3 October 2025

Via email: NSQHSSThirdEdition@safetyandquality.gov.au

Catholic Health Australia Submission: NSQHS (third edition)

Thank you for the opportunity to provide Catholic Health Australia (CHA)'s views to support the development of the third edition of the National Safety and Quality Health Service (NSQHS) Standards through Public Consultation 1. CHA appreciates the work of the National Safety and Quality Commission (the Commission) in undertaking this important review. The third edition presents a timely and strategic opportunity to shape the future of healthcare in Australia. As the care economy faces increasing complexity, workforce pressures, and rising demand, the Standards must evolve to support a system that is not only safe and high-quality, but also adaptive, outcomes-focused, and person-centred.

CHA's submission outlines strategic recommendations on how the third edition can shape the future of healthcare through tailored, meaningful actions and initiatives; strengthen clinical governance and accountability across all levels of care provision; and improve quality of care by embedding continuous improvement and innovation. We emphasise the importance of clear leadership and a defined vision of 'quality care' as being essential to building a resilient and equitable care system. Our proposed approach aims to create a cohesive, system-wide response that delivers care more efficiently whilst minimising a compliance mindset, and, most importantly, returns more time to care.

We also highlight the potential for innovations such as encouraging data-driven approaches for decision-making; incorporating new and emerging evidence-based practices to remain future-focused; and the need to maintain a balanced focus on systems and processes while moving beyond minimum compliance to evaluate outcomes and assess impact. In particular, we stress the need for a cohesive approach to value-based health care through funding model reform enabled through the third edition of the Standards. We believe in the need for these reforms to funding models so that the sector can address barriers to economic sustainability and equity of access to care in the long-term.

CHA welcomes the opportunity to contribute to ongoing discussions and assist in the implementation of reforms that will build a more resilient, sustainable, and equitable health system for all Australians. If you wish to discuss anything further, please contact Dr Katharine Bassett, Director of Health Policy on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

Kathy Hilyard
Interim Chief Executive Officer
Catholic Health Australia

Dr Katharine Bassett
Director of Health Policy
Catholic Health Australia

Catholic Health Australia – Submission on the NSQHS – Public Consultation 1

October 2025

Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide over 15 per cent of hospital-based healthcare in Australia and operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care.

Our members account for 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Background

The National Safety and Quality Health Service (NSQHS) Standards have been developed by the Australian Commission on Safety and Quality in Health Care (the Commission), in collaboration with the Australian Government, states and territories, providers, clinical experts, patients and carers, with the aim of improving the quality and safety of health service provision. The third edition of the National Safety and Quality Health Service (NSQHS) Standards is currently under development to reflect updates in the safety and quality evidence base, innovations in models of care, evolving service delivery contexts, and emerging issues since the release of the second edition in November 2017 and its update in May 2021.

This submission responds to the Commission's consultation questions to inform the development of the third edition. It comes at a time of significant transformation in Australia's health system, driven by expanding service options, new models of care, and rising consumer expectations. As demand and costs increase, a nationally consistent set of standards is essential to guide quality improvement and ensure the system remains responsive, sustainable, and patient-centred.

The Commission is seeking feedback on:

- existing and emerging safety and quality risks that should be considered as part of the development of the third edition of the NSQHS Standards
- strategies for the third edition to have a greater impact on driving high performance of health services
- opportunities for the third edition to support better integration of services across the health care sector, and to support organisations to adopt a continuous learning approach towards care provision, and shift away from a compliance mindset
- areas of duplication or redundancies that could be removed from the current standards.

As Australia's largest non-government network of health, community, and aged care services, Catholic Health Australia (CHA) and its members play a leading role in the care economy. With deep experience across the health and aged care sectors, CHA is well positioned to meaningfully contribute to the development of the third edition of the NSQHS Standards. This submission articulates the case for a strategic, cohesive, and system-wide response to deliver safety and quality care efficiently.

Overall comments

CHA welcomes the Commission's commitment to improving patient care through the development of the third edition of the NSQHS Standards. This review comes at a critical juncture for the Australian care economy, as health and aged care services face mounting pressures — including rising demand, workforce shortages, fiscal constraints, and increasing complexity of care needs. These challenges require a shift toward innovative, adaptive approaches to both regulation and care delivery. The third edition of the Standards is therefore not only timely but essential. It provides a platform to embed principles-based regulation, support integrated and person-centred models of care, and enable innovation at scale.

CHA strongly supports a shift away from a compliance-driven culture toward one that enables outcomes-based improvement. By focusing on systems that drive measurable impact — rather than simply meeting minimum requirements — the Standards can foster innovation, continuous learning, and the delivery of value-based care.

CHA views regulation as serving two essential and complementary functions, both critical to a high-performing care system:

1. Ensuring safety and compliance by identifying and addressing gaps in service delivery where minimum standards are not being met.

2. Recognising and promoting excellence by highlighting where services exceed expectations and deliver superior outcomes for consumers.

While the NSQHS Standards framework currently plays both roles, these functions can sometimes be in tension — particularly when regulatory frameworks attempt to enforce minimum standards while also encouraging innovation. Balancing these roles requires careful design and implementation to ensure that regulation supports both accountability and aspiration, without creating undue burden or stifling progress.

CHA has consistently advocated for an outcomes-based regulatory and funding framework. Such a framework should include: indicators that are meaningful to communities and service users; financial and service delivery targets aligned with broader care needs; and incentive structures that reward long-term improvements in health and wellbeing, rather than short-term throughput.

These outcomes-based measures should be embedded into existing performance and accountability systems to track progress, foster a culture of learning, and provide evidence to support the scaling of innovative models of care.

Our submission outlines the need for the third edition to:

- reduce low-value regulatory requirements;
- streamline compliance processes; and
- champion digital solutions that return time to care.

This requires a shift toward adaptive, risk-proportionate regulation — one that enables dynamic assessment of risk and performance and better reflects the complexity and diversity of care delivery across Australia. CHA and its members have observed increased frustration with the overlap between the Standards and legislative requirements governing health services. Clearer direction is needed on how the Standards are intended to interact with legislation, particularly in situations where Standards prescribe actions that are not legislatively required. This may create confusion for health service organisations and adds complexity into care coordination.

A further challenge is the variation in regulatory and legislative frameworks across jurisdictions, which continues to hinder national consistency in implementation. Differences in funding models, accountability mechanisms, resource capacity, and digital maturity create fragmentation that affects both providers and consumers.

Importantly, these inconsistencies are felt most acutely by Australians who access care across state and territory borders, including those in regional areas, those receiving specialist services interstate, and those navigating complex care pathways. For these individuals, jurisdictional variation can result in uneven standards, duplicated processes, and reduced transparency.

To address this, the third edition must include specific strategies to support harmonisation across jurisdictions, while recognising the need for flexibility in local implementation. This will require coordinated national leadership, shared digital infrastructure, and a commitment to aligning regulatory approaches wherever possible. Ultimately, achieving this vision will require a cultural shift across the sector—one that empowers providers to deliver high-quality care through flexibility, accountability, and a shared commitment to improving health outcomes for all Australians, regardless of where or how they access care.

Submission

Question 1: What existing and emerging safety and quality risks should the Commission be considering in the third edition?

Changing modalities of care provision

The Australian healthcare system is undergoing a significant shift in how care is delivered, driven by the emergence of innovative models such as telehealth and asynchronous modalities, including messaging, store-and-forward tools, automated triage, and remote monitoring. These approaches have evolved not as substitutes for quality care, but as pragmatic responses to workforce shortages, rising patient demand, and funding constraints. Further, these approaches are also being informed by the new technologies that enable new models of efficient and effective care. Despite their growing use across primary care, mental health, and allied health, the current NSQHS Standards do not yet fully reflect the realities, risks, or opportunities associated with these evolving care modalities. The permanency of Medicare-rebated telehealth and jurisdictional virtual-care strategies has accelerated this shift and made it a core, enduring feature of service delivery rather than a temporary adjunct.

