Submission on draft National Safety and Quality Health Services Standards – third edition

Partnership for Justice in Health
October 2026

09 October 2026
Professor Anne Duggan
Chief Executive Officer
Australian Commission on Safety and Quality in Health Care
Level 5, 255 Elizabeth Street
Sydney NSW 2000

Dear Professor Duggan,

We welcome the opportunity to make a submission on the draft National Safety and Quality Health Service (NSQHS) Standards (Third Edition). The Partnership for Justice in Health (P4JH) and our members are deeply committed to dismantling institutional racism and improving health outcomes for Aboriginal and Torres Strait Islander peoples. Updating these national standards is a crucial step toward embedding systemic and structural accountability across Australia's health system.

Whilst P4JH's central focus is eliminating the racism, discrimination, and bias that Aboriginal and Torres Strait Islander people experience within health services, we know this requires a whole-of-system approach. To build a genuinely safe health system, safety frameworks must actively treat institutional racism as a core patient safety hazard, embed equal-power governance with Aboriginal Community Controlled Health Organisations (ACCHOs), and enforce measurable equity indicators.

Please find information about P4JH and our detailed submission below. We welcome the opportunity to discuss our recommendations further.

Sincerely,

Mr Karl Briscoe
Co-Chair, Partnership for Justice in Health

A. About the Partnership for Justice in Health

The Partnership for Justice in Health (P4JH) is an alliance of self-determining Aboriginal and Torres Strait Islander academics, legal experts, and national peak health and justice organisations committed to working together to improve Aboriginal and Torres Strait Islander health and justice outcomes. The P4JH operates at the intersection of health and justice systems. We are committed to using our leadership and networks to realise our vision: '*Aboriginal and Torres Strait Islander people enjoy health and wellbeing that is free of racism in the health and justice systems'*.

P4JH brings a unique perspective on the ongoing impact that racism and colonisation continue to have on our people. We fill a crucial gap by amplifying the voices and lived experiences of families severely impacted by racism in the health and justice systems.

Our Leadership Group consists of:

1. Australian Indigenous Doctors' Association (AIDA)
2. Indigenous Allied Health Australia (IAHA)
3. Lowitja Institute
4. National Association for Aboriginal and Torres Strait Islander Health Workers and Health Practitioners (NAATSIHWP)
5. National Justice Project
6. Professor Juanita Sherwood (Independent Member)

B. Executive Summary

The Partnership for Justice in Health (P4JH) welcomes the opportunity to provide feedback on the draft National Safety and Quality Health Service (NSQHS) Standards (Third Edition). P4JH acknowledges the positive structural shifts in this draft, particularly the streamlining from eight standalone standards into three core standards and the intentional weaving of Aboriginal and Torres Strait Islander specific requirements across all domains. Positioning cultural safety as a core component of high-quality care—rather than siloing it within an isolated standard—represents a vital step toward whole-of-system integration.

Despite these positive structural shifts, critical gaps remain that limit the Standards' capacity to dismantle institutional racism and ensure true accountability. The current draft continues to treat racism as a passive occurrence to be "mitigated" rather than an active clinical safety risk that must be eliminated. Furthermore, culturally safe practice remains overly dependent on patient self-identification and system triggers, rather than embedding continuous workforce capability, joint governance, and structural accountability with Aboriginal Community Controlled Health Organisations (ACCHOs). Without tying broad priorities to clear, enforceable accreditation metrics, systemic barriers to high-quality care will persist.

Key Recommendations Overview:

- Embed a consistent zero-tolerance mandate across all three standards that classifies institutional racism, discrimination, and implicit bias as formal patient safety hazards.
- Align the definition of cultural safety across the NSQHS Standards directly with the AHPRA definition to ensure consistency across regulation, policy, and accreditation.
- Mandate ongoing reflexive practice and anti-racism training for all health service staff to build workforce capability rather than relying on patient self-identification.
- Enforce resourced co-design and decision-making partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) across clinical governance, planning, and service delivery.
- Improve safety reporting frameworks by requiring health services to track and audit specific equity indicators, such as Discharge Against Medical Advice (DAMA) rats as accreditation criteria.
- Explicitly embed the outcomes, standards, and indicators from the Commission's parallel First Nations-led cultural safety project directly into the final Third Edition criteria.
- Integrate trauma-informed care principles into person-centred practice and mandate culturally safe, community-advocate-supported feedback and grievance pathways.

