AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

# Annual Report 2012/13

© Commonwealth of Australia 2013

This work is copyright. It may be reproduced in whole or in part for study or training purposes, subject to the inclusion of an acknowledgement of the source.

Address requests and inquiries concerning reproduction and rights for purposes other than those indicated above in writing to:

Erica Hall Communications Coordinator Australian Commission on Safety and Quality in Health Care GPO Box 5480 Sydney NSW 2001

Or email mail@safetyandquality.gov.au.

Suggested citation: Australian Commission on Safety and Quality in Health Care, *Annual Report 2012/13*. Sydney. ACSQHC, 2013.

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

ISSN 2200-3126 (Print) ISSN 2202 7777 (Online)

ABN 97 250 687 371

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

The Hon. Peter Dutton 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 2013.

The report reflects the requirements of the *National Health Reform Act 2011* and section 9 of the *Commonwealth Authorities and Companies Act 1997* (CAC Act).

The report and the audited financial statements were prepared in accordance with the Commonwealth Authorities and Companies Orders (Financial Statements for reporting periods ending on or after on or after 1 July 2011), made by the Finance Minister under the authority of section 48 of the CAC Act.

This report was approved for presentation to you in accordance with a resolution of the Commission's Board on 18 September 2013.

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

Yours sincerely

When Many heele .

Professor Villis Marshall AC Chair Australian Commission on Safety and Quality in Health Care 20 September 2013

Т

## Contents

This annual report was prepared and submitted in accordance with parliamentary reporting and legislative requirements. It provides an overview of the Australian Commission on Safety and Quality in Health Care's operations and performance for the financial year ending 30 June 2013.

Le	etter of transmittal	I
<u>1.</u>	Overview About the Commission	<b>1</b> 2
	Highlights 2012/13	4
	Welcome from the Chair	6
	Report from the CEO	8
2.	Our work	11
	Our work priorities	12
	National safety and quality standards and accreditation	13
	Supporting quality practice and clinical standards	20
	Data set development	30
	Publishing and reporting	33
	Knowledge and leadership in safety and quality	36
3.	Assessment of safety and quality in health care	41
	A systems-based approach to improving safety and quality	42
	Consumers, patients, families and carers are at the centre of health care	43
	Supporting consumers to get the right care	44
	Measuring the safety and quality of care	44
4.	Corporate governance and accountability	45
	Legislation and requirements	46
	Strategic planning	46
	Ministerial Directions	46
	Commission Board	47
	Committees	53
	Internal governance arrangements	55
	External scrutiny	56
	Developments and significant events	57
	Environmental performance and ecologically sustainable development	57
	National Health Reform Act amendments	57

5. Our organisation	59
Organisational structure	60
People management	62
Staff profile	62
Non-salary benefits	63
Workplace health and safety	63
Learning and development Disability strategy	64 64
	04
6. Financial statements	65
Independent auditor's report	66
Statement by the Directors, Chief Executive Officer and Chief Financial Officer	68
Statement of comprehensive income	69
Balance sheet	70
Statement of changes in equity Cash flow statement	71 72
Schedule of commitments	72
Notes to and forming part of the Financial Statements for the	10
period ended 30 June 2013	75
7. Appendices	99
Appendix A: Publications	100
Appendix B: Published articles	104
Appendix C: Engagement in research	105
Appendix D: Event sponsorship	112
Appendix E: External representations	113
Appendix F: Formal consultations	115
Appendix G: Freedom of Information summary Appendix H: Compliance to ecologically sustainable development	117 118
	110
8. Indexes and references	119
Acronyms and abbreviations	120
Glossary	121
Index of tables	126
Compliance index	127
Index References	129 138
	130



## Overview

About the Commission	2
Highlights 2012/13	4
Welcome from the Chair	6
Report from the CEO	8

## About the Commission

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

### Our mission

To lead and coordinate national improvements in the safety and quality of health care.

### Our vision

A health system that is informed, supported and organised to deliver safe and high-quality health care, which contributes to:

- better experiences for patients and consumers
- better health outcomes for the population
- improved productivity, and
- greater sustainability.

### Our role

The Council of Australian Governments established the Commission to lead and coordinate national improvements in the safety and quality of health care. Our role is to provide health ministers with strategic advice on best practices to improve safety and quality in the health system. The Commission develops and supports national safety and clinical standards; formulates and implements national accreditation schemes; and develops national health-related data sets. We are also working on reducing unwarranted variations in practice and outcomes for individuals and populations, and undertaking nationally coordinated action to address healthcare associated infections. and antimicrobial resistance.

The National Health Reform Act 2011 specifies the Commission's roles and responsibilities as a permanent independent authority under the *Commonwealth Authorities and Companies Act 1997* (CAC Act). For details of the Commission's specific functions under section 9 of the National Health Reform *Act 2011* see page 12.

#### Overview

1

### Our values

The Commission values close, collaborative relationships with our partners from across the healthcare sector. These partners include consumers, healthcare providers, governments, and other healthcare organisations and agencies.

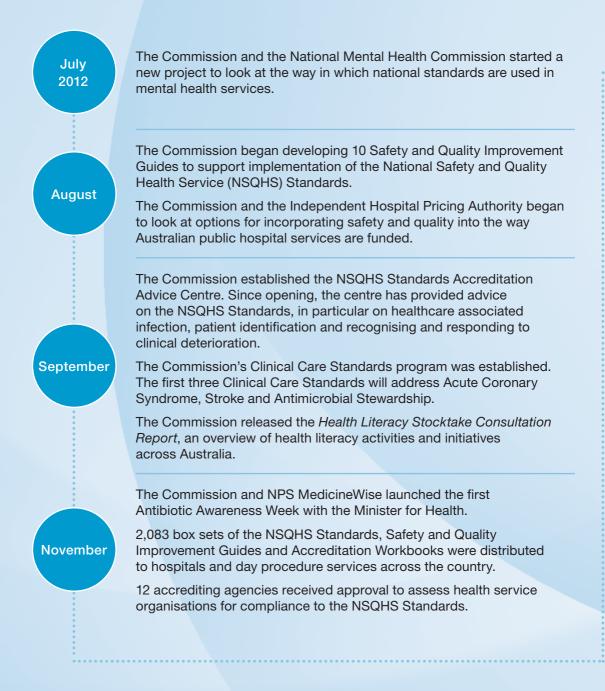
The Commission and its people act with independence, transparency, fairness, respect, accuracy and accountability. We are committed to producing high-quality work, making ongoing improvements and enhancing a supportive work culture.

### Our accountability

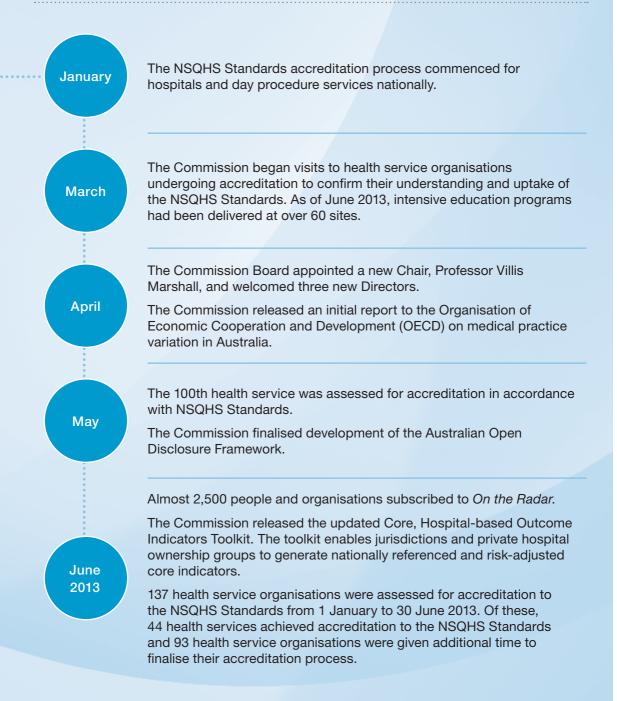
As a statutory authority of the Australian Government, the Commission is accountable to the Parliament and the Minister for Health, the Honourable Peter Dutton MP, for our performance in achieving the outcomes of our agreed work plan and priorities. The Honourable Tanya Plibersek MP was the Minister for Health and the Commission's responsible Minister during the 2012/13 reporting period.



## Highlights 2012/13







Overview ....



## Welcome from the Chair

Professor Villis Marshall AC

Lapses in the safety and quality of health care have enormous costs, in terms of the effects on people's lives and the financial costs for health service organisations. At least one in every seven dollars spent on hospital care is from injuries or illnesses acquired in hospitals. For example, it is estimated that hospital-acquired infections add a total of 850,000 bed days to Australian hospital stays each year.<sup>1</sup>

While not all lapses can be prevented, a systemic improvement in the safety and quality of health care can improve patient outcomes, reduce costs and increase capacity.<sup>2</sup>

All health systems – irrespective of their structure or financing model – face major challenges in ensuring the delivery of safe and high-quality care. The Australian Government aims to improve the long-term capacity, quality and safety of Australia's healthcare system. This will be achieved in part through the Commission's work.

In 2012/13, the Commission made significant progress towards its vision for a health system that is better informed, supported and organised, and which delivers safe and high-quality care. Some highlights for 2012/13 included:

#### **NSQHS Standards**

This year, the Commission oversaw the implementation of National Safety and Quality Health Service (NSQHS) Standards and the national accreditation process. The Commission invested considerable resources to help health service organisations achieve accreditation, including producing implementation guides and workbooks, and establishing a dedicated Accreditation Advice Centre.

#### **Clinical Care Standards**

The Commission also started developing a set of Clinical Care Standards. Being developed in consultation with healthcare providers and consumers, the Clinical Care Standards aim to improve patient outcomes and experiences, and ensure health care is safe and appropriate. The Clinical Care Standards will also promote shared decision making between patients and clinicians.

After a broad consultation process, the Commission selected acute coronary syndrome, stroke and antimicrobial stewardship as the first practice areas to be addressed. In 2013, the Commission began developing a set of Clinical Care Standards for each of these areas.

··· Overview

#### International and national collaborations

In 2012/13, the Commission embarked on several collaborative projects with national and international organisations. One of these is a project with the Independent Hospital Pricing Authority (IHPA). The Commission and the IHPA have been working together to investigate options for including safety and quality in the pricing model for Australian public hospital services.

The Commission is also coordinating Australia's participation in a medical practice variations study the Organisation for Economic Co-operation and Development (OECD) is undertaking. Australia is one of 13 countries involved in the study.

#### Acknowledgements

In April 2013, the Board farewelled its longstanding Chair, Bill Beerworth. I would like to thank Mr Beerworth for his invaluable contributions to the Commission since his appointment in 2006. I would also like to thank Board Directors Veronica Casey and Richard Bowden, whose terms also ended in 2012/13. The Board has welcomed three new members: Professor Phillip Della, the Honourable Verity Firth and Dr Shaun Larkin. They each bring a wealth of experience to the Board and I look forward to working with them over the next year.

I would like to take this opportunity to thank the Standing Council on Health, Board members, the Commission's Executive Management team and staff members for their continued commitment to the Commission's vision. Their significant achievements are described in detail throughout this annual report. Overview ....



### Report from the CEO

Professor Debora Picone AM

The end of 2012/13 marked the Commission's second anniversary as an independent statutory corporation.

It was another busy and successful year, during which the Commission further developed its planning and governance frameworks, and expanded its work programs.

Some key areas of work included:

#### Strategic planning

In February 2013, health ministers endorsed the Commission's first three-year rolling work plan, as mandated under the *National Health Reform Act 2011*. The Work Plan 2013–2016 sets out the Commission's priorities and deliverables for the period.

## Implementation of the National Safety and Quality Health Service Standards

From January 2013, accreditation to the NSQHS Standards began for hospitals and day procedure services. Health service organisations have been supportive of the NSQHS Standards and the accreditation process. Early reports indicate the NSQHS Standards have had a positive effect on safety and quality across acute health care. The success of the implementation of the NSQHS Standards can be attributed in part to the considerable support the Commission has provided to health service organisations of all sizes. The Commission produced implementation guides and resources, as well as monitoring and reporting tools, and provided accreditation advice, network coordination and mediation services.

The successful implementation of the NSQHS Standards also depended on the partnership between the federal, state and territory health systems and the private sector. Everyone has been very committed to working towards improving patient safety.

#### Reducing antimicrobial resistance

The issue of antimicrobial resistance has continued to increase in profile. In November 2012, the Commission was involved in the first Australian Antibiotic Awareness Week. The event provided a significant opportunity to promote the appropriate use of antibiotics to healthcare providers and the community on a national scale.

····· Overview

In March 2013, the Australian Antimicrobial Resistance Prevention and Containment (AMRPC) Steering Group was established. The AMRPC Steering Group will provide governance and leadership on antimicrobial resistance, and oversee the development and implementation of a national framework for work related to antimicrobial resistance.

Professor Jane Halton, the Secretary of the Department of Health and a Commission Board member, shares the role of Chair of the AMRPC Steering Group with the Secretary of the Department of Agriculture.

#### Future work

The Commission will continue to support the implementation of the NSQHS Standards and coordinate the Australian Health Services Safety and Quality Accreditation Scheme. The Commission will evaluate the impact of the NSQHS Standards in 2015.

In all its work programs, the Commission will continue to ensure that consumers, patients, families and carers are at the centre of improvements in the safety and quality of health care. The Commission aims to ensure that its work is informed by the experience of consumers, and is relevant to them.

The Commission will also seek to build on successful programs undertaken by states, territories, private hospital and primary care sectors, and consumer organisations.

#### Acknowledgements

In April 2013, Professor Villis Marshall AC was appointed as Chair of the Commission's Board. I would like to congratulate Professor Marshall on his appointment, and thank our inaugural Chair, Bill Beerworth, for his leadership during his tenure.

I would also like to acknowledge and thank the Standing Council on Health, jurisdictional Chief Executives, the Department of Health and Ageing, the Commission's Board, Inter-Jurisdictional Committee and our many committee members for contributing their insight and expertise to the Commission's work.

Finally, I would like to acknowledge the commitment of the Commission's staff members – their hard work throughout the year is reflected in the achievements presented in this report.



## Our work

Our work priorities	
National safety and quality standards and accreditation	13
Supporting quality practice and clinical standards	20
Data set development	30
Publishing and reporting	33
Knowledge and leadership in safety and quality	36

## Our work priorities

The Commission leads and coordinates improvements in the safety and quality of health care in Australia by identifying issues and policy directions, and recommending priority areas for action.

Section 9 of the *National Health Reform Act 2011* details the Commission's specific functions as:

- 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, and
- publishing reports and papers relating to healthcare safety and quality matters.

There were no changes to the *National Health Reform Act 2011* or the Commission's legislative functions during the 2012/13 financial year.

In line with these functions – as well as those spelt out in the *National Health Reform Agreement* signed by the state, territory and Australian governments, and the work that health ministers identified for the Commission, including the Australian Safety and Quality Goals for Health Care – the Commission set the following work priorities for 2012/13:

- 1. Develop and maintain national safety and clinical standards.
- 2. Formulate national accreditation schemes.
- 3. Develop a national dataset.
- 4. Undertake publishing and reporting.
- 5. Share knowledge and assume a leadership role on safety and quality in health care.

The projects and deliverables for each of these priority areas are detailed in the following pages.

# National safety and quality standards and accreditation

At the request of health ministers, the Commission developed ten National Safety and Quality Health Service (NSQHS) Standards in collaboration with healthcare providers, consumers and governments. The health ministers endorsed these standards in 2011. The Commission is supporting the use of the NSQHS Standards by developing and promoting resources that facilitate their implementation.

The Commission is providing national coordination of accreditation reforms for health system regulators, accrediting agencies and health services. This involves implementing accreditation reforms in line with the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme.

The Commission has started a new body of work to help mental health service providers apply safety and quality standards in mental healthcare settings.

In addition, the Commission is developing national Clinical Care Standards to improve patient care outcomes. The Commission is progressing this for the priority areas identified in the Australian Safety and Quality Goals for Health Care to improve patient care.

Finally, the Commission is finalising its commitment to the Australian Health Ministers' Advisory Council (AHMAC) to develop national standards for clinical quality registries.

# Implementing the NSQHS Standards

The aim of the NSQHS Standards accreditation process is to promote and support safe patient care and quality improvements across all care settings. The NSQHS Standards focus on areas where harm occurs to patients; where there are variations in practice; and where there is evidence that interventions make a difference to care.

The NSQHS Standards provide a framework for health services to improve patient care, and to implement relevant safety and quality systems. The NSQHS Standards are integral for accrediting Australian hospitals and day procedure services, as they determine how, and against what standards, a health service's performance will be assessed. The ten standards are:

- **Standard 1**: Governance for Safety and Quality in Health Service Organisations
- Standard 2: Partnering with Consumers
- **Standard 3**: Preventing and Controlling Healthcare-Associated Infections
- Standard 4: Medication Safety
- **Standard 5**: Patient Identification and Procedure Matching
- Standard 6: Clinical Handover
- Standard 7: Blood and Blood Products
- **Standard 8**: Preventing and Managing Pressure Injuries
- **Standard 9**: Recognising and Responding to Clinical Deterioration in Acute Health Care, and
- **Standard 10**: Preventing Falls and Harm from Falls.

The Commission has produced a suite of resources to support implementation of the NSQHS Standards. In November 2012, the Commission published ten Safety and Quality Improvement Guides, one for each NSQHS Standard. To support small health services, the Commission also developed a Guide for Small Hospitals.

The guides were designed to help health service organisations align their quality improvement programs with the NSQHS Standards framework. They provide examples of strategies and resources that can be applied on a local scale.

The Commission also developed a Hospital Accreditation Workbook and Day Procedure Services Accreditation Workbook to guide and support health service organisations through the accreditation process.

To facilitate and enhance uptake of the NSQHS Standards, the Commission distributed 2,083 hard copies of the NSQHS Standards and 1,804 Safety and Quality Improvement Guides to health service organisations throughout Australia. Boxed sets – including the NSQHS Standards, guides and other resources – were distributed to every hospital and day procedure service in the country. States and territories have also reproduced and distributed copies of the NSQHS Standards.

To achieve a shared understanding of the purpose of the NSQHS Standards, the Commission delivered presentations to health service organisations, jurisdictions, healthcare associations and industry groups. The Commission's representatives made presentations at over 50 meetings and conferences throughout 2012/13. The Commission's web site is also an important resource, providing healthcare providers with timely access to information, tools and resources. The NSQHS Standards and Accreditation homepage received more than 66,000 hits during 2012/13. The NSQHS Standards document was downloaded more than 16,000 times.

Hospitals and day procedure services started the accreditation process on 1 January 2013. Over 1,340 public and private hospitals and day procedure services are required to be assessed by 2016, as determined by the schedule set by health service organisations.

The Commission is beginning a program of work with researchers from the University of Newcastle to evaluate the impact of the NSQHS Standards on patient outcomes and patients' perceptions of care.

#### Key achievements 2012/13

2,083 copies of NSQHS Standards distributed

**1,804** copies of Safety and Quality Improvement Guides distributed

More than **16,000** downloads of the NSQHS Standards from the Commission's web site

#### ··· Our work 🔽



#### Supporting implementation

The Commission established the NSQHS Standards Accreditation Advice Centre in September 2012 to guide and support health service organisations, surveyors and accrediting agencies.

As at 30 June 2013, the Advice Centre had received more than 1,240 requests for information. The most frequent queries related to individual standards and their requirements (most commonly NSQHS Standards 3, 5 and 9). Users also requested implementation resources, particularly high-resolution images of the NSQHS Standards icons for reproduction in service-specific documents and materials.

The Advice Centre also coordinated network meetings to provide information to address local implementation issues. The Commission convened more than 30 online network meetings with approximately 500 healthcare representatives. The meetings were particularly useful in helping small healthcare services to better understand the NSQHS Standards.

The Commission also provided a mediation service to resolve issues during the assessment process. Mediation involves an onsite meeting between the Commission, a health service organisation and a surveyor. As at 30 June 2013, mediation had been sought by eight health service organisations being surveyed.

#### Implementation progress

The Commission has introduced a number of flexible arrangements to help health service organisations achieve accreditation to the NSQHS Standards. These include giving health service organisations additional time to address any actions that were identified as needing attention during initial assessment; specifying minimum requirements for seven core actions during 2013; and reducing the number of requirements for health service organisations undertaking mid-cycle assessment or periodic review in 2013. The Commission also identified developmental targets that health service organisations must show they are gradually adopting.

As at 30 June 2013, 137 health service organisations had undergone an accreditation assessment. Of these:

- 49 health service organisations had an organisation-wide assessment against Standards 1 to 10
- 87 health service organisations underwent a mid-cycle assessment against Standards 1 to 3
- 44 health service organisations achieved accreditation to the NSQHS Standards, and
- 93 health service organisations were given 120 days to make improvements needed to achieve accreditation.

#### Key achievements 2012/13

**137** health service organisations assessed for accreditation from 1 January to 30 June 2013 **44** health service organisations achieved accreditation and 93 were given additional time to finalise their accreditation Our work

### AHSSQA Scheme

The Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme builds on the strengths of current accreditation arrangements and provides national coordination of accreditation processes.

The Commission coordinates the AHSSQA Scheme and provides support to state and territory health departments that regulate the AHSSQA Scheme. The Commission has worked collaboratively with jurisdictions, health service organisations and accrediting agencies to implement the AHSSQA Scheme. This has included support for states and territories as they align their policies, procedures and reporting systems to the NSQHS Standards.

Queensland, South Australia, Tasmania, Western Australia and Victoria have released policy statements or frameworks that describe their jurisdiction's requirements and regulatory response. Other jurisdictions are developing similar directives.

In 2012/13, the Commission approved 12 accrediting agencies to assess health service organisations for compliance with NSQHS Standards. The Commission held two workshops with accrediting agencies to discuss the intent of the NSQHS Standards and helped to train their surveyors.

Accrediting agencies are required to provide regulators and the Commission with information on the outcome of assessments. The Commission is working with the Department of Health's Enterprise Data Warehouse team to build secure systems to collect, store and report on assessment data. The process of informing health services and establishing collection systems and tools is underway. While the Commission will collect data on 2013 accreditation assessments, the data warehouse reporting functions are not expected to be fully operational until the end of 2013.

Effective systems support healthcare providers and improve patient experiences. The NSQHS Standards provide the focus and framework for improving the safety and quality of health care.

## Evaluating the impact of the NSQHS Standards

The Department of Health is funding the Commission to research the impacts of the NSQHS Standards. This project began in the fourth quarter of the 2012/13 financial year.

This research will examine:

- the impact of the NSQHS Standards on clinical incident reporting and management, and
- patient and carer perceptions of care in the context of the NSQHS Standards.

The Commission will gather research data until 2015. The Commission will obtain advice from advisory groups, health service organisations and jurisdictions on the safety and quality impacts of the NSQHS Standards as they implement the AHSSQA Scheme.

···· Our work 🔽

#### Feedback from health service organisations on the NSQHS Standards:



"I would like to compliment the Commission on producing the safety and quality standards, in particular the medication safety standard. It was great for us as a pharmacy department (and an institution) to be able to articulate in a much more meaningful way the work that we do to improve medication safety for our patients. There were excellent resources to use and tips as to the types of evidence to use as examples. Well done!"

#### Pharmacist Consultant, Public Hospital

"Since the implementation of the NSQHS Standards, we have observed improved incident review systems. Incidents were always reviewed; however, the process was difficult to track. Audits are now more comprehensive. Documentation has also improved and healthcare providers are more involved in quality and risk."

Safety and Quality Manager, Private Hospital

### **Clinical Care Standards**

In September 2012, the Commission began developing the Clinical Care Standards program.

The program aims to reduce unwarranted variation in health care, ensure appropriate clinical care is provided, improve patient experiences, and enable decision making to be shared between consumers and healthcare providers.

A Clinical Care Standard is a set of quality statements that describe key components of clinical care a person should be offered for a specific clinical condition or defined part of a patient journey. Indicators, which enable health service organisations to support quality improvement at the local level, will accompany each of the quality statements.

The Commission has established working groups comprising consumers, clinicians and other healthcare experts to develop the initial sets of Clinical Care Standards in the areas of acute coronary syndrome, stroke and antimicrobial stewardship. The Commission has also set up an advisory committee to provide direction on developing and implementing the Clinical Care Standards.