One example of a key challenge facing the digital health sector is the ambiguity in the scope and definition of “telehealth” compared to “virtual care.” While telehealth is often associated with synchronous video or phone consultations, virtual care encompasses a broader spectrum, including remote monitoring, AI-assisted triage, shared digital care plans, patient-reported outcomes, and care delivered by multidisciplinary teams across settings. This lack of clarity can result in inefficiencies, inconsistent expectations between patients and clinicians, and variability in how data is used to inform clinical decision-making. Clear, nationally aligned definitions and minimum safety expectations for each modality (i.e., synchronous, asynchronous, remote monitoring, and AI-enabled decision support) would reduce variation and support consistent risk management.

There is a clear opportunity for the third edition of the Standards to provide guidance that supports safe, effective, and consistent care across digitally enabled models. This includes recognising virtually-enabled care as a distinct and evolving model that augments, rather than replaces, traditional care. These capabilities are particularly critical for managing chronic and complex conditions, improving transitions of care, and addressing service gaps in rural and underserved areas. Key risk domains include: clinical appropriateness and triage (including pathways to in-person assessment when indicated); limitations of remote examination; escalation and emergency protocols for deteriorating patients; safe and ethical onboarding and monitoring of patient-generated health data; digital inclusion and accessibility (connectivity, devices, cost, disability access, language support); information sharing and interoperability (timely updates to shared records and discharge summaries); privacy, consent and identity verification in virtual settings; cybersecurity and downtime contingencies; managing medico-legal accountability across teams and settings; and workforce capability, supervision and fatigue in high-volume virtual models.

To future-proof the Standards, the Commission should also consider the broader policy and funding levers that shape the delivery of care in digital environments. Quality in these models is influenced not only by clinical practice but by structural factors such as time-based billing, episodic funding, and the lack of funding for coordination activities. Without addressing these systemic drivers, the Standards risk falling behind the pace of innovation and failing to support differentiated, patient-centred models of care. Alignment with national digital health initiatives (e.g., interoperability plans, digital health strategy, and clinical governance frameworks for technology and AI) should be made explicit to avoid duplication and to embed consistent expectations for safety, usability and benefit realisation.

Finally, the Standards could play a valuable role in guiding the broader ecosystem of virtually-enabled care by promoting clearer definitions, supporting digitally integrated multidisciplinary teams, and encouraging the use of data to inform clinical decision-making. This strategic engagement with the digital health landscape will be essential to ensuring the Standards remain relevant, responsive, and continue to support innovation in care delivery. In practical terms, this could include outcome-focused expectations (e.g. timeliness of information transfer, virtual escalation success rates, interpreter use where language needs are identified, and medication reconciliation completeness in virtual transitions), coupled with proportionate evidence requirements for different service types and risk profiles.

Recommendation 1: The third edition should proactively address the shift in how care is increasingly delivered through digital tools, modalities, and approaches. This could include promoting clearer definitions of virtually-enabled care, support for digitally-integrated, multidisciplinary teams, and encouraging the use of data to inform clinical decision-making. Further, these amendments should reflect an adaptive regulatory posture, and maintain a focus on encouraging safe, ethical, and technology-enabled innovation, including design and implementation of new models of care.

Increasing patient complexity

The Australian healthcare system is facing rising patient complexity, driven by factors such as increased life expectancy, multimorbidity, and social determinants of health. According to the Australian Institute of Health and Welfare, chronic conditions contributed to between 89–92 per cent of all deaths annually from 2002 to 2022. Additionally, an estimated 38 per cent of Australians — about 9.7 million people — were living with multimorbidity (two or more chronic conditions) in 2022. This growing burden of complex, long-term health needs is compounded by an ageing population, increasing prevalence of mental health conditions, and socioeconomic disadvantage, which makes it challenging to deliver coordinated and person-centred care.

Patient complexity in Australia's healthcare system is increasingly shaped by migration trends, including the growing number of refugees and humanitarian entrants. People from refugee backgrounds often present with unique health needs influenced by pre-migration trauma, deprivation, and post-migration stressors. These cohorts may experience higher rates of chronic physical and psychological conditions, and often face barriers to accessing care due to unfamiliarity with the health system, language, and cultural differences.

Recognising that different patient cohorts bring distinct complexity modifiers is essential for designing responsive care models. For example, refugee communities may be engaging with the Australian health system for the first time, making culturally safe, trauma-informed comprehensive care a priority from both a quality and equity perspective. Catholic providers have begun work to better understand and respond to increasing patient complexity, particularly among vulnerable populations. A leading example is the Mater Refugee Complex Care Clinic (MRCCC), a multidisciplinary service offering primary care, psychiatry, and paediatrics for people from refugee and asylum seeker backgrounds. Established in 2002, MRCCC is a Mater mission initiative aimed at improving health and wellbeing in south-east Queensland. Clinicians and nurses at MRCCC bring specialist expertise in refugee health and use a detailed patient intake form to identify complexity factors. This data is then tracked over time through a dedicated dashboard, enabling the clinic to monitor demographic trends and tailor care models accordingly.

The third edition of the NSQHS Standards presents a timely opportunity to guide the design and implementation of responsive, adaptive models of care that reflect the increasing complexity of patient needs across the Australian health system. This includes recognising the impact of factors such as multimorbidity, ageing, mental health, socioeconomic disadvantage, and migration-related health challenges, particularly among refugee and humanitarian populations. Importantly, there should be clear recognition that complexity is not static — patients' needs evolve over time, systems must support dynamic care plans, proactive monitoring of change, and flexible escalation pathways.

To support this, the Standards should inform the development of incentive structures that encourage and reward health services for responding to complexity through innovative, person-centred care delivery. These incentives should promote models that are culturally safe, trauma-informed, and tailored to the needs of diverse communities. In addition, the Standards could embed expectations for risk stratification, predictive analytics, integrated care pathways, shared care models, and longitudinal outcome measurement (e.g. functional status decline, medication burden, hospitalisation-free days) to ensure that services not only respond reactively but proactively take a role in anticipating changing care needs. They should also require services to monitor differential outcomes across population subgroups (including, but not limited to: socioeconomic status, Indigenous status, refugee status, rural/remote location) to detect disparities early.

Recommendation 2: The third edition of the NSQHS Standards should guide the development of responsive, adaptive models of care that reflect rising patient complexity — driven by ageing, multimorbidity, mental health, socioeconomic disadvantage, and migration-related health needs. To support this, the Standards should inform incentive structures that reward health services for delivering innovative, person-centred care tailored to diverse populations.

Acknowledging a rights-based approach to care in aged care

The Aged Care Act 2024 introduces a legislated Statement of Rights for older people, widely recognised as a leading example of a rights-based approach in care legislation. This new framework represents a shift from aspirational principles to enforceable entitlements under law, aligning with evolving international human rights norms. CHA supports this shift as it aligns closely with the mission and values of our member organisations which is grounded in the Gospel principles of dignity, compassion, and service to the vulnerable. A rights-based approach reflects our commitment to respectful, person-centred care and to fostering environments of healing, hope, and companionship for all engaging with our care services.

Importantly, the refined Statement of Rights acknowledges the intersecting rights and freedoms of other stakeholders within the care environment, including aged care workers and other consumers. CHA strongly supports the explicit recognition and balancing of workforce rights, particularly in residential aged care settings where providers have legal obligations to ensure safe workplaces and protect residents from harm — including harm caused by other residents. This balanced approach reflects the complexity of care delivery and introduces safeguards for both consumers and the workforce, including volunteers. This mutual rights framework also offers a mechanism for mediating conflicts (e.g. resident–resident disputes, safety vs autonomy, staff safety vs resident rights) under a structured, principled paradigm.

However, the passage of the Act raises important questions about future policy harmonisation across the broader care economy, particularly whether a similar rights-based framework should be extended to health services. While the principles of dignity, respect, and person-centred care are universal, applying a legislated rights-based model to health care may introduce unintended consequences. Health services operate in fast-paced, high-acuity environments where clinical decision-making, resource constraints, and workforce pressures can complicate the practical implementation of such frameworks or policy approach.

If rights-based approach is to be extended into health care, there should be careful consideration of how rights are balanced across diverse patient populations, clinical contexts, and workforce realities. There is a risk that without the appropriate nuance, such a framework could inadvertently create conflicting expectations, increase administrative burden, or undermine clinical discretion to address patient needs appropriately. For instance, mandatory escalation or limitation on restrictive practices may conflict with patient rights or clinician judgment in intensive settings. Rights to refuse care may clash with duty-of-care in emergencies.