C. Responding to Consultation material

1. How well do the Standards reflect key safety and quality priorities? What is missing?

The Partnership for Justice in Health (P4JH) welcomes the explicit inclusion of cultural safety, health equity, and Closing the Gap Priority Reforms within the overarching governance framework of the draft National Safety and Quality Health Service (NSQHS) Standards (Third Edition). Integrating consumer partnership and cultural safety across the three core standards—rather than isolating cultural safety in a standalone chapter—is a positive step toward whole-of-system integration that embeds cultural safety as a core component of high-quality care.

However, significant gaps remain that limit the Standards' ability to dismantle systemic barriers and ensure accountability. The draft continues to treat racism as a passive occurrence rather than an active clinical safety risk, failing to explicitly name and measure institutional racism, racial discrimination, and implicit bias. Furthermore, the phrasing around anti-racism remains weak, focusing on "mitigating" negative impacts rather than establishing a zero-tolerance mandate to eliminate racism. Culturally safe care currently relies too heavily on patient self-identification or system triggers, rather than embedding continuous practitioner reflection and joint governance with Aboriginal Community Controlled Health Organisations (ACCHOs).

The standards also lack strong, explicit requirements for joint governance, co-design, and decision-making partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) and community representatives. There is also a lack of reflective practice requirements. Culturally safe care currently relies heavily on patient self-identification or system triggers. Health services must embed continuous practitioner reflection based on cultural safety standards.

The Third Edition of the NSQHS Standards must explicitly align with the binding commitments established under Schedule B (Better Outcomes for Aboriginal and Torres Strait Islander Peoples) of the National Health Reform Agreement (NHRA). Schedule B places a direct intergovernmental obligation on public hospital systems and health service providers to eliminate institutional racism, achieve health equity, and ensure culturally safe care delivery. While Schedule B establishes core requirements for tracking cultural safety and health equity, these commitments require active enforcement. The NSQHS Standards must serve as the primary mechanism that translates Schedule B obligations into mandatory, auditable accreditation criteria while establishing critical acute care equity indicators to address long-standing safety risks.

2. What changes would strengthen the Standards to support the delivery of high-quality care and better health outcomes?

- Embed a Nationally Consistent Definition of Cultural Safety: Align the definition of cultural safety across the NSQHS Standards directly with the AHPRA definition. Establishing definitional consistency across regulation, accreditation, and policy frameworks will reduce fragmentation and strengthen implementation across jurisdictions.
- Mandatory and actionable Accountability metrics: Improve hospital safety and quality reporting frameworks by formally recognising racism as a patient safety issue. Health service providers must track and report key equity indicators across acute and primary care settings, including:
    - Discharge Against Medical Advice (DAMA): Mandate systematic monitoring and auditing of DAMA rates and uncompleted treatments for First Nations patients.
    - Training Impact Audits: Move beyond tracking simple completion rates to evaluating the practical impact of accredited cultural safety and anti-racism training programs on patient outcomes and care delivery.
    - Sedation of First Nations Patients: Mandate systematic monitoring and auditing of Sedation of First Nations Patients in ED
- Embedding the Commission's Cultural Safety Project: The Commission is currently coordinating a First Nations-led project to analyse evidence on standards and indicators for cultural safety in hospitals.
    - The outcomes, standards, and indicators developed through this First Nations-led project must be explicitly referenced and embedded as mandatory accreditation criteria in the final release of the Third Edition.
- Trauma-Informed and Holistic Care Integration: Ensure health services actively minimise re-traumatisation and support holistic health concepts.
    - Explicitly integrate trauma-informed care principles into the *Person-Centred Practice Standard*, particularly for emergency, crisis, and mental health pathways.
    - Strengthen requirements around human rights frameworks and holistic models of health within acute and emergency care settings.
- Independent Complaint and Feedback Mechanisms: Establish explicit requirements for health services to implement independent, culturally safe feedback and complaint mechanisms.
    - These mechanisms must be led or supported by community advocates rather than relying solely on internal health service reporting structures, ensuring patients and families can report instances of bias or unsafe care without fear of retaliation.