The Commission will release the draft Clinical Care Standards for acute coronary syndrome, stroke and antimicrobial stewardship for public consultation at the end of 2013. This body of work will continue during 2013/14 and 2014/15 as the Commission continues to develop new Clinical Care Standards for priority areas. The Commission will work with consumer and healthcare provider groups to establish the first set of Clinical Care Standards, and will develop resources and tools to support their implementation.

Clinical Care Standards will be able to be applied in all settings of care including the acute, primary care and community sectors. Our work

# National standards for mental health services

The Commission has undertaken a number of initiatives to support the implementation of national standards in mental healthcare settings. This work has included developing networks and links with other agencies.

In collaboration with the Department of Health and Ageing, and the Safety and Quality Partnership Standing Committee (Mental Health and Drug and Alcohol Principal Committee), the Commission undertook a project to map the NSQHS Standards and National Standards for Mental Health Services (developed by the Mental Health Commission in 2011).

The project identified areas of duplication and difference between the two sets of standards. This work provided the basis for a Consultation Draft Accreditation Workbook, which was developed to help mental health services implement – and understand if they were meeting – the requirements of both sets of standards. The Commission is revising the workbook based on feedback from users. The updated workbook will be released in 2013/14.

In January 2013, the Commission commenced a scoping study with the National Mental Health Commission on implementation of the two sets of standards. The study aims to find out the current level of uptake of the two sets of standards in the public, private and community sectors. The study also aims to identify the enablers, barriers and challenges for implementation. The study will also identify any gaps in the standards' frameworks with respect to safety and quality.

The Commission conducted an online survey of mental health service providers and consumers in May 2013, attracting 425 respondents. The next phase of the study involves holding discussions with focus groups nationwide from July to September 2013.

#### 🗉 Our work 🖊

### 2

# National clinical quality registries

Australia currently has limited capacity to measure and monitor the degree to which health care benefits the patient, and how closely the care provided aligns with evidence-based practice. Developing standardised national registries of clinical quality is a cost-effective way to address this limitation.

Clinical quality registries are clinical databases that routinely collect, analyse and report on patient-related information to help improve the quality and safety of health care. In particular, clinical quality registries provide specific information about:

- the appropriateness of health care (whether the care delivered to patients is based on the best available evidence), and
- the effectiveness of health care, measured by the degree to which the care benefits the patient.

Clinical quality registries improve on current models that measure historical data using research, by reporting on the quality of health care in a timely manner. However, few registries achieve national coverage and most operate under research arrangements, with mixed buy-in from health system funders and operators.

The Commission has been developing national arrangements for clinical quality registries based on national Operating Principles and Technical Standards. The registries will enhance national reporting on the appropriateness and effectiveness of health care. In November 2012, the National Health Information and Performance Principal Committee and the Commission's Board endorsed the Commission's proposed national arrangements for clinical quality registries. The proposed arrangements – underpinned by technical, operational and accreditation models and a costed infrastructure plan – will be presented to AHMAC during 2013/14.



# Supporting quality practice and clinical standards

The Commission has undertaken a range of programs and initiatives during the 2012/13 financial year to support high-quality clinical practice. While the development of specific Clinical Care Standards (detailed on page 17) became a priority this year, the Commission has ongoing work for other clinical areas. These include:

- clinical communications
- consultation on clinical registers for high-risk implantable devices
- end-of-life care
- falls prevention
- healthcare associated infection
- health literacy
- medication safety, and
- open disclosure.

### **Clinical communications**

Clinical communication problems are a major contributing factor in 70% of hospital sentinel events.<sup>3</sup> Effective clinical handovers between clinicians can reduce common errors and improve patient safety and care.

The Commission's Clinical Communications program is applied in key areas known to influence quality and safety outcomes throughout the patient's journey and transitions in patient care, including supporting the implementation of NSQHS Standard 6: Clinical Handover.

In 2012/13, the Commission commenced a new area of work focused on patient-clinician communication. An analysis found that effective patient-clinician communication is an important element in almost all of the NSQHS Standards.

The Commission also commissioned a review of relevant research and policy literature to better understand communication between patients and clinicians. The review highlighted the importance of effective patient-clinician communication, and presented evidence for improvement strategies.

The Commission will use the findings from the literature review and analysis to identify future priorities for implementing the NSQHS Standards with respect to patient-clinician communications.

# Consultation on clinical registers for high-risk implantable devices

Several events have highlighted the need for clinical information on adverse health outcomes associated with using high-risk implantable medical devices. This information is not currently available for post-market evaluation or to efficiently notify potentially affected patients in the event of a problem with a particular device.

In October 2012, the Department of Health and Ageing engaged the Commission to provide advice on technical, governance and funding options for implementing clinical registers, to support the Therapeutic Goods Administration's post-market surveillance and patient contact capabilities for specific high-risk implantable medical devices. The report recommended that medical device information be incorporated into hospital patient administrative systems to improve the ability to identify and contact patients in the event of a safety concern about an implanted device.

### End-of-life care

More than half the people who die in Australia each year do so in acute healthcare facilities where the quality and safety of the end-of-life care they receive can vary greatly.

For a significant number of patients, clinical deterioration in acute healthcare facilities may not be preventable or reversible, but rather a part of the normal dying process.<sup>4-5</sup> Many of these patients are unlikely to benefit from invasive and burdensome therapies. Instead, they may require end-of-life care that addresses their emotional and psychosocial needs, and relieves the distressing symptoms that can occur during the natural dying process.<sup>6-7</sup>

Safe and high-quality end-of-life care can prevent, or at least minimise, significant distress for patients, their families and carers. There are also significant cost implications for society if unwanted or inappropriate medical treatments are continued.

Even with the considerable investment in palliative care services, guidelines, education programs, care pathways and advanced care planning programs, there are still gaps in the quality and safety of end-of-life care.

In 2012/13, the Commission undertook scoping and preliminary consultation work to understand the complex issues and barriers affecting the delivery of safe and high-quality end-of-life care in acute healthcare facilities. A background paper was developed which outlined the current policy and clinical framework within the Australian acute care setting as interpreted by consumers, healthcare providers and policymakers. It provides a platform for discussing the Commission's future work to improve the safety and quality of end-of-life care.

In June 2013, the Commission began working with consumers, healthcare providers and other experts to develop a national consensus statement about the standard of end-of-life care that patients, families and carers should expect in acute care settings. This high-level agreement on a consistent set of principles to guide the delivery of end-of-life care in acute facilities will be used to develop a framework for accountability, to ensure positive change at the point of care.

#### Key achievement 2012/13

More than **40** focus groups and interviews on end-of-life care held

#### Feedback from healthcare provider on end-of-life care:



"Bringing [end-of-life care] together under a national program has so many advantages. From a safety and quality point of view, it's the only way to go. Having a national framework gives us buy-in that we couldn't get any other way."

ICU and General Medicine Consultant, Private Hospital Our work

### Falls prevention

Falls are a significant cause of harm to older people across Australia, and are responsible in some cases for unnecessary hospitalisation, increased healthcare costs and premature death. Preventing and reducing the harm from falls in older people are safety and quality priorities under NSQHS Standard 10: Preventing Falls and Harm from Falls.

In 2012/13, the Commission evaluated the awareness, quality and use of its 2009 publication, *Preventing Falls and Harm from Falls in Older People: Best Practice Guidelines for Australian Hospitals.* The Centre of Research Excellence in Patient Safety at Monash University undertook the research and found:

- the guidelines would be more beneficial if they included more specific recommendations
- senior staff were more aware of the guidelines than front-line staff, and
- hospitals were particularly active in observing patients at risk of falling, but more work is needed to manage patients with delirium and confusion, and to review psychoactive medicine use.

The Commission has formed a National Falls and Falls Injury Prevention Reference Group to advise it on national falls prevention priorities, and help health service organisations to implement NSQHS Standard 10. The group met for the first time in August 2013.

# Healthcare associated infection

Preventing healthcare associated infection is a key safety and quality priority, recognised in NSQHS Standard 3: Preventing and Controlling Healthcare-Associated Infections.

The Commission aims to develop a national approach to reducing healthcare associated infection. It will do this by identifying and addressing systemic problems and gaps, and ensuring leaders and decision makers in the public and private healthcare sectors undertake comprehensive, nationally coordinated action.

#### National Hand Hygiene Initiative

The Commission contracts Hand Hygiene Australia (HHA) to implement the National Hand Hygiene Initiative (NHHI). During 2012/13, the NHHI continued to increase national awareness of hand hygiene, with more than 690 hospitals regularly submitting NHHI compliance data.

Hand hygiene compliance rates continue to improve across all jurisdictions and the private sector. At a national level, the most recent data period (January to March 2013) demonstrated the highest compliance rate (76.9%) since the NHHI's commencement.

The NHHI continues to be recognised nationally and internationally, with HHA team members presenting at leading national and international forums on infection control.



HHA, in partnership with the Royal Australasian College of Surgeons, developed an online education package for surgical trainees. Released in December 2012, more than 600 surgical trainees had passed the program as at 30 June 2013.

#### Key achievements 2012/13

77% hand hygiene compliance nationally

Over **690** hospitals regularly submit hand hygiene data

**420,000** healthcare providers have completed online learning in hand hygiene since the start of the NHHI

#### Reducing antimicrobial resistance

Studies have shown that patients with antimicrobial resistant infections are at least twice as likely to die than patients infected with non-resistant organisms. A major reason for antimicrobial resistance is the unnecessary and inappropriate use of antibiotics. Organisms that are resistant to entire classes of antibiotics are emerging rapidly, causing growing concern around the world.

One of the Commission's national priorities is reducing antimicrobial resistance. In 2012/13, the Commission was involved in the first Australian Antibiotic Awareness Week, from 12 to 18 November 2012. The event provided a significant opportunity to promote the appropriate use of antibiotics among healthcare providers and the community, through a nationally coordinated approach. The Commission worked with NPS MedicineWise, state and territory health department representatives and the private hospital sector, to develop consistent messaging and coordinate promotional opportunities.

The theme of the week was 'Preserve the Miracle'. The Commission developed resources to help health services highlight the problem of resistance and the importance of appropriate antibiotic use. This included a dedicated web page providing access to information, promotional materials, key contacts and links to learning resources.

The Minister for Health joined members of the Commission and NPS MedicineWise in Brisbane to mark the event on 14 November 2012.

#### Key achievements 2012/13

First Australian Antibiotic Awareness Week coordinated with participation from all jurisdictions and the community

OEO
More than 850 Antibiotic
Awareness Week posters and
pocket cards downloaded by health
service organisations

#### Our work

## Multi-resistant gram-negative bacteria

An emerging threat worldwide is 'gram-negative' bacteria, which have developed high levels of resistance to a wide range of antibiotics. Of particular concern are a group of organisms called carbapenem-resistant enterobacteriaceae (CRE). These bacteria have been a major cause of illness and death in a number of countries. There are early signs of their emergence and spread in Australia.

In 2011/12, the Healthcare Associated Infection (HAI) Advisory Committee agreed that multi-resistant gram-negative bacteria represent a significant threat to Australia. The Commission established a taskforce to develop priorities and recommendations to address the problem of multi-resistant gram-negative organisms, including surveillance, identification and control strategies. The taskforce comprises representatives from the Commission. the Australasian Society for Infectious Diseases, the Australasian College for Infection Prevention and Control, the Australian Society for Antimicrobials, the Public Health Laboratory Network and the Australian Group on Antimicrobial Resistance. The taskforce also included participants from all states and the Northern Territory.

During 2012/13, the taskforce developed Guideline recommendations for the control of multi-drug resistant gram negatives: Control of carbapenem-resistant enterobacteriaceae. The guideline was endorsed by all jurisdictions in April 2013 and was provided to all hospitals in Australia in August 2013.

# Standardised infection prevention and control signage

During 2012, the Commission convened a working group to determine the feasibility of developing nationally agreed, standardised infection prevention and control signage. The working group has produced a set of consistent signs for use in healthcare settings nationwide, to ensure compliance with standard, transmission-based precautions.

The Commission released these signs for use by healthcare facilities in March 2013. The four sets of posters highlight droplet, airborne, contact and standard precautions.

### Health literacy

Consumers are at the centre of the health system. The decisions they make and the actions they take are vital to ensuring that society achieves good health outcomes, and enjoys safe and high-quality health care.<sup>8</sup>

The Commission has a strong focus on consumer-centred approaches to care across all areas of its work. It has identified health literacy as a key component of consumer-centred care, and as a priority for safe and high-quality health care through a number of national policies. These include the Australian Safety and Quality Framework for Health Care, the Australian Safety and Quality Goals for Health Care, and the NSQHS Standards.

People with low levels of individual health literacy are between one and a half and three times more likely to experience an adverse outcome.<sup>9</sup> Addressing health literacy can also be seen as a way of protecting consumers from potential harm.<sup>10</sup>

··· Our work 🔽

Late in 2012, the Commission released the *Health Literacy Stocktake Consultation Report*, which provided an overview of health literacy activities and initiatives across Australia. The report noted that although there were many varied activities occurring across the country to address health literacy, there is little coordination at a national level and limited opportunities for others to benefit from this work.

Early in 2013, the Commission developed the Consumers, the health system and health literacy: Taking action to improve safety and quality consultation paper. The paper outlines the landscape and context for health literacy in Australia, and is the first step towards developing a national approach to improving health literacy. The paper was informed by meetings held with the Health Literacy Expert Advisory Group.

Public consultation commenced in June 2013. Feedback on the paper and the subject more generally will be used to inform the next phase of the project: developing a consensus statement on health literacy.

The actions taken and decisions made by consumers are fundamental to the safety, quality and effectiveness of health care. Health literacy is concerned with the skills and abilities of individual consumers, and the demands placed on them by the health system, be it in hospital, general practice or other settings.

### **Medication safety**

Australia has a system that generally provides consumers with safe medicines, delivered safely. However, as with all forms of health care, there is a risk of error, which can harm consumers. Because they are commonly used, medicines are associated with more errors and adverse events than any other aspect of care.

The Commission works to improve the safety and quality of medicine use in Australia. In conjunction with national and local organisations and individuals, the Commission's medication safety work focuses on system issues through five main streams:

- standardisation to reduce the risk of medication errors and patient harm
- continuity of care to improve the quality of medicine information and communication
- reducing practice gaps to encourage evidence-based approaches
- ensuring the safety of electronic medication initiatives, and
- advocating for medication safety and quality.

Medication safety is recognised as an accreditation requirement in NSQHS Standard 4: Medication Safety.

# Standardisation to reduce the risk of medication errors and patient harm

Standardising systems and processes is key to reducing the potential for medication error, helping healthcare providers deliver safer patient care. In 2012/13, the Commission coordinated the National Inpatient Medication Chart (NIMC) 2012 National Audit, a process to help hospitals measure the quality of their NIMC use.

The audit saw a threefold increase in the number of hospitals participating and the volume of charts audited compared to the 2011 audit. Hospitals could compare their data with similar hospitals, as well as state and national data, to identify areas for further improvement. On a national level, the data has been used to determine where further work is required to increase the safety of medicine ordering and documentation.

Throughout 2012/13, the Commission has also:

- maintained a large range of standardised tools and processes
- commenced phased implementation of a National Residential Medication Chart in 28 residential aged care facilities
- made available a National Clozapine Titration Chart and support materials for use in acute mental healthcare services
- coordinated a pilot National Subcutaneous Insulin Form for use in hospitals, and
- finalised a national pilot of a new version of the NIMC, which includes a pre-printed venous thromboembolism (VTE) prophylaxis section.

#### Key achievements 2012/13

**312** hospitals participated in the NIMC 2012 Audit

14,000 charts audited



More than **7,800** individuals completed NIMC online training

# Continuity of care to improve the quality of medicine information and communication

Communicating accurate and current information about medicines when care is transferred is critical to patient safety. Around half the medication errors in hospitals occur at transition of care. These errors can be significantly reduced through the process of medication reconciliation.

In 2012/13, the Commission helped health service organisations improve continuity of care by developing a number of information resources. These included medication reconciliation materials for health service organisations, healthcare providers and consumers, and medication information wallets for patients.

In 2012/13, the Commission also coordinated Australia's involvement in the World Health Organization (WHO) High 5s medication reconciliation project. The project aims to improve the accuracy of medicines information across the care continuum, focusing first on hospitals.

### 2

#### Key achievement 2012/13

**24,000** medication information wallets distributed to hospitals, to be given to patients when they are discharged

#### Reducing practice gaps to encourage evidence-based approaches

Practice gaps are the difference between actual and ideal performance and/or patient outcomes. Reducing practice gaps in the safe and effective use of medicines can improve the quality of care and lower the number of preventable adverse events.

In 2012/13, the Commission:

- improved the rate of VTE risk assessment documentation and VTE prophylaxis prescriptions through the NIMC VTE pilot
- developed evidence-based strategies and support materials to reduce inappropriate use of antimicrobials, including the Antimicrobial Prescribing Modules developed in conjunction with NPS MedicineWise
- promoted the safe use of medicines in perioperative areas, including userapplied labelling, by evaluating and reporting on the use of pre-printed labels for identifying medicines on perioperative sterile fields, and
- provided materials to support nationally standardised labelling of dedicated continuous-infusion lines, for safer administration of injectable medicines.

# Ensuring the safety of electronic medication initiatives

Electronic medication management systems can help health service organisations improve the safety and quality of the services they provide. However, they can also introduce new errors and risks.

In 2012/13, the Commission helped healthcare providers and health service organisations implement electronic medication management systems with its *Electronic Medication Management Systems: Guide to Safe Implementation (2nd edition).* The guide includes an implementation template and additional information for incorporating specialist functions such as infusions, renal dialysis and chemotherapy.

The Commission also started work on evidence briefings to determine if barcodes, automatic dispensing and electronic medication administration records can help reduce medication administration errors. The findings will be published in 2013/14.

# Advocating for medication safety and quality

The Commission continues to collaborate with other organisations to advocate for medication safety and quality. For example, the Commission worked to develop a national consensus on safer medication naming, labelling and packaging. The Therapeutic Goods Administration subsequently began reviewing the current regulatory arrangements, reflecting much of the Commission's initial work. Our work

### **Open disclosure**

Open disclosure is a discussion between a healthcare provider and a patient, their family, carers and other support persons, about the incidents that took place in cases where harm occurs to a patient while they were receiving health care.

Open disclosure is an important element of quality health care, and is recognised as an accreditation requirement in NSQHS Standard 1: Governance for Safety and Quality in Health Service Organisations.

The Commission's Open Disclosure Program aims to increase the extent, quality and consistency of open disclosure provided to patients who have experienced harm as a result of health care.

In July 2012, the Commission completed a two-year review of the Open Disclosure Standard, which has been in effect since 2003. The review aimed to produce a national document that would meet the information needs of patients, families and carers, healthcare providers and health services organisations to have open disclosure.



In 2012/13, a revised open disclosure document was developed and released for national consultation with key stakeholders. This consultation process comprised face-to-face forums in state capitals involving 136 people; an online survey; and a call for written submissions. The Commission received 34 written submissions and 149 completed surveys.

The feedback was used to develop the Australian Open Disclosure Framework, which was finalised in May 2013.

The Open Disclosure Framework contains important changes from the previous Open Disclosure Standard, including:

- emphasising the importance of apologising or expressing regret to harmed patients and including the words 'I am sorry' or 'we are sorry'
- giving patients and their families an opportunity to share their experience as part of dealing with adverse events
- ensuring that healthcare providers have appropriate training to participate in open disclosure discussions
- describing how to foster a culture that values reporting errors and unintended consequences as learning experiences
- encouraging health service organisations to evaluate their open disclosure processes and outcomes using a series of suggested measures, and
- assuring a clear legal path for open disclosure.

···· Our work 📿

The Commission has developed a suite of resources to support the implementation of the Open Disclosure Framework across a range of healthcare settings, including small practices. These resources include materials for consumers as well as healthcare providers.

The Commission will monitor the uptake and implementation of the Open Disclosure Framework, and will help health service organisations to roll out open disclosure processes as part of their accreditation requirements.

#### Key achievements 2012/13

Australian Open Disclosure Framework developed

**20** supporting resources developed to help acute and primary care health services implement the Open Disclosure Framework



## Data set development

The Commission has been developing specifications for core, hospital-based outcome indicators, to underpin a national model for reporting on patient safety in hospitals.

The Commission has also been progressing health information strategies for Healthcare Associated Infection (HAI) eSurveillance, a national standard for hospital cumulative antibiograms and a national set of core, common patient experience questions for hospitals. These projects feed into the Commission's broader work programs, such as the NSQHS Standards.

The Commission has developed a data plan for 2013-16 to outline its data-related roles and functions, with reference to the *National Health Reform Act 2011* and the National Health Reform Agreement.

# Core, hospital-based outcome indicators

The Commission is required to formulate indicators under the *National Health Reform Act 2011*, and to specify datasets under the National Health Reform Agreement.

When hospitals regularly monitor and review a set of outcome-based indicators, a significant variance in the results can draw attention to quality-of-care issues. During 2012/13, the Commission continued to develop and review core, hospital-based outcome indicators (CHBOI).

In July 2012, the Commission issued the CHBOI Toolkit to the Core Indicators Working Party to be used in a local pilot program. The toolkit enables jurisdictions and private hospital owners to generate nationally referenced and risk-adjusted core indicators.

Following this, the Commission convened a roundtable of jurisdictional and private hospital sector users. The roundtable provided feedback on the indicator specifications and the toolkit, including its usability and preferred graphical presentation. It also reviewed technical and statistical issues. Based on the issues and recommendations, the Commission distributed an updated CHBOI Toolkit in June 2013.

In response to advice from public health jurisdictions, the Commission convened a time-limited advisory group in May 2013, to examine the usefulness and limitations of hospital mortality indicators.

····· Our work 🔁

The Commission will continue to support CHBOI as a way to improve healthcare quality. It will also continue working on indicator specifications for condition-specific, same-hospital re-admissions.

#### HAI eSurveillance

Health ministers have endorsed the Commission to undertake the HAI eSurveillance pilot project. This project enables hospitals to routinely monitor *Staphylococcus aureus* bacteraemia (SAB) and *Clostridium difficile* infection (CDI) rates as part of the CHBOI assessment set.

Two health services undertook the HAI eSurveillance pilot during 2012. The pilot tested standardised electronic reporting using the core information components for microbiology requests and reports. The project demonstrated that the interface between laboratory information systems and clinical information systems is crucial to electronic HAI surveillance and reporting against national case definitions.

To better understand SAB and CDI surveillance and data validation processes – and the comparability of different surveillance reporting systems and datasets – the Commission initiated a project in February 2013 to document surveillance practices at the jurisdictional and hospital levels. The Commission has consulted states, territories and clinical experts about data validation processes, use of definitions and data flows.

#### A national standard for hospital cumulative antibiograms

The inappropriate use of antimicrobials leads to the emergence of resistant bacteria. Patients infected with resistant bacteria can experience delayed recovery, failed treatment or even death.

The NSQHS Standards require health services to routinely monitor antimicrobial resistance. In September 2012, the Commission initiated the development of a standard approach to testing antimicrobial susceptibility, and cumulative analysis and reporting of antibiograms.

Healthcare providers use antimicrobial susceptibility summary tables, known as cumulative antibiograms, to inform their choice of antimicrobials. These cumulative antibiograms should be available to healthcare providers and groups responsible for local antimicrobial stewardship. Guidelines for prescribing antimicrobials should also be available to inform local prescribing recommendations and formulary management.

In December 2012, the Commission convened a roundtable of experts to consider how to develop a national standard for hospital-level cumulative antibiograms. Following broad consensus on the need for a minimum standard for hospital-level antibiograms, a working group recommended a minimum standard antibiogram for use in acute healthcare facilities, which can be scaled up for larger institutions with more complex stewardship challenges. In May 2013, the Commission convened a second roundtable of experts to review the draft minimum standard for hospital-level cumulative antibiograms. The roundtable included representatives from each jurisdiction, private hospitals, and the microbiology and laboratory sectors. The roundtable members endorsed the recommendation that the minimum standard antibiogram comprise tabulated cumulative antibiograms, and that it should be produced annually.

This work will continue into 2013/14 as part of the Commission's focus on reducing antimicrobial resistance.