As such, any future adaptation of a rights-based model in health care should be co-designed with providers, clinicians, and consumers to ensure it supports both quality care and operational feasibility. In doing so, the framework should incorporate guiding principles such as the PANEL principles (Participation, Accountability, Non-discrimination, Empowerment, Legality) and mechanisms for balancing competing rights (e.g. through proportionality analysis or rights-based decision-making tools). It should also include practical implementation supports such as staff education in human rights literacy, decision-frameworks, impact assessments, complaints and redress mechanisms, monitoring of rights implementation, realistic thresholds for exceptions or restrictions, and alignment with existing regulatory obligations (e.g. consent law, mental health law, cybersecurity and privacy frameworks).

Question 2: How can the third edition have a greater impact on driving high performance?

Strategic enabler for outcomes-based models of care

The third edition of the NSQHS Standards presents a critical opportunity to support a shift toward outcomes-based funding models — a reform essential to driving efficiency, accountability, and high performance across health services. While integrated clinical practice can inherently improve productivity, its full potential will only be realised when funding models are aligned with outcomes rather than activity.

While the NSQHS Standards themselves cannot drive reform of national funding arrangements, they do play a powerful role in shaping expectations, behaviours, and system design. It is therefore important to recognise the limitations of standards that implicitly align with outdated funding models. Current arrangements often assume that existing funding structures are fit-for-purpose; however, fragmentation between health, aged care, and community services undermines continuity of care, accountability, and innovation. For example, hospitals may discharge patients prematurely to manage costs, while aged care providers often lack the clinical capability to manage complex needs, resulting in preventable readmissions.

The third edition can add value by explicitly acknowledging existing systemic challenges, and set out the conditions under which different funding approaches and models of care can succeed in tandem with one another. By doing so, the Standards can act as an enabler rather than a barrier to reform. For example, they can require organisations to demonstrate how their governance, accountability, and quality systems support integrated, outcomes-focused models, regardless of funding source.

Furthermore, the third edition could:

- Highlight the risks of perverse incentives (such as premature discharge or avoidable readmissions) and outline safeguards that protect patients when funding pressures conflict with quality and safety.
- Encourage transparency by requiring providers to publish outcomes data and show how service design aligns with both quality standards and funding realities.

In this way, the Standards need not prescribe funding reforms, but they can frame the challenges of misaligned incentives, support innovation in care models, and ensure that service providers are prepared to adapt as funding evolves to meet changing care needs. This approach positions the Standards as a bridge between the safety and quality functions and agenda of the Commission and the broader system reforms needed to achieve sustainable, high-performing care.

Specifically, the Standards could reinforce the value of outcomes-based funding mechanisms such as bundled payments, shared savings models, and pooled budgets. These models reward value over volume, incentivising collaboration, prevention, and continuity of care. They encourage providers to work together to achieve shared goals such as improved patient experience, reduced avoidable hospitalisations, and better health equity. In practice, this can include epochal “care bundles” across patient transitions across the care continuum (e.g. acute → subacute → home), chronic disease management bundles, and population-based reimbursements tied to health improvement, not just service delivery.

A key enabler of this shift is empowering care professionals to work at their full and evolving scope of practice. For example, Action 4.04 of the NSQHS Standards currently states: *"The health service organisation has processes to define and verify the scope of clinical practice for prescribing, dispensing and administering medicines for relevant clinicians."* Updating this wording to include the ability "to refine" scope of practice would better reflect the dynamic nature of workforce roles and support flexible, team-based care models. This is particularly important in primary and aged care settings, where nurse practitioners, pharmacists, and allied health professionals can play expanded roles in prescribing, coordinating care, and accessing diagnostics. Standards could require that services maintain dynamic scope-of-practice registries and review processes tied to performance outcomes, and ensure indemnity coverage, supervision, credentialing, and governance for evolving roles.

In regional, rural, and remote areas, where workforce shortages and service gaps are more pronounced, place-based funding models aligned to outcomes can enable locally tailored solutions that reflect community priorities and cultural contexts. For example, nurses supported to work at the top of their scope — enabled by remote clinicians and digital health tools — can dramatically improve access and reduce avoidable hospital transfers. Flexible commissioning can also support outreach, telehealth, and community-led models that respond to local needs. The Standards might explicitly allow and support "regional outcomes agreements" or "local commissioning envelopes" where regionally accountable provider networks manage pooled budgets and shared-risk arrangements aligned to community health outcomes.

Finally, aligning funding to outcomes allows health and social services to be integrated with broader regional development goals — supporting local employment, capacity-building, and community resilience. The third edition of the NSQHS Standards should explicitly recognise and support this shift, embedding funding reform as a core enabler of safety, quality, and system-wide innovation. This could include requiring services to map alignment between their strategic planning and funding models, to publish outcome metrics, and to trial blended funding schemes (e.g. mixture of base funding + outcome rewards) under a regulated oversight model.

Recommendation 3: The third edition should explicitly articulate the need for outcomes-based funding mechanisms as a strategic enabler for enhancing safety and quality across the health care system. This includes updating the language in the Standards to enable care professionals to work at their full scope of practice, as well as a clearer recognition for place-based approaches to care that reflects community priorities and local contexts. Additional mechanisms incorporated in the third edition could include: a clear outline of the risks of perverse incentives and safeguards that protect patients when funding pressures conflict with quality and safety; and requirement for providers to publish outcomes data ensuring that service design aligns with both quality standards and funding realities.

Technology-driven approach to driving high performance

The third edition of the NSQHS Standards presents a timely opportunity to reinforce the role of technology as a strategic enabler of safety and quality across the care economy. To support high performance and consistent implementation, the Standards should explicitly guide investment in and safe and ethical use of digitally-enabled approaches to data collection, reporting, and continuous improvement.

Technology can underpin a standardised reporting framework that integrates shared outcome measures with targeted digital solutions. However, to realise this potential, systemic barriers — such as fragmented data-sharing regulations, inconsistent safety protocols, and variable interpretations of scope-of-practice — must be addressed through coordinated reform.

Embedding digital capability frameworks, such as the Australian Digital Health Capability Framework, into reporting and compliance systems can support workforce readiness and ensure consistent, high-quality data. This framework outlines essential competencies across four domains: the digital workplace, digital professionalism, data and informatics, and digital transformation. Its integration into the Standards would help accelerate digital adoption, improve data quality, ensure appropriate and ethical use of digital data and enable more responsive, data-driven care.

Furthermore, significant investment in training and education is needed to equip the healthcare workforce with the skills to effectively use digital tools. This includes both technical competencies and an understanding of ethical and clinical implications. Providers across the care economy vary widely in their digital readiness. The third edition is an opportunity for a consistent regulatory approach to the use of such tools and/or approaches to account for these differences, support scalable infrastructure development, including secure data systems and computing capacity, and embed expectations for clear governance structures to guide risk management and ensure continuous improvement.

As such, CHA believes the third edition of the NSQHS Standards should explicitly consider how technology can support high performance, particularly in how safety and quality data is collected, shared, and used to drive improvement. To maximise impact, the Standards should not simply permit technology — they should require it where safe and beneficial, with proportional evidence requirements, support for low-maturity services, and clear alignment to national digital health goals.

Recommendation 4: The third edition of the Standards should explicitly consider how technology can be (and is) embedded in service models to enhance efficiency and productivity both within and across health services, through the acceleration of digital adoption whilst ensuring its safety, ethicality and consistency in use and implementation.

Enhancing transparency through the third edition

Public reporting of safety and quality information is a powerful lever for driving service improvement, fostering innovation, and building consumer trust. However, to maximise its impact, it is essential to critically assess and justify which measures are reported publicly. Not all data carries equal value, and indiscriminate reporting can lead to duplication, administrative burden, and diluted focus. A deliberate and evidence-informed approach ensures that reported measures are meaningful, actionable, and aligned with the goals of safety, quality, and equity.

