by the health service organisation for distribution to patients
1.8.2	Early action is taken to reduce the risks for at-risk patients
3.16.1	Compliance with relevant national or international standards and manufacturers' instructions for cleaning, disinfection and sterilisation of reusable instruments and devices is regularly monitored
Met with merit	
1.2.1	Regular reports on safety and quality indicators and other safety and quality performance data are monitored by the executive level of governance
1.1.2	The impact on patient safety and quality of care is considered in business decision-making
1.2.2	Action is taken to improve the safety and quality of patient care
1.6.1	An organisation-wide quality management system is used and regularly monitored
1.6.2	Actions are taken to maximise patient quality of care



Development of the NSQHS Standards (second edition)

The Commission commenced a review of the NSQHS Standards (first edition) in 2015. The objectives of the review were to ensure the NSQHS Standards reflect contemporary best clinical practice, and that only those actions that have improved patient outcomes were retained.

Following an initial national consultation process, the Commission developed a draft version of the second edition of the NSQHS Standards. This draft was refined following piloting and further sector-wide consultation, and was subject to a regulation impact statement.

In the second edition of the NSQHS Standards, the overall number of standards has been reduced from 10 to eight, and the number of actions has been reduced from 256 to 148.

The NSQHS Standards (2nd ed.) have been improved by:

- Reducing the duplication in the first edition of the NSQHS Standards
- Addressing safety gaps in the care of Aboriginal and Torres Strait Islander people, end-of-life care and the care of people with lived experience of mental illness or cognitive impairment
- Updating the evidence base
- Adapting and clarifying the language to improve the applicability of the NSQHS Standards to a broader range of health service organisations.

The NSQHS Standards (2nd ed.) were endorsed by the Australian Health Ministers' Advisory Council (AHMAC) in December 2016, and approved for release by the COAG Health Council in June 2017.

The Commission began developing resources to support the NSQHS Standards (2nd ed.) in 2016. It consulted with clinicians, consumers and content experts on the draft resources to ensure they meet the needs of target audiences, which include consumers, hospitals, day procedure services, multi-purpose services, small rural hospitals and governing bodies such as boards.

The Commission is also developing an interactive online resource for the NSQHS Standards (2nd ed.) that is designed to provide frontline clinicians, managers, and safety and quality coordinators with direct access to relevant information. The Commission expects that this resource will be available from mid-2018, and that its content will be expanded as the need for additional resources arises and new resources become available.

The Commission will launch the NSQHS Standards (2nd ed.) in November 2017, together with supporting resources and measures. Assessment to the NSQHS Standards (2nd ed.) will commence on 1 January 2019.

Highlights

- Developed the NSQHS Standards (2nd ed.)
- Attained the endorsement of the NSQHS Standards (2nd ed.) by COAG Health Council
- Received 66 submissions in response to the consultation regulation impact statement, with 82% of respondents supporting the introduction of the NSQHS Standards (2nd ed.)
- Completed consultation on draft resources to support the NSQHS Standards (2nd ed.), receiving 251 responses.

2. Report on performance

Revision of the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme to improve the reliability of health service organisation accreditation processes

Health service organisations are assessed and accredited against the NSQHS Standards through the AHSSQA Scheme. The Commission is responsible for maintaining and coordinating this scheme.

To become accredited, health service organisations must pass assessments to show they have implemented the NSQHS Standards. The assessments are conducted by independent accrediting agencies, approved by the Commission, as part of the AHSSQA Scheme.

The awarding of accreditation status is meant to provide assurance to the community that the health service organisation meets expected patient safety and quality standards. While the NSQHS Standards have transformed standards from a managerial activity to an assessment of patient safety and quality, accreditation processes have not changed in over 40 years. The accreditation process must be subject to innovation if it is to meet its objective.

State and territory regulators and chief executives of health service organisations have expressed concerns that the accreditation process does not reliably verify that an organisation's safety and quality systems are operational and effective. Concerns have also been raised that the NSQHS Standards and AHSSQA Scheme are open to interpretation by assessors. The most significant concerns relate to a number of hospitals that were awarded accreditation status when they clearly did not meet the NSQHS Standards, particularly Standard 1: Governance for Safety and Quality in Health Service Organisations.

To ensure the AHSSQA Scheme remains effective, significant revision of the accreditation process is required. Based on feedback received on the AHSSQA Scheme issues and possible solutions, the Commission will implement six strategies to improve the reliability of the accreditation process.

The strategies include steps to:

- Improve the veracity of health service organisation assessments
- Improve the effectiveness and expertise of the assessment team
- Assess the health service organisation's safety and quality data to better inform the assessment process
- Improve regulatory oversight
- Improve communications related to the assessments and their outcomes
- Improve resources and support for health service organisations.

The Commission has begun initial consultation on revision of the AHSSQA Scheme, with most work to be completed in 2017–18. It will collaborate with health departments, health service organisations, approved accrediting agencies and consumers in developing and implementing these strategies.

Highlights

- Developed an implementation strategy to improve the reliability of health service organisation accreditation processes
- Completed an initial consultation on the revision of the AHSSQA Scheme involving the nine approved accrediting agencies and the health departments of the Australian Government and state and territory governments
- Conducted four literature reviews, covering the use of short-notice surveys, attesting, the assessment of safety and quality culture, and the use of patient journey methodology in accreditation.

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

In 2016–17, the Australian Government provided additional funding for the Antimicrobial Use and Resistance in Australia (AURA) Surveillance System. The AURA program continues to analyse and report on antimicrobial resistance and antimicrobial use in hospitals, aged care homes and the community through a range of surveillance programs.

AURA 2016: First Australian report on antimicrobial use and resistance in human health provides the most comprehensive picture of antimicrobial resistance (AMR), antimicrobial use, and appropriateness of prescribing in Australia to date. It sets a baseline that will allow trends to be monitored over time. AURA 2016 also highlights areas where future work will inform action to prevent the spread of AMR.

Comprehensive, coordinated and effective surveillance of AMR and antimicrobial use is a national priority. Surveillance is essential to understand the magnitude, distribution and impact of AMR and antimicrobial use, as well as to identify emerging issues and trends. It allows the early detection of critical antimicrobial resistances to ensure effective action can be taken, and provides information on the effectiveness of measures designed to promote appropriate use of antimicrobials and contain AMR. Surveillance is a critical component of Australia's National Antimicrobial Resistance Strategy.

The AURA Surveillance System coordinates data from a range of sources and allows integrated analysis and reporting at a national level. The AURA Surveillance System brings together partner programs such as the Australian Group on Antimicrobial Resistance, the National Antimicrobial Prescribing Survey (NAPS), the National Antimicrobial Utilisation

Surveillance Program (NAUSP) and Queensland Health's OrgTRx system. Data is also sourced from the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS), NPS MedicineWise, the National Neisseria Network, the National Notifiable Diseases Surveillance System, the *Report on Government Services 2015* and Sullivan Nicolaides Pathology.

The AURA Surveillance System is providing critical information needed by clinicians, policymakers, researchers and health system managers to target efforts to inform antimicrobial stewardship and AMR policy and program development.

Following a six-monthly review in October 2016, the National Alert System for Critical Antimicrobial Resistances (CARAlert) was enhanced to enable state and territory health authorities to directly access CARAlert records for their jurisdiction, including the name of the public hospital where the isolate was collected. This information allows them to monitor the geographic distribution of critical antimicrobial resistances, and to liaise with hospitals to confirm infection control responses, as appropriate, in the event of an outbreak. Following the CARAlert upgrades, state and territory health departments can now generate local and national reports from the system. Direct access to CARAlert records is complemented by weekly national digest reports that include information on all critical antimicrobial resistances reported in the previous week, including the state or territory where the isolate was collected.

The Commission has a well-established national Healthcare-Associated Infection program that aims to prevent and contain antimicrobial

2. Report on performance

resistance through evidence-based infection control practices. In 2016–17, the Commission provided funding for a national hand hygiene program, and specified national definitions that allow infection rate trends to be monitored more effectively. The Commission also offered advice to improve practice through policy and guideline development, and provided national guidance on managing and measuring some emerging infections, which is key to preventing and containing antimicrobial resistance and surgical site infections.

Highlights

- Released *AURA 2016: First Australian report on antimicrobial use and resistance in human health*
- Enhanced and expanded several components of the AURA program, including CARAlert, the National Passive Antimicrobial Resistance Surveillance System and the National Antimicrobial Utilisation Surveillance Program
- Continued to publish detailed reports on each of the AURA surveillance programs and associated surveys
- Released national guidance on carbapenemase-producing Enterobacteriaceae, the diagnosis and management of *Clostridium difficile*, and approaches to surgical site infection.

Mycobacterium chimaera and heater-cooler devices used in cardiac surgery

In 2015, the European Centre for Disease Prevention and Control issued an alert regarding seven cases of *Mycobacterium chimaera* infection that were associated with the use of certain heater-cooler devices during cardiac surgery. In each case, contaminated water from inside the heater-cooler device had been aerosolised into the operating room and appeared to contaminate the surgical field during an open-chest surgical procedure. *Mycobacterium chimaera* is a slow-growing bacterium that is rarely associated with human infection. The signs and symptoms of this infection can take up to five years to appear and are often difficult to differentiate from other illnesses. Treatment typically involves prolonged combination antibiotic therapy, while compromised valves and grafts may require surgical debridement or revision.

The likely contamination of these devices at the point of manufacture meant that Australian patients who were exposed to these devices were also at risk of infection. The Commission coordinated the national response to this infection risk. It also developed infection control guidance – most recently updated in February 2017 – to provide health service organisations with infection prevention and control strategies that minimise the risk of infection associated with these devices. This complemented other guidance produced by the Communicable Disease Network Australia and the Public Health Laboratory Network on case identification and laboratory testing methods.

The Commission worked closely with state and territory health departments, the private hospital sector and the Therapeutic Goods Administration to enable rapid information-sharing on case management and risk mitigation, and to monitor further developments in post-market surveillance of heater-cooler devices.

Despite additional cases being identified around the world after the initial outbreak in Europe, the risk of infection appears to be extremely low. Infections have been predominantly associated with cardiac surgery involving a prosthetic graft or the insertion of prosthetic material, such as a replacement valve. In Australia, as of June 2017, five patient cases have been identified and no patient deaths have been reported.

Highlights

- Worked with state and territory health departments and several national agencies to deliver a coordinated national risk mitigation response to the contamination of heater-cooler units
- Published national guidance outlining infection prevention and control strategies to reduce the risk of infection for patients.

Digital patient safety

The Commission has conducted a clinical safety program for the My Health Record system since it was implemented in 2012.

In July 2016, the Australian Government established the Australian Digital Health Agency, giving it responsibility for the My Health Record system and national digital health infrastructure. The Agency appointed the Commission to operate a digital patient safety program. The Commission's Digital Patient Safety Expert Advisory Group provided clinical guidance on identifying and prioritising areas for clinical safety reviews for the My Health Record system and national digital health infrastructure.

The program aims to provide My Health Record quality assurance and enhance the clinical safety of digital health services and systems. Program activities in 2016–17 included four clinical safety reviews of national digital health infrastructure and an analysis of consumer calls to the My Health Record helpline.

The Commission also initiated a 'deep dive' analysis of health identifier issues at the interface between the My Health Record system and the clinical systems that connect to it. This will be completed in August 2017.

Commission staff members co-chair the Agency's medication safety, diagnostic imaging and pathology steering groups. The Commission also operated, on behalf of the Agency, a 24-hour My Health Record Clinical Incident Management Unit for the My Health Record system. In 2016–17, the unit responded to 24 incidents, providing rapid assessments of clinical safety risk and initiating interventions to address any clinical safety implications associated with the use of the My Health Record system.

The four clinical safety reviews undertaken during 2016–17 analysed:

- The adoption of national standardised terminology for allergies and alerts to determine uptake barriers and enabling factors
- The presentation of clinical documents in My Health Record to identify potential areas of improvement that could enhance both the user experience for clinicians and patient safety
- My Health Record system resilience and business continuity processes to identify enhancements that could improve system reliability
- Clinical functional assurance processes for new system releases to ensure appropriate functionality, optimal useability and enhanced patient safety.

In addition to its work with the Agency, the Commission published two reports on health IT safety in 2016–17:

- *Implementation of Electronic Medication Management Systems in Hospitals: A literature scan*
- *Literature Review and Environmental Scan on Approaches to the Review and Investigation of Health IT-Related Patient Safety Incidents.*

2. Report on performance

To further support the safe implementation of digital health technology in Australia, the Commission published a report titled *Barcoding and Other Scanning Technologies to Improve Medication Safety in Hospitals*. This report provides evidence on how barcoding and scanning medicines reduces misidentification and medicine administration errors in hospitals. The Commission also developed and published the *National Guidelines for On-Screen Presentation of Discharge Summaries*, with funding from the Australian Government Department of Health. In addition, the Commission finished preparing the third edition of its *Electronic Medication Management Systems: A guide to safe implementation and use*, which was issued to state and territory health departments in July 2017.

Highlights

- Conducted four clinical safety reviews of the My Health Record system and national digital health infrastructure
- Conducted an analysis of 50 helpline calls
- Operated a 24-hour My Health Record Clinical Incident Management Unit, managing 24 incidents
- Published national guidance to support the safe implementation of digital health systems in hospitals.

Patient safety in primary health care

Primary care services provide the first point of contact with the health system for the majority of Australians with a health concern. The primary care sector provides a range of services that help to prevent and manage acute and chronic conditions.¹ These services are an important part of the Australian healthcare system, and a well-functioning primary care sector can improve the overall health of the population and reduce acute hospitalisations.²

Much of the evidence about patient safety comes from the acute sector. While some of the issues and risks raised in this evidence apply to primary care, there are also specific issues in this sector that need to be examined and addressed.

In November 2015, the Commission began a program of work to develop a nationally consistent and coordinated approach to improve patient safety and quality in primary care. The program will deliver a series of strategies, tools and resources on safety and quality that are specifically tailored for use in primary care.

In May 2016, the Commission established the Primary Care Safety and Quality Framework Committee to oversee the program and provide expert advice. The committee is made up of 18 members from primary care stakeholder organisations and the Consumers Health Forum of Australia (CHF).

The following strategies have been identified as initial priorities for the Commission:

- Developing a set of safety and quality standards for primary care settings based on the NSQHS Standards (2nd ed.)
- Reviewing the Commission's practice-level indicators for primary care as part of the development of an agreed data collection and reporting framework for the primary care sector.

The Commission is preparing a consultation paper to seek feedback from primary care stakeholders on other national improvement strategies that should be developed. The consultation paper is scheduled to be released by late 2017.

Highlights

- Established the Primary Care Safety and Quality Framework Committee to oversee the patient safety in primary health care program and provide expert advice
- Began developing a set of NSQHS Standards for primary care settings and accreditation in primary care.

Medication safety

The Commission has stewardship of the standard tools used in Australian hospitals each day to prescribe, administer and dispense medicine safely. The Commission has maintained a series of nationally standardised medication charts for hospitals since 2007. Medication safety experts from around the country analyse issues logged by clinicians and provide guidance for use. The charts standardise the presentation of information on the intended use of medicines for an individual patient, as well as the presentation of medicines information in all high-risk healthcare settings. This reduces the risk of errors associated with prescribing, dispensing and administering medicines.