#### National set of core, common, patient experience questions for hospitals

The Framework for Safety and Quality in Health Care, released by the Commission in 2010, incorporates the principle of partnering with consumers. One aspect of this partnership involves measuring and responding to patient experiences.

The National Healthcare Agreement specifies the reporting of patient experience from a national, population-based survey at jurisdictional level. The Performance and Accountability Framework (PAF) specifies hospital patient experience reporting for hospital services and Medicare Locals. Most health departments and private hospitals survey patients after they are discharged, to monitor their experience and identify areas for improvement. However, there are no nationally common or comparable elements of hospitals' patient experience surveys.

In 2011/12, the Commission identified a set of proposed core, common questions during the initial stages of the project. In early 2013, the University of Adelaide trialled the question sets in two public and two private day procedure services. Validating the questions for use in the day procedure sector will greatly enhance their scope of use, as day procedures account for more than half of all hospital admissions in Australia.

In March 2013, the National Health Information Standards and Statistics Committee endorsed a national set of core, common, patient experience questions for patients admitted for overnight hospital visits. The interviews will be conducted over the phone using computer-aided software. The set of questions has been endorsed as the standard for non-mandatory data collection, and will be made available for use in hospitals nationwide in 2013/14.

## **Publishing and reporting**

During 2012/13, the Commission produced more than 40 publications and reports as part of its project work. These included safety and quality standards and frameworks, implementation guides and workbooks, review reports and literature reviews.

These resources are made available on the Commission's web site and in hard copy where necessary. During 2012/13, the Commission's web site was visited on over 325,000 occasions, and there were more than 249,000 downloads of documents and publications.

The following pages highlight a number of key publications released during the 2012/13 financial year. Details of the Commission's web site activity and newsletter readership are also included.

A full list of publications and reports is included in Appendix A on page 100. A list of research articles, published during 2012/13, that included contributions from Commission staff can be found in Appendix B on page 104.

#### Key achievement 2012/13

**325,000** visits to the Commission's web site

#### NSQHS Standards box set

Accreditation to the NSQHS Standards commenced from 1 January 2013. To support the process, the Commission developed a box set of implementation resources that was distributed to every hospital and day procedure service in Australia.

Each box set included the NSQHS Standards and ten NSQHS Standards Safety and Quality Improvement Guides. These guides help health service organisations to align their quality improvement programs with the NSQHS Standards. Each of the ten NSQHS Standards Safety and Quality Improvement Guide details the criterion of the relevant NSQHS Standard, as well as required actions and suggested implementation strategies.

An Accreditation Workbook was also included in the box set, either a Hospital Accreditation Workbook or a Day Procedure Services Accreditation Workbook. The workbooks were designed to assist the individuals responsible for coordinating accreditation processes within their health service organisation.

Each box set also included a USB drive loaded with additional resources.

Electronic versions of the revised NSQHS Standards and the ten Safety and Quality Improvement Guides are available from the Commission's web site. As at 30 June 2013, the NSQHS Standards had been downloaded more than 16,000 times.

See pages 13-15 for further information about the NSQHS Standards.

Our work …

#### Key achievements 2012/13

**1,804** NSQHS Standards box sets distributed to hospitals and day procedure services

More than **16,000** downloads of the NSQHS Standards from the Commission's web site

## NSQHS Standards Guide for Small Hospitals

In May 2013, the Commission finished developing the NSQHS Standards Guide for Small Hospitals, specifically designed to help health service organisations with fewer than 50 beds to implement the NSQHS Standards.

The NSQHS Standards Guide for Small Hospitals builds on the information in the NSQHS Standards Hospital Accreditation Workbook and the Safety and Quality Improvement Guides. It provides:

- an overview of the purpose of items and actions in the NSQHS Standards
- suggested strategies for meeting the requirements of the NSQHS Standards, and
- a list of key resources to support the implementation of the NSQHS Standards.

During June 2013, 1,293 copies of the NSQHS Standards Guide for Small Hospitals were distributed to relevant hospitals.

See pages 13-15 for further information about the NSQHS Standards.

#### Australian Open Disclosure Framework and supporting resources

In May 2013, the Commission finalised the development of the Australian Open Disclosure Framework, which is intended to replace the 2003 Open Disclosure Standard.

To support health service organisations transition from the Open Disclosure Standard to the Australian Open Disclosure Framework, the Commission has developed a number of resources and materials. The Commission has made 20 resources available on its web site, including resources for consumers, healthcare providers and health service organisations. As at 30 June 2013, the Open Disclosure Framework had been downloaded more than 400 times.

See pages 28–29 for further information on the Australian Open Disclosure Framework.

#### Health Literacy Stocktake Consultation Report

In September 2012, the Commission released the Health Literacy Stocktake Consultation Report, which provided an overview of health literacy activities and initiatives across Australia. The findings from the report are contributing to the development of a national approach to addressing health literacy in Australia.

See page 24 for further information regarding the Commission's work in the area of health literacy.

#### ··· Our work 🔁

#### Consultation Draft Accreditation Workbook for Mental Health Services

In December 2012, the Commission released a Consultation Draft Accreditation Workbook, which was developed in collaboration with the Department of Health and Ageing, and the Safety and Quality Partnership Standing Committee (Mental Health and Drug and Alcohol Principal Committee).

The workbook is intended as a tool for health services implementing, and being accredited to, the NSQHS Standards and the National Standards for Mental Health Services (developed by the Mental Health Commission in 2011).

See page 18 for further information on the Commission's work relating to mental health services.

### On the Radar

The Commission issues a weekly summary of recent research, resources and publications about safety and quality in health care, to ensure up-to-date and relevant knowledge is available to and accessible by the public. Almost 2,500 individuals subscribe to the Commission's online summary, *On the Radar*, which represents an increase of more than 100 per cent over the past year.

#### Key achievements 2012/13

100%	increase in subscriptions
to On the Rada	



Our work ....

# Knowledge and leadership in safety and quality

The Commission works collaboratively with education providers, professional organisations, peak bodies, jurisdictions and researchers to embed safety and quality in the national curricula for healthcare-related undergraduate and postgraduate education and training, and in continuing professional development.

In leading and coordinating national initiatives in safety and quality in health care, the Commission is required to contribute to other national initiatives that have implications for safety and quality.

## Supporting education, training and research

Embedding safety and quality in health education, training and research will help ensure healthcare providers adhere to evidence-based safety and quality practices. The Commission supports this objective by contributing to professional education and research; developing training tools; and participating in workshops, conferences, external committees and advisory groups.

#### Healthcare providers' education

Delivering effective and appropriate care relies on healthcare providers' knowledge of and competence in patient safety, improving the quality of care, and communicating with patients and consumers. The Commission continues to advocate for the inclusion of key competencies related to providing safe, appropriate and effective care in healthcare providers' training. The Commission is building a program of work to determine the extent to which safety- and quality-related training is incorporated in healthcare training. In January 2013, the Commission began a national survey of nursing schools to identify curriculum content and assessments related to specific safety and quality topics that are part of the NSQHS Standards.

#### Participation in research

Evidence-based knowledge of safety and quality in health care informs all the Commission's activities. The Commission participates in, contributes to and funds a range of research activities related to safety, quality and best practice in health care. A full list of research activities that the Commission was involved in during 2012/13 is provided in Appendix C on page 105.

#### **Conferences and meetings**

The Commission participates in externally convened conferences, meetings and forums that are important to its work. These events allow us to communicate directly with key stakeholders, including healthcare providers and executives, policy makers and advisors, peak bodies and consumer groups. In 2012/13, Commission representatives presented papers at more than 60 external conferences, meetings or forums, reaching more than 5,000 healthcare providers and other key stakeholders.

The Commission also sponsored three healthcare-related conferences. A list of the sponsored events can be found at Appendix D on page 112.

··· Our work 🔽

#### Training and workshops

To facilitate adoption of its programs, the Commission coordinates and participates in workshops on an as-required basis. During 2012/13, Commission representatives contributed to 15 workshops nationally.

The Commission also develops and maintains a number of online training tools to support improvements in healthcare safety and quality. During 2012/13, the Commission managed and maintained the following modules:

- NIMC online training module (in partnership with NPS MedicineWise)
- Using the National Medication
   Management Plan online training
   presentation
- modules about prescribing antimicrobials were included in the National Prescribing Curriculum (in partnership with NPS MedicineWise), and
- ten infection prevention and control online training modules.

Hand Hygiene Australia – in partnership with the Royal Australasian College of Surgeons – developed an online education package for surgical trainees, which was released in December 2012. More than 600 surgical trainees had passed the program as at 30 June 2013.

#### **External representations**

The Commission promotes evidencebased safety and quality in health care by participating in numerous international, national and jurisdictional committees, organisations and agencies.

A full list of the Commission's external representations in 2012/13 is included in Appendix E on page 113.

## Contributing to national initiatives

During 2012/13, the Commission was involved in two major national healthcare initiatives: the implementation of the Personally Controlled Electronic Health Record (PCEHR) system, and the Independent Hospital Pricing Authority's (IHPA) work regarding the pricing of Australian public hospital services.

The Commission is also leading Australia's contribution to an Organisation for Economic Co-operation and Development (OECD) study of variations in medical practice.

## Auditing the clinical safety of the PCEHR system

The introduction of the PCEHR system in 2012 has brought new benefits to healthcare consumers and providers. Monitoring and assuring the system's clinical safety is a critical governance function.

In September 2012, the Commission established the PCEHR Clinical Governance Advisory Group to provide advice to the Commission and PCEHR System Operator. The group is chaired by the Commonwealth Chief Medical Officer and includes users of the system and experts in clinical safety and governance, health IT and patient safety. The PCEHR Clinical Governance Advisory Group has met three times during 2012/13.

The Commission was appointed and funded to conduct four clinical safety audits of the PCEHR system between July 2012 and June 2014. The first two audits have been completed. The first audit report recommended a number of structural and process changes, which were accepted by the System Operator, the Department of Human Services and the National E-Health Transition Authority (NEHTA).

The second audit was completed in June 2013, and made further recommendations to improve the PCEHR system's clinical incident identification and management capabilities. The third clinical safety audit will be completed in December 2013.

#### Collaboration with the Independent Hospital Pricing Authority

The IHPA was established as part of the *National Health Reform Act 2011* to determine an efficient price for Australia's public hospital services. In doing so, the IHPA must ensure reasonable access to public hospital services; clinical safety, quality, efficiency and effectiveness; and the financial sustainability of the public hospital system.

The Commission and the IHPA have formed a partnership to examine options for incorporating safety and quality in the pricing model for Australian public hospital services.

A Joint Working Party was established in August 2012 to advise the Commission and the IHPA on this work. Chaired by the Commission's CEO Professor Debora Picone AM, the Joint Working Party includes the IHPA's CEO, Dr Tony Sherbon, as well as healthcare providers and consumers. Since its establishment, the Joint Working Party has met four times. The Joint Working Party's first project was a literature review of approaches to integrating safety and quality into healthcare pricing systems. Published in May 2013, the review found that many countries are currently implementing or considering implementing systems that link quality and safety with hospital funding, using a variety of approaches, but the evidence of the extent to which these schemes affect patient outcomes is weak. However, it does reveal that providing relevant and timely information to healthcare providers is an effective driver of improved safety and quality.

The Commission and the IHPA have subsequently carried out additional complementary work, including:

- outlining more recent literature on safety and quality
- exploring the characteristics of several healthcare systems that have implemented large-scale quality improvement mechanisms, and
- discussing the key success factors of various incentive schemes.

The Joint Working Party has supported the two agencies to undertake further work on ways in which casemix data – routinely generated in Australian hospitals – can be used to improve safety and quality.

Evidence shows that providing relevant and timely information to healthcare providers is an effective driver of improved safety and quality.

#### Our work 🔁

## OECD study of variations in medical practice

Variations in medical practices and procedures have been observed for many years, both between countries and within countries. International studies show that a significant amount of this variation appears to be unrelated to patient need or preference, which is frequently termed unwarranted variation. Unwarranted variation raises quality, efficiency and equity issues.

In October 2012, the Commission began leading Australia's contribution to an OECD study of variations in medical practice. Australia is one of 13 countries participating in this project, which aims to:

- document medical practice variations, with a focus on variations within countries
- analyse the possible causes of medical practice variations, and
- explore policy options to reduce unwarranted variations and improve resource allocation.

The OECD has identified a common set of medical procedures and interventions for analysis. These include hip fractures (a calibration procedure); cardiac catheterisation and revascularisation procedures (such as coronary bypass, coronary angioplasty and stenting); knee arthroscopy and knee replacements; hospital medical admissions; caesarean sections; and hysterectomy procedures.

An inter-jurisdictional group is advising on this work and the Australian Institute of Health and Welfare is analysing the data. The next phase of this work involves identifying ways to explore aspects of patient need, and working with clinical experts to understand the drivers of observed variations. The Commission will produce a report on observed variations early in 2014.





## Assessment of safety and quality in health care

A systems-based approach to improving safety and quality	42
Consumers, patients, families and carers are at the centre of health care	43
Supporting consumers to get the right care	44
Measuring the safety and quality of care	44

As part of its legislative functions, the Commission is required to report on the state of safety and quality of the Australian health system. This chapter provides an overview of key safety and quality themes. A full report can be found in the Commission's publication *Vital Signs 2013: The State of Safety and Quality in Australian Health Care*.

# A systems-based approach to improving safety and quality

A focus on systems is essential for ensuring effective and sustainable improvements to the safety and quality of care.<sup>11-14</sup> There have been significant improvements in safety and quality over the last few decades, and there are now more systems in place to standardise routines and processes, making it easier for healthcare providers to deliver high-quality care.

Initiatives such as the National Inpatient Medication Chart (NIMC) and the National Hand Hygiene Initiative (NHHI) provide structures that have brought improvements in the basic processes of care, and reduced the risk of harm to patients.

With the NIMC, there is now better recording of information about medicines and a structured tool to facilitate communication between healthcare providers during the complex processes associated with prescribing, dispensing and administering medicines.<sup>15</sup> Through the NHHI, more than 420,000 healthcare providers have completed online learning packages in hand hygiene. Between 2009 and 2012, there was a six-fold increase in the number of hospitals regularly auditing staff to see if they are performing hand hygiene processes properly. These audits indicate an increase in hand hygiene compliance from 64% in 2010 to 77% in 2013<sup>16</sup> and we are now beginning to see a decrease in *Staphylococcus aureus* bacteraemia rates across Australia.

The National Safety and Quality Health Service (NSQHS) Standards and Australian Health Service Safety and Quality Accreditation Scheme will continue to drive this focus on systems. They will help ensure all hospitals and day procedure services have systems in place that are known to reduce the risk of harm to patients and improve the safety and quality of care.

The Commission is also looking at how the NSQHS Standards can be used more widely across the health system to ensure a consistent approach to safety and quality in Australia.

# Consumers, patients, families and carers are at the centre of health care

There is an increasing recognition that if patients, carers and consumers play a greater role in the healthcare system, then its quality and safety will improve. People who are partners in their care, who understand and use health information effectively, who share decisions and who actively engage with care processes are more likely to have a better experience of health care, and better results from their health care.<sup>17-22</sup>

Partnerships between consumers, healthcare providers and health service organisations can occur in different ways. One of these ways relates to the partnerships that can exist between a person and their healthcare provider when care and treatment is provided. These types of partnerships can be developed through the use of shared decision-making approaches and support for self-management.

In Australia, people generally report positive experiences with the health system, saying that healthcare providers spend enough time with them, listen carefully and show respect.<sup>23</sup> However, results are not as positive when looking at the experiences of people with a chronic condition in Australia, with 64% reporting that they shared decisions with their specialists, and only 48% reporting that they were involved in managing their own care.<sup>24</sup> In addition, levels of health literacy in the Australian population are low,<sup>25</sup> and this can have an impact on the nature of interactions between consumers and healthcare providers.<sup>26</sup>

The Commission has had a role in promoting the role of consumers in safety and quality at a national level, and this will continue in the future, with a particular focus on health literacy and shared decision-making.



### Supporting consumers to get the right care

The Commission is currently leading Australia's contribution to an OECD study of variations in medical practice. This study will document the extent of medical practice variations for a specific set of medical procedures and interventions.

Additional information about variation in practice comes from audits on specific clinical topics. For example, the Stroke Foundation conducts an annual audit of care provided to patients who have had a stroke. In 2011, the audit found that only 60% of people who have a stroke are cared for in a stroke unit. Only half of patients who are treated for stroke receive a care plan to support them with their recovery, and advice and education on how to reduce the risk of another stroke.<sup>27</sup> A recent national study on acute coronary syndrome found significant variations in care across different types of hospitals and in different states.<sup>28</sup>

The Commission's work to develop clinical care standards and support shared decision-making will help to reduce the risk of people not receiving the right care. The Commission will also be building on the work that is being coordinated by the OECD to examine the extent of medical practice variation in Australia. A national study of variation, including the development of an Australian Atlas of Clinical Variation, will highlight where problems exist.

# Measuring the safety and quality of care

Measuring the safety and quality of care is a key in leading improvements. Limitations in the availability of data have been a significant challenge for the Commission.

Information regarding diagnoses and the procedures, including deaths and readmissions, is available but there is little information about whether care is safe, whether people receive the right care, and the extent to which people are involved in their care. Clinical quality registries can help to provide some of this information.

As an example, the Australia and New Zealand Dialysis and Transplant Registry shows that survival rates for people who receive a transplanted kidney are increasing over time. It also shows the frequency of peritonitis (as a complication of peritoneal dialysis) is decreasing and the number of kidneys donated is increasing each year.

Registries managed by the Australian and New Zealand Intensive Care Society have shown that the mortality rate in Australian intensive care units is progressively decreasing, while the median length of stay has remained fairly constant.

Such data provides a benchmark against which to measure the impact of future activities. The Commission is working to increase the focus on safety and quality in national data collections to allow more detailed reporting in the future.

.....

## Corporate governance and accountability

Legislation and requirements	46
Strategic planning	46
Ministerial Directions	46
Commission Board	47
Committees	53
Internal governance arrangements	55
External scrutiny	56
Developments and significant events	57
Environmental performance and ecologically sustainable development	57
National Health Reform Act amendments	57

This chapter outlines the Commission's legislative requirements, corporate governance and accountability processes.

# Legislation and requirements

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

The Commission is required to fulfil the requirements of the *Commonwealth Authorities and Companies Act 1997* (CAC Act), which regulates certain aspects of the financial affairs of Commonwealth authorities; their reporting, accountability, banking and investment obligations; and the conduct of the Commission's directors and officers.

## Strategic planning

The NHR Act requires the Commission to prepare a work plan for each financial year and submit it to the Commonwealth Minister for Health. The Minister consults with the health ministers in each state and territory about the work plan. The Standing Council on Health endorses the final work plan.

The work plan for 2012/13 set out the Commission's activities in five priority areas, and was endorsed by the Standing Council. This work plan was the basis for the first of the Commission's rolling three-year plans that will be implemented from 2013/14.

## **Ministerial Directions**

Section 16 of the NHR Act empowers the Minister for Health to make directions with which the Commission must comply. The Minister for Health made no such directions during the 2012/13 reporting period.

## **Commission Board**

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

The Board is established and governed by the provisions of the NHR Act and the CAC Act.

Standing left to right: Professor Jane Halton PSM, Professor Phillip Della, Dr Shaun Larkin, Dr Helena Williams, Ms Christine Gee, Professor Christopher Brook PSM, and Mr Russell McGowan.

Seated left to right: Ms Shelly Park, Professor Villis Marshall AC and the Honourable Verity Firth.

Australian Commission on Safety and Quality in Health Care | Annual Report 2012/13 47

## Board membership 2012/13

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

#### Professor Villis Marshall AC (Chair)

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

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

#### Qualifications: MD, MBBS and FRACS

Appointed as Chair on 1 April 2013 First appointed to the Board on 1 April 2012

#### Professor Christopher Brook PSM

Professor Christopher Brook has experience in public healthcare administration and improving the safety and quality of health care. He is currently the Executive Director for Wellbeing, Integrated Care and Ageing, as well as State Health and Medical Commander (Emergency Management) for the Department of Health, Victoria. His previous positions include Executive Director for Rural and Regional Health and Aged Care, and Director of Acute Care, both with the Department of Human Services, Victoria. Christopher was awarded a public service medal in 2011.

**Qualifications:** MB, BS, FRACP (Gastroenterology), FAFPHM, FIPAA and FRACMA

First appointed to the Board on 1 April 2012 Reappointed 1 April 2013

#### Professor Phillip Della

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

His other previous roles include Chief Nursing Officer and Principal Nursing Advisor at the Department of Health, Western Australia.

#### Qualifications: PhD and FACN

First appointed to the Board on 1 April 2013

#### The Honourable Verity Firth

The Honourable Verity Firth has legal expertise and experience in public healthcare administration. She is currently Chief Executive of the Public Education Foundation Ltd.

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

#### Qualifications: BA LLB

First appointed to the Board on 1 April 2013

#### **Ms Christine Gee**

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

Ms Gee is also involved in numerous national boards and committees including the Australian Private Hospitals Association, the Private Hospitals Association of Queensland, the Australian Government's Second Tier Advisory Committee and the Minter Ellison Health and Ageing Industry Group Advisory Board.

#### Qualifications: MBA

First appointed as a Commission member in March 2006

Appointed to the Board, as established under the CAC Act, on 1 July 2011

#### **Professor Jane Halton PSM**

Professor Jane Halton is Secretary of the Australian Department of Health. She has a wealth of experience gained through her roles in numerous leading national and international boards and committees. Professor Halton is a member of the board of the Australian Institute of Health and Welfare and the NEHTA. She is also on the executive board of the Institute for Health Metrics and Evaluation at the University of Washington in the USA, and on the advisory boards of the Centre for Applied Philosophy and Public Ethics, and the Melbourne Institute.

Professor Halton is the chair of the OECD Health Committee and Chair of the WHO Executive Board. She was also previously an Executive Board Member of the WHO; President of the World Health Assembly; and Vice-Chair of the WHO Executive Board and Chair of the WHO's Program, Budget and Administration Committee.

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

#### Qualifications: BA (Hons) Psychology

First appointed as a Commission member in March 2006

Appointed to the Board, as established under the CAC Act, on 1 July 2011

Reappointed 1 April 2013

#### **Dr Shaun Larkin**

Dr Shaun Larkin is Managing Director of HCF, Australia's largest not-for-profit health insurance fund caring for over 1.6 million Australians.

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

4

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 and BHA

First appointed to the Board on 1 April 2013

#### Mr Russell McGowan

Russell McGowan brings the consumer perspective on healthcare safety and quality issues to the Board. He survived a bone marrow transplant in the early 1990s and has been actively involved in the healthcare consumer movement ever since.

Mr McGowan is a member of the Australian Government's Medical Services Advisory Committee, the Specialist Education Accreditation Committee of the Australian Medical Council and the Board of the Public Health Association of Australia. He has previously been on the Boards of the Consumer Health Forum of Australia, the Australian Council on Healthcare Standards, the Australian General Practice Network, the Cancer Council of Australia and the National Blood Authority.

#### Qualifications: BA

First appointed as a Commission member in December 2008

Appointed to the Board, as established under the CAC Act, on 1 July 2011

#### **Ms Shelly Park**

Shelly Park has a wealth of experience in hospital and health service management in both the public and private health systems. She is currently the Chief Executive of Monash Health, a health service organisation which provides a comprehensive range of primary, secondary and tertiary health care services to a population of over one million people in the south-east of Melbourne.

Prior to her current role, Ms Park was Executive Director of Monash Medical Centre at Southern Health and Executive Director of Jessie McPherson Private Hospital. Her previous positions have included General Manager of Medical and Surgical Services at Christchurch Hospital in New Zealand. She has also been Director of Nursing and Service Support at Burwood Hospital in Canterbury, New Zealand.

**Qualifications:** BA, GAICD, FAIM and Fellow Ethical Leadership

First appointed as a Commission member in June 2009

Appointed to the Board, as established under the CAC Act, on 1 July 2011

#### Dr Helena Williams

Dr Helena Williams brings to the Board clinical expertise as a GP and previously as the Executive Clinical Director of Southern Adelaide–Fleurieu–Kangaroo Island Medicare Local Ltd. She is also the Presiding Member of the Southern Adelaide Local Health Network.