3. How well do the Standards support care delivery and coordination across services, settings, and providers? How could this be improved?

While the draft Third Edition makes positive strides toward integrating care across the health continuum, the Standards still lack sufficiently strong mechanisms to bridge mainstream clinical services

and community-based First Nations healthcare providers. Effective care delivery and coordination require seamless transitions where patient preferences, cultural safety, and multidisciplinary care plans are respected and maintained without interruption across acute, primary, and community settings.

To significantly strengthen care delivery and cross-sector coordination, the Standards should incorporate the following:

- Strengthen provisions within the *Clinical Governance Standard* requiring partnership between mainstream health services, ACCHOs, and social/community services to prevent gaps during care transitions.
    - Requirements under Section 1.11 (*Partnering with Communities*) must mandate partnerships with Aboriginal Community Controlled Health Organisations (ACCHOs) and local First Nations governance bodies. Co-design must involve shared decision-making power in budgeting, clinical design, and evaluation.
- Ensure digital clinical systems under the *Safe Clinical Systems Standard* support seamless, secure sharing of multidisciplinary care plans and consumer preferences across care settings.
    - Digital tools and health information systems must enable interoperability while protecting First Nations data sovereignty, ensuring that cultural preferences, risk assessments, and multidisciplinary management plans follow the patient across clinical environments.

5. How well do the Standards help health services learn, reflect and improve over time?

What could strengthen this?

While the draft Third Edition rightly emphasises continuous quality improvement, it relies heavily on process compliance rather than evaluating meaningful changes in clinical practice or health outcomes. To foster a health system that continuously learns and improves, quality frameworks must move beyond standard compliance audits and establish First Nations-led, independent mechanisms that actively identify, measure, and address institutional racism as a core safety risk.

- Anti-racism and cultural safety learning culture
    - Health services must establish continuous learning environments specifically focused on dismantling systemic racism and fostering reflexive practice
    - Cultural safety training must be ongoing, evaluated for practical behaviour change and designed/delivered in partnership with Aboriginal and Torres Strait Islander health leadership
- Aboriginal and Torres Strait Islander-led Evaluation Mechanisms
    - Systems for monitoring cultural safety, racism, and adverse events must be Aboriginal and Torres Strait Isalnder- led and independent, allowing patients, families, and staff to report incidents of bias or discrimination without fear of reprisal.