This means prioritising measures that reflect outcomes, safety, person-centred experience, access, efficiency, workforce capability, and innovation, while ensuring that data is used ethically and disaggregated to expose inequities and inform targeted improvements. Disaggregation should include dimensions such as Indigenous status, socioeconomic quintile, remoteness, age group, disability status, language/cultural background, refugee status, and minoritised populations to surface equity gaps. Frameworks such as the Australian Health Performance Framework (AHPF) and the OECD Health Care Quality Indicators provide strong foundations for this kind of strategic reporting. Emerging frameworks in value-based health care and benchmarking consortia (e.g. International Consortium for Health Outcomes Measurement, ICHOM) may also inform selection of globally comparable outcome sets.

The third edition of the NSQHS Standards offers a critical platform to embed this approach. By aligning reporting expectations with the principle of “collect once, report once, and use often,” the Standards can specifically aim to reduce duplication, streamline provider obligations, and ensure that data is leveraged effectively and ethically across the care economy. This edition should explicitly guide which safety and quality measures are reported publicly, and how they are communicated to consumers, to enhance transparency and drive continuous improvement. Key design considerations should include:

1. minimum reporting intervals and lag times
2. threshold suppression to protect privacy in small populations
3. narrative contextualisation of trends (not just raw numbers)
4. visualisation standards for public dashboards
5. consumer-friendly summaries and drill-down options
6. mechanisms for stakeholder feedback on reported metrics.

Incorporating public reporting into the Standards — particularly through key Actions — would ensure that safety and quality data is not only collected for compliance, but also used to inform innovation, support accountability, and empower consumers. For example, embedding a “public reporting readiness” action in Clinical Governance or Partnering with Consumers standards could require services to publish a core “safety & quality scorecard” on their website or via central registries, linking to national benchmarking portals.

However, for public reporting to be truly effective, the underlying data must be dynamically collected and updated in real time. Static or outdated data undermines trust and limits the usefulness of reporting for consumers, clinicians, and policymakers. A key lesson can be drawn from the aged care sector’s Star Ratings system, which — while well-intentioned — relies on manual backend processes that result in data being up to 12–15 months out of date. This lag significantly reduces the system’s value for real-time decision-making and consumer choice.

Furthermore, the third edition provides an opportunity to develop a robust national clinical indicator database that is accessible and informed by Australian hospitals. At present, health service organisations have limited opportunities to benchmark key quality and patient safety indicators, and access to available benchmarking tools often comes at a significant cost. A Commission-led approach, providing a broader, benchmarked data set and accessible results, would strengthen sector-wide transparency and deliver more meaningful insights to support the delivery of safe, high-quality care.

CHA recommends that the third edition take a leadership role in defining and promoting a coherent, outcome-focused public reporting framework that supports high performance and system-wide learning. By shifting from static compliance reporting to dynamic, real-time transparency, the health system can foster innovation and build public trust. This could be further reinforced by the development of a national clinical indicator database, or similar, for Australian hospitals.

Recommendation 5: Adopt a leadership role in defining and promoting a coherent, outcome-focused public reporting framework that supports high performance and system-wide learning through the third edition of the Standards. This should include public reporting of key safety and quality information, such as through a national clinical indicator database or similar, to promote transparency and consistency.

Question 3: How can the third edition support integration of services, within and across health services?

Defining and embedding quality care to support integration and collaboration

The third edition of the NSQHS Standards presents a significant opportunity to define what ‘quality care’ means in practice and ensure the definition is contemporary, fit-for-purpose, and responsive to the evolving needs of the care economy. Establishing a clear, system-wide understanding of quality care is foundational to driving integration, improving outcomes, and aligning efforts across diverse health service settings.

This definition should look to go beyond traditional activity-based metrics and instead reflect the principles of person-centred, coordinated, and outcomes-focused care. It should foreground continuity, equity, responsiveness, timely information flow, shared accountability, and adaptability to changing patient needs. For example, the delivery of care through multidisciplinary teams should be recognised as a quality measure in its own right, reflecting the value of collaborative practice in achieving better outcomes. The Standards can serve as a vehicle to standardise how this definition is applied, facilitating consistency across services while allowing flexibility for local adaptation. To that end, the Standards could provide modular “integration pathways” or templates for different care transitions (e.g. hospital → home, hospital → aged care, chronic disease clinics) that translate the definition into core process and outcome expectations.

Importantly, this definition can be used to promote integrated models of care, both within individual organisations and across the broader health and aged care systems. By embedding integration as a core component of quality, the Standards can encourage service models that prioritise continuity, shared accountability, and seamless transitions between care settings. This is particularly relevant in addressing fragmentation between primary, acute, and aged care services, and in supporting place-based approaches that reflect community needs. The Standards might also expect organisations to develop joint care plans, shared governance arrangements, and cross-setting escalation protocols as part of their accreditation evidence.

To support this shift, the third edition should also encourage a view of quality care as being inherently collaborative, not only in clinical practice but also in governance and workforce models. This means moving away from competitive behaviours and siloed structures, and instead fostering cultures of shared learning, joint decision-making, and team-based accountability. Governance frameworks should promote collaboration across disciplines and organisations, while workforce policies should enable professionals to work at their full scope and contribute meaningfully to integrated care delivery. For example, the Standards could require that health services enter into formal service-level agreements, data-sharing agreements, and joint quality committees with partner providers, and demonstrate shared outcomes rather than isolated metrics.

By using the third edition to define and operationalise quality care in this way, the Standards can play a pivotal role in shaping a health system that is not only safer and more effective, but also more connected, equitable, and resilient. In addition, embedding requirements for shared evaluation, continuous feedback loops across settings, interoperability of care records, and cross-disciplinary performance benchmarking ensures the vision of integrated quality care becomes lived practice, rather than aspirational policy.

Recommendation 6: Develop and implement a contemporary, fit-for-purpose definition of ‘quality care’ that is responsive to the evolving needs of the care economy and embed this definition within the third edition.

Embedded collaborative commissioning mechanisms to increase the integration of care services

The third edition of the NSQHS Standards presents a unique opportunity to embed clinical governance, safety, and quality measures that actively enable mechanisms of collaborative commissioning, both within individual health services and across broader systems of care. Collaborative commissioning is a powerful tool for delivering more person-centred, coordinated care by reducing duplication, addressing service gaps, and improving continuity for individuals. It also strengthens local responsiveness, fosters shared accountability for outcomes and spending, and creates a foundation for innovation and continuous improvement.

Each domain of the Standards — clinical governance, partnering with consumers, preventing and controlling infections, medication safety, comprehensive care, communicating for safety, blood management, and recognising and responding to acute deterioration — is directly relevant to supporting collaborative commissioning. These domains already provide a structured, nationally consistent framework that can underpin joint planning, shared service delivery, and integrated quality improvement both within and across health services.

For example:

- Clinical governance can support shared accountability and joint decision-making across commissioning partners.
- Partnering with consumers ensures that commissioning reflects community priorities and lived experience.
- Comprehensive care and communicating for safety promote multidisciplinary, team-based approaches that are essential to integrated service delivery.
- Medication safety and blood management offer opportunities for standardised protocols across settings, reducing variation and improving continuity.
- Recognising and responding to acute deterioration supports timely interventions across care transitions, a key challenge in fragmented systems.

CHA believes that a key barrier to advancing collaborative commissioning in Australia is the absence of a clear, consistent outcomes and evaluation framework that demonstrates its long-term value. While the rationale for integrated, person-centred care is widely accepted, there remains a lack of robust, longitudinal data on the impact of collaborative commissioning, particularly in terms of cost-effectiveness, improved health outcomes, and system sustainability. This evidentiary gap contributes to hesitancy among funders and policymakers, especially in a fiscally constrained environment where short-term returns on investment are often prioritised.

The Commission could address this gap by developing a well-articulated outcomes framework that supports joint monitoring and reporting across health services, and builds a shared vision of what successful collaborative commissioning looks like. This framework should reflect:

- shared, person-centred outcomes that are meaningful to communities and service users
- financial and service delivery targets aligned with stakeholder priorities
- incentive structures that reward long-term improvements in health and wellbeing, rather than short-term throughput
- explicit equity-weighted outcomes or bonus credits for addressing disadvantage or underserved populations.

