Australian Commission on Safety and Quality in Health Care
Via email: NSQHSSThirdEdition@safetyandquality.gov.au

25 September 2026

Catholic Health Australia Submission: National Safety and Quality Health Service Standards (third edition)

Catholic Health Australia (CHA) welcomes the opportunity to comment on the initial draft of the National Safety and Quality Health Service Standards (third edition).

CHA supports the direction the Commission has taken. Several of the recommendations in our October 2025 submission are reflected in the draft, including the definition of high-quality care as a set of interconnected domains, consumer partnership woven through every standard, and environmental sustainability embedded in the Standards rather than published as a parallel module. These are significant advances on the second edition and CHA acknowledges them.

Four areas require further consideration before the next draft. Spiritual care has been left out of the definition of whole-person care, which is inconsistent with the Commission's own end-of-life consensus statement and with the Strengthened Aged Care Quality Standards. Named clinical harms, including pressure injuries and falls, have disappeared from the Standards without a published rationale. The reduction in compliance burden that the consultation asks about cannot be verified from the material published, because no mapping from the second edition and no regulatory burden analysis have been released. And while the Standards have changed, the assessment scheme has not. Proportionality is asserted once in the introduction and operationalised nowhere in the requirements.

CHA notes that a number of members are lodging their own submissions with requirement-level feedback drawn from their operational contexts. CHA's submission therefore addresses the architecture of the third edition, including what it covers, how it will be assessed and what it will cost to implement, and should be read alongside those member submissions.

CHA members are willing to participate in the 2027 pilot of the second draft, and CHA would be pleased to coordinate expressions of interest.

CHA would welcome the opportunity to discuss this submission further. If you wish to discuss anything, please contact Dr Katharine Bassett, Director of Health Policy, on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

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Catholic Health Australia
Submission: National Safety and Quality Health Service Standards (third edition)

October 2026

Catholic Health Australia
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Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services. CHA Members provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

CHA members account for 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.

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.

Executive summary

The third edition consolidates eight standards into three and shifts the emphasis from specifying clinical processes to describing the systems and culture that produce high-quality care. CHA supports that direction. It reflects where the sector has moved, and it reflects much of what CHA put to the Commission in October 2025.

The draft delivers on several of those earlier recommendations. High-quality care is defined as a set of interconnected domains rather than as the absence of harm, and that definition carries through all three standards. Consumer partnership is distributed across the Standards rather than confined to one. Environmental sustainability and climate resilience are embedded in the requirements rather than published as a parallel module. Each of these was a CHA position and each is a material improvement on the second edition.

The difficulty is the distance between what the draft states and what it can deliver. The consultation asks whether the third edition reduces compliance burden while maintaining safety and quality. That question cannot be answered from the material published. The draft reduces the number of standards, but contains 79 requirements, 286 lettered sub-requirements and 22 further sub-elements beneath those. Without a mapping from the second edition and a regulatory burden analysis, neither CHA nor its members can say whether the assessable load has fallen, risen or stayed the same. The Commission published a regulation impact statement when it made the second edition. The third edition is a larger structural change and warrants the same.

The same gap runs through the assessment model. The draft states that implementation and assessment should be proportionate to the size, scope, complexity, clinical risk profile, service model and digital maturity of the service. That statement appears once, in the introduction, and in none of the 79 requirements. Nothing in the draft says who decides what is proportionate, on what criteria, or what a service can do if it disagrees. Broader, outcome-focused wording assessed by six accrediting agencies under an unchanged scheme is more likely to increase variation between assessors and defensive documentation by services than to reduce burden. Proportionality matters most to the services least able to carry the cost, being small rural hospitals and single-specialty day procedure services, where accreditation consumes a far higher share of total cost and where the accreditation coordinator is often also the clinical educator and the infection prevention lead.

Two omissions require attention on their own terms. The word spiritual does not appear anywhere in the draft, although the Commission's own end-of-life consensus statement names spiritual need as a guiding principle, and the Strengthened Aged Care Quality Standards require providers to support it. A resident moving from a residential aged care home to a hospital crosses from a regime that names spiritual need to one that does not. Separately, the named clinical harms carried by the second edition, including pressure injuries, falls, nutrition, delirium and venous thromboembolism, are absent from the draft, with no published mapping showing where those obligations have gone. These are among the highest-volume preventable harms in Australian hospitals and among the actions services found hardest to meet.

CHA makes 16 recommendations. They fall into four groups: restore what is missing from the scope of the Standards; publish the evidence base for the burden claim before the 2027 pilot; make proportionality operate inside the Standards rather than sit above them; and sequence the requirements that depend on national infrastructure to the timetable on which that infrastructure will exist.

Background

Catholic Health Australia (CHA) is the peak body for Catholic health, community and aged care services in Australia, and represents the largest grouping of non-government health and aged care providers in the country. The scale and spread of CHA members' footprint include:

- **Private hospitals:** CHA members operate around 68 private hospital facilities, delivering approximately 30 per cent of private hospital care in Australia. This includes a disproportionate share of regional and rural private hospital services.
- **Public hospitals:** CHA members operate 18 public hospitals under contract with state health systems, delivering approximately 5 per cent of Australia's public hospital care. These are operated by Mater, Mercy Health, Calvary, St Vincent's Health Australia and St John of God Health Care.
- **Aged care:** CHA members operate approximately 12 per cent of residential aged care facilities and deliver approximately 20 per cent of home care packages nationally, spanning residential aged care, home care, Support at Home, community aged care and palliative care services across every state and territory.
- **Community and social services:** CHA members deliver community mental health, homelessness and supported accommodation, family and domestic violence, drug and alcohol, and youth services.

CHA's members are not a homogeneous group. They include large metropolitan tertiary and teaching hospitals, regional and rural hospitals, single-specialty day procedure services, standalone mental health and rehabilitation facilities, and hospitals co-located with residential aged care on the same campus. The third edition will apply to all of them.