Dr Williams' 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: MB, BS and FRACGP

First appointed as a Commission member in April 2008

Appointed to the Board, as established under the CAC Act, on 1 July 2011

### Board meetings and attendance

Table 1: Board meetings and attendance						
Name	Board meeting					
	2 Aug 2012	26 Sep 2012	29 Nov 2012	14 Mar 2013	9 May 2013	
William Beerworth <sup>1</sup> (Chair until 31 March 2013)	$\checkmark$	$\checkmark$	$\checkmark$	$\checkmark$	-	
Prof. Villis Marshall (Chair from 1 April 2013)	$\checkmark$	$\checkmark$	$\checkmark$	$\checkmark$	$\checkmark$	
Richard Bowden <sup>2</sup>	x	-	-	-	-	
Prof. Christopher Brook	$\checkmark$	$\checkmark$	×	$\checkmark$	x	
Veronica Casey <sup>1</sup>	$\checkmark$	$\checkmark$	$\checkmark$	$\checkmark$	-	
Prof. Phillip Della <sup>3</sup>	-	-	-	-	$\checkmark$	
The Hon. Verity Firth <sup>3</sup>	-	-	-	-	$\checkmark$	
Christine Gee	$\checkmark$	$\checkmark$	×	$\checkmark$	$\checkmark$	
Prof. Jane Halton	$\checkmark$	x	$\checkmark$	$\checkmark$	$\checkmark$	
Dr Shaun Larkin <sup>3</sup>	-	-	-	-	$\checkmark$	
Russell McGowan	$\checkmark$	$\checkmark$	$\checkmark$	$\checkmark$	$\checkmark$	
Shelly Park	×	$\checkmark$	$\checkmark$	$\checkmark$	$\checkmark$	
Dr Helena Williams	$\checkmark$	×	$\checkmark$	$\checkmark$	$\checkmark$	

✓ Present

X Absent – Not a member at time of meeting

- 1 Term concluded 31 March 2013
- 2 Term concluded 11 September 2012
- 3 Appointed 1 April 2013

4

#### Board development and review

New Board members undertake a formal induction to their role, including a meeting with the Chair and CEO. They receive a Director's Induction Manual that includes details on the Board Governance Charter. Board members are briefed on relevant topics at meetings as appropriate, and are required to undertake ongoing professional development that is relevant to and in line with the Commission's needs. The Commission supports Board members to pursue these activities.

Board membership was reviewed in 2012. Three sitting members retired from the Board, including the Chair. A new Board Chair and three Directors were appointed on 1 April 2013. Two sitting members were reappointed. The terms of the remaining five members were not due for review. See Board Membership 2012/13 on pages 48-50 for dates of Board members' appointments.

### **Ethical standards**

The Board Governance Charter provides a Directors' Code of Conduct. The charter includes guidelines for managing conflicts of interest – including material personal interests – as required by the CAC Act.

### **Related-entity transactions**

In accordance with section 15 of the Commonwealth Authorities (Annual Reporting) Orders 2011, there were no related-entity transactions during 2012/13.

## Remuneration and expenses

In accordance with section 23 of the NHR Act and the relevant determinations of the Remuneration Tribunal, the Commission's Board members are entitled to remuneration and allowances. Details of Board members' remuneration and interests are set out in note 11 of the financial statements on page 90.

### 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 2012/13 to ensure it remained appropriate for its operations.

During the year, no indemnity-related claims were made, and the Commission knows of no circumstances likely to lead to such claims being made. Many liability limits under the Commission's Schedule of Cover are standard Australian Government limits, such as \$100 million in cover for general liability and professional indemnity, as well as Directors' and officers' liability. The minimum period of cover available for business interruption is 36 months. Motor vehicle, third-party property damage and expatriate cover have not been taken out, as they don't apply to the Commission.

### Committees

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

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

#### Audit and Risk Committee

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

- monitoring the effectiveness of risk management and internal control frameworks, management policies and key governance processes
- monitoring the Commission's compliance with the CAC Act's provisions and requirements and relevant regulations, and helping the authority and its Directors to comply with obligations under the CAC Act
- monitoring cost forecasting and the collection of information for the annual report
- reviewing fraud prevention and security-related matters

- reviewing operational risks, internal control measures, and internal and external audits and reporting
- reviewing matters referred to it by the Board or the CEO, and
- providing a forum for communications between Board members, the Commission's senior managers, and the authority's internal and external auditors.

The Audit and Risk Committee met six times during the 2012/13 financial year. The Chair, Ms Jennifer Clark, attended all six meetings.

The Board members sitting on the Audit and Risk Committee from 1 July 2012 to 31 March 2013 were Bill Beerworth and Shelly Park. Mr Beerworth and Ms Park attended all five meetings during this period. Mr Richard Bowden was a sitting Board member from 1 July 2012 to 31 August 2012. Mr Bowden attended one meeting during this period.

The Honourable Verity Firth was appointed as a Board and Audit and Risk Committee member from 1 April 2013. Ms Park continues in her role as a sitting Board member. Mr Trevor Burgess was appointed as an external member of the Audit and Risk Committee from 1 April 2013. Each member attended the one Audit and Risk Committee meeting held between 1 April 2013 and 30 June 2013.

Δ



#### Inter-Jurisdictional Committee (IJC)

The IJC comprises healthcare safety and quality representatives from the Australian, state and territory governments. It is responsible for advising on policy development and facilitating jurisdictional engagement. Chaired by Professor Dorothy Jones, Department of Health, Western Australia, the IJC's role is to:

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

The IJC met four times during the 2012/13 financial year.

## Other committees and consultations

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

- Private Hospital Sector Committee Chaired by Ms Christine Gee, CEO, Toowong Private Hospital and Commission Board member
- Primary Health Committee Chaired by Dr Helena Williams, Commission Board member, and
- Information Strategy Committee Chaired in 2012/13 by Professor Villis Marshall AC, Commission Board member.

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

The Commission consults widely with subject-matter experts, peak bodies, jurisdictions, consumers, and other relevant individuals and parties. The consultation includes ongoing discussions with key national and other organisations, and with an extensive network of formal reference and advisory groups. These networks provide links with healthcare providers, consumers, subject-matter experts and jurisdictional representatives. The Commission also undertakes formal consultations on specific issues. See Appendix F on page 115 for a list of the formal consultations that occurred during 2012/13.

### Internal governance arrangements

The CEO, Professor Debora Picone AM, manages the Commission's day-to-day administration. The CEO is supported by an Executive Management team, internal management committees and staff members. The Commission's internal governance arrangements include internal management, risk management, fraud control and internal audit arrangements.

#### Internal management

The Commission has three internal management committees and one panel.

- The Leadership and Business Committees meet fortnightly to facilitate information sharing and help with decision making.
- The Occupation Health and Safety Committee develops and promotes strategies to support the health and safety of all staff members and visitors.
- The Study Leave Review Panel reviews staff applications for study leave and makes recommendations to the Chief Operating Officer.

### **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 that are consistent with Australian Standards for *Risk Management* – Principles and guidelines (AS/NZS ISO 31000:2009) into its organisational culture, governance and accountability arrangements, and its planning, reporting, performance review, business transformation and improvement processes. Through the risk management framework and its supporting processes, the Commission formally establishes and communicates its approach to ongoing risk management, and guides staff in their actions and ability to accept and control risks.

### Fraud control

The Commission recognises the responsibility of all Australian Government authorities to develop, encourage and implement sound financial, legal and ethical decision-making practices. The Commission's Fraud Control Plan complies with the Commonwealth Fraud Control Guidelines. The Fraud Control Plan acts to minimise the potential for instances of fraud on the Commission's programs or activities, whether conducted by employees or persons external to the Commission. Fraud risk assessments help the Commission understand fraud risks, identify internal control gaps or weaknesses, and develop strategies to mitigate those risks. These assessments are conducted regularly across the organisation, taking into consideration the entity's business activities, processes and accounts.

4

#### Internal audit

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

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

## External scrutiny

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

## Parliamentary and ministerial oversight

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

### Freedom of information

Agencies subject to the *Freedom of Information Act 1982* (FOI Act) are required to publish information for the public as part of the Information Publication Scheme (IPS). This requirement is in Part II of the FOI Act and has replaced the former requirement to publish a section 8 statement in an annual report. The Commission has displayed on its web site (www.safetyandquality.gov.au) a plan showing what information it publishes in accordance with IPS requirements. See Appendix G on page 117 for a table summarising the list of FOI activities for 2012/13.

## Judicial decisions and reviews by external bodies

There were no judicial decisions or decisions of administrative tribunals that had a significant effect on the Commission's operations during 2012/13.

# Developments and significant events

The Commission is required under section 15 of the CAC Act to notify the Minister of developments and events that have significantly affected or may significantly affect its operations. In 2012/13, there were no such developments or significant events. There were also no such developments or significant events after 30 June 2013.

### Environmental performance and ecologically sustainable development

Section 516A of the *Environmental Protection and Biodiversity Conservation Act 1999* (EPBC Act) requires Australian Government organisations and authorities to include in their annual report details about their environmental performance and their contribution to ecologically sustainable development. The Commission is committed to making a positive contribution to ecological sustainability. The Commission's ecologically sustainable activities are detailed in Appendix H on page 118.

### *National Health Reform Act 2011* amendments

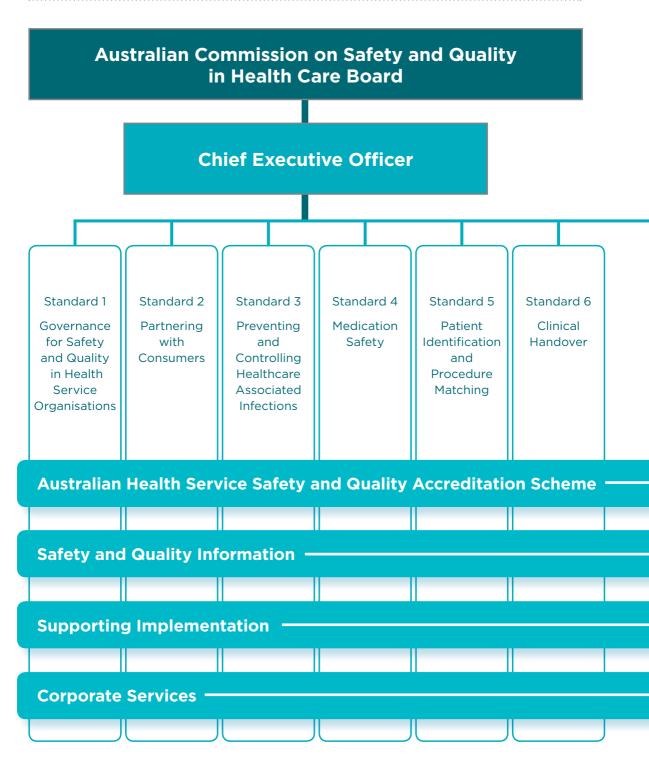
During the 2012/13 financial year, no amendments were made to the NHR Act.



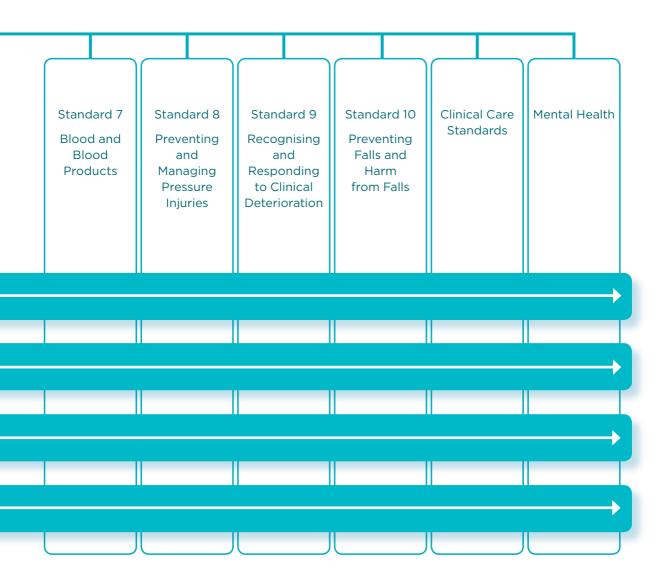
# Our organisation

Organisational structure	60
People management	62
Staff profile	62
Non-salary benefits	63
Workplace health and safety	63
Learning and development	64
Disability strategy	64

## Organisational structure



5



The Commission has a team of highly motivated and talented staff. The Executive Management team fosters a culture of professionalism and transparency in line with the values of the Commission and Australian Public Service, and is committed to managing and developing staff members to achieve the objectives and outcomes of the Commission's work plan.

## People management

In 2012/13, the Commission began developing a Human Resources Framework to examine its current and ongoing workforce needs. The framework will focus on human resource issues such as learning and development and crucial skills training, as well as attraction, retention and other workforce planning needs.

The Commission finalised a new enterprise agreement in January 2013. The agreement sets out the employment terms and conditions for non-Senior Executive Service (SES) staff until 30 June 2014.

In May 2013, all Commission staff were encouraged to participate in the Australian Public Service Commission's survey, achieving a 64% response rate.

## Staff profile

As at 30 June 2013, the Commission employed 50 full-time equivalent staff. All staff are located at the Commission's sole office at 1 Oxford Street, Darlinghurst, New South Wales, with the exception of one staff member who divides their time between Sydney and Melbourne.

Table 2 provides a breakdown of the Commission's staffing figures by classification, gender, full-time and part-time status, and ongoing and non-ongoing employment.

Table 2: Staff numbers by classification as at 30 June 2013									
ttion	Female				Male				Total
Classification	Ongoing		Non-ongoing		Ongoing		Non-ongoing		
Clas	F/T	P/T	F/T	P/T	F/T	P/T	F/T	P/T	
CEO			1						1
MO6	1					0.8			1.8
EL 2	4	1.6	1		5		1		12.6
EL 1	6	3.7	1	2.3	2	0.6			15.6
APS 6	9		3						12
APS 5	5								5
APS 4	1						1		2
Total	26	5.3	6	2.3	7	1.4	2		50

F/T: Full-time P/T: Part-time

5

## Non-salary benefits

In addition to salary and superannuation benefits, all Commission staff members are eligible for and have access to the following non-salary benefits:

- influenza vaccinations
- an annual Christmas closedown period
- eyesight testing and reimbursement of prescribed eyewear costs
- access to an Employee Assistance Program (EAP)
- time off for blood donations
- home-based working arrangements
- reimbursement of costs associated with obtaining financial advice (for staff over 54 years of age)
- reimbursement of costs associated with damage to clothing or personal effects
- support for professional and personal development, and
- access to accrued leave at half pay.

# Workplace health and safety

The Commission is committed to providing and maintaining a safe and healthy workplace for its employees. It is also committed to meeting its obligations under the *Work Health and Safety Act 2011* (WHS Act) and the *Safety, Rehabilitation and Compensation Act 1988* (SRC Act). The Commission is still in the early stages of developing and putting in place all of its human resources and associated policies, procedures and guidelines. The Commission will focus on developing health and safety policies in the second half of 2013, to ensure it complies with the WHS Act.

All of the Commission's staff members have successfully completed the Comcare Work Health and Safety e-learning training module. All new employees must complete this e-learning module as part of their induction, within two weeks of commencing work.

In 2012/13, the Commission undertook a number of activities aimed at preventing illness and injury in the workplace, including:

- appointing and training staff as first aid officers, Health and Safety Representatives and workplace harassment contact officers
- conducting twice-yearly workplace inspections and encouraging all staff to report on any incidents, accidents or hazards in the workplace, and
- making influenza vaccinations available to all staff members at no cost.

A total of 13 workplace health and safety incidents were reported in 2012/13.

The Commission has two ongoing compensation claims that will be completed by the end of 2013.

# Learning and development

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

The Commission identifies learning and development needs and opportunities through the performance development scheme (PDS). In 2012/13, ten staff members undertook external training in a variety of courses, including but not limited to Privacy Reforms, Harassment Contact Officer Refresher, Executive Level Writing and information technology-specific courses.

During 2012/13, five staff members accessed study assistance to undertake a range of tertiary courses, including Doctor of Philosophy, Masters of Business and Technology, and Bachelor of Arts and Science courses.

The Commission offers all staff members the opportunity to attend regular continuing professional development (CPD) sessions. In 2012/13, 14 CPD sessions were held.

In its commitment to continuous improvement, the Commission will develop a training and development strategy in 2013/14 to ensure staff members can perform at the highest level. This will incorporate a tailored training model that offers courses relevant to the Commission's core work, and a career development model that will help the Commission and individual staff members to develop to their full potential.

## Disability strategy

The Commission is required under clause 12 of the CAC Act to establish a Disability Action Plan. The Commission is committed to developing and implementing its Disability Action Plan during 2013/14.

## Financial statements

Independent auditor's report	66
Statement by the Directors, Chief Executive Officer and Chief Financial Officer	68
Statement of comprehensive income	69
Balance sheet	70
Statement of changes in equity	71
Cash flow statement	72
Schedule of commitments	73
Notes to and forming part of the Financial Statements for the period ended 30 June 2013	75

**Financial statements** 



#### INDEPENDENT AUDITOR'S REPORT

#### To the Minister for Health

I have audited the accompanying financial statements of the Australian Commission on Safety and Quality in Health Care for the year ended 30 June 2013, which comprise: a Statement by the Directors, Chief Executive and Chief Financial Officer; the Statement of Comprehensive Income; Balance Sheet; Statement of Changes in Equity; Cash Flow Statement; Schedule of Commitments; and Notes to and forming part of the Financial Statements comprising a Summary of Significant Accounting Policies and other explanatory information.

#### Directors' Responsibility for the Financial Statements

The directors of the Australian Commission on Safety and Quality in Health Care are responsible for the preparation of the financial statements that give a true and fair view in accordance with the Finance Minister's Orders made under the *Commonwealth Authorities and Companies Act 1997*, including the Australian Accounting Standards, and for such internal control as is necessary to enable the preparation of the financial statements that give a true and fair view and are free from material misstatement, whether due to fraud or error.

#### Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Australian Commission on Safety and Quality in Health Care's preparation of the financial statements that give a true and fair view 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 Australian Commission on Safety and Quality in Health Care's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial statements.

GPO Box 707 CANEERRA ACT 2801 19 National Circuit BARTON ACT 2600 Phone (02) 6203 7300 Fax (02) 6203 7777

6

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

#### Independence

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

#### Opinion

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

- (a) have been prepared in accordance with the Finance Minister's Orders made under the Commonwealth Authorities and Companies Act 1997, including the Australian Accounting Standards; and
- (b) give a true and fair view of the matters required by the Finance Minister's Orders including the Australian Commission on Safety and Quality in Health Care's financial position as at 30 June 2013 and of its financial performance and cash flows for the year then ended.

Australian National Audit Office

Purpa Date

Puspa Dash Executive Director

Delegate of the Auditor-General

Canberra 18 September 2013

# 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 2013 are based on properly maintained financial records and give a true and fair view of the matters required by the Finance Minister's Orders made under the Commonwealth Authorities and Companies Act 1997, as amended.

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 become due and payable.

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

Professor Villis Marshall AC Chair

Professor Debora Picone AM Chief Executive Officer

Mr. Mike Wallace **Chief Operating Officer** 

Date: 18/9/2013,

Date: 18.9,17

Date: 18.9.13

6

# **Statement of Comprehensive Income**

for the period ended 30 June 2013

		2013	2012
	Notes	\$'000	\$'000
EXPENSES			
Employee benefits	3A	6,718	5,216
Supplier	3B	7,119	7,766
Depreciation and amortisation	3C	120	65
Finance costs	3D _	7	7
Total expenses	-	13,964	13,054
LESS:			
OWN-SOURCE INCOME			
Own-source revenue			
Rendering of services	4A	2,413	912
Interest	4B	431	54
External contributions	4C	5,665	5,500
Total own-source revenue	_	8,509	6,466
Net cost of services		5 <i>4</i> 5 5	6 500
Net cost of services	-	5,455	6,588
Revenue from Government	4D	5,665	5,500
Surplus (deficit)	-	210	(1,088)
OTHER COMPREHENSIVE INCOME			
Changes in asset revaluation reserves		(3)	8
Total other comprehensive income (loss)	-	(3)	8
Total comprehensive income (loss)	-	207	(1,080)
Total comprehensive income (loss)	-	207	(1,080)

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

# **Balance Sheet**

as at 30 June 2013

6

	Natar	2013	2012
ASSETS	Notes	\$'000	\$'000
Financial Assets			
Cash and cash equivalents	5A	7,050	11,984
Trade and other receivables	5B	1,161	2,868
Total financial assets		8,211	14,852
	—	- 7	,
Non-Financial Assets			
Property, plant and equipment	6A,B	199	235
Other non-financial assets	6C	57	74
Total non-financial assets	_	256	309
Total assets		8,467	15,161
LIABILITIES Payables Suppliers Other payables	7A 7B	2,478 3,548	12,879 368
Total payables	7 D _	6,026	13,247
Provisions	_	0,020	10,247
Employee provisions	8A	1,229	919
Other provisions	8B	249	239
Total provisions	_	1,478	1,158
Total liabilities	_	7,504	14,405
Net assets	_	963	756
EQUITY			
Contributed equity		1,836	1,836
Reserves		5	8
Accumulated deficit		(878)	(1,088)
Total equity	_	963	756

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

**Statement of Changes in Equity** for the period ended 30 June 2013

	Reta	Retained	revaluation	tion	Contributed	outed	Total	al
	earn	earnings	Reserve	ve	equity	ity	equity	ity
	2013	2012	2013	2012	2013	2012	2013	2012
	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000	\$'000
Opening balance	(1,088)	ı	8	1	1,836	ı	756	1
Comprehensive income								
Other comprehensive income	•	I	(3)	Ø	•	'	(3)	Ø
Surplus (Deficit) for the period	210	(1,088)	•	I	•	1	210	(1,088)
Total comprehensive income	210	(1,088)	(3)	8	•	ı	207	(1,080)
Transactions with owners								
Contributions by owners								
Equity injection	•	ı	•	ı	•	1,836	•	1,836
Sub-total transactions with owners	•	'	•	ı	•	1,836	•	1,836
Closing balance as at 30 June	(878)	(1,088)	5	8	1,836	1,836	963	756
<b>Closing balance attributable to the Australian</b>								
Government	(878)	(1,088)	5	œ	1,836	1,836	963	756

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

6



# **Cash Flow Statement**

for the period ended 30 June 2013

	Notes	2013 \$'000	2012 \$'000
OPERATING ACTIVITIES			
Cash received			
Receipts from Government		5,665	5,500
External contributions		5,665	5,500
Rendering of services		5,597	146
Interest		449	21
Net GST received		1,226	-
Total cash received		18,602	11,167
Orak ward			
Cash used Employees		(10,320)	(647)
Suppliers		(10,320) (13,072)	(647) (372)
Total cash used		(13,072) (23,392)	(1,019)
Net cash from (used by) operating activities	9	(4,790)	10,148
Net cash nom (used by) operating activities	9	(4,790)	10,140
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		(144)	-
Total cash used		(144)	-
Net cash from (used by) investing activities		(144)	-
FINANCING ACTIVITIES			
Cash received			4 000
Contributed equity		-	1,836
Total cash received		-	1,836
Net cash from (used by) financing activities		-	1,836
Net increase (decrease) in cash held		(4,934)	11,984
Cash and cash equivalents at the beginning of the reporting period		11,984	
•	<b>F</b> A		-
Cash and cash equivalents at the end of the reporting period	5A	7,050	11,984

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

# **Schedule of Commitments**

as at 30 June 2013

BY TYPE Commitments receivable	2013 \$'000	2012 \$'000
Project Commitments <sup>1</sup>	7,127	478
Net GST recoverable on commitments	136	157
Total commitments receivable	7,263	635
Commitments payable		
Operating lease <sup>2</sup>	793	1,425
Other Commitments <sup>3</sup>	1,964	321
Total commitments payable	2,757	1,746
Net commitments by type	4,506	(1,111)
BY MATURITY Commitments receivable		
One year or less	5,340	560
From one to five years	1,923	75
Total receivable on commitments	7,263	635
Commitments payable Operating lease		
One year or less	666	640
From one to five years	127	785
Total operating lease commitments payable	793	1,425
Other commitments		
One year or less	1,887	285
From one to five years	77	36
Total other commitments payable	1,964	321
Total commitments payable	2,757	1,746
Net commitments by maturity	4,506	(1,111)

Note: Commitments are GST inclusive where relevant.