In July 2016, the Commission released the Pharmaceutical Benefits Scheme (PBS) Hospital Medication Chart, which enables prescribing and dispensing of medicines for patients on discharge. It also enables hospitals

or pharmacies to claim payment for those medicines under the PBS. This new medication chart is being used in the private hospital sector, and will also be used in public hospitals in most states and territories.

Online training modules were launched in 2017 to support the PBS Hospital Medication Chart and the National Inpatient Medication Chart. The Commission appointed NPS MedicineWise to develop and host the modules.

In January 2017, the Commission revised and published *Recommendations for Terminology, Abbreviations and Symbols Used in Medicines Documentation*.

Following scientific assessment by human factors experts, and piloting in six hospitals, a national subcutaneous insulin chart was issued for use in acute hospitals in May 2017. An insulin chart for sub-acute and mental health hospitals was issued to states and territories in July 2017.

In May 2017, the Commission published a report by the Sansom Institute for Health Research at the University of South Australia on mental health and medication safety. The report, *Medication Safety in Mental Health*, reviewed the literature, and identified areas and approaches for improving medicine management in mental health settings.

The Commission is committed to developing a national standard on dispense labelling for medicines in pharmacies. This standard is intended to improve the readability of medicine labels and the safety of patients in the community. An expert roundtable reviewed the draft standard in May 2017, and consumer testing of the prototype started in July 2017.

2. Report on performance

Highlights

- Released the PBS Hospital Medication Chart, along with training modules and materials
- Released a national subcutaneous insulin chart for hospitals and an insulin chart for sub-acute and mental health hospitals
- Revised *Recommendations for Terminology, Abbreviations and Symbols Used in Medicines Documentation*
- Started developing a national standard on dispensing labels for medicines
- Released a scoping study on medication safety in mental health settings.

National Patient Blood Management Collaborative

In 2015, the Commission led the National Patient Blood Management Collaborative, with funding from the Australian Government Department of Health. Twelve health service networks from across Australia participated in the Collaborative, which finished collecting data in March 2017. Its aim was to improve patient care and reduce the need for unnecessary transfusions by supporting improvements in the preoperative management of anaemia and iron deficiency for patients undergoing specific elective gastrointestinal, gynaecological and orthopaedic surgery procedures.

The Collaborative focused on the entire patient journey – from the time the need for surgery was identified through to surgery being performed – and recorded 12,648 patient episodes.

The Commission led a series of learning workshops that allowed the participating health service teams to analyse and share data and to discuss their experiences of local quality-improvement processes. Workshop participants also consulted with experts in the field to gather new information and develop ideas for further clinical practice improvements. Interventions to manage iron deficiency included dietary therapy, oral iron supplements and administering intravenous iron in advance of surgery.

The Collaborative's achievements included:

- Reducing red cell transfusions
- Improving the assessment and management of anaemia and iron deficiency before surgery across participating sites
- Improving the integration of care between primary and acute service systems, which provided better opportunities for continuity of care for elective surgery patients
- Helping to change clinical practice and workflows at the participating sites, which improved the overall management of elective patients.

Highlight

- Led the National Patient Blood Management Collaborative, which produced better outcomes for patients, reduced the use of transfusions and improved the coordination of care.

Mental health

The Commission has a strong commitment to improving the safety and quality of health services delivered to people with lived experience of mental health issues. One in five Australians experience mental health issues each year, and people with serious mental illness live on average 20 years less than the general population, largely due to preventable physical illness.

This year, the Commission undertook national consultation on the draft *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state* (the Consensus Statement). Stakeholders supported the approach taken in the Consensus Statement, which will be released in August 2017 following noting by AHMAC.

The consultation on the Consensus Statement highlighted the lack of any standardised mechanism for clinicians to monitor and track the signs of deterioration in a person's mental state and integrate this with a person's self-reported experience. The Commission has begun a project to develop consensus on how deterioration in a person's mental state can be monitored and reported, which can then form the basis for health service organisations to develop their own local escalation protocols.

The Commission continues to work in partnership with other agencies. In 2016–17, this included participating in the consultation process for the draft Fifth National Mental Health and Suicide Prevention Plan and the National Mental Health Commission's Equally Well Consensus Statement.

Cognitive impairment

In 2016–17, the Commission continued to promote cognitive impairment as an important safety and quality issue through the Caring for Cognitive Impairment campaign. The campaign helps hospitals prepare for assessment to the NSQHS Standards (2nd ed.), which now includes specific items to improve care for people with cognitive impairment.

As of 30 June 2017, 1,564 individuals and 160 hospitals from across Australia have joined the campaign. The campaign is also being promoted by 31 supporting organisations. The campaign website has had 11,698 visits over 12 months, and more than 500 people have participated in five campaign webinars.

Within the broader Cognitive Impairment program, specific work related to antipsychotics is under way. The first *Australian Atlas of Healthcare Variation* identified high and variable rates in the prescription of antipsychotics for people aged 65 and over. These medicines may be appropriate for a small number of people; however, concerns have been raised that antipsychotics may be overused for behavioural control and sedation given that they have limited benefit and can cause significant harm, such as stroke, pneumonia, falls and fractures, and an increased mortality risk. The first-line response for older people with behavioural and psychological symptoms of dementia should be a person-centred, non-pharmacological approach with informed consent, unless the person is severely distressed and at immediate risk of harming themselves or others.

Highlights

- Finalised the *National Consensus Statement: Essential elements for recognising and responding to deterioration in a person's mental state*
- Contributed to the development of the Fifth National Mental Health and Suicide Prevention Plan.

2. Report on performance

To identify key areas for action, the Commission held a national roundtable in October 2016. The purpose of the roundtable was to seek expert advice on ways to reduce the inappropriate use of antipsychotics in older people with behavioural and psychological symptoms of dementia, and to identify and prioritise strategies for action in the community, aged care homes and acute hospital settings. A second roundtable was held in May 2017 to consult specifically with primary care providers. The Commission is considering the outcomes of both roundtables and will release a summary report by August 2017 that includes an outline of the next steps to be taken.

Highlights

- Promoted the Caring for Cognitive Impairment campaign, with 160 hospitals, 1,564 individuals and 31 supporting organisations participating in the campaign
- Commenced work on reducing the inappropriate use of antipsychotics in older people with behavioural and psychological symptoms of dementia.

Communicating for safety

Clinical communication is a key safety and quality issue. Communication failures, lack of team communication and inadequate documentation of clinical information are known to result in errors, misdiagnosis, inappropriate treatment and poor care outcomes.

In 2016–17, the Commission included actions in the NSQHS Standards (2nd ed.) to address clinical communication gaps, dedicating an NSQHS Standard specifically to communicating for safety. To support the implementation of the Communicating for Safety Standard, the Commission has drafted guides that will be finalised at the end of 2017 in consultation with the health sector.

The Commission has also published resources to support effective patient-clinician communication at transitions of care in hospitals. These include posters and information sheets for consumers, clinicians, senior executives and clinical leaders.

Recognising that effective communication is vital across the patient journey, the Commission has started developing a framework on communicating for safety. The framework identifies key stages in the patient journey where communication is essential for safe patient care. As part of the framework, the Commission will provide information and links to resources to support effective communication between clinicians, multidisciplinary teams and patients, as well as families and carers.

The Commission is also considering developing tools for junior clinicians that aim to translate current research on clinical communication into a useable and practical resource.

Highlights

- Included the Communicating for Safety Standard in the NSQHS Standards (2nd ed.)
- Drafted guides to help large acute hospitals, small hospitals and day procedure services implement the Communicating for Safety Standard
- Published resources on improving patient-clinician communication at transitions of care in hospitals
- Started developing a framework on communicating for safety to support clinical communication across the patient journey.

Clinical governance framework

Since 2015, the Commission has completed reviews into identified patient safety problems for several state or territory health departments. These reviews have indicated that some health service organisations experience significant difficulties in implementing core clinical governance processes. These include issues with:

- Implementing an open disclosure response consistent with national and local standards
- Ensuring incident management and investigation systems can provide adequate surveillance for the purpose of recognising significant patient safety risks or failures
- Implementing corrective action in response to identified patient safety risks and failures
- Establishing complaint management systems that include a partnership with patients and carers
- Ensuring a robust and positive safety culture
- Clearly understanding the roles and responsibilities of boards, executives, clinical teams and clinicians in clinical governance.

To address these issues, and to support the delivery of safe and high-quality health care and the best possible outcomes for patients, the Commission developed the National Model Clinical Governance Framework (the Clinical Governance Framework) for public and private healthcare organisations in the acute sector.

The Clinical Governance Framework is based on the NSQHS Standards (2nd ed.), particularly the Clinical Governance for Health Service Organisations and the Partnering with Consumers standards. As part of the NSQHS Standards as a whole, these standards, these standards constitute a complete and robust clinical governance framework.

The Clinical Governance Framework will be released in August 2017. It will be supported by additional resources that the Commission has developed for specific target audiences, including clinicians, consumers and members of governing bodies such as boards.

Highlight

- Developed the National Model Clinical Governance Framework

Comprehensive Care Standard

As part of the review of the NSQHS Standards, the Commission set about identifying some of the common underlying clinical and systems issues that may place a person at risk of harm. Safety and quality gaps are frequently reported as failures to provide adequate care in specific situations or settings, or for specific conditions, or as failures to achieve expected outcomes in particular populations.

In 2016–17, the Commission, with its partners, developed the Comprehensive Care Standard, which has been included in the NSQHS Standards (2nd ed.). Comprehensive care is the coordinated delivery of the total health care required or requested by a patient. This care is aligned with the patient's expressed care goals and healthcare needs, considers the impact of the patient's health issues on their life and wellbeing, and is clinically appropriate regardless of whether the care trajectory is focused on recovery or end of life.

2. Report on performance

The purpose of the Comprehensive Care Standard is to address the cross-cutting issues that underlie many adverse events and to optimise health care while considering how risk and harm can be minimised along each patient journey. This requires a shift from focusing on specific errors and incidents to examining the origins of care failures within the cultural conditions and systems of a health service organisation. Inadequate risk assessment, goal setting and care planning can result in failures to deliver care that meets a person's needs and is consistent with their preferences. The way that clinical teams operate and collaborate, and the way that work flow is coordinated and organised can have a significant impact on the delivery of safe and high-quality care.

In 2017, the Commission started developing a conceptual model for comprehensive care, and in 2017–18, the Commission will consult broadly on the model. This model supports the identification and development of tools and resources to help health service organisations deliver comprehensive care and meet the requirements of the NSQHS Standards (2nd ed.). This work includes scoping approaches for integrated screening and assessment.

Highlights

- Developed the Comprehensive Care Standard
- Developed a model for supporting the delivery of comprehensive care, and started consultation on the tools and resources needed to support the delivery of comprehensive care, including tools for screening and assessment.

National safety and quality model for colonoscopy

The Australian Government Department of Health appointed the Commission to conduct a national consultation and develop a safety and quality model for colonoscopy. The appointment was made in the context of the anticipated growth in colonoscopy numbers from the planned expansion of the National Bowel Cancer Screening Program (NBCSP).

The model is intended to optimise the safety and efficacy of screening, diagnostic and therapeutic colonoscopies. A colonoscopy involves the endoscopic examination of the entire large bowel (from the rectum to the caecum) with a flexible endoscope. The distal portion of the small bowel (terminal ileum) may also be examined. The procedure is performed on adult, and less commonly paediatric, patients. It is the gold standard for investigating and managing large bowel pathology.

A screening colonoscopy is performed following a positive bowel cancer faecal occult blood test as part of surveillance for colorectal cancer. A diagnostic colonoscopy is used to investigate and diagnose other bowel conditions. A therapeutic colonoscopy is used to dilate strictures, place stents, decompress the colon, remove foreign bodies and polyps, and treat bleeding lesions.

Consultation on the safety and quality model for colonoscopy was completed in July 2016. The model that emerged from this process was reviewed by clinical colleges and societies, state and territory health departments, and the private hospital sector. It was then released for public consultation in August 2016.

The model requires health service organisations to demonstrate implementation of a clinical care standard for colonoscopy, certification and recertification of proceduralists, and local monitoring of a succinct set of quality indicators.

In 2017–18, the Commission will develop a clinical care standard for colonoscopy.

Highlight

- Developed a national safety and quality model for colonoscopy, with the support and endorsement of all clinical colleges and societies whose members perform colonoscopy.

Device safety

In 2016–17, state and territory health departments asked the Commission to examine two issues related to the safety of medicines and medical devices.

Clearing house portal for medication alerts and medical device safety notifications

Medication alerts relate to the erroneous use of medicines (prescribing, dispensing or administering), which is typically caused by one or more contributing factors. Several issues relating to medical device errors have been raised with the Commission. A number of organisations issue safety alerts and advisories about the use of medicines and medical devices; however, there is no formal, coordinated method of sharing this information.

State and territory health departments asked the Commission to establish a web-based clearing house portal for medication alerts and medical device safety notifications, and to be responsible for its ongoing oversight and management.

The Commission established the clearing house portal in June 2017 to display medication and medical device alerts and advisories from each state and territory in one location. It complements existing national and international resources for medication and medical device alerts.

State and territory delegates access the clearing house portal via a secure, password-controlled section of the Commission's website. Once they load an alert or advisory to the clearing house portal, all other delegates are informed via an automatically generated email. Each state and territory continues to issue alerts and advisories within their existing methods.

The Commission will generate routine and ad-hoc reports and summaries of the volume and nature of alerts and advisories.

Small-bore connectors for liquids and gases in healthcare applications

In April 2016, the International Standard ISO 80369-6:2016, *Small bore connectors for liquids and gases in healthcare applications – Part 6: Connectors for neuraxial applications*, was published, specifying the design and dimensions of small-bore connectors intended for all neural applications. The standard aims to reduce the injection of erroneous substances via intrathecal, epidural and other neural routes.

State and territory health departments recommended that the Commission work with clinical groups to assess the standard's fitness for purpose in Australia, and provide advice on its uptake and use in Australian hospitals.

The Australian and New Zealand College of Anaesthetists (ANZCA) and the Commission convened a roundtable on ISO 80369-6:2016 in August 2016. It was attended by representatives from peak clinical groups in Australia and endorsed ISO 80369-6:2016 as fit for purpose in Australia.

2. Report on performance

ANZCA and the Commission developed a joint position statement supporting ISO 80369-6:2016 as part of a global initiative to improve patient safety through reducing erroneous epidural and intrathecal injections. The statement recommends that devices incorporating small-bore connectors be classified and regulated in accordance with ISO 80369-6:2016, and specifies the planning required to implement neuraxial connectors safely.

The statement was issued to public and private sector health facilities and relevant professional bodies in June 2017.

Highlights

- Established a clearing house portal for medication alerts and medical device safety notifications
- Held a roundtable on small-bore connectors for liquids and gases with ANZCA
- Released a joint position statement with ANZCA on safe use of neuraxial connectors.