CHA notes that several members are lodging their own submissions with requirement-level feedback drawn from their operational contexts, including detailed comment on clinical requirements, service-specific applicability and implementation sequencing. CHA's submission therefore addresses the architecture of the third edition, including what it covers, how it will be assessed, and what it will cost to implement, rather than the drafting of individual requirements which members are better placed to judge against their own case mix and service model.

Overarching comments and recommendations

CHA supports the direction of the third edition. The Commission has taken up much of what CHA advocated for in its October 2025 submission, including:

- Defining high-quality care as a set of interconnected domains rather than as the absence of harm
- Weaving consumer partnership through every standard instead of confining it to one
- Embedding environmental sustainability and climate resilience inside the Standards rather than publishing them as a parallel module
- Stating an intent to move away from a compliance focus toward continuous improvement.

There are however four areas which require further consideration:

- **Spiritual care has been left out of whole-person care:** The word "spiritual" does not appear anywhere in the draft. This is inconsistent with the Commission's own end-of-life consensus statement, which the draft incorporates by reference, and with the Strengthened Aged Care Quality Standards, which name it expressly.
- **Named clinical harms have disappeared without a published rationale:** Pressure injuries, falls, nutrition, delirium and cognitive impairment, and venous thromboembolism are not mentioned in the draft. No mapping has been published showing where they have gone.
- **The burden reduction cannot be verified from the material published:** The draft reduces eight standards to three. It contains 79 requirements, 286 lettered sub-requirements and a further 22 sub-elements. Without a mapping from the second edition and a regulatory burden analysis, no one can say whether the assessable load has fallen, risen or stayed the same.
- **The Standards have changed but the assessment scheme has not:** Proportionality is asserted once in the introduction and operationalised nowhere in the requirements. Broader, outcome-focused wording assessed by six accrediting agencies under an unchanged model is more likely to increase variation and defensive documentation than to reduce burden.

Recommendations

1. Add spiritual need to the definition of whole-person care, and add requirements for identifying and responding to spiritual needs in clinical assessment and at the end of life.
2. Retain named minimum harm domains, either in the requirements or in a mandatory schedule cross-referenced to the national Hospital-Acquired Complications list.
3. Consider whether the Standards should address the governance of clinical artificial intelligence, in terms that are technology-neutral and that sit within existing clinical governance.
4. Consider how the Clinical Governance Standard could address board oversight of risks to the continuity of safe care arising from service viability and workforce availability.
5. Pair the benchmarking requirements with a published commitment on which national comparators and registries will exist, and for which service types, by 2030.
6. Consolidate the workforce training obligations into a single requirement expressed as competencies rather than as separate training programs.
7. Extend the Integrated Health and Aged Care Services Module, or an equivalent single-assessment pathway, to any organisation assessed against both the NSQHS Standards and the aged care standards, regardless of funding source.

8. Sequence the interoperability requirements to the Commonwealth's sharing by default timetable, and assess them only once the corresponding national obligation is in force for that service type.
9. Reword the requirements that reach across organisational boundaries so they oblige the service to seek, document and escalate accountability arrangements, not to guarantee another party's participation.
10. Publish, before the 2027 pilot, a mapping from every second edition action to its third edition destination, a comparable count of assessable elements in both editions, and a regulatory burden analysis on the model of the 2018 Decision Regulation Impact Statement.
11. Apply a consistent, stated rule for attributing each requirement to the board, the health service, or clinicians, and apply it throughout.
12. Provide that where a service holds current certification or licensing that demonstrably meets a requirement, evidence of that certification satisfies the requirement without separate demonstration, and publish the recognised schemes.
13. Publish a cross-reference table showing which requirements are satisfied by a common organisational system, and instruct assessors accordingly.
14. Publish, with the second draft, the assessment model that will accompany the third edition, together with worked descriptions of what meeting a requirement looks like at different service scales.
15. Operationalise proportionality inside the Standards by marking applicability at requirement level, and give services a documented, reviewable process for agreeing proportionate application before assessment.
16. Design the 2027 pilot to include a small regional hospital, a single-specialty day hospital and a campus co-located with residential aged care, publish the measured implementation effort by service type, and confirm a transition period of no less than 24 months before first assessment.

What the draft gets right

CHA is pleased to see several of the recommendations from our October 2025 submission reflected in the initial draft, including:

- A contemporary definition of quality care that goes beyond harm avoidance. High-quality care is defined as person-centred, safe, effective, accessible and integrated, provided in a way that is equitable, efficient and sustainable. The definition carries through all three standards rather than sitting in the front matter.
- Consumer partnership treated as a way of working rather than as a standard to be passed. It is distributed across the Clinical Governance and Person-Centred Practice standards, with requirements on co-design, on recruiting and supporting consumers in governance roles, and on measuring the effectiveness of those partnerships.
- Environmental sustainability integrated into the Standards rather than published as a parallel module. It appears at board level in requirement 1.06, in emergency preparedness and business continuity in 1.27, and in medicines procurement and disposal in 3.14.
- A shift in emphasis from compliance toward continuous improvement. The draft states that the third edition moves away from a sole focus on complying with accreditation requirements towards building the culture of the whole organisation, and that assessment focuses on the effectiveness of systems supporting high-quality care rather than on uniform implementation models.

CHA also supports the draft's treatment of credentialing and facility-specific scope of practice in 1.20, the explicit governance of digitally enabled care and cyber security in 1.04, the integration of clinical research governance into the clinical governance framework rather than as a separate scheme, and the requirement in 1.07 to identify and reduce care that provides little benefit. These are significant advances on the second edition.

Response to consultation questions

Question 1: How well do the Standards reflect key safety and quality priorities, and what is missing?