Design should explicitly align with existing national infrastructure to support the principle of “collect once, report once, use often”, for example, mapping indicators to the National Preventive Health Strategy and publishing through the AIHW National Preventive Health Monitoring Dashboard to ensure comparability across jurisdictions. Where relevant, PHN reporting should leverage existing domains from the PHN Performance and Quality Framework, so joint reporting complements rather than duplicates Commonwealth requirements, aligning with the third edition of the Standards. Additionally, integration with the National Performance and Accountability Framework, the Australian Health Performance Framework, and future digital health outcome repositories would maximise synergy and comparability.

By embedding these principles and mechanisms into the third edition of the NSQHS Standards, the Commission can play a pivotal role in enabling collaborative commissioning as a core driver of integration, innovation, and high performance across the health system.

Recommendation 7: Embed key principles and mechanisms to support collaborative commissioning within the third edition to ensure that joint reporting and outcomes measurement at various levels of the healthcare system is cohesive, encourages collaboration, and drives integrated models of care.

Broadening the language to incorporate a greater diversity of views

The third edition of the NSQHS Standards presents a valuable opportunity to refine its language to more effectively promote integration of care service delivery across and within health services. A key example is Action 1.15, which currently requires health service organisations to identify the diversity of consumers, recognise higher-risk groups, and incorporate this information into care planning. While this is a critical foundation, there is clear scope to reflect more contemporary approaches that respond to changing patient demographics and the need for place-based, holistic, and integrated models of care.

To truly embed integration and responsiveness, the Standards should adopt language that reflects broader principles of consumer partnership and participation, not only identifying diversity, but actively engaging with it. This includes recognising that consumers may wish to participate in their care in different ways, and that codesign and participatory approaches are increasingly recognised as best practice in improving service quality, responsiveness, and trust. The Standards could explicitly require engagement via lived-experience panels, community advisory groups, user-led evaluation, peer navigators, and culturally safe participatory methods (e.g. storytelling, photovoice, participatory action research). It should also allow flexibility in modes of involvement (online, face-to-face, asynchronous feedback) to accommodate different preferences, accessibility needs, and capacity constraints.

For example, Standard 2 – Partnering with Consumers could more explicitly articulate the concept of codesign, moving beyond consultation and partnership to genuine collaboration through participation. Participatory approaches that focus on human experiences rather than clinical workflows have been shown to improve both patient and staff satisfaction, as well as service responsiveness[1]. These approaches help ensure that care is not only clinically effective, but also emotionally and culturally resonant with consumers. The wording could require collaborative change initiatives (not just provider-led), joint priority setting with consumers, consumer involvement in evaluation, and transparent feedback loops showing how input has been used.

Catholic providers are already demonstrating how this can work in practice. Calvary's model of care for older people, which prioritises Personhood, Environment, Activity, Relationships and Safe Care – known as the PEARs Model exemplifies improvement science in action, where consumer feedback is actively sought, validated, and translated into practice. The PEARs team leads data collection, co-design, and consultation processes to identify priority areas for improvement across aged care homes, resulting in scalable enhancements across the Calvary ecosystem. This model reflects a commitment to personhood, particularly for older people and those living with dementia, by embedding relational care principles into everyday practice. The experience of PEARs suggests that embedding a "consumer partnership maturity continuum" (from feedback → co-design → co-governance) can help services progressively deepen their engagement.

The success of the PEARs Model highlights the importance of integrating consumer voices into governance and continuous improvement, offering a scalable framework for sector-wide transformation. It demonstrates that participatory, co-designed, and evidence-informed approaches can meaningfully enhance aged care and health services more broadly.

By broadening the language of the third edition to reflect these principles, the NSQHS Standards can better support inclusive, integrated, and collaborative models of care, ensuring that quality care is defined not only by clinical outcomes, but by the lived experiences and values of the people it serves. In this way, the Standards can help shift the paradigm from 'services for patients' to 'services with people' — advancing equity, trust, responsiveness, and sustainability in the provision of care.

Recommendation 8: The third edition of the NSQHS Standards should adopt language that reflects broader principles of consumer partnership and participation—moving beyond identifying diversity to actively engaging with it. This includes encouraging participatory approaches to care delivery, particularly in settings where multidisciplinary teams are involved, to ensure care is responsive, inclusive, and shaped by the lived experiences of those receiving it.

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[1] One example is Van Citters A. (2017). *Experience-Based Co-Design of Health Care Services.* Cambridge, Massachusetts: Institute for Healthcare Improvement. Available online at: https://www.ihi.org/library/publications/experience-based-co-design-health-care-services

Question 4: How can the third edition support a continuous learning approach and minimise a compliance mindset?

Adaptive, principles-based regulation

CHA continues to advocate for a systematic shift toward adaptive, principles-based regulation that is focused on outcomes, risk, and continuous improvement rather than rigid compliance. This approach recognises that high-performing providers should be supported to innovate and improve, not constrained by low-value regulatory requirements or duplicative oversight.

The third edition presents a timely opportunity to embed this shift. Specifically, as part of the development of the third edition the Commission should look to:

- Reduce regulatory oversight for providers with a demonstrated history of compliance, allowing resources to be redirected toward improvement and innovation. This could take the form of tiered regulation, risk-based audit frequency, accreditation waivers or "light touch" pathways for high performers, or conditional easing of documentation requirements.
- Refine accreditation processes to focus on continuous improvement, where baseline compliance is acknowledged as standard care, and quality care is defined as exceeding expectations — through innovation, consumer partnership, and measurable impact. The Standards might incorporate maturity curves, recognition tiers (e.g. "exemplar" status), or incentives for innovation pilots, rather than a binary pass/fail model.
- Adopt strengths-based approaches to regulation, including accreditation and in the training of the regulatory workforce. This could involve showcasing exemplary work and innovative models across Australia, with a view to recognise key strengths and excellence of these models. Such approaches would enable a focus on leveraging regulation to design and deliver the best possible system in which providers can confidently demonstrate how they are delivering quality care.

This principles-based approach should be underpinned by a shared foundation of language, standards, and outcome measures that can be tailored to different care contexts. To manage diversity of services (acute, primary, rural, mental health, aged care), the Standards should apply a risk-proportionate lens — more flexibility where risks are low, tighter requirements where risks are higher. Greater alignment across the regulatory landscape must not result in a one-size-fits-all model, but rather a flexible framework that supports diverse service models and community needs. This also builds on from our previous response which articulates a need for a contemporary definition of quality care, which will help build a shared vision for delivering quality care that is efficient and effective to meet changing consumer needs. Where feasible, mutual recognition with other accreditation or certification programs (e.g. ISO, digital health standards) should be allowed to reduce regulatory duplication and minimise administrative burden.

A nationally coordinated framework with interoperable reporting systems, clear distinctions between compliance thresholds and aspirational quality indicators, and embedded digital solutions will help build a more person-centred and integrated care system. It will also support continuous learning and improvement by enabling providers to benchmark performance, share insights, and adapt care delivery in real time. To ensure equity, supporting mechanisms (i.e., technical, financial, governance) should be provided to lower-capacity or less digitally mature services so that they are not disadvantaged by higher technical expectations.

Clinical ethics services offer a practical example of adaptive, principle-based approach to regulation in healthcare. Embedding these services within health service governance and quality frameworks supports continuous learning and ethically sound, person-centred care. In Australia, clinical ethics services help ensure care aligns with community values. Catholic providers, for instance, integrate their ethical principles throughout service delivery, emphasising dignity, compassion, and holistic care – an integral component of their specific ethics of care. Incorporating clinical ethics into a refined definition of quality care — such as in the third edition of standards — would strengthen regulatory approaches that are responsive and outcomes-focused. For example, requiring an ethics advisory review for novel service models, escalation protocols for rights conflicts, or ethics-informed decision-support tools could help operationalise principles.

Importantly, regulatory reform must be informed by lessons from previous efforts and grounded in evidence-informed practice. Embedding principles of Value-Based Health Care (VBHC) into the third edition offers a strategic pathway forward. VBHC prioritises outcomes that matter most to individuals, supports quality improvement, and promotes efficient resource use. It also encourages minimisation of "over-treatment" or low-value care, and alignment of incentives across providers and payers. Aligning regulatory efforts with VBHC ensures reforms are person-centred, equitable, and sustainable.