1. Project commitments - comprises services committed to be provided by the Commission, under signed agreements, where the Commission has yet to perform the services required.

2. Operating lease commitments - the Commission has committed to a 3 year lease term agreement which commenced in September 2011. The lease is effectively non-cancellable. Lease payments are subject to annual increases or reviews until the end of the lease.

3. Other commitments - comprises amounts committed under signed agreements where the contracted organisation has yet to perform the services required.

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

# **Table of Contents – Notes**

- Note 1: Summary of Significant Accounting Policies
- Note 2: Events After the Reporting Period
- Note 3: Expenses
- Note 4: Income
- Note 5: Financial Assets
- Note 6: Non-Financial Assets
- Note 7: Payables
- Note 8: Provisions
- Note 9: Cash Flow Reconciliation
- Note 10: Contingent Assets and Liabilities
- Note 11: Directors Remuneration
- Note 12: Related Party Disclosures
- Note 13: Senior Executive Remuneration
- Note 14: Remuneration of Auditors
- Note 15: Financial Instruments
- Note 16: Financial Assets Reconciliation
- Note 17: Compensation and Debt Relief
- Note 18: Reporting of Outcomes



# **Note 1: Summary of Significant Accounting Policies**

## 1.1 Objectives of the entity

The Australian Commission on Safety and Quality in Health Care (the Commission) is an Australian Government controlled entity. 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 now a Commonwealth Authority operating under the requirements of the *Commonwealth Authorities and Companies Act 1997*. The Commission commenced as an independent, statutory authority on 1 July 2011, funded jointly by all governments in Australia.

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 programs is dependent on Government policy and on continuing funding by Parliament for the Commission's administration and programs.

## 1.2 Basis of Preparation of the Financial Statements

The financial statements are general purpose financial statements and are required by clause 1(b) of Schedule 1 to *the Commonwealth Authorities and Companies Act 1997*.

The financial statements have been prepared in accordance with:

- a) Finance Minister's Orders (FMOs) for reporting periods ending on or after 1 July 2011; and
- b) Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

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

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

Unless an alternative treatment is specifically required by an accounting standard or the FMOs, assets and liabilities are recognised in the balance sheet when and only when it is probable that future economic benefits will flow to the Commission or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under executor contracts are not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the schedule of commitments or the schedule of contingencies.

Unless alternative treatment is specifically required by an Accounting Standard, income and expenses are recognised in the Statement of Comprehensive Income when and only when the flow, consumption or loss of economic benefits has occurred and can be reliably measured.

## **1.3 Significant Accounting Judgements and Estimates**

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

## **1.4 New Australian Accounting Standards**

#### Adoption of New Australian Accounting Standard Requirements

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

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

#### Future Australian Accounting Standard Requirements

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

## 1.5 Revenue

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

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

The stage of completion of contracts at the reporting date is determined by reference to surveys of work performed.



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

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

#### Revenue from Government - CAC Act body payment item

Funding received or receivable from agencies (appropriated to the Department of Health and Ageing as a CAC Act body payment item for payment to the Commission) is recognised as Revenue from Government unless they are in the nature of an equity injection or a loan.

#### **Rendering of Services**

Contributions for specific projects or a contractual agreement. 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:

- i) the amount of revenue, stage of completion and transaction costs incurred can be reliably measured; and
- ii) the probable economic benefits 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.

## 1.6 Gains

### Resources Received Free of Charge

Resources received free of charge are recognised as gains when, and only when, a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense.

Resources received free of charge are recorded as either revenue or gains depending on their nature.

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, unless received from another Government entity as a consequence of a restructuring of administrative arrangements (Refer to Note 1.7).

#### Sale of Assets

Gains from disposal of assets are recognised when control of the asset has passed to the buyer.

## 1.7 Transactions with the Government as Owner

### Equity Injections

Amounts that are designated as equity injections for a year are recognised directly in contributed equity in that year.

#### Restructuring of Administrative Arrangements

Net assets received from or relinquished to another Government entity under a restructuring of administrative arrangements are adjusted at their book value directly against contributed equity.

## 1.8 Employee Benefits

For the period 1 July 2011 to 10 May 2012, staff of the Commission were seconded from the Department of Health and Ageing. Included in employee benefits are amounts paid as reimbursement to the Department of Health and Ageing, for employee benefits incurred on the Commission's behalf. On 10 May 2012, the staff seconded from the Department of Health and Ageing became employees of the Commission.

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

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

Other long-term employee benefits are measured as net total of the present value of the defined benefit obligation at the end of the reporting period minus the fair value at the end of the reporting period of plan assets (if any) out of which the obligations are to be settled directly.

#### <u>Leave</u>

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

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

The liability for long service leave is measured at the present value of the estimated future cash flows to be made in respect of all employees at year end. The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.



#### Superannuation

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

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

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported by the Department of Finance and Deregulation as an administered item.

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

The liability for superannuation recognised as at 30 June represents outstanding contributions for the final fortnight of the year.

## 1.9 Leases

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

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

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

### 1.10 Borrowing Costs

All borrowing costs are expensed as incurred.

## 1.11 Cash

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

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

## 1.12 Financial Assets

The Commission classifies its financial assets as loans and receivables.

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

### Loans and Receivables

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

#### Impairment of Financial Assets

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

If there is objective evidence that an impairment loss has been incurred for loans and receivables or held to maturity investments held at amortised cost, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows discounted at the asset's original effective interest rate. The carrying amount is reduced by way of an allowance account. The loss is recognised in the Statement of Comprehensive Income.

## 1.13 Financial Liabilities

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

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

## 1.14 Contingent Liabilities and Contingent Assets

Contingent liabilities and contingent assets are not recognised in the balance sheet but are reported in the relevant schedules and notes. They may arise from uncertainty as to the existence of a liability or asset or represent an asset or liability in respect of which the amount cannot be reliably measured. Contingent assets are disclosed when settlement is probable but not virtually certain and contingent liabilities are disclosed when settlement is greater than remote.

The Commission has no contingent assets and liabilities. Hence, a Schedule of Contingencies has not been prepared.



## 1.15 Acquisition of Assets

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

Assets acquired at no cost, or for nominal consideration, are initially recognised as assets and income at their fair value at the date of acquisition, unless acquired as a consequence of restructuring of administrative arrangements. In the latter case, assets are initially recognised as contributions by owners at the amounts at which they were recognised in the transferor's accounts immediately prior to the restructuring.

# 1.16 Property, Plant and Equipment

### Asset Recognition Threshold

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

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

### **Revaluations**

Fair values for each class of asset are determined as shown below:

Asset Class	Fair Value Measured at
Leasehold improvements	Depreciated replacement cost
Plant and equipment	Market selling price

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	<u>2013</u>	<u>2012</u>
Leasehold improvements	Lease term	Lease term
Plant and equipment	5 years	N/A

#### Impairment

All assets were assessed for impairment at 30 June 2013. Where indications of impairment exist, the asset's recoverable amount is estimated and an impairment adjustment made if the asset's recoverable amount is less than its carrying amount.

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

#### **Derecognition**

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

## 1.17 Taxation

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

Revenues, expenses, assets and liabilities are recognised net of GST except:

- i) where the amount of GST incurred is not recoverable from the Australian Taxation Office; and
- ii) for receivables and payables.

# Note 2: Events After the Reporting Period

No matters or circumstances have arisen since the end of the financial year which significantly affected or may affect the operations of the Commission, the results of these operations or the state of affairs of the Commission in subsequent years.

# Note 3: Expenses

	2013	2012
	\$'000	\$'000
Note 3A: Employee Benefits		
Wages and salaries	5,072	3,910
Superannuation:		
Defined contribution plans	666	484
Defined benefit plans	209	138
Leave and other entitlements	735	647
Other employee benefits	36	37
Total employee benefits	6,718	5,216
Note 3B: Suppliers		
Goods and services		
Consultants	31	55
Contracts for services	4,371	4,579
Travel	517	529
Information and communication	516	384
Printing and postage	117	395
Other	794	1,089
Total goods and services	6,346	7,031
Goods and services are made up of:		
Provision of goods – external parties	127	662
Rendering of services – related entities	1,321	387
Rendering of services – external parties	4,898	5,982
Total goods and services	6,346	7,031
Other supplier expenses		
Operating lease rentals		
Minimum lease payments – external parties	53	_
Sublease – related entities	651	- 674
Workers compensation expenses	69	61
Total other supplier expenses	773	735
Total supplier expenses	7,119	7,766
וטנמו שמאאוובו באאבוושבש	1,113	1,100

Financial statements

6

	2013	2012
	\$'000	\$'000
Note 3C: Depreciation and Amortisation Depreciation:		
Land and Buildings	120	65
Total depreciation	120	65
Note 3D: Finance Costs Unwinding of discount	7	7
Total finance costs	7	7
The unwinding of discount relates to make good on lease.		
Note 4: Income		
	2013	2012
OWN-SOURCE REVENUE	\$'000	\$'000
Note 4A: Rendering of Services Rendering of services – related entities	2,379	500
Rendering of services – external parties	34	412
Total sale of goods and rendering of services	2,413	912
Note 4B: Interest		
Deposits	431	54
Total interest	431	54
Note 4C: External Contributions		
States and Territories contributions	5,665	5,500
Total external contributions	5,665	5,500
REVENUE FROM GOVERNMENT		
Note 4D: Revenue from Government		
Department of Health and Ageing:	E 00E	E E00
CAC Act body payment item Total revenue from Government	5,665	5,500
	5,665	5,500



# Note 5: Financial Assets

	2013	2012
	\$'000	\$'000
Note 5A: Cash and Cash Equivalents		
Cash on hand and at bank	7,050	11,984
Total cash and cash equivalents	7,050	11,984
The decrease in cash and cash equivalents from 2012 to 2013 is primarily due to repayments to the Department of Health and Ageing for services provided under a memorandum of understanding arrangement.		
Note 5B: Trade and Other Receivables		
Good and Services:		
Related entities – Department of Health and Ageing	1,000	1,378
External parties		368
Total receivables for goods and services	1,000	1,746
Other receivables:		
GST receivable from the Australian Taxation Office	134	1,055
Interest - related entities	4	33
Interest - external parties	11	-
Other - related entities	12	30
Other - external parties	-	4
Total other receivables	161	1,122
Total trade and other receivables (gross)	1,161	2,868
Less impairment allowance account: Goods and services		
Total impairment allowance account		
Total trade and other receivables (net)	- 1,161	2,868
	1,101	2,000
Receivables are expected to be recovered in:		
No more than 12 months	1,161	2,868
Total trade and other receivables (net)	1,161	2,868
Receivables are aged as follows:		
Not overdue	1,149	2,868
Overdue by 61 to 90 days	12	-
Total trade and other receivables (net)	1,161	2,868

No receivables were impaired at 30 June 2013 (2012: Nil).

# **Note 6: Non-Financial Assets**

	2013 \$'000	2012 \$'000
Note 6A: Property, Plant and Equipment		
Fair value	384	300
Accumulated depreciation	(185)	(65)
Total property, plant and equipment	199	235

No indicators of impairment were found for property, plant and equipment. No property, plant or equipment were expected to be sold or disposed of within the next 12 months. The Commission only held leasehold improvements, plant and equipment.

#### **Revaluations of non-financial assets**

All revaluations are conducted in accordance with the revaluation policy stated at Note 1.

# Note 6B: Reconciliation of the opening and closing balances of property, plant and equipment

	2013	2012
	\$'000	\$'000
As at 1 July		
Gross book value	300	-
Accumulated depreciation and impairment	(65)	-
Net book value 1 July	235	-
Additions:		
By make good	-	240
By purchase	84	60
Depreciation expense	(120)	(65)
Net book value 30 June	199	235

#### Net book value as of 30 June represented by:

Gross book value	384	300
Accumulated depreciation	(185)	(65)
	199	235

Financial	statements
-----------	------------



Note 6C: Other Non-Financial AssetsPrepayments57Total other non-financial assets57Total other non-financial assets - are expected to be recovered in: No more than 12 months57Total other non-financial assets - are expected to be recovered in: No more than 12 months57Total other non-financial assets57Total other non-financial assets57Total other non-financial assets57No indicators of impairment were found for other non-financial assets.Note 7: Payables2013 \$'000Note 7A: SuppliersTrade creditors and accruals2,478Total supplier payables2,478Supplier payables expected to be settled within 12 months: Related entities - Department of Health and Ageing Related entities - Other External parties947Total Settlement is usually made within 30 days.1,340Note 7B: Other Payables24Salaries and wages150Superannuation24Querannuation24Querannuation24Querannuation-GST payable to ATO-Cother64-Total other payables3,548Salaries and wages50Superannuation-GST payable to ATO-Gther6A-Total other payables3,548Superannuation-Superannuation-Cother6A-Total other payables-S		2013 \$'000	2012 \$'000
Total other non-financial assets5774Total other non-financial assets - are expected to be recovered in: No more than 12 months5774Total other non-financial assets5774No indicators of impairment were found for other non-financial assets.5774No indicators of impairment were found for other non-financial assets.5774No te 7: Payables2013 \$'0002012 \$'000Note 7: Payables2013 \$'0002012 \$'000Note 7A: Suppliers2,47812,879Total supplier payables2,47812,879Supplier payables expected to be settled within 12 months: Related entities - Department of Health and Ageing 	Note 6C: Other Non-Financial Assets		
Total other non-financial assets - are expected to be recovered in: No more than 12 months5774Total other non-financial assets5774Total other non-financial assets5774No indicators of impairment were found for other non-financial assets.5774Note 7: Payables20132012\$'000\$'000Note 7: Payables20132012\$'000\$'000\$'000Note 7A: Suppliers2,47812,879Trade creditors and accruals2,47812,879Total supplier payables expected to be settled within 12 months: Related entities - Department of Health and Ageing Related entities - Other94711,740Related entities - Other191112External parties1,3401,027Total2,47812,879Settlement is usually made within 30 days.2,47812,879Salaries and wages150196Superannuation2426Unearned income3,36880GST payable to ATO-62Other64			
No more than 12 months5774Total other non-financial assets5774No indicators of impairment were found for other non-financial assets.Note 7: Payables20132012 \$'000\$'000\$'000Note 7A: SuppliersTrade creditors and accruals2,478Total supplier payables2,478Supplier payables expected to be settled within 12 months: Related entities - Department of Health and Ageing Related entities - Other947Supplier payables expected to be settled within 12 months: Related entities - Other External parties1,340Total Supplier payables1,2,879Staties and wages150Salaries and wages150Superannuation Unearned income2,48Solaries and wages3,368Solaries and wages3,368Solaries and wages6ATO-64	Total other non-financial assets	57	74
Total other non-financial assets5774No indicators of impairment were found for other non-financial assets.Note 7: PayablesNote 7: Payables20132012\$'000\$'000Note 7A: Suppliers\$'000Trade creditors and accruals2,47812,879Total supplier payables2,47812,879Supplier payables expected to be settled within 12 months:94711,740Related entities - Department of Health and Ageing94711,740Related entities - Other191112External parties1,3401,027TotalSettlement is usually made within 30 days.2,47812,879Salaries and wages150196Superannuation2426Unearned income3,36880GST payable to ATO-62Other64	Total other non-financial assets - are expected to be recovered in:		
No indicators of impairment were found for other non-financial assets.          No indicators of impairment were found for other non-financial assets.         Note 7: Payables         2013       2012         \$'000       \$'000         Note 7A: Suppliers         Trade creditors and accruals       2,478       12,879         Total supplier payables       2,478       12,879         Supplier payables expected to be settled within 12 months:       947       11,740         Related entities - Department of Health and Ageing       947       11,740         Related entities - Other       191       112         External parties       1,340       1,027         Total       2,478       12,879         Settlement is usually made within 30 days.       2,478       12,879         Stataries and wages       150       196         Superannuation       24       26         Unearned income       3,368       80         GST payable to ATO       -       62         Other       6       4	No more than 12 months	57	74
Note 7: Payables20132012 \$'000Note 7A: SuppliersTrade creditors and accruals2,478Total supplier payables2,4782,47812,879Supplier payables expected to be settled within 12 months: Related entities - Department of Health and Ageing Related entities - Other94711,740 Related entities - Other191External parties1,3401,0272,478Total2,478Settlement is usually made within 30 days.Note 7B: Other PayablesSalaries and wages150Superannuation24Unearned income3,368GST payable to ATO-62-Other6	Total other non-financial assets	57	74
20132012\$'000\$'000Note 7A: Suppliers2,478Trade creditors and accruals2,478Total supplier payables2,478Supplier payables expected to be settled within 12 months: Related entities - Department of Health and Ageing Related entities - Other External parties94711,740 191191191112Total Settlement is usually made within 30 days.1,340Note 7B: Other Payables150Salaries and wages Superannuation150Superannuation24Cother3,368GST payable to ATO Other-64	No indicators of impairment were found for other non-financial assets.		
Supplier s2,47812,879Total supplier payables2,47812,879Supplier payables expected to be settled within 12 months: Related entities - Department of Health and Ageing Related entities - Other External parties94711,740Related entities - Other External parties191112Supplier payables expected to be settled within 30 days.2,47812,879Note 7B: Other Payables2,47812,879Salaries and wages150196Superannuation2426Unearned income3,36880GST payable to ATO-62Other64	Note 7: Payables		
Note 7A: SuppliersTrade creditors and accruals2,47812,879Total supplier payables2,47812,879Supplier payables expected to be settled within 12 months: Related entities - Department of Health and Ageing Related entities - Other94711,740External parties1,3401,027Total2,47812,879Settlement is usually made within 30 days.2,47812,879Salaries and wages150196Superannuation2426Unearned income3,36880GST payable to ATO-62Other64		2013	2012
Trade creditors and accruals2,47812,879Total supplier payables2,47812,879Supplier payables expected to be settled within 12 months: Related entities - Department of Health and Ageing Related entities - Other External parties94711,740Related entities - Other External parties191112External parties1,3401,027Total Settlement is usually made within 30 days.2,47812,879Note 7B: Other Payables2,47812,879Salaries and wages Superannuation150196Superannuation Unearned income Other2426Other64		\$'000	\$'000
Total supplier payables2,47812,879Supplier payables expected to be settled within 12 months: Related entities - Department of Health and Ageing Related entities - Other External parties94711,740Related entities - Other External parties191112External parties1,3401,027Total Settlement is usually made within 30 days.2,47812,879Note 7B: Other Payables150196Superannuation2426Unearned income3,36880GST payable to ATO Other64	Note 7A: Suppliers		
Supplier payables expected to be settled within 12 months:Related entities - Department of Health and Ageing947Related entities - Other191External parties1,340Total2,478Settlement is usually made within 30 days.Note 7B: Other PayablesSalaries and wages150Superannuation24Unearned income3,368GST payable to ATO-Other6	Trade creditors and accruals	2,478	12,879
Related entities - Department of Health and Ageing Related entities - Other94711,740Related entities - Other191112External parties1,3401,027Total2,47812,879Settlement is usually made within 30 days.22Note 7B: Other Payables150196Superannuation2426Unearned income3,36880GST payable to ATO-62Other64	Total supplier payables	2,478	12,879
Related entities - Department of Health and Ageing Related entities - Other94711,740Related entities - Other191112External parties1,3401,027Total2,47812,879Settlement is usually made within 30 days.22Note 7B: Other Payables150196Superannuation2426Unearned income3,36880GST payable to ATO-62Other64	Supplier payables expected to be settled within 12 months:		
Related entities - Other191112External parties1,3401,027Total2,47812,879Settlement is usually made within 30 days.Note 7B: Other PayablesSalaries and wages150196Superannuation2426Unearned income3,36880GST payable to ATO-62Other64		947	11,740
Total2,47812,879Settlement is usually made within 30 days.100100Note 7B: Other Payables150196Salaries and wages150196Superannuation2426Unearned income3,36880GST payable to ATO-62Other64		191	112
Settlement is usually made within 30 days.Note 7B: Other PayablesSalaries and wages150Superannuation24Unearned income3,368GST payable to ATO-Other6	External parties	1,340	1,027
Note 7B: Other PayablesSalaries and wages150196Superannuation2426Unearned income3,36880GST payable to ATO-62Other64	Total	2,478	12,879
Salaries and wages150196Superannuation2426Unearned income3,36880GST payable to ATO-62Other64	Settlement is usually made within 30 days.		
Superannuation2426Unearned income3,36880GST payable to ATO-62Other64	Note 7B: Other Payables		
Superannuation2426Unearned income3,36880GST payable to ATO-62Other64	Salaries and wages	150	196
Unearned income3,36880GST payable to ATO-62Other64	-		
GST payable to ATO - 62 Other 6 4	•	3,368	80
Other 6 4		-	62
Total other payables3,548368		6	4
	Total other payables	3,548	368

All other payables are expected to be settled in no more than 12 months.

Financial statements

## **Note 8: Provisions**

	2013 \$'000	2012 \$'000
Note 8A: Employee Provisions	<b>\$ 000</b>	φ 000
Leave	1,229	919
Total employee provisions	1,229	919
Employee provisions are expected to be settled in:		
No more than 12 months	873	668
More than 12 months	356	251
Total employee provisions	1,229	919
Note 8B: Other Provisions		
Provision for restoration obligations	249	239
Total other provisions	249	239
Other provisions are expected to be settled in:		
More than 12 months	249	239
Total other provisions	249	239
Reconciliation of the opening and closing balances of other		
provisions:		
	2013	2012
	\$'000	\$'000
Carrying amount at 1 July	239	-
Provisions made	-	240
Amounts recognised in other comprehensive income	3	(8)
Change in discount rate	7	7
Closing balance at 30 June	249	239

The Commission has committed to a 3 year lease term agreement for Level 7, 1 Oxford Street Darlinghurst NSW which commenced in September 2011. The rental agreement contains provisions requiring the restoration of the premises to their original condition at the conclusion of the rental agreement term. The Commission has made a provision to reflect the present value of this obligation.



# Note 9: Cash Flow Reconciliation

Reconciliation of cash and cash equivalents as per Balance Sheet to Cash Flow Statement	2013 \$'000	2012 \$'000
Cash and cash equivalents as per:	- 050	44.004
Cash flow statement	7,050	11,984
Balance sheet Difference	7,050	11,984
Difference		
Reconciliation of net cost of services to net cash from operating activities:		
Net cost of services	(5,455)	(6,588)
Add revenue from Government	5,665	5,500
Adjustments for non-cash items		
Depreciation and amortisation	120	65
Movements in operating recognised in equity	(3)	8
Capitalisation of accruals not classified as operating	60	(300)
Changes in assets / liabilities		
(Increase) / decrease in net receivables	1,707	(2,868)
(Increase) / decrease in prepayments	17	(74)
Increase / (decrease) in employee provisions	310	919
Increase / (decrease) in supplier payables	(10,401)	12,879
Increase / (decrease) in other payables	3,180	368
Increase / (decrease) in other provisions	10	239
Net cash from (used by) operating activities	(4,790)	10,148

# Note 10: Contingent Assets and Liabilities

#### **Quantifiable Contingencies**

As at 30 June 2013, the Commission had no quantifiable contingencies.

#### Unquantifiable Contingencies

As at 30 June 2013, the Commission had no unquantifiable contingencies.

#### Significant Remote Contingencies

As at 30 June 2013, the Commission had no material remote contingencies.

# Note 11: Directors Remuneration

The number of non-executive directors of the Commission included in these figures are shown below in the relevant remuneration bands:

	2013	2012
	No.	No.
\$0 to \$29,999*	12	12
\$30,000 to \$59,999	1	-
	13	12

Total remuneration received or due and receivable by directors of the<br/>Commission\$154,584\$61,763

\* 5 directors included in this band waived their right or were not eligible to receive remuneration during 2012-13 (2011-12: 5). Remuneration of executive directors is included in Note 13: Senior Executive Remuneration.