Spiritual care is missing from the definition of whole-person care

The word "spiritual" does not appear anywhere in the draft, including in the Person-Centred Practice Standard, the key area titled "Caring for the whole person", the requirements on advance care planning or end-of-life care, or in the glossary. The key area defines whole-person care as understanding and addressing an individual's physical, cognitive, psychological, cultural and social needs. CHA views this as inconsistency inside the Commission's own document set and inside Commonwealth regulation.

The Commission's National Consensus Statement: essential elements for safe and high-quality end-of-life care, second edition, states as one of its nine guiding principles that end-of-life care should consider cultural, spiritual and psychosocial needs.[1] Requirement 2.08a of the draft requires clinicians to provide coordinated care at the end of life in accordance with that consensus statement. The draft therefore incorporates by reference a Commission document that names spiritual need, while its own definition of whole-person care omits it.

The gap is wider against aged care. Action 5.7.3(b) of the Strengthened Aged Care Quality Standards, in force since 1 November 2025, requires providers to deliver palliative care that supports the individual's spiritual, cultural and psychosocial needs.[2] Section 23 of the Aged Care Act 2024 gives older people a statutory right to have their identity, culture, spirituality and diversity valued and supported.[3] A resident transferred from a CHA residential aged care home to a CHA hospital moves from a regime that names spiritual need to one that does not. For the members who operate both on a single campus, that is a live discontinuity.

The evidence supports inclusion in the Standards, rather than being left to external faith communities. A 2022 systematic review covering 371 serious-illness studies and 215 health-outcome studies graded for risk of bias and synthesised through a multidisciplinary Delphi panel, concluded that spiritual care should be incorporated into care for patients with serious illness and into the training of interdisciplinary teams.[4] In addition, a prospective cohort of 343 patients with advanced cancer found that patients reporting their spiritual needs were inadequately supported by clinical staff were less likely to receive a week or more of hospice care, 54 per cent against 72.8 per cent, and more likely to die in intensive care, 5.1 per cent against 1.0 per cent, with end-of-life costs of

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[1] Australian Commission on Safety and Quality in Health Care. National Consensus Statement: essential elements for safe and high-quality end-of-life care, 2nd edition. Sydney: ACSQHC; 2023. Available at https://www.safetyandquality.gov.au/sites/default/files/2023-12/national_consensus_statement_-_essential_elements_for_safe_and_high-quality_end-of-life_care.pdf

[2] Department of Health, Disability and Ageing. Strengthened Aged Care Quality Standards. Canberra: Commonwealth of Australia; August 2025, Standard 5, Outcome 5.7, Action 5.7.3(b). Available at https://www.health.gov.au/sites/default/files/2025-08/strengthened-aged-care-quality-standards-august-2025.pdf

[3] Aged Care Act 2024 (Cth), s 23(3)(c).

[4] Balboni, T. A., VanderWeele, T. J., Doan-Soares, S. D., Long, K. N., Ferrell, B. R., Fitchett, G., ... & Koh, H. K. (2022). Spirituality in serious illness and health. *Jama*, *328*(2), 184-197.

US$4,947 against US$2,833.[5] This same cohort study found that patients well supported by religious communities outside the health service received less hospice care and more aggressive intervention near death.[6] The protective effect appeared only where the clinical team also provided spiritual care. Another study across six Sydney hospitals found approval rates between 94 and 99.8 per cent for every tested way of opening a conversation about spirituality.[7]

The implementation infrastructure already exists. The Spiritual Health Association has mapped spiritual care in health against the second edition of the NSQHS Standards, and maintains a capability framework and credentialing framework for spiritual care practitioners. Furthermore, spiritual care was recognised in Victoria as an allied health profession in 2016.[8]

Recommendation 1. Amend the definition of whole-person care to read physical, cognitive, psychological, spiritual, cultural and social needs. Add a sub-requirement under 2.04 requiring the multidisciplinary care team to identify and respond to spiritual needs where relevant to the person's care, and a corresponding sub-requirement under 2.08 for care at the end of life. Add a definition of spiritual care to the glossary.

Named clinical harms have disappeared without a published rationale

The following terms do not appear anywhere in the draft:

- pressure injury
- falls and nutrition
- malnutrition
- delirium
- venous thromboembolism
- sepsis.

In addition, cognitive impairment does not appear as a named risk state, with the word cognitive appearing only in relation to acute deterioration. The second edition's Comprehensive Care Standard required specific systems for each of these.

These clinical harms are among the highest-volume preventable harms in Australian hospitals and are core to the national Hospital-Acquired Complications list, which the draft itself references at 2.06b. They were also among the hardest actions to meet. Published analysis of 495 assessments conducted between January 2019 and December 2020 identified the actions on pressure injuries and

[5] Balboni, T., Balboni, M., Paulk, M. E., Phelps, A., Wright, A., Peteet, J., ... & Prigerson, H. (2011). Support of cancer patients' spiritual needs and associations with medical care costs at the end of life. *Cancer*, *117*(23), 5383-5391.
[6] Balboni, T. A., Balboni, M., Enzinger, A. C., Gallivan, K., Paulk, M. E., Wright, A., ... & Prigerson, H. G. (2013). Provision of spiritual support to patients with advanced cancer by religious communities and associations with medical care at the end of life. *JAMA internal medicine*, *173*(12), 1109-1117.
[7] Best, M. C., Jones, K., Merritt, F., Casey, M., Lynch, S., Eisman, J., ... & Kearney, M. (2023). Australian patient preferences for the introduction of spirituality into their healthcare journey: A mixed methods study. *Journal of Religion and Health*, *62*(4), 2323-2340.
[8] Spiritual Health Association. Guidelines for Quality Spiritual Care in Health, 2nd edition. Melbourne: Spiritual Health Association; 2024, available at https://spiritualhealth.org.au/resource/guidelines-for-quality-spiritual-care-in-health/. On the Victorian recognition, see Hennequin, C. (2020). Charting and documenting spiritual care in health services: Victoria, Australia. In S. Peng-Keller & D. Neuhold (Eds.), Charting Spiritual Care: The Emerging Role of Chaplaincy Records in Global Health Care. Springer.