Priority 2: Partnering with patients, consumers and communities

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

Person-centred healthcare systems

There is good evidence to show that using person-centred approaches to care can lead to better health outcomes, better patient experiences and greater efficiency. Delivering person-centred care allows consumers to have more control over treatment decisions, giving them a greater sense of ownership of their health.

The Commission is committed to supporting a health system in which patients, consumers and members of the community are treated as partners in all aspects of healthcare planning, design, delivery and evaluation. The Commission has been examining different ways to support the shift towards a more consistently person-centred healthcare system.

In 2016–17, the Commission integrated new requirements into the NSQHS Standards (2nd ed.) on partnering with consumers, both in governance and in care delivery. This involved developing a range of new actions and integrating person-centred principles across the NSQHS Standards (2nd ed.), with a particular focus on the Partnering with Consumers, Clinical Governance and Comprehensive Care standards.

The Commission also started work on identifying the common attributes or characteristics of high-performing person-centred healthcare organisations. In 2017, it conducted a series of interviews and site visits with high-performing international and Australian health service organisations, together with a literature review, to help identify these attributes and the actions that can be taken to foster them. In 2017–18, the Commission will use this work to develop guidance for health service organisations on fostering person-centred care.

Highlights

- Integrated person-centred actions and principles into the NSQHS Standards (2nd ed.)
- Undertook interviews with Australian and international health service organisations, together with a literature review, to identify the key attributes of high-performing person-centred healthcare organisations.

2. Report on performance

Supporting consumers to be partners in their own care

Consumers are increasingly interested in acting as, and are being relied upon to act as, partners in the decision-making and delivery of their health care. The shift in community expectations about the way health care is delivered, together with the increasing proportion of people experiencing complex and chronic health conditions that need to be managed in the community, has strengthened the argument to better involve, activate and empower consumers to be partners in their own care.

Supporting consumers to be partners in their own care involves providing them with high-quality information about health and care, about the way the health system operates, and about safety and quality.

In 2016–17, the Commission published two reports exploring consumers' needs and preferences for health information. The first report outlined the peer-reviewed literature in this area. The second report described the findings of a series of workshops and interviews with Aboriginal and Torres Strait Islander consumers, and separately with consumers from culturally and linguistically diverse backgrounds, on the types of health information that were important to them, and how they were best delivered. These reports will help the Commission develop guidance for health service organisations in 2017–18 on preparing health information for consumers.

The Commission also conducted extensive consultation and user testing for a consumer resource titled *Top tips for safe health care*. Released in April 2017, *Top Tips for Safe Health Care* provides information about some of the key things people should consider when thinking about their health care or interacting with the healthcare system. It provides tips, links to trusted health information sources and information about important safety issues.

Highlights

- Published a literature review on consumers' needs and preferences in relation to health information
- Published a report on the findings of research about the health information needs and preferences of Aboriginal and Torres Strait Islander consumers as well as consumers from culturally and linguistic diverse backgrounds
- Released the *Top Tips for Safe Health Care* resource for consumers.

Shared decision making and health information

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

In late 2016, the Commission finalised and released three patient decision aids on the use of antibiotics for sore throats, middle ear infections and acute bronchitis. Clinicians and consumers can use these aids during a consultation to weigh up the risks and benefits of using antibiotics and make a decision together about what is best for them. In addition to these tools, the Commission has started work on developing decision support tools for osteoarthritis of the knee and heavy menstrual bleeding that will support implementation of the clinical care standards on these topics.

The Commission has, in partnership with the RACGP, completed an online education module on risk communication and shared decision making for general practitioners. The model has also been adapted for use by four additional colleges.

The Commission also developed and released, in partnership with Healthdirect Australia, an online tool for consumers called the Question Builder. This tool, which is freely available on the Healthdirect website, helps consumers prepare for a doctor's appointment by building a list of questions they could ask their doctor, and considering the questions their doctor might ask them.

Highlights

- Tested and published three patient decision aids on the use of antibiotics for sore throats, middle ear infections and acute bronchitis
- Developed and released an online education module on risk communication and shared decision making for general practitioners
- Developed and released, in partnership with Healthdirect Australia, the online Question Builder to help consumers prepare a list of questions for medical appointments.

End-of-life care

Delivering high-quality end-of-life care is about ensuring that the consumer's needs and preferences are understood and met. This requires a goal-directed and person-centred approach.

In 2016–17, the Commission consulted on, finalised and released the *National Consensus Statement: Essential elements for safe and high-quality paediatric end-of-life care*, which describes the core requirements for delivering safe and high-quality end-of-life care to

children in Australia. It is based on the *National Consensus Statement: Essential elements for safe and high-quality end-of-life care*, which was endorsed by health ministers in 2015.

The Commission also released a report on a pilot study, undertaken in partnership with Canberra Hospital, of an end-of-life care audit tool and staff survey. The audit and survey tools are aimed at providing data on the delivery of end-of-life care in hospitals and on staff perceptions of how it is delivered.

In 2016, following this pilot, the Commission commenced a validation study of the audit tool and survey, which are currently being tested in nine hospitals across Australia. The findings of this study will be published in 2017–18. The Commission is also developing an end-of-life care audit toolkit that will be made available to all health service organisations by early 2018.

In 2016–17, the Commission also published a literature review scoping existing indicators for end-of-life care in acute settings.

Highlights

- Released the *National Consensus Statement: Essential elements for safe and high-quality paediatric end-of-life care*
- Published the findings from a pilot study of an end-of-life care audit tool and survey in Canberra Hospital
- Commenced a validation study of the audit tool and survey in nine hospitals across Australia
- Scoped existing indicators for end-of-life care in acute settings.

National guidelines for on-screen presentation of medicines information for consumers

In October 2016, the Commission published the *National Guidelines for On-Screen Display of Consumer Medicines Information* (the Consumer Guidelines). This followed the release of the *National Guidelines for On-Screen Display of Clinical Medicines Information* (the Clinical Guidelines) in January 2016.

The Consumer Guidelines specify consistent and unambiguous terms for the display of medicines information in online information systems that are accessible to consumers. The Consumer Guidelines draw on the recommendations and rationales in the Clinical Guidelines. However, they also contain important exceptions and additions to reflect the needs of consumers when accessing electronic information about their medicines.

As part of the development process, examples of on-screen medicines information were tested in a consumer focus group. The guidelines reflect the information needs and preferences broadly agreed upon.

The Commission is grateful to the Consumers Health Forum, the Australian Digital Health Agency and consumers in the focus group for their contributions to this work, and to the Australian Government Department of Health for its financial support.

Highlight

- Published national guidelines for the on-screen display of consumer medicines information.



Priority 3: Quality, cost and value

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

Identifying healthcare variation

Mapping variation is an invaluable tool for understanding how our healthcare system is providing care. Sometimes variation is expected, and even a good thing – for instance, when it reflects a response to differences in patient needs or patients' choice of treatment options. However, differences in the use of health services that do not reflect these factors indicate what is known as 'unwarranted variation'. Where unwarranted variation is thought to exist, it can be seen as an opportunity for the health system to improve. This improvement may involve increasing access to treatments that produce better outcomes for patients, or reducing access to treatments with little or uncertain benefit.

The *Australian Atlas of Healthcare Variation*, released in 2015, brought discussions about variation in health care into the mainstream in Australia. In response to the data and findings presented in the first Atlas, state and territory governments have been working to understand unwarranted variation by further analysing the data, and by working with clinicians to change models of care and the thresholds for interventions. Clinical colleges and societies are also investigating clinical variation within their specialties. The Commission has produced clinical care standards for several of the healthcare interventions that vary substantially in their use around the country.

The Commission launched the *Second Australian Atlas of Healthcare Variation* in June 2017. The second Atlas presents a clear picture of substantial variation in health care across Australia in areas such as chronic diseases, women's health and surgical interventions.

Hysterectomy rates in Australia are seven times as high in the area with the highest rate compared to the area with the lowest rate. Overall, hysterectomies remain more common in Australia than in other developed countries. Endometrial ablation, a less invasive and often preferred alternative to hysterectomy for abnormal uterine bleeding, has very high rates of variation – 21 times as high in the area with the highest rate compared to the area with the lowest rate. These results suggest that not all women with abnormal uterine bleeding are aware of the treatment options available to them.

The second Atlas found hospitalisation rates for some common chronic conditions were up to 16 times as high in some local areas compared to others. These conditions included chronic obstructive pulmonary disease, diabetes complications, heart failure, cellulitis, and kidney and urinary tract infections. The high hospitalisation rates and substantial variations found for these conditions show that recommended care is not always provided for people with these conditions. They also indicate opportunities for improvement in the health system.

2. Report on performance

The second Atlas provides information on hospitalisation rates for Aboriginal and Torres Strait Islander people, as well as information on the percentage of services that are funded publicly and privately. It also includes analysis by socioeconomic status.

The Commission consulted widely to interpret the data in the second Atlas. Clinicians, policymakers, epidemiologists, researchers and consumers have helped to identify the likely drivers of variation for each type of hospitalisation examined, and most importantly, what needs to be done to improve care. The second Atlas contains a number of clear recommendations based on the best available evidence.

Highlights

- Acted on the recommendations of the first Atlas
- Released the *Second Australian Atlas of Healthcare Variation*.



Table 2: *Second Australian Atlas of Healthcare Variation* key findings and recommendations

Area of variation			Recommendations
Hysterectomy (number of hospitalisations per 100,000 women aged 15 years and over, 2014–15)			3a. The Medicare Benefits Schedule (MBS) Review Taskforce to ensure that MBS item descriptors relating to treatments for heavy menstrual bleeding are aligned with the care described in the Heavy Menstrual Bleeding Clinical Care Standard. 3b. State and territory health departments to ensure that women who have heavy menstrual bleeding have been offered clinically appropriate treatment options, as described in the Heavy Menstrual Bleeding Clinical Care Standard, before they are placed on a waiting list for hysterectomy. 3c. Relevant professional colleges to include intrauterine device insertion within their advanced training programs. They should also review incentives for clinicians to participate in continuing professional development training programs on intrauterine device insertion, and access to such programs, to increase the number of clinicians skilled in insertion of the levonorgestrel intrauterine system.
	Rate (number per 100,000)	For people living in...	
Local area highest rate	763	Maryborough-Pyrenees (Vic)	
Local area lowest rate	115	Gungahlin (ACT)	
6.6-fold difference			
Endometrial ablation (number of hospitalisations per 100,000 women aged 15 years and over, 2012–13 to 2014–15)			1b. Local Hospital Networks, Primary Health Networks and the Aboriginal Community Controlled Health Service sector to promote appropriate care for the management of people with chronic obstructive pulmonary disease (COPD) using: i. The COPD-X Plan: Australian and New Zealand Guidelines for the Management of Chronic Obstructive Pulmonary Disease 2016 as the routine model of care
	Rate (number per 100,000)	For people living in...	
Local area highest rate	390	Burnie-Ulverstone (Tas)	
Local area lowest rate	19	Fairfield (NSW)	
20.5-fold difference			
Chronic obstructive pulmonary disease (number of potentially preventable hospitalisations per 100,000 people, 2014–15)			
	Rate (number per 100,000)	For people living in...	
Local area highest rate	990	Alice Springs (NT)*	
Local area lowest rate	63	Sherwood-Indooroopilly (Qld)	
15.7-fold difference			

* Two local areas recorded higher rates but these are excluded from the fold difference as they need to be treated with caution.

2. Report on performance

Area of variation			Recommendations
			<ul style="list-style-type: none">ii. Targeted anti-smoking programs in populations with high smoking rates, including areas with a high proportion of the population who are Aboriginal and Torres Strait Islander Australians, rural and remote areas, and areas of socioeconomic disadvantage. <p>1c. State and territory health departments to develop culturally appropriate pulmonary rehabilitation programs for Aboriginal and Torres Strait Islander Australians with COPD.</p>
Diabetes complications (number of potentially preventable hospitalisations per 100,000 people, 2014–15)			1e. Local Hospital Networks, Primary Health Networks and the Aboriginal Community Controlled Health Service sector to promote appropriate care for the management of people with diabetes using:
	Rate (number per 100,000)	For people living in...	
Local area highest rate	601	Outback-North (Qld) [†]	<ul style="list-style-type: none">i. The guidelines General Practice Management of Type 2 Diabetes 2016–18 as the routine model of care
Local area lowest rate	52	Manly (NSW) and Brisbane Inner-West (Qld)	<ul style="list-style-type: none">ii. The Australian National Diabetes Strategy 2016–2020 to ensure the provision of integrated models of careiii. Performance management frameworks to assess compliance of care with relevant diabetes treatment guidelines.
11.6-fold difference			

[†] One local area recorded a higher rate but this is excluded from the fold difference as it needs to be treated with caution.

Area of variation			Recommendations
Knee replacement (number of hospitalisations per 100,000 people aged 18 years and over, 2014–15)			<p>4a. The Medicare Benefits Schedule (MBS) Review Taskforce to ensure that MBS descriptors reflect the care described in the Osteoarthritis of the Knee Clinical Care Standard.</p> <p>4b. State and territory health departments to use the Osteoarthritis of the Knee Clinical Care Standard to promote appropriate care for the management of people with knee pain, including conservative non-surgical management using a combination of non-pharmacological and pharmacological treatments.</p> <p>4c. State and territory health departments to promote timely access to joint replacement or joint-conserving surgery when conservative management no longer provides adequate pain relief or maintenance of function.</p>
	Rate (number per 100,000)	For people living in...	
Local area highest rate	507	Mid West (WA)	
Local area lowest rate	128	Maribyrnong (Vic) and Darwin City (NT)	
4.0-fold difference			

2. Report on performance

Improving appropriateness of care

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

During 2016–17, the Commission launched and broadly disseminated the Delirium, Hip Fracture Care and Osteoarthritis of the Knee clinical care standards.

In response to findings from the first Atlas and feedback from state and territory health departments, the Commission began developing the Heavy Menstrual Bleeding and Venous Thromboembolism Prevention clinical care standards in 2016–17. This included establishing expert topic working groups – made up of consumers, clinicians, researchers and nominated representatives from key health organisations or relevant technical experts – to inform the development of these new standards, which will be released in 2017–18.

In 2016, the Australian and New Zealand Hip Fracture Registry released its first annual report, which detailed patient and facility data. The release also coincided with the launch of the Hip Fracture Care Clinical Care Standard. Most of the indicators in the Hip Fracture Care Clinical Care Standard can be collected through this registry, which will assist in monitoring care in line with the standard. The Commission also released a document called *Hip Fracture Care – The case for improvement*.

This is an educational resource designed to help clinicians and health service organisations implement the Hip Fracture Care Clinical Care Standard. Similarly, the Stroke Foundation conducts biennial audits into acute stroke care in line with the Acute Stroke Clinical Care Standard indicators.

A process has been developed to guide the review of clinical care standards. It will be piloted in 2017–18 using the initial clinical care standards released in 2014–15.

The Commission also finalised a framework to guide evaluation activities that measure the effectiveness of clinical care standards. Initial activities have commenced and will continue in the coming years.