# Note 12: Related Party Disclosures

The directors of the Commission during the year were:

	<u>Commenced</u>	<u>Ceased</u>
Professor Villis Marshall AC (Chair from 1 April 2013)	1/04/2012	
Bill Beerworth (Chair until 31 March 2013)	1/07/2011	31/03/2013
Richard Bowden	1/07/2011	11/09/2012
Professor Chris Brook PSM	1/04/2012	
Veronica Casey	1/07/2011	31/03/2013
Professor Phillip Della	1/04/2013	
The Hon Verity Firth	1/04/2013	
Christine Gee	1/07/2011	
Professor Jane Halton PSM	1/07/2011	
Dr Shaun Larkin	1/04/2013	
Russell McGowan	1/07/2011	
Shelly Park	1/07/2011	
Dr Helena Williams	1/07/2011	

The aggregate remuneration of directors is disclosed in Note 11.

#### Transactions with directors of director related entities

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

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

#### Transactions with related parties

Transactions between related parties are on normal commercial terms and conditions unless otherwise stated.

6

# Note 13: Senior Executive Remuneration

# Note 13A: Senior executive remuneration expenses for the reporting period

	2013	2012
	\$	\$
Short-term employee benefits		
Salary	809,068	600,000
Annual leave accrued	74,828	56,176
Performance bonuses	24,200	14,976
Total short-term employee benefits	908,096	671,152
Post-employment benefits Superannuation Total post-employment benefits	<u> </u>	<u> </u>
Other long-term benefits Long service leave Total other long-term benefits	14,302 14,302	58,173 58,173
Termination benefits Total	- 1,022,411	- 840,076

#### Notes:

1. Note 13A is prepared on an accruals basis.

2. Note 13A excludes acting arrangements and part-year service where remuneration expensed for a senior executive was less than \$180,000.

Note 13B: Average Annual Reportable Remuneration Paid to Substantive Senior **Executives During the Reporting Period** 

			2013			
Average annual reportable remuneration <sup>1</sup>	Senior Executives	Reportable salary²	Contributed superannuation <sup>3</sup>	Reportable allowances <sup>4</sup>	Bonus paid⁵	Total
-	No.	<u>م</u>	\$	\$	\$ <del>9</del>	\$
Total remuneration (including part-time arrangements):						
less than \$180,000	~	127,527	18,706		'	146,232
\$270,000 to \$299,999	7	229,033	37,065		12,100	278,198
\$390,000 to \$419,999	~	373,094	25,597	1,162	'	399,853
Total	4					
			2012			
Average annual reportable remuneration <sup>1</sup>	Senior Executives	Reportable salarv²	Contributed superannuation <sup>3</sup>	Reportable allowances⁴	Bonus paid⁵	Total
-	No.	ς <del>ο</del>	<del>ه</del> -	\$	ۍ •	θ
Total remuneration (including part-time arrangements):						
less than \$180,000	2	64,593	5,681	I	ı	70,274
\$210,000 to \$239,999	~	198,923	26,075	ı	14,976	239,974
\$240,000 to \$269,999	-	210,862	32,473	ı	'	243,335
\$360,000 to \$389,999	-	313,589	53,102	1,126	'	367,817
Total	5					
Notes:						
<ol> <li>This table reports substantive senior executives who received remuneration during the reporting period. Each row is an averaged figure based on headcount for individuals in the band.</li> </ol>	ed remuneration	during the repor	ting period. Each row	is an averaged fiç	gure based	on
2. 'Reportable salary' includes the following:						
a) gross payments (less any bonuses paid, which are separated out and disclosed in the 'bonus paid' column);	rated out and dis	sclosed in the 'bc	onus paid' column);			
b) reportable fringe benefits (at the net amount prior to 'grossing up' to account for tax benefits);	ssing up' to acco	ount for tax benef	fits);			
<ul> <li>c) exempt foreign employment income; and</li> </ul>						
d) salary sacrificed benefits.						

Bonus paid' represents average actual bonuses paid during the reporting period in that reportable remuneration band. The 'bonus paid' within a particular band may vary between financial years due to various factors such as individuals commencing with or leaving the Commission during the financial year

Reportable allowances' are the average actual allowances paid as per the 'total allowances' line on individuals' payment summaries.

executives in that reportable remuneration band during the reporting period.

4.

Ω.

ю.

The 'contributed superannuation' amount is the average cost to the Commission for the provision of superannuation benefits to substantive senior

taff	
y Paid Staf	
Note 13C: Other Highly	
: Other	
te 13C	
No	

			2013			
Average annual reportable remuneration <sup>1</sup>	Staff	Reportable salary²	Contributed superannuation <sup>3</sup>	Reportable allowances <sup>4</sup>	Bonus paid⁵	Total
	No.	<b>`</b> \$	\$	\$	\$	\$
Total remuneration (including part-time arrangements):						
\$180,000 to \$209,999	ო	158,612	27,060		16,915	202,586
\$210,000 to \$239,999	-	183,182	27,160	892	17,078	228,312
\$240,000 to \$269,999	-	200,333	31,240	377	25,245	257,195
Total	S					
			2012			
		Reportable	Contributed	Reportable	Bonus	
Average annual reportable remuneration <sup>1</sup>	Staff	salary²	superannuation <sup>3</sup>	allowances <sup>4</sup>	paid <sup>5</sup>	Total
	No.	⇔	\$	Ф	¢	Ф
Total remuneration (including part-time arrangements):						
\$180,000 to \$209,999	2	151,949	26,091	374	18,064	196,478
\$210,000 to \$239,999	-	173,879	27,653	1,751	18,000	221,283
Total	З					
Notes:						
1. This table reports staff:						
<ul> <li>a) who were employed by the Commission during the reporting period;</li> <li>b) whose reportable remineration was \$180,000 or more for the financial period; and</li> </ul>	ng period;	cial period: and				
c) were not required to be disclosed in Tables A, B or director disclosures.	r disclosu	res.				
Each row is an averaged figure based on headcount for individuals in the band	als in the b	and.				
2. 'Reportable salary' includes the following:						
a) gross payments (less any bonuses paid, which are separated out and disclosed in the 'bonus paid' column); b) reportable fringe benefits (at the net amount prior to 'grossing up' to account for tay benefits).	ated out an	account for tay h	e 'bonus paid' column);			
<ul> <li>c) reportance mingle periods (at the mindling provide growing up to account of the second of the year); and</li> <li>c) exempt foreign employment income (nil paid by the Commission during the year); and</li> <li>d) salary sacrificed benefits.</li> </ul>	or do do lucion do	ring the year); ar	d d			
3. The 'contributed superannuation' amount is the average cost to the Commission for the provision of superannuation benefits to other highly paid staff in that reportable remuneration band during the reporting period.	to the Co J.	mmission for the	provision of superannu	ation benefits to ot	her highly pai	d staff in
4. 'Reportable allowances' are the average actual allowances paid as per the 'total allowances' line on individuals' payment summaries.	aid as per	the 'total allowa	nces' line on individuals	payment summari	es.	
5. 'Bonus paid' represents average actual bonuses paid during the reporting period in that reportable remuneration band. The 'bonus paid' within a particular band may vary between financial years due to various factors such as individuals commencing with or leaving the Commission during the financial year.	the report s such as	ing period in that individuals comm	reportable remuneratio lencing with or leaving t	in band. The 'bonus the Commission du	s paid' within ring the finan	a particular cial year.

6

# Note 14: Remuneration of Auditors

	2013 \$'000	2012 \$'000
Financial statement audit services were provided to the Commission by the Australian National Audit Office (ANAO).		
Cost of the services provided Financial statement audit services	50	50
Total	50	50
Iotal		
No other services were provided by the ANAO.		
Note 15: Financial Instruments		
Note 15A: Categories of financial instruments		
	2013	2012
	\$'000	\$'000
Financial assets	,	
Loans and receivables:		
Cash on hand and at bank	7,050	11,984
Trade and other receivables Total	<u>1,027</u> 8,077	<u>1,813</u> 13,797
	8,077	13,797
Carrying amount of financial assets	0,077	15,757
Financial liabilities		
At amortised cost:		
Trade creditors and accruals		
Suppliers	2,478	12,879
Total	2,478	12,879
Carrying amount of financial liabilities	2,478	12,879
Note 45D: Not income and expense from		
Note 15B: Net income and expense from financial assets		
Loans and receivables		
Interest revenue	431	54
Net gain/(loss) loans and receivables	431	54
Net gain/(loss) from financial assets	431	54



# Note 15C: Fair value of financial instruments

	Carrying	Carrying
	amount	amount
	2013	2012
Financial assets	\$'000	\$'000
Loans and receivables:		
Cash and cash equivalents	7,050	11,984
Trade and other receivables	1,027	1,813
Total	8,077	13,797
Carrying amount of financial assets	8,077	13,797
Financial liabilities		
At amortised cost:		
Suppliers	2,478	12,879
Total	2,478	12,879
Carrying amount of financial liabilities	2,478	12,879

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

# Note 15D: Credit risk

The Commission was exposed to minimal credit risk as loans and receivables were cash and trade receivables. The maximum exposure to credit risk was the risk that arises from potential default of a debtor. This amount was equal to the total amount of trade receivables at 30 June 2013: \$1,027,000 (2012: \$1,813,000).

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

The Commission holds no collateral to mitigate against credit risk.

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

		Not past due nor impaired		r impaired
	2013	2012	2013	2012
	\$'000	\$'000	\$'000	\$'000
Cash and cash equivalents	7,050	11,984	-	-
Trade and other receivables	1,015	1,813	12	-
Total	8,065	13,797	12	-

## Note 15E: Liquidity risk

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

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

#### Maturities for financial liabilities 2013:

	On demand \$'000	Within 1 year \$'000	Total \$'000
Other financial liabilities			
Suppliers	-	2,478	2,478
Total	-	2,478	2,478

#### Maturities for financial liabilities 2012:

	On demand \$'000	Within 1 year \$'000	Total \$'000
Other financial liabilities			
Suppliers	-	12,879	12,879
Total	-	12,879	12,879

## Note 15F: Market risk

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

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

# Note 16: Financial Assets Reconciliation

		2013	2012
	Notes	\$'000	\$'000
Financial assets			
			44.050
Total financial assets as per balance sheet		8,211	14,852
Less: non-financial instrument components:			
Other receivables	<u>5B</u>	134	1,055
Total non-financial instruments components	_	134	1,055
Total non-financial assets as per financial instruments note	_	8,077	13,797

# Note 17: Compensation and Debt Relief

No payments were made during the reporting period for compensation and debt relief (2011-12: Nil).

# Note 18: Reporting of Outcomes

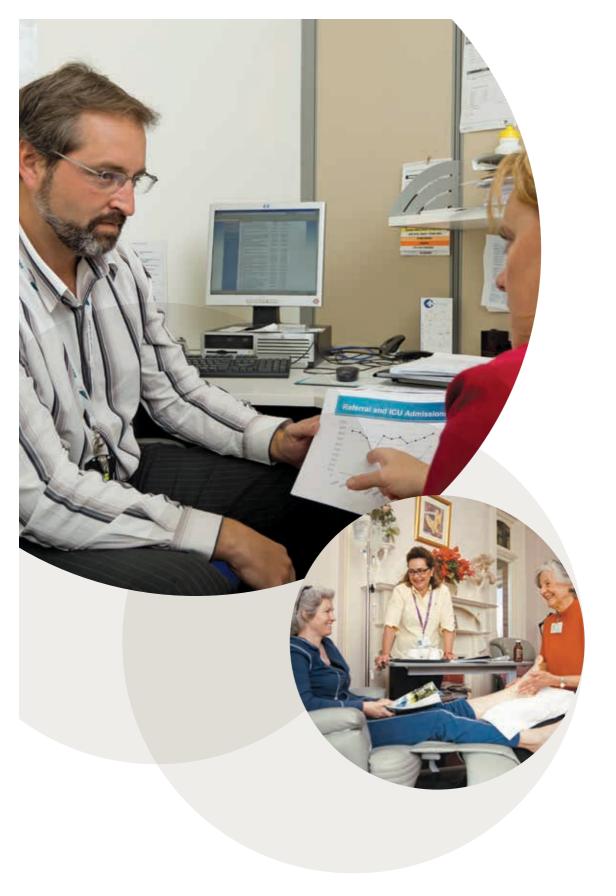
## Note 18A: Net Cost of Outcome Delivery

The Commission is structured to meet one outcome:

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

	Outco	Outcome 1	
	2013 \$'000	2012 \$'000	
Expenses			
Departmental	13,964	13,054	
Income from non-government sector			
Sale of goods and rendering of services	2,413	912	
Interest	431	54	
External contributions	5,665	5,500	
Total income from non-government sector	8,509	6,466	
Net cost of outcome delivery	5,455	6,588	

The primary statements of these financial statements represent the Major Classes of Departmental Expense, Income, Assets and Liabilities by Outcome, as required by the FMOs. Accordingly these tables are not repeated in note 18.



# Appendices

Appendix A: Publications	100
Appendix B: Published articles	104
Appendix C: Engagement in research	105
Appendix D: Event sponsorship	112
Appendix E: External representations	113
Appendix F: Formal consultations	115
Appendix G: Freedom of Information summary	117
Appendix H: Compliance to ecologically sustainable development	118



# Appendix A

# **Publications**

The following table summarises the key publications released by the Commission during 2012/13, as discussed on page 33. Additional newsletters, resources and other materials released throughout the year have not been listed here but are available via the Commission's web site.

Publication	Description	Date released
Clinical communications		
Patient-Clinician Communication: An Overview of Relevant Research and Policy Literatures Idema, R and Manidis, M	Commission funded literature review of patient-clinician literature, reports and strategies	June 2013
Healthcare associated infection		
Core Information components: Structured requests and reports for Healthcare Associated Infections	Document to support the definition of a national approach to surveillance of healthcare associated infections	January 2013
Implementation guide for the Surveillance of Staphylococcus aureus bacteraemia	Guide to ensure consistency in the reporting of <i>Staphylococcus</i> <i>aureus</i> bacteraemia to enable accurate national reporting and benchmarking	March 2013
Implementation guide for the Surveillance of Clostridium difficile infection	Guide to support hospitals with implementation of hospital identified <i>Clostridium difficile</i> infection surveillance	March 2013
Health information strategy		
Core hospital-based outcome indicator Toolkit	A toolkit enabling jurisdictions and private hospital ownership groups to generate nationally referenced and risk adjusted core indicators	June 2013
National set of core, common patient experience questions – overnight admitted patients	A set of questions endorsed as the standard for non-mandatory data collection	March 2013
Hospital pricing and safety and quality		
A literature review on integrating quality and safety into hospital pricing systems	A literature review of approaches to integrating quality and safety into hospital pricing systems	May 2013

# Appendices 7

Publication	Description	Date released
Supplementary Briefing and Literature Update: Integrating safety and quality into hospital pricing systems	This paper has been prepared to supplement the research undertaken with regards to pricing for safety and quality in health care	May 2013
Medication safety		
National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines: Evaluation of label adherence to reusable hollowware containers used in the operating room (2nd report)	A second evaluation of label adherence to reusable hollowware containers in the operating room to support and extend information provided in Report 1 (April 2012)	July 2012
National Residential Medication Chart User Guide • for Pharmacists • for Medical Practitioners • for Nursing and Care Staff	National Residential Medication Chart user guides to ensure nationally consistent implementation and use in the phased implementation stage of the project	August 2012
National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines: Evaluation of standardised medicine line labels for medicines in dedicated continuous infusions	Report of evaluation of standardised pre-printed medicine line labels in four intensive care units	November 2012
National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines: Evaluation of pre-printed labels for identification of medicines and fluids on the perioperative sterile field	Report of evaluation of pre-printed medicine line labels in perioperative areas	January 2013
National Residential Medication Chart "RACF Pack": Implementation toolkit	A collection of resources to support residential aged care facilities with implementation of the National Residential Medication Chart	January 2013
National Inpatient Medication Chart Venous Thromboembolism Pilot Final Report	Report of national piloting of a draft National Inpatient Medication Chart with a pre-printed VTE prophylaxis section	June 2013
Mental health		
Draft mapping of the NSQHS Standards (2011) with the National Standards for Mental Health Services (2010)	Document presents the results of work to map the NSQHS Standards (2011) with the National Standards for Mental Health Services (2010)	September 2012



Appendices

Publication	Description	Date released
Consultation Draft Accreditation Workbook for Mental Health Services	Workbook developed to guide mental health services through the accreditation process for the NSQHS Standards, and highlight areas where mental health services will have also substantively achieved relevant National Standards for Mental Health Services	December 2012
NSQHS Standards and accreditation		
National Safety and Quality Health Service Standards, October 2012	Revised document presenting the NSQHS Standards developed in consultation and collaboration with jurisdictions, technical experts and stakeholders, including health professionals and patients	October 2012
Safety and Quality Improvement Guides	Individual guides designed to	October
<ul> <li>Standard 1: Governance for Safety and Quality in Health Service Organisations</li> <li>Standard 2: Partnering with Consumers</li> <li>Standard 3: Preventing and Controlling Healthcare Associated Infections</li> <li>Standard 4: Medication Safety</li> <li>Standard 5: Patient Identification and Procedure Matching</li> <li>Standard 6: Clinical Handover</li> <li>Standard 7: Blood and Blood Products</li> <li>Standard 8: Preventing and Managing Pressure Injuries</li> <li>Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care</li> <li>Standard 10: Preventing Falls and Harms from Falls</li> </ul>	assist health services to align their quality improvement programs using the framework of the NSQHS Standards	2012
NSQHS Standards Hospital Accreditation Workbook	Workbook developed for individuals within hospitals who are responsible for coordinating the accreditation process	October 2012
NSQHS Standards Day Procedure Service Accreditation Workbook	Workbook developed for individuals within day procedure services who are responsible for coordinating the accreditation process	October 2012

# Appendices 7

Publication	Description	Date released
NSQHS Standards Guide for Small Hospitals. Sydney	Guide specifically designed to support small hospitals with the implementation of safety and quality improvements in line with the NSQHS Standards	May 2013
Open disclosure		
Open Disclosure Standard Review Consultation Report	Report detailing the outcomes of national consultation on the review of the Open Disclosure Standard	October 2012
Australian Open Disclosure Framework	Framework intended for use by	June 2013
20 supporting resources were released with the Open Disclosure Framework. Details and downloads can be found under the Open Disclosure section of the Commission web site	health service organisations across all settings and sectors. To be used to inform new open disclosure policies and modify existing ones	
Partnering with consumers		
Health Literacy Stocktake Consultation Report	A snapshot of key approaches in Australia to address health literacy. Includes case studies of specific projects and activities	September 2012
Consumers, the health system and health literacy: Taking action to improve safety and quality (consultation paper)	Consultation paper that outlines the landscape and context for health literacy in Australia today and proposes some key components of a nationally coordinated and consistent approach to health literacy	June 2013

.....



# **Appendix B**

# **Published articles**

The following table lists the journal articles, published during 2012/13, to which Commission staff contributed.

#### Table 4: Published articles with contribution from Commission

Article name / authors	Publication / Date
Measuring organisational and individual factors thought to influence the success of quality care: a systematic review of instruments Brennan, S.E., Bosch, M., Buchan, H., Green, SE	Implementation Science December 2012
Anatomy of an Incident Disclosure: The Importance of Dialogue. Iedema R, Allen S	The Joint Commission Journal on Quality and Patient Safety October 2012, (vol. 38, no. 10, pp 435–442)
Learning from incident reports in the Australian medical imaging setting: handover and communication errors	British Journal of Radiology January 2013
Hannaford N, Mandel C, Crock C, Buckley K, Magrabi F, Ong M, Allen S, Shultz T	
Measuring team factors thought to influence the success of quality improvement in primary care: a systematic review of instruments	Implementation Science February 2013
Brennan, S.E., Bosch, M., Buchan, H., Green, SE	
Refining a taxonomy for guideline implementation: results of an exercise in abstract classification	Implementation Science March 2013
Mazza D, Bairstow P, Buchan H, Chakraborty SP, Van Hecke O, Grech C, Kunnamo I	
Out of the frying pan? Streamlining the ethics review process of multisite qualitative research projects	Australian Health Review April 2013
ledema R, Allen S, Britton K, Hor S	
An empirical test of accreditation patient journey surveys: Randomized trial	International Journal for Quality in Health Care
Greenfield, DR, Hinchcliff, R, Westbrook, MT, Jones, D, Low, L, Johnston, BW, Banks, M, Pawsey, M, Moldovan, M, Westbrook, J & Braithwaite, J	July 2012 (vol. 24, no. 5, pp. 495–500)

7

# Appendix C

# **Engagement in research**

The following table summarises the research activities and projects that the Commission was involved with during 2012/13, as discussed on page 36.

Research	Research organisation	Brief description	Commission role	Project status
Rapid identification of patient safety incidents reported by health professionals	Centre for Health Informatics, Australian Institute of Health Innovation, The University of New South Wales	<ul> <li>The scientific aims of this project are to:</li> <li>1. Automate identification of the type of patient safety incident by applying text classification methods and evaluating their performance.</li> <li>2. Automate identification of the level of risk associated with a patient safety incident by applying text classification methods and evaluating their performance.</li> </ul>	Associate Investigator	Project to be completed in 2014
Strengthening organisational performance through accreditation research: the ACCREDIT Project	Centre for Clinical Governance Research in Health, Australian Institute of Health Innovation, University of New South Wales	<ul> <li>A collaboration of 12 inter related studies with the aims of:</li> <li>a) evaluating current accreditation processes</li> <li>b) analysing the costs and benefits of accreditation</li> <li>c) improving future accreditation via evidence</li> <li>d) developing and applying new standards of consumer involvement in accreditation</li> </ul>	Associate Investigator and National Partner Organisation	Project to be completed in 2015

#### Table 5: Commission engagement in research during 2012/13

Research	Research organisation	Brief description	Commission role	Project status
Handover Errors in Radiology	Australian Patient Safety Foundation	Identify and analyse incidents in radiology that have occurred as a result of errors in the handover of information between health providers, throughout any stage of the imaging cycle. The project is a Royal Australian and New Zealand College of Radiologists (RANZCR) initiative, managed under the Quality Use of Diagnostic Imaging Program, and funded by the Australian Government Department of Health and Ageing under their diagnostic imaging quality projects program.	Commission representative on Clinical interest group as well as content expert, analyst and co-author to publication	Completed in 2013
Assessing Preventable Hospitalisation Indicators (APHID) Study	University of Western Sydney	This project will investigate the validity of 'potentially preventable hospitalisations' (PPH) as a measure of the quality and affordability of primary and community care in Australia. It will explore relationships between use of primary care services, hospital admissions for PPH diagnoses, and health outcomes and quantify the contributions of person, geographic and service level factors to variations in PPH	Funding partner; Associate investigator	Project to be completed in 2014

_	

Research	Research organisation	Brief description	Commission role	Project status
Listen to me, I really am sick! Understanding patient and family perspectives in triggering responses to medical emergencies	Deakin University	<ul> <li>The aims of this study are to:</li> <li>1) investigate the role and influence of patients and relatives in triggering responses from health providers to critical patient deterioration in hospital; and</li> <li>2) to identify communication strategies that may decrease preventable serious adverse events. A qualitative design using patient and family member interviews, and medical record reviews, will be undertaken. Data will be analysed using narrative inquiry.</li> </ul>	Partner organisation Participation on a project advisory panel	Project to be completed in 2015
Centre for Research Excellence in Primary Health Care Microsystems: Stream 2 – Improving Safety and Quality in Primary Health Care	Centre for Research Excellence in Primary Health Care Microsystems, University of Queensland Professor Claire Jackson, University of Queensland Professor James Dunbar, Director of Greater Green Triangle University Department of Rural Health	The CRE research program addresses primary health care quality, safety, governance, performance measurement and sustainability issues identified within the national health reform agenda. A systematic approach to improving patient safety through a Collaborative run by the Australian Primary Care Collaboratives of the Improvement Foundation. The Primary Care Practice Improvement Tool (PC-PIT) developed by the CRE will provide Australian primary care with an easy-to-use quality improvement tool that can be embedded into their existing quality improvement cycle.	Associate Investigator and National Partner Organisation	Project to be completed in 2014

7 Appendices

Research	Research organisation	Brief description	Commission role	Project status
ECCHO Effective Clinical Communication in Handover	University of Technology Sydney, Flinders University, University of Adelaide, University of Melbourne, University of Queensland, Curtin University and four health departments from New South Wales, the Australian Capital Territory, South Australia, Western Australia, Victoria and Queensland.	The ECCHo project is a three-year national research study involving a team from universities and health departments in New South Wales, the Australian Capital Territory, South Australia, Western Australia, Victoria and Queensland, who are studying effective (and ineffective) communication during clinical handovers. The research team is working with health care providers in hospitals in New South Wales, the Australian Capital Territory, Western Australia and South Australia to observe, describe and analyse how health care providers in different hospital settings do their clinical handovers.	National Representative member of National Clinical Advisory Group (NCAG)	Project to be completed 2014

Research	Research organisation	Brief description	Commission role	Project status
Implementing Falls Prevention Research into Policy and Practice: NHMRC Partnership for Better Health Program	NeuroScience Research Australia, University of New South Wales	<ul> <li>This five year project</li> <li>represents a partnership</li> <li>between key Australian</li> <li>falls prevention</li> <li>researchers, policy makers</li> <li>and technology companies</li> <li>which aims to:</li> <li>a) fill gaps in evidence</li> <li>relating to the</li> <li>prevention of falls in</li> <li>older people,</li> <li>b) translate evidence into</li> <li>policy and practice so</li> </ul>	Partner Organisation providing in kind resourcing Member of the Program Management Board	Project to be completed 2014
		<ul> <li>c) disseminate evidence to health providers working with older people, to improve the workforce capacity to prevent falls and associated injuries in the future.</li> </ul>		
Centre of Research Excellence in e Health	Centre for Health Informatics (University of New South Wales)	The Centre for Research Excellence will conduct a collaborative research program with three major aims, focusing on the safety and quality of clinical and consumer e-health systems, where research evidence is urgently needed, and opportunities for translational impact are high.	Member of Advisory Committee	Project to be completed in 2016

7 Appendices

Research	Research organisation	Brief description	Commission role	Project status
Evaluating hand hygiene interventions and their ability to reduce healthcare associated infection	Queensland University of Technology	The National Hand Hygiene Initiative (NHHI) is currently being implemented to improve hygiene among healthcare workers. This research will evaluate the NHHI and measure how well the program worked, what factors were important to its success, and whether implementing the program was good value for money.	Policy partner for the NHMRC Partnership Project 2 Associate Investigators, Chair of the Steering Committee	Research has commenced
Centre for Research Excellence in Reducing Healthcare Associated Infection	Queensland University of Technology	Research areas identified: a) estimating the impact of healthcare associated infection on length of hospital stay and death risk b) clinical effectiveness	Health policy partner and a Chief Investigator	Research has commenced
		of infection control interventions c) transmission dynamics of infectious pathogens		
		<ul> <li>d) implementation costs</li> <li>of infection reduction at</li> <li>the health system level</li> </ul>		
		<ul> <li>e) decision making by politicians, bureaucrats and health managers</li> <li>f) emerging pathogens</li> </ul>		

-	Ζ

Research	Research organisation	Brief description	Commission role	Project status
Guideline Implementation: Developing collaborative capacity for rapid cycle research and application	University Health Network (Toronto)	An international collaboration to create a network of agencies interested in: a) validating, testing and applying interventions and tools based on the guideline implementability framework	Member of Steering Committee and Collaborator Committee	Research has commenced
		b) generating a user informed research agenda for developing, implementing and evaluating the impact of tools and interventions based on the implementability framework		
		<ul> <li>c) enabling rapid cycle</li> <li>real world testing of</li> <li>implementability tools</li> <li>and interventions</li> </ul>		
		d) accelerating the translation of this new knowledge into guideline development and quality improvement practices.		
		Funded by Canadian Institutes of Health Research.		