In the short-to-medium term, there should be a conscious effort to critically assess the extent to which each requirement in the Standards aligns with VBHC principles. This includes evaluating whether each action contributes to meaningful outcomes, supports innovation, and avoids unnecessary administrative burden. A "burden test" for each action (e.g., cost vs value) should be applied, and actions failing to justify their utility should be removed or simplified.

By aiming to achieve adaptive regulation, the third edition can help foster a culture of trust, accountability, and excellence — where providers are empowered and rewarded to go beyond compliance and deliver care that truly meets the needs of their communities. Over time, this could allow regulation to evolve from policing to enabling — monitoring risk, encouraging innovation, and focusing regulatory energy where it is most needed.

Recommendation 9: As part of the development of the third edition, look towards:

- Reducing regulatory oversight for providers with a demonstrated history of compliance, allowing resources to be redirected toward improvement and innovation.
- Refining accreditation processes to focus on continuous improvement, where baseline compliance is acknowledged as standard care, and quality care is defined as exceeding expectations—through innovation, consumer partnership, and measurable impact.
- Adopt strengths-based approaches to regulation, including accreditation and in the training of the regulatory workforce.

A sector-led implementation approach

To ensure the third edition of the NSQHS Standards delivers on its objectives, it is essential that it includes embedded monitoring and evaluation functions from the outset. These functions should not only track implementation progress but also provide mechanisms for course correction, enabling the Standards to remain responsive and fit-for-purpose throughout their rollout. A "learning loop" design (plan → implement → evaluate → adapt) should be built into the Standards framework itself, so that iteration is expected and normalised rather than being viewed as exceptional.

As part of the proposed implementation timeframes, a detailed implementation plan should include clearly defined outcome measures for each initiative outlined in the third edition. These measures will enable robust assessment of effectiveness and efficiency at scale, and should be developed in consultation with sector stakeholders to ensure relevance and credibility. This is particularly important given the evolving nature of care delivery and the increasing emphasis on integrated, person-centred models. Outcomes should be stratified by population group and service context to identify variation, and benchmarking targets should incorporate both improvement and aspirational benchmarks.

In addition to embedded monitoring, there is a strong case for establishing a dedicated evaluation function to assess the overall impact of the third edition. This function should examine not only implementation fidelity, but also the extent to which the Standards are driving improvements in safety, quality, and system integration. Evaluation should include both quantitative and qualitative data, and the evaluation approach should be designed to inform future iterations of the Standards and broader policy reform. Process evaluation (how the Standards are used, barriers, enablers) and outcome evaluation (impact on care, patient safety, cost-efficiency) could be combined. Mixed-methods case studies, site visits, and narrative feedback from staff and consumers should complement performance metrics. Further, contemporary evaluation methods and approaches that enable dynamic insights and learning to inform iterative improvements to delivery should be prioritised over isolated, point-in-time approaches to evaluative methods and reporting.

To support this process, pilot testing across a diverse range of health services will be critical. CHA members, who operate across community care, public and private hospitals, and aged care services, are well-positioned to participate as pilot sites. Their diversity of service types, geographic reach, and demonstrated commitment to sector reform make them ideal partners for testing implementation approaches, refining outcome measures, and contributing to a shared evidence base. Pilot sites should represent variation in scale, remoteness, complexity, innovation readiness, and under-resourced contexts to stress test feasibility and adaptability.

Moreover, CHA members have a strong track record of engaging in improvement science and consumer partnership initiatives, which aligns with the ethos underpinning the development of the third edition. Their involvement would provide valuable insights into how the Standards can be applied across different contexts, and help ensure that implementation is both scalable and adaptable. As part of this collaboration, CHA could co-host learning collaboratives, shared learning workshops, and federated data-sharing among pilot sites to accelerate cross-site learning.

By embedding robust monitoring and evaluation mechanisms, and leveraging the expertise and diversity of CHA members as pilot partners, the Commission can ensure that the third edition of the NSQHS Standards is not only well-implemented, but also continuously improved to meet the needs of Australia’s evolving health system. This approach ensures that the Standards evolve in step with innovation, maintain real-world relevance, and minimise the risk of stagnation or misalignment with practice over time.

Recommendation 10: To support a culture of continuous learning and reduce compliance-driven behaviours, the third edition of the NSQHS Standards should be accompanied by a well-designed implementation plan that includes a dedicated and contemporary evaluation function, ongoing monitoring, and clear outcome measures. As part of this rollout, the Standards could be piloted with CHA members, whose diverse service mix and commitment to sector reform position them well to provide meaningful feedback and contribute to a shared evidence base for improvement.

Question 5: What needs to change in the current format and structure of the standards for the third edition to be easier to understand and act on?

The current format of the NSQHC Standards has been instrumental in setting a nationally consistent benchmark for safety and quality. However, for providers the Standards can sometimes feel dense, repetitive, and overly compliance-focused, which risks disengagement and limits their potential as a driver of continuous improvement. Importantly, the third edition, and subsequent editions, should demonstrate a clear prioritisation of embedded codesign and genuine collaborative methods throughout the design, development and delivery of the Standards. This will fundamentally promote adoption given a shared understanding of purpose and process by sector stakeholders, which will in turn enable clearer outputs.

This misalignment becomes especially problematic during short-notice assessment surveys, where health services must rapidly interpret and respond to assessor expectations. In many cases, assessors appear to apply requirements that are not explicitly supported by either the Standards or legislation, leading to inconsistent interpretations and undue pressure on health services. For example, assessors may expect hospitals to upload specific data items to My Health Record, despite the fact that such uploads are not currently mandated under legislation. This expectation is not clearly articulated in the Standards or accompanying guidance materials, resulting in ambiguity and potential non-compliance risks for health services trying to reconcile assessor expectations with their legal obligations. To address this, the third edition should explicitly clarify where assessor expectations align with, extend beyond, or diverge from legislative requirements, and provide practical guidance on how health services should navigate these interactions between legislative requirements and the Standards. To make the third edition easier to understand and act on, the Commission should consider the following changes:

Streamlined structure with clearer hierarchy

- Consolidate overlapping actions and reduce duplication across Standards (e.g. consumer engagement requirements are currently distributed across multiple Standards, creating fragmentation).
- Use a consistent “logic model” (why → what → how → measure) so users can quickly see the purpose, intent, and required action.
- Provide concise “at a glance” summaries, flowcharts, and decision-trees that guide frontline staff in applying the Standards.

Plain language and contextual relevance

- Simplify technical language and provide concrete examples that illustrate how the Standards apply in different care settings (acute, primary, aged care, rural, virtual care).
- Ensure the format recognises emerging models of care (telehealth, multidisciplinary teams, digitally enabled care) so that users see themselves reflected in the requirements.

Outcome-oriented framing

- Shift from prescriptive checklists to principles and outcomes that services can tailor locally.
- For each Action, pair baseline compliance requirements with aspirational quality indicators that encourage innovation.
- Integrate examples of outcome measures and data sources that services can adopt or adapt, reducing ambiguity.

Integrated tools and resources

- Embed links to practical resources (case studies, templates, dashboards, decision-support tools) directly within the Standards, ideally in a digital format.
- Consider a modular "digital handbook" approach that allows services to filter content by sector, size, or maturity level.
- Provide visual cues (icons, colour-coding) to distinguish compliance requirements, aspirational practices, and evidence resources.

It is the experience of CHA ad its members that material supporting the Standards are distributed across multiple documents – for example, one workbook provides reflective questions and guidance for evidence required, while another document might detail actions, key tasks, and strategies for improvement. Alignment and consolidation of the content across the Standards, as well as other resources, would provide a more streamlined and practical resource for health services. If needed, each Standard could be presented as a separate manual, embedding a clear logical flow (as previously described) to ensure accessibility without exacerbating complexity or volume of content.

Improved usability for different audiences

- Include tailored guidance sections for boards, executives, clinicians, consumers, and accrediting bodies to clarify respective responsibilities.
- Offer tiered levels of detail: a high-level "executive summary" for governance, detailed actions for managers, and quick-reference guides for frontline staff.
- Translate key requirements into consumer-friendly language to support transparency and enable shared accountability.

Alignment and consistency

- Explicitly map each Standard and Action to national frameworks (AHPF, PHN Performance Framework, Preventive Health Strategy) to reduce duplication.
- Use consistent definitions and terminology across all domains (e.g. "partnership," "integration," "outcomes") to avoid confusion.
- Clearer guidance on how to navigate overlap or inconsistencies between Standards and other legislative requirements to mitigate risk of confusion or added complexities.