Highlights

- Launched clinical care standards on delirium, hip fracture care and osteoarthritis of the knee
- Started developing clinical care standards on heavy menstrual bleeding and venous thromboembolism prevention
- Published *Hip Fracture Care – The case for improvement*, an educational resource designed to help clinicians and health service organisations implement the Hip Fracture Care Clinical Care Standard
- Finalised a clinical care standards evaluation framework that will guide future activities.

Pricing for safety and quality

In April 2016, COAG signed a Heads of Agreement intended to form the basis of an addendum to amend elements of the National Health Reform Agreement for three years, until 30 June 2020. As part of this agreement, COAG resolved to develop, and begin to implement, reforms to improve health outcomes for Australians, and decrease avoidable demand for public hospital services.

Under the Heads of Agreement, states, territories and the Australian Government Department of Health agreed to work with the Independent Hospital Pricing Authority (IHPA) and the Commission to develop a comprehensive, risk-adjusted model that integrates quality and safety into hospital pricing and funding, and reduces avoidable hospital readmissions. This work has focused on pricing and funding for sentinel events, hospital-acquired complications and avoidable hospital readmissions.

The Commission's involvement in this work has included:

- Reviewing the sentinel events list
- Curating the hospital-acquired complications list

- Providing clinical advice on risk adjustment for the hospital-acquired complications list
- Developing advice, in consultation with the states and territories, on a list of clinical conditions that can be considered avoidable hospital readmissions
- Continuing to collaborate with IHPA.

For details on the Commission's review of the sentinel events list and curation of the hospital-acquired complications list, see 'Minimising healthcare-related harm' on page 45.

Highlights

- Provided advice to the Australian Health Ministers' Advisory Council on a list of clinical conditions that can be considered avoidable hospital readmissions
- Provided clinical advice on risk adjustment for the hospital-acquired complications list.



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

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

Indicators and dataset specifications

In 2016–17, the Commission continued working on resources that outline best practice for developing and reviewing safety and quality indicators. This included completing the *Toolkit for Developing Safety and Quality Indicators*, which aims to provide best practice guidance on indicator and dataset development and review processes. The Commission's *Data Governance Framework* and *Data Plan 2016–2019* were also completed.

In 2016–17, the Commission continued developing and maintaining indicators and dataset specifications that helped improve safety and quality in health care. It developed and specified indicator sets to support the implementation of clinical care standards on osteoarthritis of the knee, delirium and heavy menstrual bleeding. The Commission is also researching and developing indicator sets for the clinical care standard on preventing venous thromboembolism.

The Commission completed specifications for defining and coding severe acute maternal morbidity during 2016–17, and continued to support data collection and reporting in relation to hand hygiene compliance. It has begun defining data models, tool specifications and indicator sets to increase the transparency of accreditation processes and outcomes. Work is underway to integrate post-partum haemorrhage indicators into national datasets.

Hospitals, states and territories, and private hospital ownership groups use the Core Hospital-Based Outcome Indicators (CHBOI) for routine local-level safety and quality reviews. To ensure the CHBOI are consistent with international methodological best practice, the Commission has progressed the development of the Australian Composite Model Hospital Standardised Mortality Ratio (ACM HSMR). This is a new model for measuring in-hospital mortality.

In 2016–17, two jurisdictions piloted the ACM HSMR to assess its utility and functionality for monitoring safety and quality at the local level. Feedback was largely positive; however, issues requiring additional work still remain, including variation between the states and territories in data elements used in cohort specification and risk adjustment. This work will continue in 2017–18, with a view to incorporating the ACM HSMR into the CHBOI toolkit.

Highlights

- Created a toolkit for developing and reviewing safety and quality indicators
- Continued developing and maintaining indicator sets for the clinical care standards, maternal morbidity, hand hygiene and accreditation
- Continued developing and piloting the ACM HSMR.

Patient-reported experience measures

During 2016–17, the Commission developed and piloted a non-proprietary set of questions to facilitate national consistency in the way patients' experiences are measured. These questions form a short measurement instrument known as the Australian Core Patient Experience Question Set (CorePEQS).

The consultative approach for the CorePEQS included conducting initial qualitative research with a group of 86 consumers drawn from each state or territory to define the factors that influence healthcare experiences. Seven more phases of qualitative and quantitative research followed. To establish the reliability and validity of the instrument, the Commission also conducted pilot testing in four states. Around 1,500 consumers participated in the pilot testing, which covered day and overnight settings in private and public hospitals.

The CorePEQS is due for release in September 2017, and will be available for use with day stay and overnight hospital patients free of charge.

Highlight

- Developed a non-proprietary instrument to measure patients' experiences of health care in a consistent way nationally.

Minimising healthcare-related harm

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

Hospital-acquired complications list

A hospital-acquired complication refers to a complication for which clinical risk-mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring. The hospital-acquired complications list was released in 2015. After the birth trauma and perineal laceration complications were included, the list was refined further and final specifications were released in October 2016.

In 2016–17, the Commission started developing supporting resources for the hospital-acquired complications list with the aim of improving clinical documentation, and supporting local monitoring and quality improvement. This work will continue in 2017–18. The Hospital-Acquired Complications Curation Clinical Advisory Group was convened to support this work and future refinements to the list.

National sentinel events list

In 2016–17, the Commission continued its review of the national sentinel events list. The list comprises eight sentinel events – that is, adverse events that result in death or very serious harm to the patient. The Productivity Commission's *Report on Government Services* details the number of sentinel events that occur each year. This is the first review of the list since 2004, when Australian health ministers introduced mandatory reporting on sentinel events.

2. Report on performance

The Commission also established the Sentinel Events Review Steering Committee to guide the revision of the list. The committee is made up of safety and quality experts from each state or territory, and a consumer representative. The Commission undertook significant clinical consultation in 2016–17 as part of the list redevelopment process. Open public consultation will take place in mid-2017, with a report to AHMAC scheduled for December 2017.

Highlights

- Released specifications for the national hospital-acquired complications list
- Curated the hospital-acquired complications list
- Established the Sentinel Events Review Steering Committee.

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 2016–17, the Commission continued working to implement the *Framework for Australian Clinical Quality Registries*. The framework, which was endorsed by AHMAC in 2014, specifies national arrangements under which peak clinical groups and health service organisations can work with governments to monitor and report on the quality (or appropriateness and effectiveness) of health care.

In 2016–17, the Commission released two key reports on clinical quality registries:

- Economic Evaluation of Clinical Quality Registries*. This evaluation of five clinical quality registries in Australia found that high-quality clinical quality registries can improve clinical practice at a relatively low cost, leading to a significant net positive return on investment.
- Prioritised List of Clinical Domains for Clinical Quality Registry Development*. This report documents the process of applying the AHMAC-endorsed prioritisation criteria to create a prioritised list of clinical domains that could potentially be developed into national clinical quality registries. The development of this list included analysing the available data and consulting with stakeholders.

Highlights

- Completed economic evaluations of clinical quality registries
- Consulted on, and released a list of, high-priority clinical domains for the development of national clinical quality registries.

The state of safety and quality in Australian health care

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

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 receiving care in Australia are safe, and that they receive high-quality care. This means there is no single source of data that can provide comprehensive information about the safety and quality of the Australian healthcare system.

The Commission leads and coordinates national improvements in safety and quality, and part of its work relates to supporting better measurement to understand the state of safety and quality nationally, and also to enable local improvement. This section highlights some of the work the Commission is doing to support better understanding of the state of safety and quality in Australia.

The introduction of the NSQHS Standards gave a nationally consistent approach to safety and quality in Australia's hospitals for the first time. The first edition of the NSQHS Standards included requirements for establishing an organisation-wide quality management system that monitors and reports on safety and quality and informs improvements to patient care. These requirements have been strengthened in the second edition of the NSQHS Standards, with clear responsibilities for health service organisations to monitor

performance, identify areas for improvement, implement improvement strategies, and provide reports on safety and quality performance. The governing body also has a clear responsibility to review reports, and monitor the organisation's progress on safety and quality performance. These requirements will support the use of local data about safety and quality for improvement.

Another new action in the second edition of the NSQHS Standards is the requirement for health service organisations to monitor variation in practice against expected health outcomes, to provide feedback to clinicians on their variation, and to use information on unwarranted clinical variation to inform improvements in safety and quality. These new requirements were based on knowledge about the extent of variation in practice in Australia.

The first *Australian Atlas of Healthcare Variation* published in 2015 and the *Second Australian Atlas of Healthcare Variation* published in June 2017 indicate that there is substantial variation in clinical practice in many areas, including chronic disease, women's health, some surgical and diagnostic interventions, and prescribing for a range of conditions. These findings have driven action by the Commission, state and territory governments, and clinical groups to reduce variation and improve appropriateness of care.

2. Report on performance

In April 2016 the Commission was asked by the COAG Health Council to work with the IHPA to examine ways to improve safety and quality by reducing avoidable hospital readmissions and integrating safety and quality into hospital funding and pricing. To do this, the Commission worked with clinicians, consumers, health service managers and policymakers to develop a set of hospital-acquired complications that can be used to report on the incidence, and in time, prevalence of patient safety events that may be prevented.

These, and other sources of information such as the AURA Surveillance System, provide information about safety and quality that can inform local improvements, clinical responses, allocation of resources, and national policy. The Commission will continue to work collaboratively with its partners and stakeholders in providing a comprehensive picture of safety and quality in Australian health care.

A full report on key safety and quality themes can be found in the Commission's publication *Vital Signs 2017: The state of safety and quality in Australian health care*.



Annual performance statements

As the accountable authority of the Australian Commission on Safety and Quality in Health Care (the Commission), the Board presents the 2016-17 annual performance statements of the Commission, as required under paragraph 39(1)(a) of the *Public Governance, Performance and Accountability Act 2013*. In the opinion of the Board, based on advice from Commission management and the Audit and Risk Committee, these annual performance statements accurately reflect the performance of the Commission and comply with subsection 39(2) of the Public Governance, Performance and Accountability Act.



Professor Villis Marshall AC
Board Chair

Entity purpose

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

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

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

2. Report on performance

Our performance

This year has been one of significant achievements for the Commission with the successful delivery of its *Health Portfolio Budget Statements 2016–17* targets and activities and the achievement of almost all key performance indicators (KPIs) for this period. The Commission fell just short of the required number of clinicians completing the healthcare-associated infection online education module. The Commission will develop strategies to ensure it meets this target in 2017–18.

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

There was no change to the framework in which the Commission operated in the 2016–17 reporting period, and no change to the Commission's purposes, activities or organisational capability. The following examples highlight the key achievements of the Commission's work for 2016–17 and demonstrate the benefits of this national approach:

- The implementation of the National Safety and Quality Health Service (NSQHS) Standards and the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme continues to be a success. By 30 June 2017, all operating health service organisations in Australia to be assessed to the NSQHS Standards have now been assessed at least once, and an increasing number have received a second organisation-wide assessment.
- The second edition of the NSQHS Standards was finalised following extensive consultation. Following endorsement by Health Ministers, it will be released in November 2017 and assessment to the second edition will be required from January 2019.
- In 2016–17 the Commission started to examine the application of the NSQHS Standards in primary care, and a draft set of standards designed to support safety and quality in primary care will be released for consultation in mid-2017.

- The *Second Australian Atlas of Healthcare Variation* was launched in June 2017. The Atlas highlighted significant differences in treatment for the same conditions across the country in the areas of surgery, chronic disease and infection, women's health, maternity and cardiovascular care. There has been significant progress in implementation of the recommendations from the first Atlas by the Commission, state and territory governments, local health services and clinical bodies. A report describing the impact of the first Atlas will be released in December 2017.
- The Commission released three clinical care standards in 2016–17 in the areas of hip fracture, delirium, and osteoarthritis of the knee. The clinical care standards identify and define the care people should expect to receive or be offered and can play an important role in delivering appropriate care and reducing unwarranted variation.
- Following establishment of the national surveillance system for antimicrobial resistance and antibiotic usage (AURA) in 2016, there has been a significant increase in participation across all elements of the system, with 159 hospitals now contributing information on antibiotic usage and 281 contributing information on appropriateness.
- The Commission continues to focus on improving safety and quality by developing tools and resources to support patients and consumers to be involved in their own care. In 2017, *Top Tips for Safer Care* and the Question Builder were released.
- In response to issues identified by the Commission in safety and quality reviews that have been carried out for the states and territories, the Commission has developed a national model clinical governance framework. The purpose of the framework is to ensure that patients and consumers receive safe and high-quality care by describing the elements that are essential for acute health service organisations to implement to achieve integrated corporate and clinical governance systems. It is based on the NSQHS Standards.

2. Report on performance

Performance against the Health Portfolio Budget Statements and Corporate plan 2016–17

The Commission's *Corporate Plan 2016–17* was prepared under section 35(1) (a) of the Public Governance, Performance Accountability Act, and published in accordance with section 16E (3) of the Public Governance, Performance and Accountability Rule 2014. The *Corporate Plan 2016–17* describes the planned program of work for the four-year period and specifies how the Commission will measure its performance during that period. The *Corporate Plan 2016–17* can be accessed on the Commission's website, at www.safetyandquality.gov.au/about-us/corporate-plan/

The Commission's KPIs for the 2016–17 period were published in the *Health Portfolio Budget Statements 2016–2017* and the *Corporate Plan 2016–17*. The following is a report of the Commission's performance against these KPIs.

Strategic Priority 1: Patient Safety

Qualitative performance criteria

Successful implementation of the National Safety and Quality Health Service (NSQHS) Standards and ongoing monitoring of safety and quality performance of hospitals and day procedure services.

Criteria source

Program 1.1, *2016–17 Health Portfolio Budget Statements*, p.188; *Corporate plan 2016–17*, p.15.

2016–17 performance target

2016–17 Health Portfolio Budget Statement: 100% of hospitals and day procedure services assessed to the NSQHS Standards.

Corporate Plan 2016–17: Final draft version 2 of the NSQHS Standards (renamed the second edition of the NSQHS Standards).

Result against performance criteria

The Commission continues to negotiate with states and territories on ongoing arrangements to support implementation of the NSQHS Standards in hospitals and day procedure services, community and other health services. The Commission uses performance data to identify safety and quality lapses by health services and negotiates with states and territories to implement remedial actions. The Commission will continue to provide national coordination and reforms of assessment processes with health system regulators, accrediting agencies and health services and amending the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme. In 2016–17 the AHSSQA Scheme was reviewed and reformed to improve the performance of accrediting agencies and to address the performance issues identified by the health service organisations. The Commission also supports health services to meet the requirements of the NSQHS Standards and embed partnerships to support the next edition of the NSQHS Standards.

Result against performance target

2016–17 Health Portfolio Budget Statements: 100% of all hospitals and day procedure services in Australia have been assessed to the NSQHS Standards.

Corporate Plan 2016–17: The Commission successfully submitted the final draft version of the NSQHS Standards to Australian Health Ministers' Advisory Council and received unanimous approval from the Commonwealth, states and territories. The Commission is moving forward in 2017 to launch the second edition with associated documents, this is scheduled for November 2017.

Quantitative performance criteria

Percentage of public hospitals meeting the benchmark for hand hygiene compliance.