falls among those most frequently attracting findings of the 36 actions in the Comprehensive Care Standard.[9]

CHA understands the intent, and that generic requirements on risk in 1.25b and on comprehensive assessment in 2.04 and 2.06 are presumably meant to absorb them. This however presents three risks:

1. Services allocate attention to what the Standards name. Removing the names removes the national signal, at a point where the harms themselves have not gone away.
2. Six approved accrediting agencies will each form their own view of what "common causes of harm" means in 1.25b. Named harms are one of the few things in the current scheme that assessors interpret consistently.
3. The measurement infrastructure, including the Hospital-Acquired Complications list and the associated pricing adjustments, is built around named harms. Standards that no longer name them will drift away from the data that measures them.

Recommendation 2. Retain named minimum harm domains. This can be done in the requirements or in a mandatory schedule cross-referenced to the national Hospital-Acquired Complications list, with services required to demonstrate systems for those harms relevant to their case mix. Whichever approach is taken, publish the rationale for the change so the sector can see where each second edition obligation has gone.

Clinical artificial intelligence requires clearer governance

The draft strengthens requirements for digital infrastructure, cyber security, information security management and interoperability, but does not explicitly address artificial intelligence (AI). Requirement 1.04a provides oversight of digital tools used for clinical support and decision-making, complemented by requirements on evaluation at 1.17h, risk at 1.24b and incident management at 1.26b. These provide a foundation for AI governance, but currently leave services and assessors to interpret how they apply to AI-specific risks.

The third edition will not be assessed until 2030. AI-assisted triage, imaging interpretation, deterioration and sepsis prediction, ambient documentation and clinical summarisation are already deployed in Australian hospitals, including in CHA member services. There would be value in the Standards supporting responsible adoption through clearer expectations that AI improves care, preserves clinical judgement, and augments rather than replaces the relationship between patient and clinician. The same expectations would sensibly extend to operational applications where these influence access to care or clinical priorities.

CHA also sees value in services establishing whether an AI tool is suitable for their patients and care setting before deployment, and monitoring its performance and equity impacts as its use evolves. That oversight would sit naturally within existing clinical governance, with clear accountability and a workforce equipped to recognise limitations and exercise independent clinical judgement. It would support informed patient participation through clear explanations of AI's role in care and opportunities to question its outputs, with consent requirements proportionate to the application and its risks.

[9] Murgo, M., & Dalli, A. (2022). Australian health service organisation assessment outcome data for the first 2 years of implementing the Comprehensive Care Standard. *Australian Health Review*, *46*(2), 210-216.

Recommendation 3. CHA suggests the Commission consider whether the Standards should address the governance of clinical artificial intelligence, including suitability for the patients and care setting before deployment, monitoring of performance and equity impacts in use, clinician accountability, workforce capability to recognise limitations, and transparency to patients. Any such requirement would sit within existing clinical governance rather than as a separate scheme, and would need to be technology-neutral if it is to remain useful to 2030 and beyond.

Question 2: What changes would strengthen the delivery of high-quality care and better health outcomes?

The efficiency and sustainability domains are defined but not made operative

High-quality care is defined to include efficiency and sustainability. Sustainability is then operationalised environmentally, through 1.06, 1.27 and 3.14, however efficiency is barely operationalised at all. Requirement 1.02b asks boards to align financial, operational and business decision-making with the organisation's strategic direction for high-quality care, and 1.07 requires the reduction of low value care and waste. There is no requirement anywhere addressing the sustainability of the service itself.

The context makes this a serious omission. In 2024, the Commonwealth's Private Hospital Sector Financial Health Check (Health Check) found operating costs growing faster than revenue, with the weighted average EBITDA margin across the hospitals assessed falling from 8.7 per cent in 2018-19 to 4.4 per cent in 2022-23,[10] and capital replacement rates declining in a way that points to reduced investment and longer-term asset deterioration risk. It identified maternity and mental health as under particular pressure, recording nine private maternity ward closures between 2015-16 and 2022-23 and a falling share of psychiatric services delivered in private hospital settings despite growing demand for psychiatric care.

Since the Health Check, the sector's financial position has continued to decline. ABS Australian Industry data show that as recently as 2017-18, private hospitals earned an operating profit of about $1.6 billion, a margin of 8.1 per cent. The sector's result has then deteriorated in every year since 2020–21, from an operating profit of about $1.0 billion that year, which fell to $480 million in 2021-22 and $298 million in 2022-23. The sector subsequently moved into deficit in 2023-24 and recorded an operating loss of about $756 million in 2024-25 – five consecutive years of decline, with margins falling from 4.7 per cent to negative 3.1 per cent.

Figures from 2024-25 represent the latest point in a sustained deterioration in the sector's finances. Operating expenses now equal 103 per cent of total income, meaning the sector is spending more than it earns. The main driver is a widening gap between costs that hospitals have limited control over, and revenue that they largely cannot set. Wages and salaries have risen from 47.5 per cent of total income in 2017-18 to 54.6 per cent in 2024-25, the highest level in the ABS series, increasing by more than 40 per cent over seven years to about $11.9 billion. At the same time, hospital revenue is largely determined through negotiated contracts with private health insurers, which have not kept pace with rising costs. Sector earnings before capital costs, about $1.2 billion, must now fund the buildings, equipment and debt of a $25 billion industry.[11]

When a service closes or is thinned, the safety and quality consequence falls on patients who lose access, on the remaining services absorbing the demand, and on the workforce moved or lost. Standards that define sustainability as a domain of high-quality care, and then require nothing of boards on the viability of the service, leave the most consequential risk to high-quality care outside the frame.