By adopting these changes, the third edition can move beyond a static compliance manual and become a living, adaptive framework that is clearer, easier to implement, and more effective in supporting high-quality, person-centred, and integrated care.

Jurisdictional challenges in implementing the Standards

One of the most significant barriers to achieving implementation consistency is the variation in regulatory and legislative requirements across jurisdictions. Although health practitioner regulation is governed through a national law, this law is enacted separately in each state and territory, sometimes with local variations or conditions. Hospital licensing, public health mandates, and facility-based regulation also remain state responsibilities. As a result, the introduction of new national requirements often requires mapping, adaptation, or supplementation at the jurisdictional level. This complicates implementation and can result in inconsistency in how the Standards are understood or enforced.

Differences in funding and accountability mechanisms across jurisdictions add another layer of complexity. Each state and territory administers its own public health system, with distinct performance frameworks, reporting requirements, and commissioning arrangements. These differences mean that providers often navigate overlapping obligations: meeting NSQHS Standards while also complying with state-specific legislation, policies, and reporting structures. In some cases, this duplication can lead to inefficiency, regulatory fatigue, or confusion about which obligations take priority.

Implementation is further shaped by differences in resource capacity and maturity between jurisdictions. Some states and health services are equipped with advanced digital systems, robust workforce models, and established quality improvement programs. Others, particularly in rural and remote areas, face workforce shortages, infrastructure deficits, and fragmented care pathways. For these services, adopting new or more complex NSQHS requirements without additional support risks widening inequities rather than driving consistent national improvements.

Cross-border care presents another challenge. Patients frequently access services across state and territory boundaries, particularly in border regions. Variations in privacy laws, information-sharing rules, and local standards can create uncertainty about accountability and hinder seamless integration of care. This undermines one of the central goals of the NSQHS Standards: to provide a consistent, safe, and high-quality experience for all consumers, regardless of where care is delivered.

Evidence from previous reviews of the NSQHS Standards underscores these issues. While the Standards have succeeded in providing a unifying national framework, their implementation has required considerable adaptation to local contexts. Studies of comprehensive care, for example, found that while the principles of national standards were broadly accepted, the approaches to implementation varied across jurisdictions, reflecting differences in policy settings and service contexts.

These challenges highlight the importance of designing the third edition of the NSQHS Standards with jurisdictional diversity in mind. The Commission has a clear opportunity to embed flexibility, adaptability, and harmonisation strategies into the framework. This could include tiered requirements, distinguishing between universal “must-have” elements and aspirational indicators that can be tailored locally. Formal collaboration with state and territory health departments will be essential to harmonise definitions, reporting requirements, and accreditation pathways, and to avoid duplication with existing obligations. Legal mapping of each Standard to relevant jurisdictional legislation should be undertaken to identify overlaps or conflicts early in the rollout process.

Pilot programs across multiple jurisdictions could further test the feasibility of implementation in different contexts, highlighting barriers unique to particular states or service types. As previously mentioned, CHA members who operate a range of service types across jurisdictions would be well-placed to support these initiatives as pilot testing sites.

Furthermore, additional supports — including funding, digital tools, and capability-building resources — should be prioritised for under-resourced services to ensure that jurisdictional differences in infrastructure or workforce capacity do not translate into inequities in safety and quality outcomes.

Ultimately, the success of the third edition of the NSQHS Standards will depend not only on the robustness of the content, but also on the adaptability of the framework to Australia's federated health system. By acknowledging jurisdictional variation, embedding mechanisms for alignment, and providing proportional support, the Commission can ensure that the Standards function as intended: a unifying driver of safety, quality, and innovation, rather than another layer of complexity in an already fragmented system.

Recommendation 11: While the current structure and outline of the Actions embedded throughout the Standards has been instrumental in setting a nationally consistent benchmark for safety and quality, there is an opportunity for amendments to improve its accessibility, relevance, and consistency of implementation across different care contexts. This requires addressing jurisdictional variation, intentionally embedding mechanisms to achieve harmonisation and alignment across related resources and frameworks, and conscious efforts to prevent increased complexity for an already fragmented system.

Question 6: Are there areas of duplication or redundancies that could be removed from the current standards?

Over time, as more evidence, frameworks, and regulatory overlays have been layered onto the NSQHS Standards, there is scope to identify and minimise regulatory redundancies and overlaps. Removing duplication can reduce administrative burden, improve clarity, and sharpen focus on high-impact areas. Below are key areas where duplication or redundancies seem evident, along with suggestions for consolidation.

Suggestions for consolidation of duplicated requirements in the Standards

Repeated consumer engagement/partnering actions across multiple Standards

Many of the same or similar requirements for consumer involvement, feedback, codesign, patient information, and consent are echoed across Standards (e.g. Clinical Governance, Partnering with Consumers, Communicating for Safety). While important, this leads to repetition. The draft third edition could consolidate all core consumer engagement requirements into one central "consumer partnership" module or standard and then reference that module across other domains, rather than restating similar obligations.

Overlapping safety monitoring/governance requirements

Some standards require monitoring, audit, risk registers, escalation processes, safety committees, and governance oversight. These elements often overlap with the foundational Clinical Governance standard. The third edition could more strictly delineate governance and oversight obligations (e.g. oversight, committee structures, performance review) within a single location (Clinical Governance) and permit the operational standards (e.g. infection control, deterioration, medication safety) to focus only on domain-specific metrics, protocols, and escalation logic.

Repetition of "communicating/handover/information transfer" under multiple Standards

"Communicating for Safety" currently overlaps with other domains (e.g. Comprehensive Care, Clinical Governance, Medication Safety) in requiring documentation, information transfer, and reconciliation. There is potential to integrate those communication/transfer requirements into fewer "transition-of-care / handover" core actions, and have other standards refer to that common requirement rather than replicate it.

Redundant auditing/documentation across domains

Many Standards mandate audits, reviews, evaluation of compliance, documentation, record-keeping, and reporting. Some of these auditing processes are similar in structure (e.g. audit of adherence, review of performance, feedback loops). The third edition could define a core audit/quality review process that supports multiple domains (i.e. one audit mechanism feeding multiple domain measures) rather than expecting distinct audits per domain.

Duplication with other national/regional requirements

As outlined above, some NSQHS actions duplicate state/territory regulatory requirements, accreditation bodies' demands, or other national safety frameworks (e.g. data privacy, WHS, AMS, digital health standards). The Standards should explicitly remove or defer to recognised equivalent external certifications. For example, if a service is ISO-aligned or conforms to a national digital health standard, this should be recognised and counted as meeting requires of the Standards to reduce double reporting burden.

Over-specified "process over purpose" actions

A number of current actions are overly specific about how a task should be done (e.g. precise checklists, frequency, format) rather than focusing on the safety purpose or outcome. This specificity can create duplication when other standards prescribe similar formats. The third edition could shift many of these to principle-based or outcome-based requirements, reducing redundancy in the "how" and allowing flexibility locally.

Modernising the approach to health care records management

The third edition of the NSQHS Standards presents a timely opportunity to modernise the language and approach to health care records management, aligning it with the rapid evolution of digital health technologies and the increasing demand for interoperable, secure, and patient-centred data systems.

Current approaches to records management often remain prescriptive and redundant, focusing on static documentation practices that do not reflect the dynamic, real-time nature of contemporary care delivery. To support integrated models of care, such as collaborative commissioning and multidisciplinary service delivery, health services must be able to pool, exchange, and analyse data seamlessly across sectors.

A key enabler of this transformation is the adoption of FHIR (Fast Healthcare Interoperability Resources) as the national standard for health data exchange. FHIR provides a flexible, scalable framework for structuring and sharing clinical data across public and private providers, and across federal and state-funded systems. Its use is already embedded in the National Healthcare Interoperability Plan 2023–2028, which commits governments to identity management, standards adoption, secure information-sharing, and benefits measurement. The Australian Digital Health Agency (ADHA) has also signalled FHIR as the foundation for My Health Record upgrades, including enhanced event summaries, pathology results, and e-prescriptions, making alignment with this standard critical for ensuring that health services remain interoperable with national infrastructure.