Criteria source

Program 1.1, *2016–17 Health Portfolio Budget Statements*, p.188.

2016–17 target

Public hospitals meeting the benchmark of $\geq 75\%$ for hand hygiene compliance.

Result against performance criteria

Data reported by Hand Hygiene Australia confirms that public hospitals have met the benchmark hand hygiene compliance rates for the 2016–17 reporting period.

The overall compliance rates for each audit were above the listed target and are as follows:

Audit Period 1 — 2016: 84.1%

Audit Period 2 — 2017: 84.6%

Audit Period 3 — 2017: 84.3%

Further information can be found at www.hha.org.au

Quantitative performance criteria

Number of clinicians completing the health care associated infection online education modules.

Criteria source

Program 1.1, *2016–17 Health Portfolio Budget Statement*, p.188.

2016–17 target

$\geq 13\,000$ clinicians completing the healthcare-associated infection online education modules.

Result against performance criteria

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

In the 2016–17 financial year, 12,680 clinicians and students have registered and completed at least one of the modules. The figure falls just short of the target and the Commission will develop strategies to ensure the 2017–18 target is achieved.

Key performance indicator

Develop and consult on a national model clinical governance framework.

Source

Corporate Plan 2016–17, p. 16.

Result against the key performance indicator

The Commission developed a draft national clinical governance framework and established an advisory committee to provide feedback and drive improvements of the document. The Commission has sought advice from jurisdictions, the private health sector, primary care committee and the Board. This advice has been used to revise the document and independent consultants have been hired to consult both internationally and domestically with key industry leaders.

Key performance indicator

Review and revise reporting of antimicrobial resistance (AMR) and antimicrobial use (AU) to provide information and data to support jurisdictions and the private sector to implement strategies in infection control and AMR prevention and containment.

2. Report on performance

Source

Corporate Plan 2016–17, p. 16.

Result against the key performance indicator

The Commission has undertaken a broad range of activities to ensure a comprehensive approach to the availability of data and reports resulting from the antimicrobial use and resistance in Australia (AURA) Surveillance System. The AURA Coordination Unit has continued to work with its program partners to improve the breadth and utility of antimicrobial use (AU) and antimicrobial resistance (AMR) surveillance data for state and territory health departments, for the private sector and for the community more generally. These data provide the platform for better understanding of patterns of AU and AMR to inform strategies to improve prescribing, and to prevent and contain resistant organisms.

One of the newly established components of AURA, the operation of the national alert system for critical antimicrobial resistances (CARs), CARAlert has provided state and territory health departments with almost real-time access to surveillance data on CARs. The system offers significant opportunities for timely planning for response to potential outbreaks, where this action is required. The state and territory contact points also have direct access to CARAlert records for their state or territory, and details of public hospitals in their jurisdictions where the isolate in which a CAR was confirmed was collected. In the first year of operation 1,064 results from 73 originating laboratories across Australia were entered into the database

This information allows states and territories to monitor the geographic distribution of CARs, to distribute the information to clinicians and health service managers and to liaise with hospitals to confirm an infection control response has been initiated. State and territory health authorities can also generate local and national reports from the system. Departments will be consulted

shortly on local use of the system and further support that the AURA Coordination Unit could provide.

Work continues to focus on increasing the volume and representativeness of data for each of the components of the surveillance system, with increasing numbers of public and private hospitals participating in programs which provide valuable data on AMR and AU and the appropriateness of AU. The Commission will look in more detail at factors that drive variation in antimicrobial prescribing and use.

Strategic Priority 2: Partnering with patients, consumers and communities

Qualitative performance criteria

Provide safety and quality information to the general public.

Criteria source

Program 1.1, *2016–17 Health Portfolio Budget Statements*, p.188.

2016–17 performance target

Reporting in the Annual Report on the state of safety and quality in health care, and in the report for the general public, *Vital Signs 2016*.

Reporting to the general public through regular ACSQHC newsletters and website publications.

Result against performance target

Vital Signs 2016 was published in October 2016. This Annual Report reports on safety and quality in health care at Chapter 2, Reporting on Performance.

The Commission regularly provides publications and updates via its website www.safetyandquality.gov.au/ and via social media, such as twitter (@ACSQHC).

Key performance indicator

Develop draft national statement, policy or framework on essential elements for a person-centred healthcare system.

Source

Corporate Plan 2016–17, p16.

Result against the key performance indicator

Two reviews have been completed: an expert commentary on person-centred care and a review of person-centred care in the context of complex adaptive systems. Scoping has been undertaken and a draft report prepared identifying attributes of high-performing person-centred healthcare organisations. Interviews with high-performing person-centred Australian and international healthcare organisations have been conducted. This material will form the basis of a national approach to a person-centred healthcare system, and provide advice to health services about becoming high-performing person-centred services.

Key performance indicator

Review of national and international literature and undertake environmental scan on patient safety models.

Source

Corporate Plan 2016–17, p. 17.

Result against the key performance indicator

In March 2017, the Commission completed a desktop review of national and international literature on patient safety models and an initial environment scan of international contemporary practice. This work will inform the development of a patient safety learning model in 2017–18, supported by further consultation to determine current state and territory practices, stakeholder perspectives on key elements and areas for future development.

Strategic Priority 3: Quality, cost and value

Qualitative performance criteria

Production of a *Second Australian Atlas of Healthcare Variation* covering topic areas agreed by Commonwealth, States and Territories.

Criteria source

Program 1.1, *2016–17 Health Portfolio Budget Statements*, p.189; *Corporate Plan 2016–17*, p. 17.

2016–17 Reference point or target

2016–17 Health Portfolio Budget Statements: Produce and disseminate new and updated maps of healthcare variations in Australia for a set of topic areas agreed by the Commonwealth, States and Territories by 30 June 2017.

Corporate Plan 2016–17: Publish second Australian Atlas of healthcare variation and develop an interactive web-based national Atlas of Healthcare Variation.

Result against performance criteria and target

On 7 June 2017 the Commission successfully completed the launch of the *Second Australian Atlas of Healthcare Variation*, in collaboration with the Australian Government, state and territory governments, specialist medical colleges, clinicians and consumer representatives. This was the second time that data from the Medicare Benefits Schedule, Pharmaceutical Benefits Scheme and Admitted Patient Care National Minimum Data Set were all used to explore variation across different healthcare settings. The launch of the *Second Australian Atlas of Healthcare Variation* was accompanied by an online interactive platform of maps, available at www.acsqhc.maps.arcgis.com/apps/MapAndAppGallery/index.html?appid=fd3b04ebe3934733b7ecb8514166c08f

2. Report on performance

The successful launch of the second Atlas produced 49 recommendations that suggest ways in which coordinated action can be taken at all levels of the healthcare system. These are expected to be implemented across the Australian healthcare system over the coming years.

Qualitative performance criteria

Develop Clinical Care Standards for consultation, informed by outcomes from the work on health care variation.

Criteria source

Program 1.1, *2016–17 Health Portfolio Budget Statements*, p. 189; *Corporate Plan 2016–17*, p. 17.

2016–17 Reference point or target

2016–17 Health Portfolio Budget Statements: Clinical standards focusing on high-impact, high-burden and high-variation areas of clinical care are developed by 30 June 2017.

Corporate Plan 2016–17: National release of the clinical care standards developed in 2015–16, including those on hip fracture care, delirium and osteoarthritis of the knee.

Result against performance criteria and target

In the Commission's work plan 2016–17 it was decided that clinical care standards would be produced on delirium, hip fracture care and osteoarthritis of the knee by 30 June 2017.

By 30 June 2017, the Commission had launched clinical care standards on delirium, hip fracture care and osteoarthritis of the knee. The Commission has also commenced work on two clinical care standards, one on venous thromboembolism and another on heavy menstrual bleeding.

Hard-copy resources were made available to health services across Australia, professional colleges and organisations, and relevant consumer groups. They are also freely available on the Commission's website at www.safetyandquality.gov.au/acsqhc_program/clinical-care-standards/

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

Qualitative performance criteria

Provide safety and quality information and resources to health professionals.

Criteria source

Program 1.1, *2016–17 Health Portfolio Budget Statements*, p.189.

2016–17 Reference point or target

Development and distribution of new/updated sector-specific implementation tools and resources for the public and private acute sector and primary care.

Result against performance criteria or target

The Commission has provided safety and quality information and resources to health professionals in both the public and private acute sector and primary care, such as:

- Three clinical care standards (delirium, hip fracture and osteoarthritis of the knee)
- Medication charts
- Antimicrobial use and resistance data
- Audit tools covering a range of different safety and quality issues.

Qualitative performance criteria

Condition-specific clinical indicator sets developed.

Criteria source

Program 1.1, *2016–17 Health Portfolio Budget Statements*, p.190.

2016–17 target

To develop two condition-specific clinical indicator sets.

Result against performance criteria or target

In 2016–17, the Commission has developed and published three condition-specific indicator sets to accompany the clinical care standards on delirium, hip fracture and osteoarthritis of the knee.



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Corporate governance and accountability

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

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Legislation and requirements

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

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

Compliance with legislation

The Commission has complied with the provisions and requirements of:

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

The Commission did not have any significant non-compliance issues with finance law during the 2016–17 reporting period.

Strategic planning

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

The strategic plan covers four priority areas:

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

Ministerial directions

Section 16 of the National Health Reform Act empowers the Minister for Health to make directions with which the Commission must comply. The Minister for Health made no such directions during the 2016–17 reporting period.

Commission 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 obligations.

The Board is established and governed by the National Health Reform Act and the Public Governance, Performance and Accountability Act.

Board membership 2016-17

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

Professor Villis Marshall AC (Chair)

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

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

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

Qualifications: MD, MBBS, FRACS

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

3. Corporate governance and accountability

Mr Martin Bowles PSM

Mr Martin Bowles was appointed 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. He has also been Deputy Secretary of the Department of Climate Change and Energy Efficiency, and Deputy Secretary of the Department of Defence. In 2012, Mr Bowles 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.

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

Qualifications: BBus, GCPubSecMgmt

Board membership: First appointed on 14 May 2015

Dr David Filby PSM

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

Dr Filby served on the board of the Australian Institute of Health and Welfare for 14 years and on the board of Helping Hand Aged Care Inc. for nine years, including six as Chair. He was also a board member of the National Health Performance Authority until June 2016, and previously served on the board of South Australia's Child Health Research Institute Council. Dr Filby holds an Adjunct Professorship in the Faculty of Health Sciences at Flinders University. In 2007, he was awarded the

Sydney Sax Medal by the Australian Healthcare and Hospitals Association, and in 2008, he received a PSM.

Qualifications: PhD

Board membership: First appointed on 29 July 2016

Adjunct Professor John Walsh AM

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

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

Professor Walsh was the Deputy Chair of the National Health Performance Authority until June 2016, and chaired the independent panel overseeing *Caring Together: The Health Action Plan for NSW*. He has also held board memberships with several organisations including the NSW Motor Accidents Authority and NSW Home Care Service.

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

Qualifications: BSc, FIAA

Board membership: First appointed on 29 July 2016

Professor Phillip Della

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

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

Qualifications: PhD, FACN

Board membership: First appointed on 1 April 2013; term concluded on 31 March 2017

Ms Christine Gee

Ms Christine Gee brings to the Board extensive experience in private hospital administration, having held executive management positions for more than 25 years. She has been the Chief Executive Officer of Toowong Private Hospital since 1997. She is also Chair of the Commission's Private Hospital Sector Committee.

Ms Gee is involved in numerous national and state boards and committees, including the Australian Private Hospitals Association, the Private Hospitals Association of Queensland, the Queensland Board of the Medical Board of Australia, and the Australian Government's Second Tier Advisory Committee.

Qualifications: MBA

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

Ms Wendy Harris QC

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

Between 2011 and 2015, she was Board Chair of the Peter MacCallum Cancer Centre, Australia's only public hospital dedicated to cancer treatment, research and education. In addition to being a member of the Commission's Board, Ms Harris chairs the National Model Clinical Governance Framework Advisory Panel.

Previous directorships include 10 years on the board of Barristers' Chambers Limited, which is the repository of the Victorian Bar's substantial property assets, and the provider of chambers accommodation and ancillary services for its members. Ms Harris is currently a member of the Bar Council of the Victorian Bar Inc.

Qualifications: LLB (Hons)

Board membership: First appointed in July 2015

Dr Shaun Larkin

Dr Shaun Larkin worked for The Hospitals Contribution Fund of Australia (HCF), Australia's largest not-for-profit health fund, from 1997 to 2017.

After serving as General Manager in a number of executive roles, including in strategic development, benefits management, corporate ventures and operations, he was selected as HCF's Managing Director in 2009.

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

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

Qualifications: HlthScD, MHSc, MBA, BHA

Board membership: First appointed on 1 April 2013

3. Corporate governance and accountability

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 was most recently the Chief Executive Officer of St Vincent's Private Hospital 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 recognised as the Telstra Victorian Business Woman of the Year for the private sector.

Qualifications: RN, RM, BN, GDip Nursing Administration

Board membership: First appointed 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 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's previous board directorships include Cancer Council SA, Noarlunga Health Services, the South Australian Divisions of General Practice, the Australian General Practice Network and the Southern Adelaide Health Service.

Qualifications: MBBS, FRACGP

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

Board meetings and attendance

Table 3: Board meetings and attendance

Name	Board meeting				
	28 July 2016	14 September 2016	27 October 2016	24 February 2017	27 April 2017
Professor Willis Marshall AC (Chair) ¹					
Mr Martin Bowles PSM					
Adjunct Professor John Walsh AM ²					
Dr David Filby PSM					
Professor Phillip Della ³					
Ms Christine Gee ²					
Ms Wendy Harris QC ⁴					
Dr Shaun Larkin ²					
Mrs Cheryle Royle ²					
Dr Helena Williams ²					

■ Present ■ Absent ■ Not a member at the time of the meeting

¹ Term concluded on 31 March 2017; reappointed until 30 June 2017

² Reappointed on 29 July 2016

³ Term concluded on 31 March 2017

⁴ Appointed on 24 July 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 the *Board Operating Guidelines*, which inform the conduct of Board members and describe their responsibilities and duties under legislation.

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

Ethical standards

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

Related-entity transactions

In accordance with the requirements prescribed by section 17BE of the Public Governance, Performance and Accountability Rule and the Department of Finance's *Resource Management Guide No. 136 – Annual reports for corporate Commonwealth entities*, related-entity transactions during 2016–17 are disclosed in Appendix C.

Indemnity and insurance

The Commission holds directors' and officers' liability insurance cover through Comcover, the Australian Government's self-managed fund. As part of its annual insurance renewal process, the Commission reviewed its insurance coverage in 2016–17 to ensure the coverage was still appropriate for its operations.