[10] Department of Health and Aged Care, Private Hospital Sector Financial Health Check, 2024.
[11] Australian Bureau of Statistics, Australian Industry (cat. no. 8155.0), private hospitals, 2007–08 to 2024–25.

CHA is not asking the Commission to regulate financial viability as this is not its role, however we suggest that boards be required to consider the effect of service and financial decisions on the safety and quality of care, and to plan for safe transition where a service cannot be sustained. That is a clinical governance obligation and it belongs in the Clinical Governance Standard.

Recommendation 4. CHA suggests the Commission consider how the Clinical Governance Standard, at 1.01 or 1.24, could address board oversight of risks to the continuity of safe care arising from service viability and workforce availability, including planning for the safe transition of patients and services where a service is reduced or closed.

Outcome-focused reporting depends on national infrastructure that does not yet exist for this sector

Requirement 1.31e asks services to compare and report performance against target ranges, peer organisations, and state, territory and national benchmarks. Requirement 1.32 asks them to contribute complete and accurate data for all eligible patients to relevant clinical quality registries. CHA supported outcome-focused reporting in its October 2025 submission and supports these requirements in principle.

In practice they assume a national data infrastructure that does not exist for the private sector. The Australian Institute of Health and Welfare states directly that there is no current comprehensive dataset describing private hospitals in Australia, and the Australian Bureau of Statistics discontinued the Private Health Establishments Collection. Furthermore, there is no published breakdown of current private hospital beds or admissions by ownership type. A private hospital cannot benchmark against national data that is not collected, and cannot compare against a peer group that has not been defined.

Recommendation 5. Pair the benchmarking and registry requirements with a published commitment, developed with the Independent Health and Aged Care Pricing Authority and the Australian Institute of Health and Welfare, setting out which national comparators will exist by 2030 and which registries private hospitals and day procedure services are expected to contribute to. Without that, 1.31e is an obligation services cannot discharge and assessors cannot fairly assess.

The workforce obligations need to be feasible in the workforce we actually have

The draft places substantial new obligations on the workforce, including:

- Validated surveys of workforce culture including psychosocial and cultural safety in 1.13f
- Team-based training in 1.17e
- Digital health literacy uplift in 1.04g
- Training in the prevention, recognition and management of behaviours of concern in 2.11a
- Training in person-centred care, shared decision making and consent in 2.02a
- Training in recognising early physical and cognitive deterioration in 2.17a.

Each of these is defensible on its own, however together they are a considerable training and measurement load. The Commonwealth's own Nursing Supply and Demand Study projects a shortfall of 70,707 full-time equivalent nurses by 2035, of which 26,665 is in acute care.[12] New training obligations therefore land on services that already cannot fill rosters, and land hardest on small, rural

[12] Department of Health and Aged Care. *Nursing Supply and Demand Study 2023-2035*. Canberra: Commonwealth of Australia; 2024. Available at https://hwd.health.gov.au/resources/primary/nursing-supply-and-demand-study-2023-2035.pdf

and day services, where the accreditation coordinator is frequently also the clinical educator, the infection prevention lead and a working clinician.

Recommendation 6. Consolidate the workforce training obligations into a single requirement expressed as required competencies rather than as separate training programs. This lets services meet them through integrated education, and directs assessors to look for demonstrated capability rather than for the existence of six distinct courses.

Question 3: How well do the Standards support care delivery and coordination across services, settings and providers?

The draft's treatment of coordinated care is stronger than the second edition. Requirements 1.23, 2.19, 2.21 and 2.22 together set clear expectations about accountability after discharge, about mismatch between a patient's needs and the level of clinical support available, and about the completeness of information at transitions. CHA supports these requirements, however there are three practical problems which limit how far they can be delivered.

The hospital to aged care transition sits across two regulatory regimes

A CHA member operating a private hospital and a residential aged care home on the same campus complies with the NSQHS Standards under the Australian Health Service Safety and Quality Accreditation Scheme, and with the Strengthened Aged Care Quality Standards under the Aged Care Quality and Safety Commission. That is two standards sets, two regulators, two assessment cycles and two evidence sets, applied to one continuum of care that the draft rightly says should be seamless.

The Integrated Health and Aged Care Services Module allows approved organisations to meet the requirements of both standards sets in a single assessment process, consolidating the elements of the aged care standards not covered by the NSQHS Standards into 14 module items. It was updated on 1 November 2025 to align with the strengthened aged care standards.[13] However, its availability is limited to Commonwealth-funded organisations delivering integrated services.

Recommendation 7. Extend the Integrated Health and Aged Care Services Module, or an equivalent single-assessment pathway, to any organisation assessed against both standards sets, regardless of funding source. Build the third edition so the module maps cleanly to it from the outset, rather than being retrofitted after publication.

The interoperability requirements assume capability the sector does not have

Requirement 3.04b requires healthcare record systems to be interoperable with national digital health infrastructure including My Health Record, diagnostic testing reporting systems, and point of care testing devices. Requirement 2.22e requires information at transitions of care to be transmitted using that infrastructure.

The most recent published figures from the Australian Digital Health Agency show 91 per cent of public hospital beds actively using My Health Record, against 55 per cent of private hospitals with

[13] Australian Commission on Safety and Quality in Health Care. Integrated Health and Aged Care Services Module. Sydney: ACSQHC; updated 1 November 2025. Available at https://www.safetyandquality.gov.au/standards/integrated-health-and-aged-care-services-module

inpatient facilities and 4 per cent of private day hospitals.[14] With day hospitals making up a significant number of private facilities in Australia, a requirement that 96 per cent of day hospitals do not currently meet is not a stretch target but a capital works and vendor conformance program, which the Standards cannot fund.

