

Submission by the Australian Nursing and Midwifery Federation

Australian Commission on Safety and Quality in Health Care – National Safety and Quality Health Standards (Third Edition) Consultation

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Nursing &
Midwifery
Federation**

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Introduction

1. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 356,000 nurses, midwives and care-workers across the country.
2. Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.
3. Our strong and growing membership and integrated role as both a trade union and professional organisation provides us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.
4. Through our work with members, we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.
5. The ANMF thanks the Australian Commission on Safety and Quality in Healthcare (ACSQHC) for the opportunity to provide feedback on the initial draft of the National Safety and Quality Health Service (NSQHS) Standards (third edition).

Key Messages

6. The ANMF supports the development of the third edition of the NSQHS Standards and welcomes the opportunity to contribute further to their refinement. The Standards provide an important mechanism for strengthening safety and quality across Australia's health and maternity system. Overall, the third edition of the Standards should place greater emphasis on the conditions, systems, and workforce capabilities required to deliver safe, high-quality care, while reducing unnecessary compliance and administrative burden. The ANMF recommends that the third edition:
7. **Strengthen workforce and worker safety as fundamental to patient safety**, including explicit requirements for safe staffing, workforce composition and skill mix, workforce planning and



workload management, alongside stronger recognition of psychosocial safety and workplace violence and aggression.

8. **Embed cultural safety, equity and inclusion throughout the Standards**, including stronger expectations for culturally safe care for Aboriginal and Torres Strait Islander Peoples and other diverse and marginalised populations.
9. **Strengthen environmental sustainability and climate resilience as core components of safe, high-quality care**, recognising that climate change, pollution and biodiversity loss can directly affect population health, health-service infrastructure, workforce capacity and continuity of care. The Standards should support health and maternity services to identify and manage climate-related risks, strengthen resilience to extreme weather and other environmental disruptions, and reduce the environmental impacts of healthcare delivery.
10. **Strengthen organisational accountability and governance**, ensuring responsibility for safety, quality, accreditation and continuous improvement is shared across health professions and workforce groups, with clear accountability at board and executive levels.
11. **Support safe and effective care across the whole health system**, including hospitals, community and other care settings, with stronger requirements for continuity, transitions of care, coordination and information sharing across services and sectors.
12. **Strengthen digital health safety and capability**, including interoperability, cybersecurity, data governance and appropriate safeguards for artificial intelligence, supported by ongoing education and regular review of the Standards as technologies and their risks evolve.
13. **Embed a continuous learning and improvement approach**, drawing on Safety-II principles, reflective practice, feedback from incidents and everyday clinical work, meaningful workforce participation in quality improvement, and mechanisms that support learning between accreditation cycles.
14. **Ensure the Standards are practical and implementable**, including representative piloting across metropolitan, tertiary, rural, remote, public and private health and maternity services before implementation, with implementation guidance, practice exemplars and supporting resources developed and tested alongside the Standards.



15. **Use existing evidence, clinical and workforce data wherever appropriate**, avoiding parallel data collection, reporting and documentation requirements and recognising differences in digital maturity and analytical capability across health and maternity services.
16. **Reduce duplication and compliance burden**, with clearer and more proportionate requirements that focus on meaningful safety and quality outcomes and enable health and maternity services to demonstrate compliance through existing governance, risk, quality improvement, workforce and incident management systems.
17. **Ensure implementation is appropriately resourced**, recognising that new or expanded requirements require adequate workforce capacity, protected time, education, digital infrastructure and other resources to avoid unintended impacts on care delivery.
18. Taken together, these changes would support a third edition that is clearer, more practical and more focused on the conditions that enable safe care, rather than simply increasing compliance requirements. The ANMF considers that the Standards will have the greatest impact when they support health and maternity services and their workforces to learn, adapt and continuously improve, while maintaining clear organisational accountability for safety and quality.