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

3. Corporate governance and accountability



The Commission's Board. Front row left to right: Professor Willis Marshall AC (Chair), Adjunct Professor John Walsh AM. Back row left to right: Ms Wendy Harris QC, Professor Phillip Della, Dr David Filby PSM, Ms Christine Gee, Dr Shaun Larkin and Mrs Cheryle Royle

Committees

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

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

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

Audit and Risk Committee

The Board established the Audit and Risk Committee in compliance with section 45 of the Public Governance, Performance and Accountability Act and section 17 of the Public Governance, Performance and Accountability Rule. The committee is chaired by Ms Jennifer Clark. Ms Clark brings to the Audit and Risk Committee her extensive knowledge and experience in business, finance and governance through her career as a non-executive director since 1991 and as an investment banker for over 20 years.

The primary role of the Audit and Risk Committee is to help the Board discharge its responsibilities in relation to financial reporting, performance reporting, risk oversight and management, internal control, and compliance with relevant laws and policies. The committee's responsibilities include:

- Monitoring the effectiveness of risk management frameworks, including identifying and managing the Commission's business and financial risks, including fraud
- Monitoring the Commission's compliance with legislation, including the Public Governance, Performance and Accountability Act and Rule

- Monitoring the preparation of the Commission's annual financial statements and making a recommendation to the Board on their approval
- Reviewing the appropriateness of the Commission's performance measures, and how these measures are assessed and reported
- Assessing whether relevant policies are in place to maintain an effective internal control framework, including for security arrangements and business continuity
- Reviewing the work undertaken by the Commission's outsourced internal auditors, including approving the internal audit plan and reviewing all audit reports and issues identified in those reports.

Board member Dr Shaun Larkin was appointed as a member of the Audit and Risk Committee in November 2016. Mr Trevor Burgess held the position of external member of the Audit and Risk Committee during 2016–17. Although members of the Commission's senior management attended meetings as advisors, they were not members of the Audit and Risk Committee, which is in accordance with section 17 of the Public Governance, Performance and Accountability Rule.

The Audit and Risk Committee met five times during 2016–17. The Chair and members attended all relevant meetings.

3. Corporate governance and accountability

Inter-Jurisdictional Committee

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

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

The committee met five times during the 2016–17 financial year.

Other committees and consultations

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

- Private Hospital Sector Committee
- Primary Care Committee.

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

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

The Commission consults widely with subject-matter experts, peak bodies, states and territories, consumers and other relevant individuals and organisations. This 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 state and territory representatives. The Commission also undertakes formal consultation on specific issues.

Internal governance arrangements

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

Internal management

The Commission has two internal management groups and three committees.

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

The Work Health and Safety Committee develops and promotes strategies to support the health and safety of all employees and visitors. The Workplace Consultative Committee facilitates regular consultation and employee participation in the development and review of HR and operational policies and procedures. The Information and Records Management Steering Committee assesses the Commission's record keeping, promotes good records management practices across the Commission and develops strategies to digitise the Commission's records.

Risk management

Risk management is part of the Commission's strategy to promote accountability through good governance and robust business practices. The Commission is committed to embedding risk management principles and practices consistent with the Australian Standard AS/NZS ISO 31000:2009 *Risk management – Principles and guidelines* 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 helps employees accept and manage risks.

Fraud control

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

Internal audit

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

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

External scrutiny

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

Freedom of information

Agencies subject to the *Freedom of Information Act 1982* are required to make information available to the public as part of the Information Publication Scheme (IPS). In accordance with Part II of the Act, each agency must display on its website a plan showing what information it publishes in accordance with the requirements of the scheme. The Commission’s plan and freedom of information (FOI) disclosure log are available on its website:
www.safetyandquality.gov.au

See Appendix A for a table summarising FOI activities for 2016–17.

Judicial decisions and reviews by external bodies

There were no judicial decisions or external reviews that significantly affected the Commission in 2016–17.

In 2016–17, there were no reports on the operations of the Commission by the Auditor-General (other than the reports on financial statements), a parliamentary committee, the Commonwealth Ombudsman or the Office of the Australian Information Commissioner.

Parliamentary and ministerial oversight

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

Executive remuneration

Table 4: Remuneration paid to executives during 2016–17

Total remuneration	Executives No.	Average Reportable Salary \$	Average Contributed superannuation \$	Average Allowances \$	Average bonus paid \$	Average Total remuneration \$
\$200000 and less	1	59,207	6,785	–	26,137	92,130
\$200001 to \$250000	0	–	–	–	–	–
\$250001 to \$300000	1	219,413	39,106	–	25,549	284,068
\$300001 to \$350000	1	234,190	40,187	424	26,765	301,565
\$350001 to \$400000	0	–	–	–	–	–
\$400001 to \$450000	1	388,770	27,695	–	–	416,465
Total number of executives	4					

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

Table 5: Remuneration paid to highly paid staff during 2016–17

Total remuneration	Executives No.	Average Reportable Salary \$	Average Contributed superannuation \$	Average Allowances \$	Average bonus paid \$	Average Total remuneration \$
\$200001 to \$250000	2	165,964	28,503	142	20,040	214,649
\$250001 to \$300000	3	210,115	36,955	213	27,580	274,863
\$300001 to \$350000	2	244,316	41,948	578	28,072	314,913
\$350001 to \$400000	0	–	–	–	–	–
Total number of executives	7					

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

Developments and significant events

The Commission is required under subsection 19(1) of the Public Governance, Performance and Accountability Act to inform the responsible Minister and the Finance Minister of any significant decisions or issues that have affected or may affect its operations. In 2016–17, there were no such decisions or issues.

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 contribution to ecologically sustainable developments. The Commission is committed to making a positive contribution to ecological sustainability. The Commission's ecologically sustainable activities are detailed in Appendix B.

Advertising and market research

Section 311A of the *Commonwealth Electoral Act 1918* requires Australian Government departments and agencies to include in their annual reports particulars of any amounts over \$13,000 that were paid to advertising agencies, market research organisations, polling organisations, direct mail organisations or media advertising organisations. The Commission made no such payments over \$13,000 in 2016–17.

National Health Reform Act amendments

No amendments were made to the National Health Reform Act during 2016–17.

Government policy orders

No government policy orders applicable to the Commission were issued in 2016–17.

4



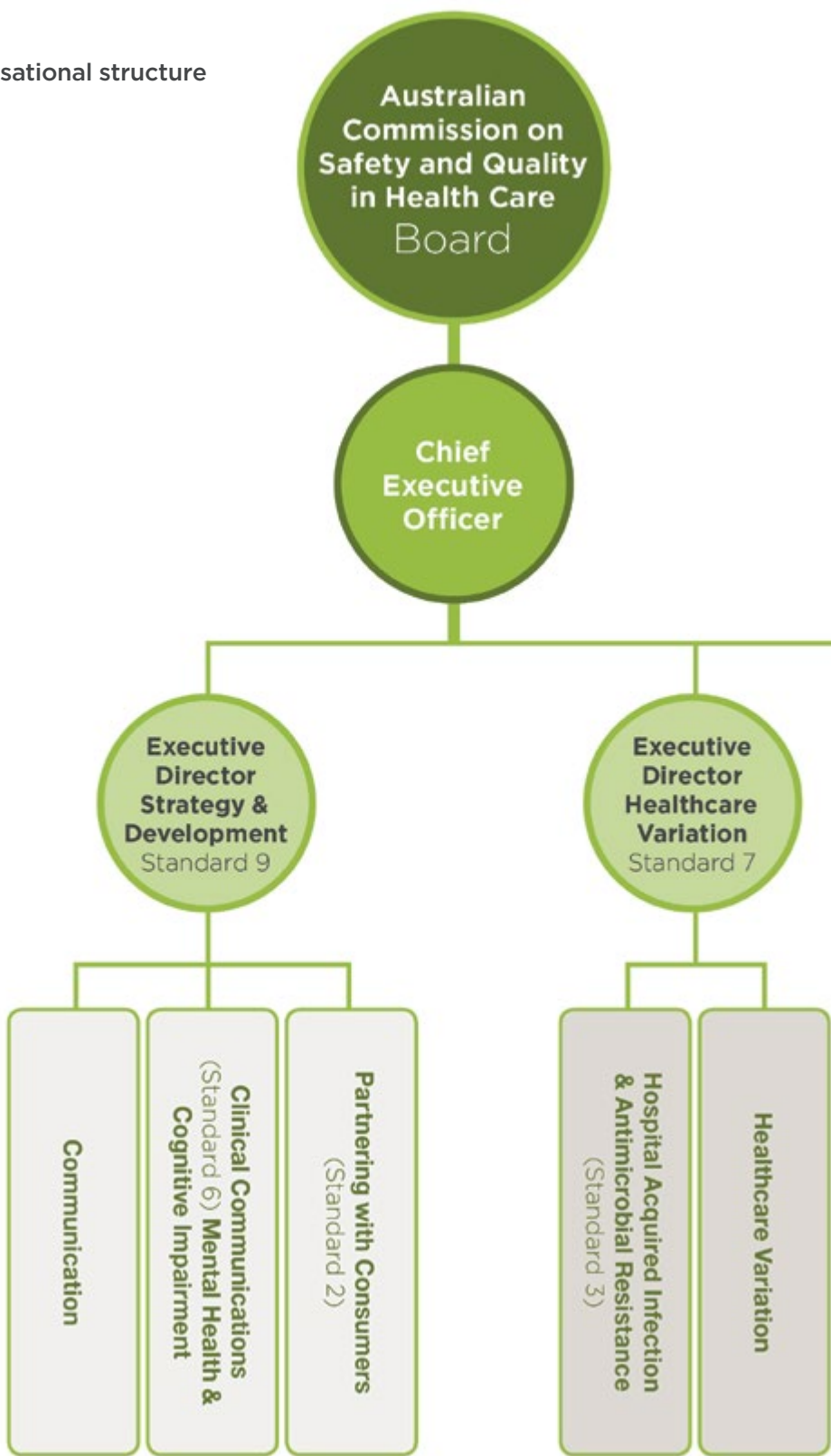
Our organisation

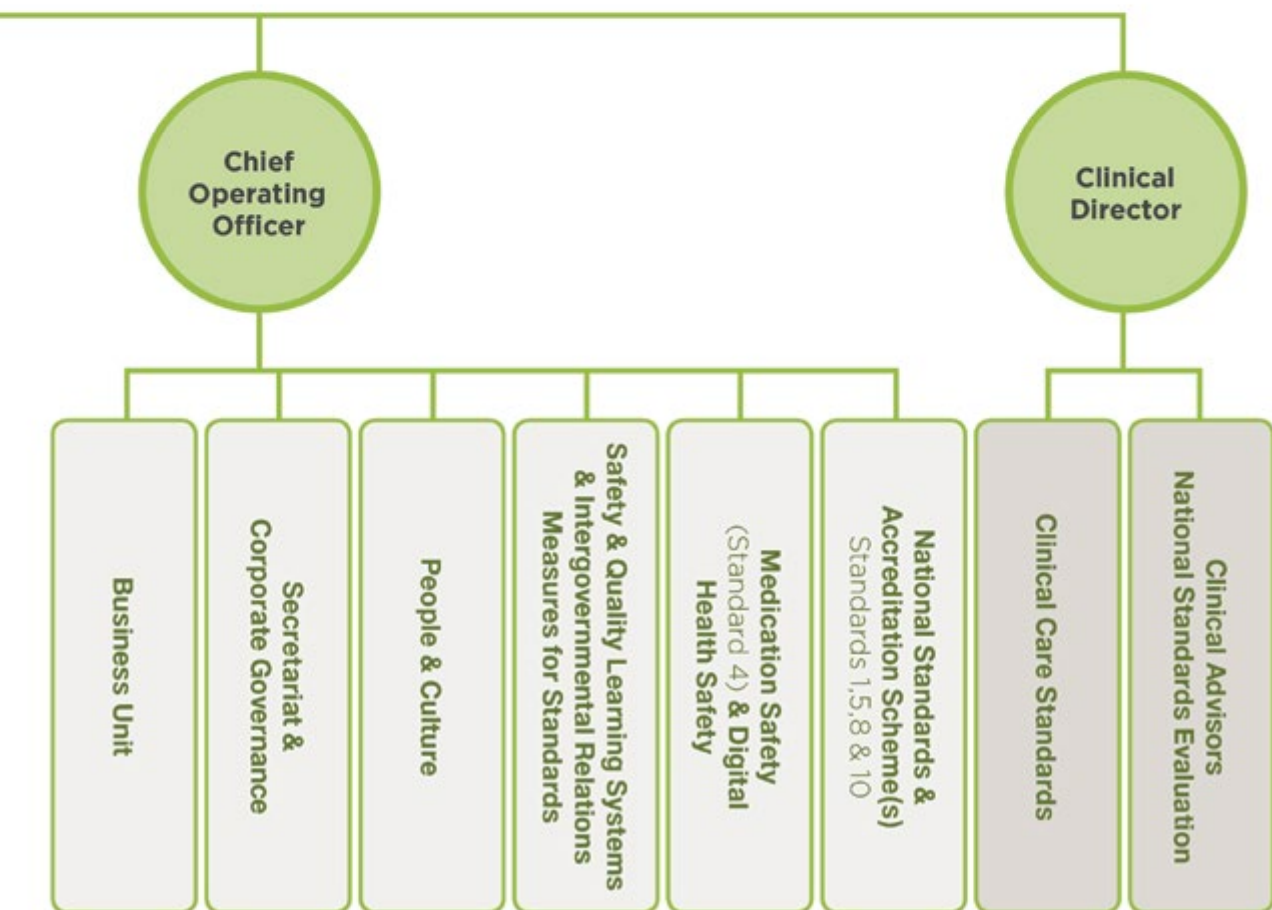
The Commission employs a diverse range of highly skilled professionals with experience across the healthcare industry. Because of the nature of its work, the Commission has a strong national presence in safety and quality in both the public and private sectors.

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

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Figure 2: Organisational structure





People management

The Commission continues to deliver high performance by providing ongoing support through its performance management systems and through embedding a strong sense of direction across the organisation. All employees are required to have an individual performance and development plan in place, and managers and employees have joint accountability for capability and career development.

The Commission participates in the online induction program offered by the Australian Public Service Commission (APSC), giving new employees the opportunity to learn how the Australian Public Service (APS) operates

and understand the behaviours expected of all staff members.

In May 2017, the Commission encouraged all staff members to participate in the APSC’s employee census survey.

Staff profile

As of 30 June 2017, the Commission employed 79.3 full-time equivalent employees. Most employees are located in Sydney. The following table provides a breakdown of the Commission’s employee profile by classification, gender, full-time or part-time status, and ongoing or non-ongoing status.

Table 6: Employee profile as of 30 June 2017

Classification	Female				Male				Total
	Ongoing		Non-ongoing		Ongoing		Non-ongoing		
	Full time	Part time	Full time	Part time	Full time	Part time	Full time	Part time	
CEO			1						1
MO6	1			0.2		0.8		0.5	2.4
EL 2	9.4	2.8	1		5.6	0.6			19.4
EL 1	21.1	3.9	1	2.4	8			0.8	37.2
APS 6	9	1.4	1		2				13.4
APS 5	1				4				5
APS 4	1								1
Total	42.5	8.1	4	2.6	19.6	1.4	0	1.3	79.3

Workplace health and safety

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

In 2016–17, the Commission implemented a revised work health and safety policy, new work health and safety procedures, and a new rehabilitation policy. All new staff members are required to complete work health and safety training as part of their induction.