D. Detailed Proposed Amendments to Draft Standards

Draft Standard/ Requirement	Proposed Amendment	Reason for change
Clinical Governance Standard		
Clinical Governance Standard *(Req 1.01)*	Embed an explicit mandate to eliminate institutional racism and require health service boards to implement an active Anti-Racism and Cultural Safety Governance Framework. Classify racism, implicit bias, and cultural unsafety as formal clinical safety hazards requiring measurable board-level reporting.	Shifting from passive avoidance to active anti-racism ensures board-level accountability for systemic discrimination and clinical safety. Aligns with Closing the Gap Priority Reform 3 and places an active duty on leadership to eliminate institutional hazards.
Clinical Governance Standard *(Req 1.03)*	Require culturally safe and accessible complaints pathways for patients, families and staff to report racism and discrimination, with protections against victimisation and retaliation	Ensures Aboriginal and Torres Strait Islander patients, families, and healthcare workers can report incidents of racism and culturally unsafe care without fear of compromised care, discrimination, or professional reprisal.
Clinical Governance Standard *(Req 1.05b and cross-standard language)*	Enforce consistent terminology establishing an explicit zero-tolerance mandate to eliminate institutional racism, discrimination and bias. Replace passive, ambiguous phrasing (such as *"mitigating"*, *"addressing"* or *"avoid")* across all standards.	Terms like *"mitigating"* or *"addressing"* treat racism as a tolerable risk to be minimised rather than a patient safety hazard. Consistent, unambiguous language across all standards mandates active elimination and enforces strict board accountability.
Clinical Governance Standard *(Req 1.11)*	Mandate formal, resourced partnerships and shared decision-making structures with ACCHOs and local First Nations communities. Require health service boards to demonstrate how ACCHOs and community advice has directly influenced executive decisions, policy formulation, and service design.	Ensures true co-design and community sovereignty in health governance and service delivery, converting tokenistic engagement into enforceable, shared-power governance and accountability.

Clinical Governance Standard *(Req 1.23)*	Strengthen culturally safe care within continuity of care by requiring partnerships with ACCHOs and other culturally safe services across care transitions, discharge planning and follow-up care.	Ensures continuity of culturally safe care across healthcare transitions, directly addressing high rates of Discharge Against Medical Advice (DAMA), uncompleted treatment pathways, and patients discharged without clear diagnosis or follow-up plan
Clinical Governance Standard *(Req 1.25)*	Explicitly recognise racism, discrimination and culturally unsafe care as patient safety risks and require measurable actions to monitor and address them	Ensures health service systems treat cultural unsafety with the same clinical severity and reporting rigor as medical errors and physical hazards.
Clinical Governance Standard *(Req 1.29 & 1.31)*	Require health services to monitor, report and act on equity and cultural safety outcomes, including experiences of racism and discrimination, consistent with Indigenous Data Sovereignty principles.	Supports transparent, auditable quality metrics while respecting Aboriginal and Torres Strait Islander community ownership and control over data.
Person-Centred Practice Standard		
Person-Centred Practice Standard *(Definitional Consistency)*	Embed a nationally consistent definition of cultural safety across all three standards, aligned directly with the AHPRA definition.	Ensures definitional consistency across regulation, accreditation, and policy frameworks, reducing system fragmentation across jurisdictions.
Person-Centred Practice Standard *(Req 2.01, 2.04 & 2.10)*	Embed reflexive practice and cultural safety as mandatory requirements across all three standards, rather than confining them to descriptive text under Person-Centred Practice. Include an explicit clinician obligation to deliver trauma-informed care that recognises the impacts of colonisation and actively identifies, challenges, and addresses racial bias.	Prevents cultural safety and reflexive practice from being treated as isolated individual tasks. System-wide embedding ensures organisational accountability across governance, clinical systems, and direct patient care.
Safe Clinical Systems Standard		
Safe Clinical Systems Standard	Mandate the integration and full scope of practice utilisation of Aboriginal and Torres Strait Islander Health	Ensures First Nations health professionals are recognized as core clinical team members,

	Workers and Practitioners across all clinical streams.	improving patient outcomes and care continuity.
Safe Clinical Systems Standard	Recognise racism, discrimination and cultural unsafety as patient safety risks within clinical safety and quality systems and require monitoring and reporting on inequities in care and outcomes for Aboriginal and Torres Strait Islander peoples.	Explicitly embeds active anti-racism and health equity monitoring into daily clinical safety frameworks, ensuring systems measure, report, and mitigate racial disparities in patient care and clinical outcomes with the same rigor applied to physical and medical harm.
Monitoring & Quality Improvement *(Cross-Standard)*	Mandate independent, First Nations-led evaluation mechanisms and bind the indicators from the Commission's concurrent Cultural Safety Project directly to accreditation.	Provides transparent, measurable data needed to track system reform, monitor DAMA rates, and enforce compliance during accreditation audits.