The Commonwealth has phased its own sharing by default reforms carefully. The obligation begins with pathology and diagnostic imaging providers from 1 July 2026. Hospitals are not yet in scope, no date has been set, and the Department has committed that expansion will be consulted on so there are no surprises.[15] The Standards should therefore not get ahead of the Commonwealth's own sequencing.

Recommendation 8. Sequence 3.04b and 2.22e to the Commonwealth's sharing by default timetable. State expressly that these requirements will be assessed only once the corresponding national obligation, and its funding and vendor conformance arrangements, are in place for that service type.

Some coordination obligations reach beyond the assessed organisation's control

Requirement 2.19c requires clinicians to clearly define roles, responsibilities and points of contact for ongoing care, including explicit identification of who is accountable following discharge or transfer, particularly where care is shared across clinicians, teams, health services or organisations. CHA supports this requirement, however in practice, a private hospital cannot compel a public hospital, a general practice, a specialist in private rooms or an aged care provider to accept accountability for a patient after discharge. Assessed literally, services will be found not met for the conduct of parties they do not control, and will respond by generating documentation that proves they asked.

Recommendation 9. Reword the requirements that reach across organisational boundaries so they oblige the service to seek, document, and escalate the accountability arrangement, not to guarantee the other party's participation. The same drafting issue arises in 1.23a and 2.22b.

Question 4: Are the Standards easy to understand and free from duplication?

The scale of the draft is not visible from its structure

The draft presents as a substantial simplification, from eight standards to three. However, the three standards contain 79 numbered requirements and those requirements contain 286 lettered sub-requirements, and 22 further numbered sub-elements beneath those. The Clinical Governance Standard alone contains 32 requirements and 125 lettered sub-requirements. It is not clear whether moving from eight standards to three represents any reduction in what a service must implement and evidence.

The 2018 Decision Regulation Impact Statement for the second edition estimated transition costs of $85,263 per private hospital, $84,960 for public hospitals over 50 beds, $6,088 for day procedure

[14] Australian Digital Health Agency. *Hospitals using the My Health Record system*. Canberra: ADHA. Available at https://www.digitalhealth.gov.au/initiatives-and-programs/my-health-record/which-organisations-use-my-health-record/hospitals-using-the-my-health-record-system

[15] Health Legislation Amendment (Modernising My Health Record-Sharing by Default) Act 2025 (Cth). See also Australian Digital Health Agency, Better access to health information, available at https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/better-access-to-health-information

services and $2,842 for small public hospitals.[16] Respondents to that process said the Commission had understated the costs. The third edition is a larger structural change than the second edition was, and warrants a similar analysis.

Recommendation 10. Before the 2027 pilot, publish:

- A mapping from every second edition action to its third edition destination
- A comparable count of assessable elements in both editions
- A regulatory burden analysis on the model of the 2018 Decision Regulation Impact Statement, disaggregated by service type and size.

Accountability is attributed inconsistently

The requirements attribute obligations to at least seven different actors: the board; the board, executive and leaders; the executive and leaders; clinicians; the multidisciplinary care team; the clinical and non-clinical workforce; and the health service. The distinctions are not always principled. Requirement 1.24, on risk management, is directed to the board, executive and leaders. Requirement 1.26, on incident management, is directed to the executive and leaders. Requirement 3.05, on infection risk, is directed to the health service, while 3.10, on medication history, is directed to clinicians.

In a small hospital these are frequently the same two or three people. In a large service they are distinct governance layers with distinct evidence trails. Inconsistent attribution multiplies the evidence a service must assemble and gives assessors latitude to ask for it at whichever level they choose.

Recommendation 11. Apply a consistent rule for attribution and state it in the introduction. The simplest workable rule is that requirements about setting direction, allocating resources and holding accountability sit with the board and executive, requirements about designing and operating systems sit with the health service, and requirements about clinical practice sit with clinicians and multidisciplinary care teams. This rule should then be applied throughout.

Duplication with other regulatory and certification schemes is not addressed

CHA members already hold and are audited against substantial and overlapping obligations. Every state and territory licenses or registers private hospitals separately from NSQHS accreditation. New South Wales prescribes 19 licence classes with general standards in one schedule and class-specific standards in another.[17] Queensland applies ten Private Health Facilities Standards alongside the Clinical Services Capability Framework and the Queensland Development Code.[18] Members also hold, variously, the Strengthened Aged Care Quality Standards, the National Clinical Trials Governance Framework, obligations under the Security of Critical Infrastructure Act for hospitals

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[16] Australian Commission on Safety and Quality in Health Care. *Review of the National Safety and Quality Health Service Standards: Decision Regulation Impact Statement*. Canberra: Office of Best Practice Regulation; 30 January 2018. Accessed at: https://oia.pmc.gov.au/sites/default/files/posts/2018/01/review_of_the_national_safety_and_quality_health_service_standards_-_decision_ris.pdf

[17] Private Health Facilities Act 2007 (NSW); Private Health Facilities Regulation 2024 (NSW), Schedules 2 and 3. See NSW Health, Licensing of private health facilities, available at https://www.health.nsw.gov.au/Hospitals/privatehealth/Pages/licensing-of-private-health-facilities.aspx

[18] Private Health Facilities Act 1999 (Qld); Private Health Facilities Regulation 2016 (Qld). See Queensland Health, Private health facilities legislation and standards, available at https://www.health.qld.gov.au/system-governance/licences/private-health/legislation-standards

with a general intensive care unit, My Health Record conformance requirements aligned to the Essential Eight, Privacy Act obligations including the automated decision-making transparency requirements commencing 10 December 2026, and ISO 9001 and ISO 27001 certification.[19]

The draft's requirements on information security management systems, privacy, cyber incident detection and reporting in 1.04, business continuity in 1.27, and medical device regulation in 3.16 to 3.21 restate obligations that already exist in law or in other certification schemes. Restating them in the Standards does not make patients safer, but makes the same evidence get assembled twice for two different auditors.