The Commission undertook a number of activities during 2016–17 aimed at encouraging employees to adopt healthy work and lifestyle practices, including:

- Conducting ergonomic workstation assessments for new staff members and providing access to standing desk solutions
- Conducting biannual workplace inspections and encouraging all staff members to report incidents, accidents or hazards in the workplace
- Appointing new first aid officers, including one trained in mental health first aid
- Appointing new fire wardens
- Providing access to an employee assistance program
- Providing a resilience-building training session for all staff members
- Making influenza vaccinations available to all staff members
- Providing access to reimbursement of eyewear costs for use with screen-based equipment.

There were 11 minor incidents reported in 2016–17. There were no notifiable incidents in 2016–17. No notices were issued to the Commission and no investigations were initiated in 2016–17 under the Work Health and Safety Act.

Learning and development

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

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

During 2016–17, the Commission's study support and training arrangements ensured the ongoing development of staff members' skills and capabilities. Participation in study and training included 18 staff members accessing study support assistance and 38 staff members completing 49 external training courses. Commission staff members are currently undertaking a range of tertiary courses, including Master of Public Health, Master of Health Service Management and Master of Health Policy courses, and various graduate certificates in health-related fields.

Disability strategy

In 2016–17, the Commission revised its workplace diversity program in accordance with APS strategies relating to Indigenous employment, disability employment and gender equality. The program provides a framework that enables the Commission to foster diversity and provide a safe, accessible and supportive working environment for all staff members.

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

During 2016–17, the Commission participated in the APS Disability Champions Network.

Indigenous employment

In 2016–17, the Commission did not meet its Indigenous employment target of 2.5% as it had no employees who identified as Indigenous.

The Commission is committed to improving the recruitment, retention and career development of Indigenous employees. The Commission undertook two recruitment processes for identified Indigenous roles during 2016–17. One role remains vacant while the other was filled through a secondment arrangement.



5



Financial statements

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INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

Opinion

In my opinion, the financial statements of the Australian Commission on Safety and Quality in Health Care for the year ended 30 June 2017:

- (a) comply with Australian Accounting Standards – Reduced Disclosure Requirements and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and
- (b) present fairly the financial position of the Australian Commission on Safety and Quality in Health Care as at 30 June 2017 and its financial performance and cash flows for the year then ended.

The financial statements of the Australian Commission on Safety and Quality in Health Care, which I have audited, comprise the following statements as at 30 June 2017 and for the year then ended:

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

Basis for Opinion

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

Accountability Authority's Responsibility for the Financial Statements

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

Australian National Audit Office



Colin Bienke
Senior Director

Delegate of the Auditor-General

Canberra
15 September 2017

Financial Statements


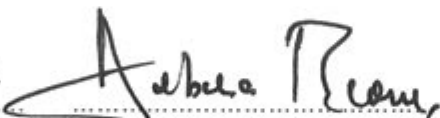

Australian Commission on Safety and Quality in Health Care

Statement by the Directors, Chief Executive and Chief Financial Officer

In our opinion, the attached financial statements for the year ended 30 June 2017 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 Willis Marshall AC Chair	Adj. Professor Debora Picone AM Chief Executive Officer	Mike Wallace Chief Operating Officer / Chief Financial Officer
Date: 13.9.17	Date: 13.9.17	Date: 13.9.17

Statement of Comprehensive Income

for the period ended 30 June 2017

	Notes	2017 \$'000	2016 \$'000	Original Budget 2017 \$'000	
EXPENSES					
Employee benefits	1.1A	12,206	12,179	13,705	^A
Suppliers	1.1B	16,577	14,875	7,727	^B
Depreciation	2.2A	260	138	-	
Total expenses		29,043	27,192	21,432	
LESS:					
OWN-SOURCE INCOME					
Own-source revenue					
Rendering of services	1.2A	10,789	12,408	2,906	^{B,C}
Interest	1.2B	216	353	200	
External contributions	1.2C	7,406	7,190	7,406	
Total own-source revenue		18,411	19,951	10,512	
Gains					
Reversal of provision	1.2D	-	250	-	
Resources received free of charge	1.2E	-	479	-	
Total gains		-	729	-	
Total own-source income		18,411	20,680	10,512	
Net cost of services		10,632	6,512	10,920	^C
Revenue from Government	1.2F	10,920	7,190	10,920	^C
Surplus		288	678	-	
OTHER COMPREHENSIVE INCOME					
Total other comprehensive income (loss)		-	-	-	
Total comprehensive income (loss)		288	678	-	^D

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

Original Budget Compared to 2017 Actual Variance Commentary

Statement of Comprehensive Income

^A Variance due to fewer staff transferring from the National Health Performance Authority (NHPA) to the Commission and also a reduction due to the average staffing level cap imposed by Department of Finance, not expected at the time of preparing the Portfolio Budget Statements (PBS).

^B The budget reflects projects contracted at the time of preparing the PBS. The variance arises due to additional 2016-17 funding and project expenditure for projects contracted subsequent to preparation of the PBS.

^C The PBS records a Grants Received total of \$13.8m. This is comprised in the financial statements as Revenue from Government of \$7.4m and \$3.5m (see note 1.2) and Rendering of Services \$2.9m. The Original Budget has been restated to reflect this.

^D The budget is derived on a break even assumption.

5. Financial statements

Statement of Financial Position

as at 30 June 2017

		2017	2016	Original Budget 2017	
	Notes	\$'000	\$'000	\$'000	
ASSETS					
Financial Assets					
Cash and cash equivalents	2.1A	6,333	10,851	9,089	A, B
Trade and other receivables	2.1B	1,858	2,182	2,838	A
Total financial assets		8,191	13,033	11,927	
Non-Financial Assets					
Property, plant and equipment	2.2A	138	398	44	
Other non-financial assets	2.2B	530	391	207	A
Total non-financial assets		668	789	251	
Total assets		8,859	13,822	12,178	
LIABILITIES					
Payables					
Suppliers	2.3A	1,796	3,031	738	A
Other payables	2.3B	1,773	5,827	7,565	A, B
Total payables		3,569	8,858	8,303	
Provisions					
Employee provisions	3.1	2,576	2,538	1,731	A
Other provisions		-	-	250	
Total provisions		2,576	2,538	1,981	
Total liabilities		6,145	11,396	10,284	
Net assets		2,714	2,426	1,894	
EQUITY					
Contributed equity		1,836	1,836	1,836	
Reserves		5	5	5	
Retained surplus		873	585	53	C
Total equity		2,714	2,426	1,894	

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

Original Budget Compared to 2017 Actual Variance Commentary

Statement of Financial Position

^A The budget reflects projects contracted at the time of preparing the PBS. The variance is due to the increase in actual activity compared to when the PBS was prepared.

^B The variance arises due to the completion in 2016-17 of project work for which funding was received in advance. The completion of projects in 2016-17 has reduced the balance of cash and unearned income.

^C The 2016-17 budget was derived on a break even assumption and an estimated carried forward surplus at the time of budget preparation.

Statement of Changes in Equity

for the period ended 30 June 2017

	2017 \$'000	2016 \$'000	Original Budget 2017 \$'000	
CONTRIBUTED EQUITY				
Opening balance	1,836	1,836	1,836	
Closing balance as at 30 June	1,836	1,836	1,836	
RETAINED EARNINGS / (ACCUMULATED LOSSES)				
Opening balance	585	(93)	53	A
Comprehensive income				
Surplus / (Deficit) for the period	288	678	-	A
Total comprehensive income	873	585	53	A
Closing balance as at 30 June	873	585	53	A
ASSET REVALUATION RESERVE				
Opening balance	5	5	5	
Total comprehensive income	5	5	-	
Closing balance as at 30 June	5	5	5	
TOTAL EQUITY				
Opening balance	2,426	1,748	1,894	A
Comprehensive income				
Surplus for the period	288	678	-	A
Total comprehensive income	2,714	678	-	
Transactions with owners				
Contributions by owners				
Equity injection	-	-	-	
Total transactions with owners	-	-	-	
Closing balance as at 30 June	2,714	2,426	1,894	A

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

Original Budget Compared to 2017 Actual Variance Commentary

Statement of Changes in Equity

^A The 2016-17 budget was derived on a break even assumption and an estimated carried forward surplus at the time of budget preparation.

5. Financial statements

Cash Flow Statement

for the period ended 30 June 2017

	Notes	2017 \$'000	2016 \$'000	Original Budget 2017 \$'000
OPERATING ACTIVITIES				
Cash received				
Receipts from Government		10,920	7,190	10,930
State and Territory contributions		7,406	7,190	7,406
Rendering of services		7,078	9,843	818 ^A
Interest		249	353	200
Net GST received		1,076	818	500 ^A
Total cash received		26,729	25,394	19,854
Cash used				
Employees		(12,137)	(11,972)	(13,705) ^B
Suppliers		(19,110)	(16,812)	(8,149) ^A
Total cash used		(31,247)	(28,784)	(21,854)
Net cash used by operating activities		(4,518)	(3,390)	(2,000)
INVESTING ACTIVITIES				
Cash used				
Purchase of property, plant and equipment		-	(13)	-
Total cash used		-	(13)	-
Net cash used by investing activities		-	(13)	-
Net decrease in cash held		(4,518)	(3,403)	(2,000)
Cash and cash equivalents at the beginning of the reporting period		10,851	14,254	11,089
Cash and cash equivalents at the end of the reporting period	2.1A	6,333	10,851	9,089

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

Original Budget Compared to 2017 Actual Variance Commentary

Cash Flow Statement

^A The budget reflects projects contracted at the time of preparing the PBS. The variance arises due to additional 2016-17 funding and project expenditure for projects contracted subsequent to preparation of the PBS.

^B Variance arises due to fewer staff transferring from the NHPA to the Commission and also a reduction in the average staffing level cap imposed by Department of Finance, not expected at the time of preparing the budget.

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Overview

Objectives of the entity

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

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

The Commission is structured to meet a single outcome:

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

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

Basis of Preparation of the Financial Statements

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

The financial statements have been prepared in accordance with:

- a) *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015* (FRR) for reporting periods ending on or after 1 July 2015; and
- b) Australian Accounting Standards and Interpretations – Reduced Reporting Requirements issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

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

New Accounting Standards

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

Taxation

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

Budget Variances Commentary

The primary statements include commentary on comparisons between the original 2017 budget as presented in the 2016-17 Portfolio Budget Statements (PBS) to the Commission's 2016-17 financial outcome in accordance with Australian Accounting Standards. The budget has not been subject to audit.

1 Financial Performance

2017	2016
\$'000	\$'000

1.1 Expenses

1.1A: Employee Benefits

Wages and salaries	9,076	9,020
Superannuation:		
Defined contribution plans	1,363	1,371
Defined benefit plans	259	241
Leave and other entitlements	1,449	1,442
Other employee benefits	59	105
Total employee benefits	12,206	12,179

1.1B: Suppliers

Goods and services supplied or rendered

Contracts for services	10,672	10,238
Travel	795	956
Information and communication	950	683
Printing and postage	832	474
Property outgoings	424	162
Other	1,371	1,237
Total goods and services supplied or rendered	15,044	13,750

Goods and services supplied or rendered are made up of:

Goods supplied	857	542
Services rendered	14,187	13,208
Total goods and services supplied or rendered	15,044	13,750

Other supplier expenses

Operating lease rentals		
Minimum lease payments	1,306	939
Workers compensation expenses	227	186
Total other supplier expenses	1,533	1,125
Total supplier expenses	16,577	14,875

	2017	2016
	\$'000	\$'000
Leasing commitments		
The Commission has a lease for Level 5 of 255 Elizabeth Street, Sydney.		
The lease is due to expire 31 December 2017.		

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

Within 1 year	644	1,306
Between 1 to 5 years	-	664
More than 5 years	-	-
Total operating lease commitments	644	1,970

Accounting Policy

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

5. Financial statements

2017	2016
\$'000	\$'000

1.2 Income

OWN-SOURCE REVENUE

1.2A: Rendering of Services

Rendering of services	10,789	12,408
Total rendering of services	10,789	12,408

Accounting Policy

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

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

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

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

1.2B: Interest

Deposits	216	353
Total interest	216	353

Accounting Policy

Interest revenue is recognised using the effective interest method.

1.2C: External Contributions

States and Territories contributions	7,406	7,190
Total external contributions	7,406	7,190

GAINS

1.2D: Reversal of provision

Reversal of provision	-	250
Total reversal of provision	-	250

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

2017	2016
\$'000	\$'000

1.2E: Resources received free of charge

Resources received free of charge	-	479
Total other gains	-	479

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

Accounting Policy

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

1.2F: Revenue from Government

Department of Health:

Corporate Commonwealth entity payment item – Australian Health Ministers Advisory Council (AHMAC)	7,406	7,190
Corporate Commonwealth entity payment item – Smaller government measures	3,514	-
Total revenue from Government	10,920	7,190

Accounting Policy

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

2 Financial Position

2017	2016
\$'000	\$'000

2.1 Financial Assets

2.1A: Cash and Cash Equivalents

Cash on hand or on deposit	6,333	10,851
Total cash and cash equivalents	6,333	10,851

2.1B: Trade and Other Receivables

Good and services receivables:

Goods and services	1,434	1,806
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Total goods and services receivable	1,434	1,806
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Other receivables:

Receivable from the Australian Taxation Office	410	320
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Interest	14	47
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Other	-	9
-------	---	---

Total other receivables	424	376
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Total trade and other receivables (gross)	1,858	2,182
--	--------------	--------------

Total trade and other receivables (net)	1,858	2,182
--	--------------	--------------

No receivables were impaired at 30 June 2017 (2016: Nil).

Accounting Policy

Receivables

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

Impairment of Financial Assets

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

2.2 Non-Financial Assets

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

Reconciliation of the opening and closing balances of property, plant and equipment for 2017

	Leasehold improvement \$'000	Plant and equipment \$'000	Total \$'000
As at 1 July 2016			
Gross book value	479	103	582
Accumulated depreciation and impairment	(119)	(65)	(184)
Net book value 1 July 2016	360	38	398
Depreciation expense	(240)	(20)	(260)
Net book value 30 June 2017	120	18	138
Net book value as of 30 June 2017 represented by:			
Gross book value	479	103	582
Accumulated depreciation and impairment	(359)	(85)	(444)
	120	18	138

Leasehold improvements at Level 5, 255 Elizabeth Street previously belonging to the Office of the Fair Work Ombudsman were received free of charge to the Commission on 1 January 2016 and have been recognised at fair value at 30 June 2017.

5. Financial statements

Accounting Policy

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

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the statement of financial position, except for purchases of leasehold improvements costing less than \$50,000 and for all other purchased of property, plant and equipment costing less than \$5,000, which are expensed in the year of acquisition.

Revaluations

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

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

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

Depreciation

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

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

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

Asset Class	2017	2016
Leasehold improvements	Lease term	Lease term
Plant and equipment	5 years	5 years

Impairment

All assets were assessed for impairment at 30 June 2017. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

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

Derecognition

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

Assets acquired at no cost

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

2017	2016
\$'000	\$'000

2.2B: Other Non-Financial Assets

Prepayments	530	391
Total other non-financial assets	530	391

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

2.3: Payables

2.3A: Suppliers

Trade creditors and accruals	1,796	3,031
Total supplier payables	1,796	3,031

Settlement is usually made within 30 days.