# Appendix D

# **Event sponsorship**

The Commission sponsored three events which took place during 2012/13, as discussed on page 36.

#### Table 6: Event sponsorship 2012/13

Event name	Organiser	Date held	Sponsorship amount
10th Australasian Conference in Safety and Quality in Health Care	Australasian Association for Quality in Health Care	September 2012	\$15,000
The Quantum Leap: Redefining Health's Boundaries	Australian Healthcare and Hospitals Association	September 2012	\$15,000
5th Biennial ANZ Falls Prevention Society Conference	Australian and New Zealand Falls Prevention Society	October 2012	\$10,000



# Appendix E

### **External representations**

The following table lists the various international, national and jurisdictional committees and organisations at which the Commission has been represented during 2012/13, as discussed on page 37.

#### Table 7: Commission external representation 2012/13

Committee / Organisation
Acute Coronary Syndrome Implementation Working Group, Heart Foundation
Australasian College of Emergency Medicine, Quality and Patient Safety Standards Reference Group
Australian Health Protection Principal Committee
Australian Private Hospitals Association, Psychiatric Sub Committee
Breast Screen Accreditation Committee
Centre for Culture Ethnicity and Health, Health Literacy Advisory Group
Centre of Research Excellence in Post Marketing Surveillance of Medicines and Medical Devices Advisory Board
Centre of Research Excellence in Primary Health Care Clinical Microsystems, National Advisory Committee and Advisory Committee for Stream 2: Quality and Safety in Primary Care
Clinical Excellence Commission, In Safe Hands Steering Committee
Committee of Presidents of Medical Colleges
Consumers Health Forum, Informed Consent Steering Committee
Deakin University Centre for Quality Patient Safety Research, External Advisory Committee
Health Literacy Network convened by the Clinical Excellence Commission
Health Workforce Australia, Health Professional Prescribing Pathways Project
Implementing Falls Prevention Research into Policy and Practice NHMRC Partnership Program Scientific Advisory Committee, Neuroscience Research Australia, University of NSW
Joint Accreditation System of Australia & New Zealand
Mental Health and Drug and Alcohol Principal Committee
Mental Health Information Strategy Subcommittee
National Blood Authority, Haemovigilance Advisory Committee
National Health and Medical Research Council, Health Care Committee
National Health Enterprise Data Warehouse Board
National Health information and Performance Principal Committee
National Health Information Standards and Statistics Committee, Patient Experience Information Development Working Group
National Health Performance Authority, Patient Experience Working Party
National Lead Clinicians, Integrated Care Working Group
National Lead Clinicians, Promoting Best Practice Working Group



Appendices

#### Committee / Organisation

National Trauma Research Institute, Australian Trauma Quality Improvement Steering Committee
NPS MedicineWise, Medicine Insight Advisory Group
Organisation for Economic Co-operation and Development, Expert Group on Medical
Practice Variations
Patient Experience Information Development Working Group
Queensland Health Patient Safety and Quality Improvement Service, Recognising and Managing the
Deteriorating Patient Reference Group
Queensland Health Patient Safety and Quality Improvement Service, Statewide Clinical Handover
Reference Group
Reducing Adverse Medication Events in Mental Health Working Party, Safety and Quality Partnerships
Standing Committee
Royal District Nursing Service, Research Advisory Committee
Safety and Quality Partnerships Standing Committee, Mental Health and Drug and Alcohol
Principal Committee
Therapeutic Goods Administration, Medicine Labelling and Packaging Review External
Reference Group
University of Technology Sydney, Faculty of Health, Health Service Management, Curriculum Review,
Clinical Governance

# Appendix F

# **Formal consultations**

The following table summarises the formal consultations undertaken during 2012/13 to inform the Commission's work with respect to specific issues, as discussed on page 54.

Table 8: Summary	of formal	consultations	undertaken	durina 2012/13
rabio or oanniary	01 10111a	oonoantationio	anaontanton	aaning 2012, 10

Consultation topic	Method	Information received	Date	
Medication safety				
National Residential Medication Chart (NRMC) phased implementation	Written survey of end users	120 responses	July 2013	
Phased implementation of NRMC pilot	Commencement of supply and claim of PBS/RPBS medicines from a medication chart in 27 RACFs in NSW	Ongoing development, NRMC 2 (revised version of NRMC 1) commenced	April – July 2013	
Draft National NRMC Transition Framework: Moving beyond the NRMC phased implementation pilot sites in NSW to federally funded residential aged care facilities in Australia	Collaborative drafting workshops with pilot sites, onsite consultation, surveys and focus groups	Ongoing development during pilot phase	April – July 2013	
Mental health				
Draft Accreditation Workbook for Mental Health Services	Online survey and request for written submissions	39 survey responses 6 written submissions	January – March 2013	
National scoping study on national standards in mental health services	Online survey and meetings	425 survey responses	March – June 2013	
National Safety and Quality Health Service Standards and accreditation				
Implementation of NSQHS Standards in jurisdictions	Workshops and meetings with jurisdictions	Ongoing feedback	July 2012 – June 2013	
Implementation of NSQHS Standards – implications for private health insurers	Workshops and meetings with private health insurers	Ongoing feedback	July 2012 – June 2013	



Consultation topic	Method	Information received	Date
Draft NSQHS Standards	Online survey and	57 written submissions	August 2012
Safety and Quality Improvement Guides, Hospital	request for written submissions	297 survey responses	
Day Procedure Workbooks and Dental Practice Guides			
NSQHS Standards Guide for Small Hospitals	Request for written submissions	12 written submissions	February 2013
Effectiveness of accreditation online networks	Online survey	105 responses	May 2013
Open disclosure			
Review of the Open Disclosure Standard	Online survey, written submissions and consultation forums	149 online surveys completed; 34 detailed written submissions; Feedback from 136 consultation forum participants	July – August 2012
Recognising and responding to clinical deterioration			
Issues in end-of-life care in hospitals	Interviews and focus groups	43 interviews and focus groups	November 2012 – February 2013

# Appendix G

## Freedom of Information summary

The following table summarises the year's Freedom of Information (FOI) requests and their outcomes, as discussed on page 56.

#### Table 9: Freedom of Information summary 2012/13

Activity	Number
Requests	
On hand at 1 July 2012	0
New requests received	2
Total requests handled	2
Total requests completed as at 30 June 2013	2
Action of request	
Access granted in full	2
Access granted in part	0
Access refused	0
Access transferred in full	0
Request withdrawn	0
No records	0
Response times	
0–30 days	0
30–60 days	2
Internal review	
On hand as at 1 July 2012	0
Requests received	0
Decision affirmed	0
Decision amended	0
Request withdrawn	0
Review by Administrative Appeals Tribunal	
Applications received	0
Review by the Officer of the Australian Information Commissioner	
Applications received	0

# Appendix H

# Compliance to ecologically sustainable development

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

#### Table 10: Summary of Commission's compliance to ecologically sustainable development

EPBC Act requirement	Commission response
The activities of, and the administration of legislation by, the Commission during 2012/13 accorded with the principles of ecologically sustainable development Outcomes specified for the Commission in an <i>Appropriations Act</i> for 2012/13 contribute to ecologically sustainable development	The Commission gives appropriate consideration to the effects its activities may have on the environment, including in terms of its work plan and corporate governance. Instances where the Commission's activities have environmental impacts are mitigated wherever possible. The Commission is not responsible for administering any legislation. The Commission's single appropriations outcome focuses on improving safety and quality in health care across the health system rather than environmental outcomes and, as such, has no implications on environmental protection and biodiversity conservation.
Effects of the Commission's activities on the environment	The Commission's offices are located in a 4.5-star (NABERS rating) building and the Commission's staff work proactively with the building manager to achieve energy savings where possible. Office lighting is automated to power off outside business hours, and the standard 'two globe' fittings have been replaced with a single globe, resulting in a 50% reduction in lighting energy consumption. The Commission encourages its staff to view documents online where possible and print only when necessary. The Commission's waste practices are in accordance with the National Waste Policy.
Measures the Commission is taking to minimise its impact on the environment	The Commission is working hard to further reduce its environmental effects, particularly in the area of information and communication technology (ICT). In 2012/13, the Commission implemented a number of initiatives required by the Australian Government ICT Sustainability Plan 2010–2015. These initiatives included introducing and using 100% post-consumer recycled paper, and modifying the Commission's ICT infrastructure, which will deliver desktop energy savings and reduce the Commission's carbon footprint. The Commission is also partnering with the City of Sydney's <i>CitySwitch</i> program to explore further environmental sustainability options.
Mechanisms for reviewing and increasing the effectiveness of those measures	The Commission is implementing a number of initiatives to reduce its environment impact, with a view to introducing a formal environmental policy. Review mechanisms will be included in this policy.

# 8

# Indexes and references

Acronyms and abbreviations	120
Glossary	121
Index of tables	126
Compliance index	127
Index	129
References	138

8

# Acronyms and abbreviations

AHMAC	Australian Health Ministers' Advisory Council
AHSSQA Scheme	Australian Health Service Safety and Quality Accreditation Scheme
CAC Act	Commonwealth Authorities and Companies Act 1997
CHBOI	core, hospital-based outcome indicators
the Commission	Australian Commission on Safety and Quality in Health Care
EPBC Act	Environment Protection and Biodiversity Conservation Act 1999
HAI	Healthcare associated infection
ННА	Hand Hygiene Australia
IHPA	Independent Hospital Pricing Authority
IJC	Inter-Jurisdictional Committee
NEHTA	National E-Health Transition Authority
NHHI	National Hand Hygiene Initiative
NHMRC	National Health and Medical Research Council
NHR Act	National Health Reform Act 2011
NIMC	National Inpatient Medication Chart
NSQHS Standards	National Safety and Quality Health Service Standards
OECD	Organisation for Economic Co-operation and Development
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
RPBS	Repatriation Pharmaceutical Benefits Scheme
SRC Act	Safety, Rehabilitation and Compensation Act 1988
WHO	World Health Organization
WHS Act	Work Health and Safety Act 2011

# Glossary

Accreditation: A status that is conferred on an organisation or individual when they have been assessed as having met particular standards. The two conditions for accreditation are compliance with an explicit definition of quality (that is, a standard) and passing an independent review process aimed at identifying the level of congruence between practices and quality standards.<sup>29</sup>

Acute healthcare facility: A hospital or other healthcare facility providing healthcare services to patients for short periods of acute illness, injury or recovery.

Adverse event: An incident in which harm resulted to a person receiving health care.

**Antibiogram:** A profile of the antimicrobial resistance and susceptibility of a particular microorganism.<sup>30</sup>

**Antimicrobial:** A chemical substance that inhibits or destroys bacteria, viruses and fungi, including yeasts or moulds.<sup>31</sup>

Antimicrobial stewardship: A program implemented in a health service organisation to reduce the risks associated with increasing microbial resistance, and to extend the effectiveness of antimicrobial treatments. Antimicrobial stewardship may incorporate a broad range of strategies, including monitoring and reviewing antimicrobial use.<sup>31</sup> **Casemix data:** The Department of Health manages a number of hospital related data collections. These contain information about hospital activity in the public and private systems. "Casemix data" is a short hand term for the National Admitted Patient Care Dataset, which contains de-identified patient level hospital separation information including patient demographics, hospital episode and clinical information (ICD-10-AM).

**Clinical communication:** An exchange of information that occurs between healthcare providers treating a patient. Communication can be formal (for example, when a message conforms to a predetermined structure in a health record or stored electronic data), or informal (when a message's structure is determined solely by the relevant parties, for example, a face-to-face or telephone conversation).<sup>32</sup>

**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.<sup>33</sup>

#### Clinical practice guidelines:

Systematically developed statements to help practitioners and patients make decisions about appropriate health care for specific circumstances.<sup>34</sup>

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

**Consumers:** Patients and potential patients, carers and organisations representing consumers' interests.<sup>35</sup>

#### Consumer-centred care:

A consumer-centred approach to care involves treating consumers and/or carers with dignity and respect; communicating and sharing information between consumers and/or carers and healthcare providers; encouraging and supporting consumers' participation in decision making; and fostering collaboration with consumers and/or carers and healthcare organisations in planning, designing, delivering and evaluating health care. Internationally, the terms patient-based, person-centred, relationship-based, patient-centred, and patient- and family-centred care are also used.

#### Core, hospital-based outcome indicators

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

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

**Dataset specifications:** Specifies a group of data elements and the conditions under which this group is collected. A data set specification can define the sequence in which data elements are included, whether they are mandatory, what verification rules should be employed and the characteristics of the collection (for example, its scope).

**Electronic medication management system:** Enables medicines to be prescribed, supplied, administered and reconciled electronically. **Fall:** An event that results in a person inadvertently coming to rest on the ground.<sup>36</sup>

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

#### Hand Hygiene Australia (HHA):

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

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

#### 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 the healthcare facility.<sup>37</sup>

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

Health service organisation: A separately constituted health service that is responsible for the clinical governance, administration and financial management of a service unit(s) that provide health care. A service unit is a group of healthcare providers and others working in a systematic way to deliver health care to patients. This can take place in any location or setting, including pharmacies, clinics, outpatient facilities, hospitals, patients' homes, community settings, medical practices and healthcare providers' clinic rooms. **Hospital:** A healthcare facility licensed by the respective regulator as a hospital, or declared as a hospital.

**Infection:** The invasion and reproduction of pathogenic or disease-causing organisms inside the body. This may cause tissue injury and disease.<sup>31</sup>

**Infection control or infection control measures:** Actions to prevent the spread of pathogens between people in a healthcare setting. Examples of infection control measures include targeted healthcare-associated infection surveillance, infectious disease monitoring, hand hygiene and wearing personal protective equipment.<sup>31</sup>

**Jurisdictions:** State and territory governments.

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

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

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

**Medication error:** Any preventable event that may cause or lead to inappropriate medication use or patient harm, while the medication is in the healthcare provider or consumer's control.<sup>38</sup>

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

**Medicine:** A chemical substance given to prevent, diagnose, cure, control or alleviate disease, or otherwise improve the physical or mental welfare of people. Prescription, non-prescription and complementary medicines, irrespective of their administration route, are included in this definition.<sup>39</sup>

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

National Hand Hygiene Initiative (NHHI): An initiative to develop a national approach to improving hand hygiene and monitor its effectiveness.

National Inpatient Medication Chart (NIMC): A suite of nationally standard medication charts, both paper and electronic, that present and communicate information consistently between healthcare providers on the medicines prescribed, dispensed, administered and reconciled for individual inpatients.

#### National Residential Medication Chart

(NRMC): The medication chart or set of standard elements for a medication chart the Commission developed. It permits Pharmaceutical Benefits Scheme (PBS) prescribers to prescribe, and eligible approved suppliers to claim for eligible PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS) medicines. It also sets out required fields for safely using medicines in residential aged care facilities.

#### National Safety and Quality Health Service (NSQHS) Standards:

The Commission developed ten Standards in consultation and collaboration with jurisdictions, technical experts and a wide range of relevant people, including healthcare providers and patients. The NSQHS Standards aim to protect the public from harm and to improve the quality of health services. They provide a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum safety and quality standards are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals.

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

Open disclosure is a discussion and an exchange of information that may take place over several meetings.

**Patient:** A person receiving health care. Synonyms for 'patient' include consumer and client.

**Patient safety:** Reducing the risk of unnecessary harm associated with health care to an acceptable minimum.

**Perioperative:** Pertaining or relating to the period of time surrounding a surgical procedure, including the preoperative, intraoperative, and postoperative periods.

**Point-of-care:** The time and location of an interaction between a patient and healthcare provider for the purpose of delivering care.

**Practice gaps:** The difference between actual and ideal performance and/or patient outcomes.

**Practice-level indicators:** Indicators designed for voluntary inclusion in quality improvement strategies at the local practice or service level. They are intended for local use by organisations and individuals providing primary healthcare services.

**Pressure injuries:** These are localised to the skin and/or underlying tissue, usually over a bony prominence and caused by unrelieved pressure, friction or shearing. Pressure injuries occur most commonly on the sacrum and heel but can develop anywhere on the body. Pressure injury is a synonymous term for pressure ulcer.

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

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

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

**Standard:** Agreed attributes and processes designed to ensure that a product, service or method will perform consistently at a designated level.

**Venous thromboembolism:** The blocking of a blood vessel by a blood clot dislodged from its site of origin. It includes both deep vein thrombosis and pulmonary embolism.

# Index of tables

8

Table		Page reference
Table 1	Board meetings and attendance	51
Table 2	Staff numbers by classification as at 30 June 2013	62
Table 3	Key Commission publications released during 2012/13	100
Table 4	Published articles with contribution from Commission staff	104
Table 5	Commission engagement in research during 2012/13	105
Table 6	Event sponsorship 2012/13	112
Table 7	Commission external representation 2012/13	113
Table 8	Summary of formal consultations undertaken during 2012/13	115
Table 9	Freedom of Information summary 2012/13	117
Table 10	Summary of Commission's compliance to ecologically sustainable development	118
Table 11	Mandatory reporting orders as per the CAC Orders or the NHR Act	127

.....



The Commission is bound by various legislative requirements to disclose certain information in this annual report. The main requirements are detailed in the Commonwealth Authorities (Annual Reporting) Orders 2011 (CAC Orders) and the *National Health Reform Act 2011* (NHR Act).