The Productivity Commission has already recommended the remedy for the adjacent sectors. Its final report on delivering quality care more efficiently, released in December 2025, recommended cross-sectoral registration and audits across aged care, the NDIS, and veterans' care, with mutual recognition of registration and audits as an interim step, a single digital portal, a combined modular set of practice and quality standards, and report once, use often principles. It estimated the saving from aligning provider processes at $91 million a year. Its evidence included one provider facing seven accreditation and audit processes requiring similar evidence at a cost of $150,000 to $200,000 a year, and another accountable to more than 350 pieces of legislation and a minimum of 16 program audits every three years.[20] It should be noted that acute health sat outside that inquiry's terms of reference, however it should not sit outside the principle.

Recommendation 12. Provide in the third edition that where a service holds current certification or licensing that demonstrably meets a requirement, evidence of that certification satisfies the requirement without separate demonstration. Publish the list of recognised schemes and the requirements each satisfies. Begin with information security certification and Essential Eight conformance, medical device regulation through the Therapeutic Goods Administration, and jurisdictional private hospital licensing.

Internal duplication should be signposted, not left to services to work out

Consumer partnership appears in 1.02a, 1.09, 1.11, 1.12, 2.01 to 2.03, 2.16, 2.19a and 2.20e. Data governance, analysis and reporting appear in 1.28 to 1.32, and again in 3.07, 3.15 and 3.24. Benchmarking and reporting to the community appear separately in 1.31e, 1.32c, 3.05e, 3.07b and 3.24c. Emergency and business continuity preparedness appears in 1.27, and cyber downtime preparedness again in 1.04d.

Weaving consumer partnership through the Standards was the right decision and CHA advocated for this. But distribution is not the same thing as duplication, and the draft does not distinguish them. The introduction observes that similar implementation strategies may apply to multiple requirements and that identifying the links will reduce duplication of effort. It then leaves services to identify those links themselves, and leaves assessors free to disagree with the links they identify.

Recommendation 13. Publish a cross-reference table showing which requirements are satisfied by a common organisational system, and instruct assessors that a single well-evidenced system satisfies each linked requirement without separate evidence being assembled for each.

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[19] Privacy and Other Legislation Amendment Act 2024 (Cth), Schedule 1, inserting Australian Privacy Principles 1.7 to 1.9, commencing 10 December 2026.

[20] Productivity Commission. Delivering quality care more efficiently: Inquiry Report. Canberra: Productivity Commission; December 2025, Recommendation 1.2. Available at https://assets.pc.gov.au/2025-12/quality-care.pdf

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

The draft says assessment focuses on the effectiveness of systems to support high-quality care rather than requiring uniform implementation models, that implementation and assessment should be proportionate, and that the third edition moves away from a sole focus on complying with accreditation requirements toward building organisational culture. Every one of those is a statement about the assessment scheme, not about the Standards. The Standards do not control how they are assessed. The Australian Health Service Safety and Quality Accreditation Scheme, the six approved accrediting agencies and the jurisdictional regulators do. Nothing in the draft changes any of them.

Changing the wording without changing the assessment model will not produce improvement

A 2012 review of the empirical research underpinning accreditation standards found that no study had examined how standards should be written or structured to be understandable, unambiguous, achievable and reliable in assessment.[21] A large systematic review of accreditation, covering 76 studies across 22 countries, found consistent positive effects on safety culture and process measures, no measurable effect on patient experience or readmissions, paradoxical results for mortality and healthcare-associated infections, and four studies associating accreditation with higher job stress, particularly for nurses.[22] A single-site interrupted time series analysis found 74 per cent of quality measures rising in the lead-up to accreditation, and 48 per cent showing a significant negative change in slope afterwards.[23]

The specific risk of moving to broader, outcome-focused wording without changing the assessment model is well documented. Principles-based regulation tends to produce conservative over-compliance, because a regulated entity that is uncertain how a principle will be interpreted does more rather than less.[24] The review of the Care Quality Commission in the United Kingdom in 2024 found that an assessment framework with no description of what good or outstanding care looks like produced a lack of consistency, with providers describing ratings as an incomprehensible process they could not influence.[25] That review also found that separating sectoral expertise from inspection teams produced assessors without relevant clinical experience.[26]

Australia has six approved accrediting agencies assessing against one national standard set. Research into the reliability of Australian health service accreditation identified individual assessors, team dynamics, and agency management processes among six factors affecting reliability, and also

[21] Greenfield, D., Pawsey, M., Hinchcliff, R., Moldovan, M., & Braithwaite, J. (2012). The standard of healthcare accreditation standards: a review of empirical research underpinning their development and impact. *BMC health services research*, *12*(1), 329.
[22] Hussein, M., Pavlova, M., Ghalwash, M., & Groot, W. (2021). The impact of hospital accreditation on the quality of healthcare: a systematic literature review. *BMC health services research*, *21*(1), 1057.
[23] Devkaran, S., & O'Farrell, P. N. (2015). The impact of hospital accreditation on quality measures: an interrupted time series analysis. *BMC health services research*, *15*(1), 137.
[24] Black, J. (2008). Forms and paradoxes of principles-based regulation. *Capital Markets Law Journal*, *3*(4), 425-457.
[25] Dash, P. (2024). Review into the Operational Effectiveness of the Care Quality Commission: Interim Report. *London: Department of Health and Social Care*.
[26] Dash, P. (2024). Review into the Operational Effectiveness of the Care Quality Commission: Interim Report. *London: Department of Health and Social Care*.

identified multiple agencies assessing against a single standard set as a reliability concern in itself.[27] The Commission commissioned a literature review on improving inter-assessor reliability in 2014.[28] CHA is not aware of any published measure of inter-assessor agreement in the Australian scheme since then.