2.3B: Other Payables

Salaries and wages	62	36
Superannuation	11	6
Unearned income	1,687	5,770
Other	13	15
Total other payables	1,773	5,827

3 People and Relationships

2017	2016
\$'000	\$'000

3.1 Employee Provisions

Leave	2,576	2,538
Total employee provisions	2,576	2,538

Employee provisions are expected to be settled in:

No more than 12 months	1,513	1,532
More than 12 months	1,063	1,006
Total employee provisions	2,576	2,538

Accounting Policy

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

Leave

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

The liability for long service leave has been determined by reference to the work of an actuary as at 30 June 2017. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Superannuation

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

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

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

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

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

3.2 Key Management Personnel Remuneration

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the Commission, directly or indirectly, including any director (whether executive or otherwise) of the Commission. The Commission has determined the key management personnel to be the Portfolio Minister, Chief Executive Officer, Chief Operating Officer, 5 Senior Medical Officers and 10 Directors. Key management personnel remuneration is reported in the table below:

	2017	2016
	\$'000	\$'000
Short-term employee benefits	1,526	1,469
Post-employment benefits	201	194
Other long-term benefits	132	121
Termination benefits	-	-
Total key management remuneration expenses¹	1,859	1,784

The total number of key management personnel that are included in the above table are 17 (2016: 16). 2 directors included in this number waived their right or were not eligible to receive remuneration during 2017 (2016: 3). The directors of the Commission, including appointments and cessations during the year are listed in note 3.3.

¹The above key management personnel remuneration excludes the remuneration and other benefits of the Portfolio Minister. The Portfolio Minister's remuneration and other benefits are set by the Remuneration Tribunal and are not paid by the Commission.

3.3 Related Party Disclosures

Related party relationships

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

	<u>Commenced</u>	<u>Ceased</u>
Professor Willis Marshall AC (Chair from 1 April 2013)	1/04/2012	
Mr Martin Bowles PSM	14/05/2015	
Professor Phillip Della	1/04/2013	31/03/2017
Christine Gee	1/07/2011	
Ms Wendy Harris QC	24/07/2015	
Dr Shaun Larkin	1/04/2013	
Mrs Cheryle Royle	14/05/2015	
Dr Helena Williams	1/07/2011	
Dr David Filby	29/07/2016	
Professor John Walsh AM	29/07/2016	

Transactions with related parties

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

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

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

- Dr Helena Williams provided project support and expert advice to the Commission. Fees paid by the Commission for these services were \$5,339 (2016: \$1,881).
- A number of directorships expired on 31 March 2016 with several directors receiving reappointment on 29 July 2016. During the period when they were not directors, Dr. Helena Williams (\$1,742) and Christine Gee (\$2,178) attended meetings on behalf of the Commission for which they received fees paid in 2016-17.

4 Managing Uncertainties

4.1 Contingent Assets and Liabilities

Quantifiable Contingencies

As at 30 June 2017, the Commission had no quantifiable contingencies (2015-16: nil).

Unquantifiable Contingencies

As at 30 June 2017, the Commission had no unquantifiable contingencies (2015-16: nil).

Significant Remote Contingencies

As at 30 June 2017, the Commission had no material remote contingencies (2015-16: nil).

4.2 Financial Instruments

	2017	2016
	\$'000	\$'000

4.2A: Categories of financial instruments

Financial assets

Cash on hand and at bank	6,333	10,851
Trade and other receivables	1,448	1,862
Total financial assets	7,781	12,713

Financial liabilities

Financial liabilities measured at amortised cost:

Trade creditors and accruals		
Suppliers	1,796	3,031
Total financial liabilities	1,796	3,031

4.2B: Net gains or losses on financial assets

Interest revenue	216	353
Net gain from financial assets	216	353

Accounting Policy

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

Effective Interest Method

Income is recognised on an effective interest rate basis.

4.3: Fair Value Measurement

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

	Fair value measurement at the end of the reporting period	
	2017 \$'000	2016 \$'000
Non-financial assets		
Leasehold improvements	120	360
Plant and Equipment	18	38
Total non-financial assets	138	398

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



6



Appendices

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Appendix A: Freedom of information summary

The following table summarises the year's freedom of information (FOI) requests and their outcomes, as discussed on page 70.

Table 7: Freedom of information summary 2016–17

Activity	Number
Requests	
On hand as at 1 July 2016	0
New requests received	6
Total requests handled	5
Total requests completed as at 30 June 2017	5
Total requests on hand as at 30 June 2017	0
Action of request	
Access granted in full	2
Access granted in part	1
Access refused	2
Access transferred in full	0
Request withdrawn	1
No records	0
Response times	
0–30 days	6
30–60 days	0
Internal review	
On hand as at 1 July 2017	0
Requests received	2
Decision affirmed	2
Decision amended	0
Request withdrawn	0
Review by the Administrative Appeals Tribunal	
Applications received	0
Review by the Office 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 subsection 516A(6) of the *Environmental Protection and Biodiversity Conservation Act 1999*.

Table 8: Summary of the Commission's compliance with ecologically sustainable development

EPBC Act requirement	Commission response
The activities of the Commission during 2016–17 accord with the principles of ecologically sustainable development	The Commission ensures its decision-making and operational activities mitigate environmental impact, with the principles of ecologically sustainable development embedded in the Commission's approach to its work plan and in corporate, purchasing and operational guidelines.
Outcomes specified for the Commission in an Appropriations Act for 2016–17 contribute to ecologically sustainable development	The Commission's single appropriations outcome focuses on improving safety and quality in health care across the Australian health system. As such, the Commission does not directly contribute to ecologically sustainable development.
The effect of the Commission's activities on the environment are documented	The Commission's offices are located across two 5-star (NABERS rating) buildings, with the Commission working proactively with building management to achieve energy savings where possible. The Commission continues to improve its use of electronic media to disseminate publications, reports and written materials to minimise its printing output.
Measures the Commission is taking to minimise its impact on the environment are identified	<p>The Commission is further reducing its environmental impact by improving its website functionality and increasing its use of multi-channel strategies to distribute information electronically. To reduce travel, the Commission uses remote meeting attendance options where feasible.</p> <p>All staff members and visitors are expected to responsibly use and dispose of materials, as well as responsibly use electricity and water.</p>
Mechanisms for reviewing and increasing the effectiveness of those measures are identified	The Commission has a range of mechanisms for reviewing current practices and policies. In addition, staff members are encouraged to identify behavioural, procedural or policy changes that may reduce their environmental impact, and that of their team and the Commission more broadly.

Appendix C: Related-entity transactions

Table 9: Related-entity transactions during 2016–17

Vendor No.	Commonwealth Entity	Number of Transactions	Transaction Value	Description
100362	Department of Health	11	\$596,225.90	Payments processed in 2016–17 for corporate services received from the Department of Health under a shared services agreement between the Commission and Health



7



Indexes and references

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Acronyms and abbreviations

AC	Companion of the Order of Australia
ACM HSMR	Australian Composite Model Hospital Standardised Mortality Ratio
AHMAC	Australian Health Ministers' Advisory Council
AHSSQA Scheme	Australian Health Service Safety and Quality Accreditation Scheme
AM	Member of the Order of Australia
AMR	Antimicrobial resistance
ANZCA	Australian and New Zealand College of Anaesthetists
AO	Officer of the Order of Australia
APS	Australian Public Service
APSC	Australian Public Service Commission
AU	Antimicrobial use
AURA	Antimicrobial Use and Resistance in Australia
BBus	Bachelor of Business
BHA	Bachelor of Health Administration
BN	Bachelor of Nursing
BSc	Bachelor of Science
CARAlert	National alert system for Critical Antimicrobial Resistances
CHBOI	Core Hospital-Based Outcome Indicators
COAG	Council of Australian Governments
COPD	Chronic obstructive pulmonary disease
CorePEQS	Australian Core Patient Experience Question Set
FACN	Fellow of the Australian College of Nursing
FIAA	Fellow of the Institute of Actuaries of Australia
FRACS	Fellow of the Royal Australasian College of Surgeons
FRACGP	Fellow of the Royal Australian College of General Practitioners

GCPubSecMgmt	Graduate Certificate in Public Sector Management
GDip	Graduate Diploma
HCF	Hospitals Contribution Fund of Australia
IHPA	Independent Hospital Pricing Authority
KPI	Key performance indicator
LLB	Bachelor of Laws
MBA	Master of Business Administration
MBS	Medicare Benefits Schedule
MBBS	Bachelor of Medicine, Bachelor of Surgery
MD	Doctor of Medicine
MHSc	Master of Health Science
NAPS	National Antimicrobial Prescribing Survey
NAUSP	National Antimicrobial Utilisation Surveillance Program
NBCSP	National Bowel Cancer Screening Program
NSQHS Standards	National Safety and Quality Health Service Standards
PBS	Pharmaceutical Benefits Scheme
PhD	Doctor of Philosophy
PSM	Public Service Medal
RACGP	Royal Australian College of General Practitioners
RM	Registered midwife
RN	Registered nurse
RPBS	Repatriation Pharmaceutical Benefits Scheme

Glossary

Accreditation	A status that is conferred on an organisation or individual when they have been assessed as having met particular standards. The two conditions for accreditation are compliance with an explicit definition of quality (that is, a standard) and passing an independent review process aimed at identifying the level of congruence between practices and quality standards.
Adverse event	An incident that results in harm to a patient or consumer.
Antimicrobial	A chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts and moulds. ³
Antimicrobial resistance	A property of organisms – including bacteria, viruses, fungi and parasites – that allows them to grow or survive in the presence of antimicrobial levels that would normally suppress growth or kill susceptible organisms. ³
Antimicrobial stewardship	A program implemented in a health service organisation to reduce the risks associated with increasing antimicrobial resistance, and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies, including monitoring and reviewing antimicrobial use. ³
Clinical care standards	Standards developed by the Commission and endorsed by health ministers that identify and define the care people should expect to be offered or receive for specific conditions.
Clinical communication	The exchange of information about a person's care that occurs between treating clinicians, the patient and members of a multidisciplinary team. Communication can take different forms, including face-to-face or electronic communication, or communication via telephone, written notes or other documentation.
Clinical governance	The set of relationships and responsibilities established by a health service organisation between its department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care and continuously improve services.
Clinical handover	The transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. ⁴
Clinician	A healthcare provider, trained as a health professional. Clinicians include registered and non-registered practitioners, or teams of health professionals, who spend the majority of their time delivering direct clinical care.

Cognitive impairment	Deficits in one or more of the areas of memory, communication, attention, thinking and judgement. Cognitive impairment can be temporary or permanent, and can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Dementia and delirium are common forms of cognitive impairment seen in hospitalised older patients. ⁵ Cognitive impairment can also be caused by a range of other conditions, such as an acquired brain injury, a stroke, intellectual disability or drug use.
Consumers	A person who has used, or may potentially use, health services. A healthcare consumer may also act as a consumer representative to provide a consumer perspective, contribute consumer experiences, advocate for the interests of current and potential health service users, and take part in decision-making processes. ⁶
Core Hospital-Based Outcome Indicators (CHBOI)	A succinct set of indicators that hospitals routinely monitor and review. These hospital-based outcome indicators can be generated by state or territory health authorities or private hospital owners that hold the source data and reported back to the facilities that provide healthcare services.
Delirium	An acute disturbance of consciousness, attention, cognition and perception that tends to fluctuate during the course of the day. Delirium is a serious condition that can be prevented in 30–40% of cases, and should be treated promptly and appropriately. Hospitalised older people with existing dementia are at the greatest risk of developing delirium. Delirium can be hyperactive (the person has heightened arousal, or can be restless, agitated and aggressive) or hypoactive (the person is withdrawn, quiet and sleepy). ⁷
Electronic medication management system	Enables medicines to be prescribed, dispensed, administered and reconciled electronically.
End of life	The period when a patient is living with, and impaired by, a fatal condition, even if the trajectory is ambiguous or unknown. This period may be years in the case of patients with chronic or malignant disease, or very brief in the case of patients who suffer acute and unexpected illnesses or events such as sepsis, stroke or trauma. ⁸
Hand hygiene	A general term referring to any hand-cleansing action.
Healthcare variation	This occurs where patients with the same condition receive different types of care. For example, among a group of patients with the same condition, some may have no active treatment, some may be treated in the community and others in hospital, and some may have surgery while others receive medication. Some variation in how health care is provided is desirable because of differences in patients' needs, wants and preferences (see 'unwarranted healthcare variation').

7. Indexes and references

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. ⁹
Medication chart	A chart used by an authorised prescriber to record medication and treatment orders, as well as by nursing staff to record and monitor the administration of such medicines and treatment.
My Health Record	A secure online summary of a consumer's health information, managed by the System Operator of the national e-health record system (the Secretary to the Australian Government Department of Health). Healthcare providers are able to share health records to a consumer's My Health Record, in accordance with the consumer's access controls. This may include information such as medical history and treatments, diagnoses, medications and allergies. Also known as a Personally Controlled Electronic Health Record.
National Safety and Quality Health Service (NSQHS) Standards	Standards developed by the Commission in consultation and collaboration with states and territories, technical experts, health service organisations and patients. The NSQHS Standards aim to protect the public from harm, and to improve the quality of health services. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum safety and quality standards are met, and a quality improvement mechanism that allows health service organisations to realise aspirational or developmental goals.
Partnering with consumers	Treating consumers and/or carers with dignity and respect, communicating and sharing information between consumers and/or carers and health service organisations, encouraging and supporting consumers' participation in decision-making, and fostering collaboration between consumers and/or carers and health service organisations in planning, designing, delivering and evaluating health care. Other terms are used internationally, such as patient-based, consumer-centred, person-centred, relationship-based, patient-centred, and patient- and family-centred care.
Patient	A person receiving health care. Synonyms for 'patient' include 'consumer' and 'client'.
Patient safety	Reducing the risk of unnecessary harm associated with health care to an acceptable minimum.
Shared decision making	The integration of a patient's values, goals and concerns with the best available evidence about the benefits, risks and uncertainties of treatment to achieve appropriate healthcare decisions. ¹⁰
Standard	Agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.
Unwarranted healthcare variation	Variation not attributed to a patient's needs, wants or preferences. It may reflect differences in clinicians' practices, the organisation of health care or people's access to services. It may also reflect poor-quality care that is not in accordance with evidence-based practice.

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

Mandatory reporting orders as required under legislation

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Amendments to the Commission's enabling legislation, and to any other legislation directly relevant to its operation	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule, subsection 17BE(a)	71
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Assessment of the impact of the performance of each of the Commission's functions	National Health Reform Act, subsection 53(a)	16–57
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Enabling legislation, functions and objectives	Public Governance, Performance and Accountability Amendment (Corporate Commonwealth Entity Annual Reporting) Rule, subsection 17BE(a)	6, 60

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