#### Table 11: Mandatory reporting orders as per the CAC Orders or the NHR Act

Requirement	Reference	Page listing compliant information
Amendments to the Commission's enabling legislation and to any other legislation directly relevant to its operation	CAC Orders 2011, sub-clause 16(d)	57
Approval by directors	CAC Orders 2011, clause 6	I.
Assessment of the effect of each of the Commission's functions	NHR Act 2011	11–39
Assessment of the performance of each of the Commission's functions	NHR Act 2011	11–39
Assessment of safety of healthcare services provided	NHR Act 2011	41
Board committees	CAC Orders 2011, clause 14	53–54
Commonwealth Disability Strategy	CAC Orders 2011, clause 12	64
Statement on governance	CAC Orders 2011, clause 14	45–57
Directors	CAC Orders 2011, clause 13	48–50
Ecologically sustainable development and environmental performance	CAC Orders 2011, sub-clause 12, ref Environment Protection and Biodiversity Conservation Act 1999, section 516A	57, 118
Education and performance review processes for Directors	CAC Orders 2011, clause 14	52
Enabling legislation, functions and objectives	CAC Orders 2011, clause 10	12
Ethics and risk management policies	CAC Orders 2011, clause 14	52, 55
Financial statements	Sub-clause 1(b) and sub-clause 2(1) of Schedule 1 to the CAC Act. Finance Ministers' Orders for Financial Reports July 2009	65–97
Financial statements certification: a statement, signed by the Directors	Sub-clause 2(3) of Schedule 1 to the CAC Act	68
Financial statements certification: Auditor-General's Report	Sub-clause 1(c) and Part 2 of Schedule 1 to the CAC Act	66
Fraud risk assessment and control	Commonwealth Fraud Control Guidelines 2002	55



Requirement	Reference	Page listing compliant information
General policies of the Australian Government and General Policy Orders	CAC Orders 2011, clause 12	n/a
Indemnities and insurance premiums for officers	CAC Orders 2011, clause 19	52
Information Publication Scheme Statement	CAC Orders 2011, clause 12	56, 117
Judicial decisions and decisions by administrative tribunals	CAC Orders 2011, clause 17	57
Key activities and changes that have affected the Commission	CAC Orders 2011, clause 16	11–39, 57
Letter of transmittal detailing approval by Directors	CAC Orders 2011, clause 6	I
Location of major activities and facilities	CAC Orders 2011, clause 14	inside cover, 62
Ministerial directions	CAC Orders 2011, sub-clause 12	46
Operational and financial results	CAC Orders 2011, sub-clause 16(b)	11–39, 65–97
Organisational structure	CAC Orders 2011, clause 14	60
Other legislation	CAC Orders 2011, clause 12	57
Related-entity transactions	CAC Orders 2011, clause 15	52
Reporting of significant events, as required by section 15 of the CAC Act	CAC Orders 2011, sub-clause 16(a)	57
Reports about the Commission by the Auditor-General, a parliamentary committee, the Commonwealth Ombudsman or the Office of the Australian Information Commissioner	CAC Orders 2011, clause 17	56–57
Responsible Minister	CAC Orders 2011, clause 11	3
Review of performance	CAC Orders 2011, clause 16	11–39
Work health and safety	CAC Orders 2011, clause 12, ref <i>Work Health and Safety Act</i> <i>2011</i> , Schedule 2, Part 4	63

# Index

#### Α

abbreviations, 120 accountability, 3 accreditation, 13-19 see also National Safety and Quality Health Service (NSQHS) Standards AHSSQA scheme, 9, 13, 16-17, 42 assessment, 5 hospitals and day procedure centres, 8, 14 implementation, 6 mental health, 18 NSQHS box set. 33-34 NSQHS Standards Accreditation Advice Centre, 4 Accreditation Workbook, 4, 14, 33 accrediting agencies, 4, 16 administration, 55-56 administrative tribunals, 57 aged see older patients AHSSQA scheme, 9, 13, 16-17, 42 antibiograms, 30, 31-32 Antibiotic Awareness Week, 4, 23 antibiotic use, 23 Antimicrobial Prescribing Modules, 27 antimicrobial resistance, 8-9, 23, 27, 31 assets contingent, 89 financial, 85, 97 non-financial, 86 Audit and Risk Committee, 53 audit, internal, 56

auditors

remuneration, 94

report, 66-67

Australasian College for Infection Prevention and Control, 24

Australasian Society for Infectious Diseases, 24

Australia and New Zealand Dialysis and Transplant Registry, 44

Australian and New Zealand Intensive Care Society, 44

Australian Antibiotic Awareness Week, 8, 23

Australian Antimicrobial Resistance Prevention and Containment (AMRPC) Steering Group, 9

Australian Atlas of Clinical Variation, 44

Australian Group on Antimicrobial Resistance, 24

Australian Health Ministers' Advisory Council (AHMAC), 13

Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme, 9, 13, **16–17**, 42

Australian Institute of Health and Welfare, 39

Australian Open Disclosure Framework, 28–29, **34** 

Australian Public Service Commission's survey, 62

Australian Safety and Quality Framework for Health Care, 24

Australian Safety and Quality Goals for Health Care, 12, 13, 24

Australian Society for Antimicrobials, 24

#### В

balance sheet. 70 barcodes, 27 Beerworth, Bill, 7, 9, 51, 53, 90 Board, 47-52 Code of Conduct, 52 committees see committees development and review, 52 Directors' remuneration, 90 Directors' statement, 68 Governance Charter, 52 indemnity and insurance, 52 meetings and attendance, 51 membership, 47, 48-50 related-entity transactions, 52 remuneration and expenses, 52 Bowden, Richard, 51, 53, 90 Brook, Professor Christopher, 48, 51, 90 Burgess, Trevor, 53 Business Committees, 55

#### С

CAC Act see Commonwealth Authorities and Companies Act 1997 (CAC Act) carbapenem-resistant enterobacteriaceae (CRE), 24 casemix data, 38, 121 cash flow, **72**, 89 CEO's report, **8–9** Chair's welcome, **6–7** CHBOI (core, hospital-based outcome indicators), **30–31** CHBOI Toolkit, 30

Clark, Jennifer, 53 Clinical Care Standards program, 4, 6, 13, **17** Clinical Communications program, 20 clinical quality registries, 19 Clozapine Titration Chart, 26 Code of Conduct. 52 collaborative projects, 7, 37-39 Comcare Work Health and Safety e-learning training module, 63 Commission Board see Board commitments schedule, 73 committees, 53-54 Audit and Risk Committee, 53 Inter-Jurisdictional Committee (IJC), 53. **54** internal management, 55 Commonwealth Authorities and Companies Act 1997 (CAC Act) Board, 47, 52 compliance, 53 enabling legislation, 2, 46 Commonwealth Authorities (Annual Reporting) Orders 2011, 52 compensation, 97 compensation claims, 63 compliance index, 127-128 conferences, 36, 112 **Consultation Draft Accreditation Workbook** for Mental Health Services, 18, 35 consultations, 54, 115-116 consumers see patients Consumers, the health system and health literacy, 25

contingent assets and liabilities, 89 continuing professional development (CPD), 64 continuous-infusion lines, 27 core, hospital-based outcome indicators (CHBOI), 5, **30–31** Core, Hospital-based Outcome Indicators Toolkit, 5 Core Indicators Working Party, 30 cumulative antibiograms, 31–32

#### D

data collection patient experience, 32 safety and quality, 44 data set development, 30-32 day procedure services accreditation, 14 Day Procedure Services Accreditation Workbook, 14, 33 debt relief. 97 decision making, 55 Della, Professor Phillip, 48, 51, 90 Department of Health Consultation Draft Accreditation Workbook, 35 Enterprise Data Warehouse, 16 implantable medical devices, 20 mental health services, 18 Department of Human Services, 38 Dialysis and Transplant Registry, 44 Directors see Board Directors' statement. 68 Disability Action Plan, 64

#### Е

ecologically sustainable development, 57, 118

education see training

elderly see older patients

electronic medication management systems, 27

*Electronic Medication Management Systems: Guide to Safe Implementation,* 27

employees see staff

enabling legislation see Commonwealth Authorities and Companies Act 1997 (CAC Act); National Health Reform Act 2011 (NHR Act)

end-of-life care, 21

enterprise agreement, 62

environmental performance, 57, 118

Environmental Protection and Biodiversity Conservation Act 1999 (EPBC Act), 57, 118 equity statement, **71** 

eSurveillance pilot project, 31

ethical standards, Board, 52

event sponsorship, 36, 112

Executive Management team, 55

expenses, 83–84

external representations, 37, 113-114

external scrutiny, 56-57

#### F

falls prevention, **22** financial assets, 85, 97 financial instruments, 94–96

financial statements, 65-97 auditor's report, 66-67 balance sheet. 70 cash flow. 72 changes in equity, 71 comprehensive income, 69 Directors' statement, 68 schedule of commitments. 73 first aid officers. 63 Firth, Hon. Verity, 48-49, 51, 53, 90 Framework for Safety and Quality in Health Care, 32 fraud control, 55 Fraud Control Plan, 55 Freedom of Information Act 1982 (FOI Act), 56 freedom of information (FOI), 56, 117

#### G

Gee, Christine, 49, 51, 54, 90 glossary, 121–125 governance, internal, **55–56** 'gram-negative' bacteria, 24 Guide for Small Hospitals, 14, **34** *Guideline recommendations for the control of multi-drug resistant gram negatives*, 24

#### Н

HAI Advisory Committee, 24 HAI eSurveillance pilot project, 30, **31** Halton, Professor Jane, 9, 49, 51, 90 hand hygiene, 22–23, 37, 42 Hand Hygiene Australia (HHA), 22–23, 37 health and safety, workplace, **63** 

health literacy, 4, 24-25, 34 Health Literacy Expert Advisory Group, 25 Health Literacy Stocktake Consultation Report, 4, 25, 34 healthcare-associated infection, 22-24, 30 - 31Healthcare Associated Infection (HAI) Advisory Committee, 24 Healthcare Associated Infection (HAI) eSurveillance pilot project, 30, 31 high-risk implantable devices, 20-21 highlights of 2012/13, 4-5 Hospital Accreditation Workbook, 14, 33 Hospital Pricing Authority (IHPA), 37, 38 hospitals accreditation, 8, 14 cumulative antibiograms, 31-32 funding, 4, 37 Guide for Small Hospitals, 34 NIMC, 26 outcome indicators, **30–31** patient experience questions, 30, 32 patient safety, 30 pricing, 7, 38 human resources see staff Human Resources Framework, 62 hygiene, hand, 22-23, 37, 42

#### l

IHPA (Independent Hospital Pricing Authority), 4, 7, 38
IJC (Inter-Jurisdictional Committee), 53, 54
implantable medical devices, 20–21
implementation guides, 8
income, 69, 84

indemnity, 52 Independent Hospital Pricing Authority (IHPA), 4, 7, 38 infection control antibiograms, 31 antimicrobial resistance, 23 hand hygiene, 22-23, 42 healthcare associated, 22-24, 30-31 multi-resistant gram-negative bacteria, 24 signage, 24 Staphylococcus aureus, 42 influenza vaccinations, 63 Information Publication Scheme (IPS), 56 Information Strategy Committee, 54 injectable medicines, 27 insurance, 52 intensive care units, 44 Inter-Jurisdictional Committee (IJC), 53, 54 internal audit, 56 internal governance, 55-56 international collaborations, 7, 39

#### J

Jones, Professor Dorothy, 54 journal articles, 33, **104** judicial decisions, **57** 

#### Κ

kidney transplants, 44

#### L

labelling medications, 27 Larkin, Dr Shaun, 49–50, 51, 90 learning and development, **64**  legislation, **46** amendments, 57 the Board, 47 CAC Act *see Commonwealth Authorities and Companies Act 1997* (CAC Act) the Commission's functions, 12 enabling *see National Health Reform Act 2011* (NHR Act) environmental protection, 57 FOI, 56 remuneration, 52 workplace health and safety, 63 liabilities, 89

#### Μ

management, 55, 62 Marshall, Professor Villis, 5, 6-7, 9, 48, 51, 54,90 McGowan, Russell, 50, 51, 90 measuring the safety and quality of care, 44 mediation service, 15 medical practice variation, 5, 7, 37, 39, 44 medication electronic management systems, 27 errors, 26, 27 information and communication. 26 naming, labelling and packaging, 27 National Inpatient Medication Chart (NIMC), 42 reconciliation, 26 safety, 25-27 MedicineWise, 4, 23, 27, 37 meetings, 36 Mental Health and Drug and Alcohol Principal Committee, 18, 35



mental health services

Consultation Draft Accreditation Workbook for Mental Health Services, **35** national standards, 4, 13, **18** 

Minister for Health, 3, 4, 23, 46

ministerial directions, 46

ministerial oversight, 56

mission of the Commission, 2

Monash University Centre of Research Excellence in Patient Safety, 22

multi-resistant gram-negative bacteria, 24

#### Ν

National clinical quality registries, 19

National Clozapine Titration Chart, 26 National E-Health Transition Authority (NEHTA), 38

National Falls and Falls Injury Prevention Reference Group, 22

National Hand Hygiene Initiative (NHHI), 22–23, 42

National Health and Hospitals Network Act 2011, 2

National Health Information and Performance Principal Committee, 19

National Health Information Standards and Statistics Committee, 32

National Health Reform Act 2011 (NHR Act)

amendments, **57** Board, 47, 52

Commission's functions, 12

data plan, 30

enabling legislation, 2, 46

IHPA, 38

strategic planning, 8

National Health Reform Agreement, 12, 30 National Healthcare Agreement, 32 National Inpatient Medication Chart (NIMC) 2012 National Audit, 26 harm reduction, 42 online training module, 37 VTE pilot, 27 National Mental Health Commission, 4, 18 National Prescribing Curriculum, 37 National Residential Medication Chart. 26 National Safety and Quality Health Service (NSQHS) Standards, 13-19 accreditation see accreditation Accreditation Advice Centre, 4, 15 AHSSQA scheme, 9, 13, 16-17 box set, 33-34 Clinical Care Standards, 17 clinical quality registries, 19 evaluating, 16-17 future, 9 Guide for Small Hospitals, 34 implementation, 6, 13-15 mental health services, 18 Safety and Quality Improvement Guides, 4, 33 Standard 1: Governance for Safety and Quality in Health Service Organisations, 28 Standard 3: Preventing and Controlling Healthcare-Associated Infections, 22 Standard 4: Medication Safety, 25 Standard 6: Clinical Handover, 20 Standard 10: Preventing Falls and Harm from Falls, 22

Ρ

National Safety and Quality Health Service Standards, 8

National Standards for Mental Health Services, 18, 35

National Subcutaneous Insulin Form, 26

NHHI (National Hand Hygiene Initiative), 22-23.42

NHR Act see National Health Reform Act 2011 (NHR Act)

NIMC see National Inpatient Medication Chart (NIMC)

non-financial assets, 87

NPS MedicineWise, 4, 23, 27, 37

NSQHS Standards see National Safety and Quality Health Service (NSQHS) Standards

#### Ο

Occupation Health and Safety Committee, 55

occupational health and safety, 63

OECD study of variations in medical practice, 5, 7, 37, 39, 44

older patients

end-of-life care, 21

falls prevention, 22

Ombudsman, 56

On the Radar online summary, 5, 35

online education package, 37

open disclosure, 28-29, 34

Open Disclosure Framework, 28-29, 34

Open Disclosure Standard, 28, 34

**Operating Principles**, 19

operational results, 4-5

Organisation for Economic Co-operation and Development (OECD) study of variations in medical practice, 5, 7, 37, 39, 44

organisational structure, 60-61 outcomes (financial report), 97 Park, Shelly, 50, 51, 53, 90 parliamentary oversight, 56 patients, 43-44 care standards see National Safety and Quality Health Service (NSQHS) Standards communication with, 20 end-of-life care, 21 health literacy, 24-25 hospital experience questions, 30, 32 hospital safety, 30 infections see infection control medication safety, 26 monitoring, 19 open disclosure, 28-29 support, 44 payables, 88 PCEHR (Personally Controlled Electronic Health Record) system, 37–38 Performance and Accountability Framework (PAF), 32 perioperative medication use, 27 Personally Controlled Electronic Health Record (PCEHR) system, 37-38 Picone, Professor Debora, 8-9, 38, 55 posters, 24 'Preserve the Miracle', 23 Preventing Falls and Harm from Falls in Older People, 22



Primary Health Committee, 54 Private Hospital Sector Committee, 54 provisions, 89 Public Health Laboratory Network, 24 publications, **33–35**, **100–104** 

#### R

registries of clinical quality, 19 related entry transactions, 52 related party disclosures, 92 remuneration auditors, 96 Directors, 52, 91 senior executives, 93-95 reports, 33-35, 100-104 representations, external, 37, 113-114 research, 36-37, 105-111 articles, 33, 104 NSQHS Standards, 16 Residential Medication Chart. 26 risk management, 55 role of the Commission, 2 Royal Australasian College of Surgeons, 23, 37

#### S

Safety and Quality Improvement Guides, 4, 14

Safety and Quality Partnership Standing Committee (Mental Health and Drug and Alcohol Principal Committee), 18, 35

Safety, Rehabilitation and Compensation Act 1988 (SRC Act), 63

schedule of commitments, 73

Schedule of Cover, 52 scrutiny, external, 56, 57 senior executive remuneration, 91–93 Sherbon, Dr Tony, 38 signage, 24 significant events, 57 sponsorships, 112 staff Disability Action Plan, 64 health and safety, 55 management, 62 non-salary benefits, 63 profile, 62 study leave, 55 training, 64 workplace health and safety, 63 standards see National Safety and Quality Health Service (NSQHS) Standards Standards Accreditation Advice Centre, 4.15 Standards for Risk Management – Principles and guidelines, 55 Standing Council on Health, 46 Staphylococcus aureus infection, 42 statement of changes in equity, 71 statement of comprehensive income, 69 strategic planning, 8, 46 Stroke Foundation, 44 study assistance, 64 Study Leave Review Panel, 55 Subcutaneous Insulin Form, 26 surveillance, electronic, 31



Technical Standards, 19 Therapeutic Goods Administration, 20, 27 training for accreditation, 5 Commission staff, **64** healthcare providers, **36–37** 

#### U

University of Adelaide, 32 University of Newcastle, 14 Using the National Medication Management Plan online training presentation, 37

#### V

values of the Commission, **3** variations in medical practice, 5, 7, 37, 39, 44 venous thromboembolism (VTE), 26, 27 vision of the Commission, **2** VTE (venous thromboembolism), 26, 27

#### W

web site, 14, 33 Williams, Dr Helena, 50, 51, 54, 90 *Work Health and Safety Act 2011* (WHS Act), 63 Work Plan 2013–2016, 8 workbooks, 14 worker's compensation claims, 63 workplace health and safety, **63** workshops, 37 World Health Organization (WHO) High 5s medication reconciliation project, 26

# References

- Graves N, Halton K, Paterson D, Whitby M. The economic rationale for infection control in Australian hospitals. *Healthcare Infection* 2009;14(3):81–88.
- 2. Ovretveit J. Does improving quality save money? London. The Health Foundation, 2009.
- Australian Commission on Safety and Quality in Health Care. Implementation Toolkit for Clinical Handover Improvement. In: Care ACoSaQiH, editor. Sydney, 2011.
- Jones D. Diagnosing dying by the rapid response system. 7th International Conference on Rapid Response Systems and Medical Emergency Teams. Sydney, 2012.
- Jones D, Bagshaw S, Barrett J, Bellomo R, Bhatia G, Bucknall T, et al. The role of the medical emergency team in end-of-life care: a multicenter, prospective, observational study. *Critical Care Medicine* 2012;40(1):98–103.
- AI-Qurainy R, Collis E, Feuer D. Dying in an acute hospital setting: The challenges and solutions. *International Journal of Clinical Practice* 2009;63(3):508–515.
- Lamont E. A demographic and prognostic approach to defining the end of life. *Journal of Palliative Medicine* 2005;8 (Suppl 1):S12–21.
- National Health and Hospitals Reform Commission. A healthier future for all Australians: Final report of the National Health and Hospitals Reform Commission. Canberra. NHHRC, 2009.

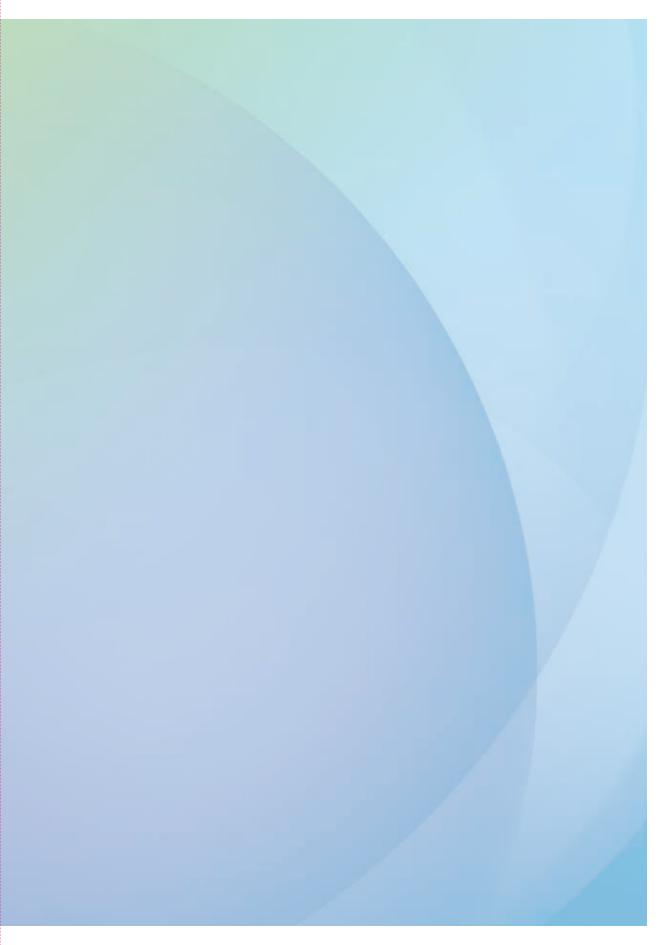
- DeWalt D, Berkman N, Sheridan S, Lohr K, Pigone M. Literacy and health outcomes: Systematic review of the literature. *Journal of General Internal Medicine* 2004;19:1228–1239.
- Wolf M, Cooper Bailey S. The role of health literacy in patient safety. Perspectives on Safety. San Francisco. Agency for Healthcare Research and Quality, 2009.
- Best A, Greenhalgh T, Lewis S, Saul JE, Carroll S, Bitz J. Large-system transformation in health care: A realist review. *Millbank Quarterly* 2012;90(3):421–456.
- Grol R, Wensing M, Eccles M. *Improving Patient Care: The Implementation of Change in Clinical Practice*. Edinburgh; New York: Elsevier Butterworth Heinemann, 2005.
- Nelson EC, Batalden PB, Godfrey MM, Lazar JS, editors. Value by Design: Developing Clinical Microsystems to Achieve Organizational Excellence. San Francisco: Jossey-Bass, 2011.
- Nolan TW. Execution of Strategic Improvement Initiatives to Produce System-Level Results. *IHI Innovation* Series White Paper. Cambridge, Massachusetts. Institute for Healthcare Improvement, 2007.
- Australian Commission on Safety and Quality in Health Care. NIMC Audit Reprot 2012. Sydney. ACSQHC, 2013.
- Hand Hygiene Australia. 2013. (Accessed 6 August 2013, at http://www.hha.org.au)

- 17. Arbuthnott A, Sharpe D. The effect of physician-patient collaboration on patient adherence in non-psychiatric medicine. *Patient Education and Counseling* 2009;77(1):60–67.
- Epstein RM, Franks P, Shields CG, Meldrum SC, Miller KN, Campbell TL, et al. Patient-centered communication and diagnostic testing. *Annals of Family Medicine* 2005;3(5):415–421.
- Jha AK, Orav EJ, Zheng J, Epstein AM. Patients' perception of hospital care in the United States. *New England Journal of Medicine* 2008;359(18):1921–1931.
- 20. Meterko M, Wright S, Lin H, Lowy E, Cleary PD. Mortality among patients with acute myocardial infarction: The influences of patientcentered care and evidence-based medicine. *Health Services Research* 2010;45(5p1):1188–1204.
- 21. Schneider J, Kaplan SH, Greenfield S, Li W, Wilson IB. Better physician-patient relationships are associated with higher reported adherence to antiretroviral therapy in patients with HIV infection. *Journal of General Internal Medicine* 2004;19(11):1096–1103.
- Stewart M, Brown J, Donner A, McWhinney I, Oates J, Weston W, et al. The impact of patient-centered care on outcomes. *Journal of Family Practice* 2000;49(9).

- 4839.0 Patient Experiences in Australia: Summary of Findings, 2011–12. 2012. (Accessed 25 June 2013, at http://www.abs.gov.au/ ausstats/abs@.nsf/mf/4839.0).
- Schoen C, Osborn R, Squires D, Doty M, Pierson R, Applebaum S. New 2011 survey of patients with complex care needs in eleven countries find that care is often poorly coordinated. *Health Affairs* 2011;30(12):2437–2448.
- 25. Australian Bureau of Statistics. Health Literacy, Australia. Canberra. Australian Bureau of Statistics, 2008.
- Paasche-Orlow MK, Wolf MS. The causal pathways linking health literacy to health outcomes. *American Journal of Health Behavior* 2007;31(Suppl 1):S19–S26.
- Stroke Foundation. National Stroke Audit – Acute Services Clinical Audit Report 2011. Melbourne. Stroke Foundation, 2011.
- Chew DP, French J, Briffa TG, Hammett CJ, Ellis CJ, Ranasinghe I, et al. Acute coronary syndrome care across Australia and New Zealand: the SNAPSHOT ACS study. *Medical Journal of Australia* 2013;199(1–7).
- 29. Australian Council for Safety and Quality in Health Care. Standard for Credentialling and Defining the Scope of Clinical Practice: A National Standard for credentialling and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals, 2004.

- 30. Medical Dictionary for the Health Professions and Nursing. Farlex, 2012.
- 31. Cruickshank M, Ferguson J, editors. Reducing Harm to Patients from Health Care Associated Infection: The Role of Surveillance. Sydney: Australian Commission on Safety and Quality in Health Care, 2008.
- Coiera EW, Jayasuriya RA, Hardy J, Bannan A, Thorpe MEC. Communication loads on clinical staff in the emergency department. *Medical Journal of Australia* 2002;176:415–418.
- National Patient Safety Agency. Seven steps to patient safety. London. National Patient Safety Agency, 2004.
- Field M, Lohr K, editors. *Guidelines* for clinical practice: from development to use. Washington DC.: National Academy Press, 1992.
- 35. Consumer representative program policy. Consumers Health Forum of Australia, 2011. (Accessed 24 March 2011, at https://www.chf.org.au/ consumer-representatives-programpolicy.php#link11).

- Falls, Fact Sheet No 344. WHO, 2010. (Accessed 14 April 2011, at http://www.who.int/mediacentre/ factsheets/fs344/en/).
- National Health & Medical Research Council. Australian Guidelines for the Prevention and Control of Infection in Healthcare. Canberra. NHMRC, 2010:260.
- What is a medication error? National Coordinating Council for Medication Error Reporting and Prevention. (Accessed 28 March 2011, at http://www.nccmerp.org/ aboutMedErrors.html).
- Australian Pharmaceutical Advisory Council. Guiding principles for medication management in the community. Canberra. Commonwealth of Australia, 2006.



# AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

ABN 97 250 687 371

Level 7, 1 Oxford Street DARLINGHURST NSW 2010 GPO Box 5480 SYDNEY NSW 2001 Telephone: (02) 9126 3600 Fax: (02) 9126 3613

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