To reflect this shift, the third edition of the Standards should:

- Explicitly reference FHIR standards in relevant actions and criteria, particularly those related to health care records, data exchange, and digital infrastructure.
- Update the language in Standard 4 (Medication Safety) to promote interoperability in documentation practices. For example, actions related to documenting patient information could be revised to emphasise interoperability between and within health services, rather than simply maintaining internal records.
- Encourage alignment with existing national digital infrastructure, such as the AIHW National Preventive Health Monitoring Dashboard and PHN Performance and Quality Framework, to support the principle of “collect once, report once, use often,” as previous discussed.
- Promote continuous improvement by encouraging health services to adopt digital tools that support real-time data collection, shared care planning, and outcome tracking.
- Address cybersecurity and privacy explicitly, by requiring robust safeguards for patient consent, data sharing, and secure cloud-based storage, given the rising incidence of cyberattacks on Australian health services.
- Ensure accessibility and equity by encouraging health services to provide patients with digital access to their records in culturally and linguistically appropriate ways, reducing barriers for Aboriginal and Torres Strait Islander peoples, refugees, and people in rural and remote areas.

To support implementation, the Commission could also:

- Showcase best practice case studies of interoperability in action, illustrating how FHIR-enabled systems have improved care coordination, reduced duplication, and enhanced patient outcomes.
- Incorporate regular review mechanisms to assess how health services are performing against interoperability-related actions, and use these insights to refine future iterations of the Standards.
- Provide implementation guidance and workforce training linked to the Australian Digital Health Capability Framework, ensuring that clinicians, administrators, and consumers are equipped to engage with interoperable systems.

- Encourage alignment with international best practice (e.g. OECD and WHO digital health interoperability principles) to future-proof Australian systems and facilitate cross-border collaboration in research and care delivery.

By aligning health care records management with FHIR standards and broader digital health reforms, the third edition of the NSQHS Standards can help build a more connected, efficient, and person-centred health system that supports integrated care delivery and continuous improvement across all settings.

Recommendation 12: The third edition could modernise the approach to health care records management by explicitly referencing FHIR standards as well as cybersecurity and privacy risks, promote alignment with existing digital infrastructure, and promote continuous improvement by encouraging health services to adopt digital tools that support real-time data collection, shared care planning, and outcome tracking. Further, ensure accessibility and equity by encouraging health services to provide patients with digital access to their records in culturally and linguistically appropriate ways.

Embedding synergies between the third edition and other work managed by the Commission

The third edition of the Standards presents a valuable opportunity to reduce duplication, foster sector-wide collaboration, and embed a culture of continuous improvement. Health service organisations are required to consider a range of frameworks and resources alongside the Standards. Specific examples include Oral Health Recommendations, Clinical Care Standards, and Medication Safety Principles. It is the experience of CHA and its members that these frameworks and resources, in conjunction with the Standards, are reviewed by assessors during compliance and accreditation assessments of health services.

However, as more resources are developed in varying formats, it is becoming increasingly difficult for health services to implement and maintain all requirements while keeping pace with the growing volume of material released by the commission. Greater integration and streamlined guidance would support practical implementation and reduce duplication.

A key area for refinement is the integration of isolated Modules — such as the Healthcare Sustainability and Resilience Module — into the broader Standards framework. These Modules, while addressing emerging priorities like climate health, are currently developed and implemented in parallel to the Standards, resulting in duplication of effort and fragmented implementation. Historically, siloed implementation has led to inconsistent uptake, ‘module fatigue’, and missed opportunities to align reporting systems. Incorporating their content directly into the third edition of Standards would streamline compliance, reduce administrative burden, and enable more cohesive and efficient care delivery.

The Commission is uniquely positioned to lead this integration and drive greater collaboration across the sector. For example, the Sustainability and Resilience Module already aligns with national priorities outlined in the National Health and Climate Strategy, and addresses the healthcare sector’s significant contribution to greenhouse gas emissions — estimated at 7 per cent of Australia’s total, double that of the aviation sector. Hospitals, particularly NFP health services and aged care providers, face significant challenges in meeting sustainability goals due to restrictive funding models and limited support for decarbonisation efforts. By embedding these sustainability principles within the Standards, the Commission can drive coordinated action and policy alignment across health and aged care services. Embedding these priorities will also help reinforce reporting synergies, such as linking environmental metrics (energy, waste, water) with safety and quality metrics so that sustainability becomes part of quality performance rather than being tracked as a separate compliance requirement.

Many Catholic providers are already advancing climate resilience initiatives within their health services. However, a more unified approach — anchored in the Standards — would amplify these efforts, reduce duplication, and promote shared learning. For instance, embedding sustainability and resilience expectations within Clinical Governance, Infrastructure, Emergency Preparedness, and Quality Improvement domains ensures that these principles are not an ‘add-on’ but fundamental to safe and quality care. Refining the third edition to incorporate these modules and align with broader frameworks will not only support more consistent implementation but also cultivate a culture of continuous improvement and innovation across the sector. Furthermore, harmonising with other Commission-managed work (e.g. digital health modules, virtual care workstreams, consumer partnership modules, workforce safety modules) ensures that the third edition becomes the central integrative framework, rather than a fragmented set of parallel efforts.

Question 7: Please provide any additional comments you think will assist the Commission with the development of the third edition of the NSQHS Standards?

Alignment of the third edition with the broader care ecosystem

The third edition should be more explicitly considered alongside other frameworks and standards, as it requires consideration of the broader ecosystem of systems and processes that support each episode of care delivered in health services. Embedding VBHC principles — where care is designed around outcomes that matter to patients, not just clinical metrics — would help reframe safety and quality as progress toward universal health coverage. VBHC also encourages de-emphasis of volume-based incentives and supports integration of funding, delivery, and accountability across sectors.

To strengthen its impact, clearer guidance is needed on how to identify and embed synergies with other standards and frameworks. For example, there are clear intersections between the Standards and the Strengthened Quality Standards in Aged Care, particularly as the population ages and patient complexity increases. For Catholic providers that operate both health services and aged care, aligning these frameworks could drive greater efficiencies and reduce administrative burden, ultimately enabling more time for direct care. Where feasible, mutual recognition or shared oversight arrangements should be enabled (i.e. cross-accreditation or single audits covering overlapping domains) to reduce duplication. Articulating how policies and processes can be integrated across these frameworks will support more consistent, person-centred care.

Further, this alignment is especially relevant to Standard 5 – Comprehensive Care, which rightly emphasises the importance of identifying Aboriginal and Torres Strait Islander patients to support culturally appropriate care. However, it should also explicitly recognise other vulnerable and marginalised cohorts who require tailored care planning. For instance:

- Refugee communities may be engaging with the Australian health system for the first time, often during a critical episode of care. Culturally safe, trauma-informed care is essential from the outset. As highlighted earlier, the Mater Refugee Complex Care

Clinic (MRCCC) demonstrates how multidisciplinary, data-informed models can effectively respond to these needs.

- Older patients receiving palliative care require coordinated, holistic care across settings — whether in hospitals, aged care homes, or community-based services. Palliative care often involves clinical, psychosocial, and spiritual support delivered by multidisciplinary teams. The Standards should reflect this complexity by encouraging anticipatory care planning aligned with patient goals and values. It might also include triggers for early palliative integration, advance-care planning, and care continuity across transitions.

Additionally, the current approach of routinely asking patients for information — such as cultural background or care preferences — could be reconsidered. Repeated questioning may be experienced as intrusive, particularly when such data could be documented and accessed through existing patient records. To address this, actions within the Comprehensive Care Standard should be refined to align with other Standards that support interoperability, such as those referencing digital health infrastructure and data-sharing protocols. For example, aligning with FHIR (Fast Healthcare Interoperability Resources) standards would enable secure, consistent access to patient information across care settings, reducing duplication and improving responsiveness. This would support a more contemporary, streamlined approach to records management and care planning—one that reflects the realities of modern, integrated health service delivery.

Recommendation 13: The third edition should explicitly recognise and embed synergies with other standards and frameworks to strengthen its impact on improving safety and quality of care delivered in health services, particularly where health services are operating in integrated, multidisciplinary team environments to address a range of care needs.