Broader wording makes assessor judgement more consequential. If the assessment scheme, the assessor workforce, and the reliability of judgement are not addressed alongside the Standards, the predictable result is more variation between assessors, more defensive documentation by services, and more burden rather than less.

Recommendation 14. Publish, alongside the second draft, the Commission's plan for the assessment model that will accompany the third edition. It should cover assessor training and credentialing, what evidence will and will not be required, how proportionality will be applied and by whom, how consistency across the six accrediting agencies will be assured and measured, and how inter-assessor reliability will be reported publicly. Worked descriptions of what meeting a requirement looks like at different service scales should be published alongside, using at least a large metropolitan hospital, a regional hospital, and a single-specialty day hospital. Standards written at a high level without worked examples transfer interpretive risk to services.

Question 6: What changes would reduce the compliance burden while maintaining safety and quality?

Proportionality is asserted once and operationalised nowhere

The word proportionate appears once in the draft in a substantive sense, in the introduction, where implementation and assessment are said to be proportionate to the size, scope, complexity, clinical risk profile, service model, and digital maturity of the individual health service. It does not appear in any of the 79 requirements, and the draft does not say who decides what is proportionate, on what criteria, or how a service can contest the decision.

This matters most for the services least able to absorb burden. The only Australian study to cost accreditation directly found that, averaged over the accreditation cycle, it consumed 0.03 per cent of total costs in a specialist teaching hospital and 0.60 per cent in the smallest rural hospital, with absolute costs ranging from $11,910 for a small remote hospital in a self-assessment year to $424,350 for a regional referral hospital in a survey year.[29] Data from Flanders, Belgium shows small hospitals paying 51 per cent more per bed than large ones.[30] The same requirements therefore cost a

[27] Greenfield, D., Debono, D., Hogden, A., Hinchcliff, R., Mumford, V., Pawsey, M., ... & Braithwaite, J. (2015). Examining challenges to reliability of health service accreditation during a period of healthcare reform in Australia. *Journal of health organization and management*, *29*(7), 912-924.
[28] Australian Commission on Safety and Quality in Health Care. *Improving Inter-Assessor Reliability for Health Service Accreditation: A Literature Review*. Sydney: ACSQHC; October 2014. https://www.safetyandquality.gov.au/sites/default/files/resources/attachments/Improving%20Inter-Assessor%20Reliability%20for%20Health%20Service%20Accreditation%20A%20literature%20Review%20-October%20-2014.pdf
[29] Mumford, V., Greenfield, D., Hogden, A., Forde, K., Westbrook, J., & Braithwaite, J. (2015). Counting the costs of accreditation in acute care: an activity-based costing approach. *BMJ open*, *5*(9), e008850.
[30] Brouwers, J., Seys, D., Claessens, F., Van Wilder, A., Bruyneel, L., De Ridder, D., ... & Kesteloot, K. (2022). The cost of a first and second hospital-wide accreditation in Flanders, Belgium. *International Journal for Quality in Health Care*, *34*(3), mzac062.

small service proportionally more than a large one, and the smaller the service, the more of that cost is staff time taken from care.

Day Hospitals Australia has stated that the current accreditation system does not address the model of care delivered by day hospitals.[31] Around 348 private day hospitals operate in Australia,[32] and many are single-specialty, deliver low-acuity same-day elective work, and have no board in the sense the Clinical Governance Standard assumes, no clinical research function, no intensive care unit, no blood bank and no aged care interface. They are nonetheless assessed against requirements written for organisations that have all of those.

The draft already contains the drafting device that would fix this. Requirement 2.23 carries a note that it applies only if the health service participates in clinical research. That approach should be used systematically rather than once.

Recommendation 15. Operationalise proportionality inside the Standards. Mark applicability at requirement level in the Standards themselves rather than in guidance, using the drafting device already applied at 2.23. Separately, give services a defined, documented and reviewable process for establishing the proportionate application of a requirement to their context, agreed with the accrediting agency before assessment rather than argued during it.

Transition and pilot

Assessment against the third edition begins in 2030, following final publication in 2028 and piloting in 2027. Services will need to redesign policies and procedures, retrain staff, rebuild evidence structures and in some cases procure new systems. The transition to the second edition was costed at $85,263 per private hospital in 2018,[33] and stakeholders at the time said that figure was understated. The third edition is a larger change.

The pilot is the Commission's opportunity to test implementation effort before it is locked in. It will only do that if the pilot cohort includes the services for which the draft is hardest to apply.

Recommendation 16. Design the 2027 pilot to include at least one small regional hospital, at least one single-specialty day procedure service, and at least one hospital campus co-located with residential aged care (CHA members are willing to participate in the pilot). Publish the pilot findings including measured implementation effort by service type. Confirm a transition period of no less than 24 months between final publication and first assessment, and confirm that no requirement will be assessed before the national infrastructure it depends on is in place.

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[31] Day Hospitals Australia. Year in Review 2024; 2025. Available at https://www.dayhospitalsaustralia.net.au/wp-content/uploads/2025/01/Year-in-Review-2024-1.pdf

[32] Australian Digital Health Agency. Hospitals using the My Health Record system. Canberra: ADHA. The Agency lists 348 private day hospitals and 293 private hospitals with inpatient facilities.

[33] Australian Commission on Safety and Quality in Health Care. *Review of the National Safety and Quality Health Service Standards: Decision Regulation Impact Statement*. Canberra: Office of Best Practice Regulation; 30 January 2018. Accessed at: https://oia.pmc.gov.au/sites/default/files/posts/2018/01/review_of_the_national_safety_and_quality_health_service_standards_-_decision_ris.pdf