Consultation Questions

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

19. The initial draft of the Standards reflects several important contemporary safety and quality priorities of relevance and interest to the ANMF, particularly cultural safety, Aboriginal and Torres Strait Islander governance, environmental sustainability, person-centred care, digital health, psychological safety, and continuous improvement. The strengthened focus on partnership with Aboriginal and Torres Strait Islander Peoples, formal power-sharing, and cultural safety is particularly welcome, however we note that other groups including gender and sexually diverse people and people with disability are not explicitly referenced. The inclusion of climate resilience and sustainability within clinical governance is also an important development that the ANMF is pleased to recognise.
20. A critical safety and quality priority is also missing from the Standards: explicit requirements for safe staffing and appropriate workforce composition and skills mix. Staffing levels and skills mix are known factors that underpin positive consumer outcomes and experiences. Likewise, the ANMF's 2025 submission on the development of the Standards identified workforce safety as fundamental to patient safety and the ANMF has continued to advocate for legislated minimum safe staffing levels to be embedded within the NSQHS Standards. The current draft does not establish minimum staffing levels, nurse- or midwife-to-patient ratios, or requirements for appropriate workforce composition and skills mix. Instead, Requirements 1.13(e) and 1.17(f) largely rely on health and maternity services identifying workforce risks and aligning clinician capability with patient needs. This does not provide a measurable or enforceable mechanism for ensuring safe staffing. While overall, the ANMF supports the direction of the draft, it cannot adequately reflect contemporary safety and quality priorities without addressing safe staffing and workforce safety explicitly. Patient safety depends on having enough appropriately skilled health professionals working in safe environments. The third edition of the Standards must therefore move beyond general expectations to identify measurable organisational responsibilities for staffing, workforce safety, and the conditions required to deliver safe high-quality care.
21. The draft captures many priorities well however there is a significant gap around workplace violence and aggression against workers. The only relevant content is one clause under Person-Centred Practice where it states "supports workforce safety and wellbeing... when responding to behaviours of concern" with no dedicated Standard. This is out of step with the evidence: NSWNMA found 88%



of nurses, midwives and carers experienced or witnessed violence in the past six months, and AIHW's July 2026 data shows assault-related hospitalisations of healthcare workers have doubled in a decade, now the second leading cause of injury hospitalisation for the workforce, behind only falls. Given this trajectory, and that cybersecurity receives four dedicated, specific action items in the same draft, worker safety from violence deserves parity: a standalone, named priority area, not a single clause folded into patient-centred care provisions.

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

22. To better reflect key safety and quality priorities and strengthen the Standards to support the delivery of high-quality care and better health outcomes, the ANMF recommends the following changes:

Introduce an explicit safe staffing requirement within the Standards

23. The new draft Standards include no explicit mention of safe staffing levels, workforce composition, workload/workforce planning or skills mix (e.g., mandated numeric ratio or minimum staffing level requirements). Instead, the Standards include more principle-level language (e.g., "align the skills, capability and experience of clinicians with patients' care requirements" (1.17f), "respond to risks to patient care arising from workforce gaps or pressures" (1.13e)). This is more an 'accountability-for-outcomes' focus rather than a genuine Standard that would be measurable or enforceable. Our concern is that outcome-based discretion with no mechanism or measurable approach to achieving safe staffing is not sufficient. A new requirement must be included to ensure health and maternity services implement minimum safe staffing levels, that include an evidence-based workforce composition, including access to an appropriately qualified and experienced skills mix of nurses and midwives that is based on patient acuity, complexity, workload and service demand. The requirement must also include measurable indicators and should complement, and not weaken or replace, stronger jurisdictional staffing legislation that is already in place at the State level in some jurisdictions.
24. Linked to this is how the casual clinical workforce is accounted for within the Standards. Requirement 1.17a addresses orienting "agency staff, locums, and staff rotating from other sites." The language here presents this issue as something that appears be routine within health and maternity services



rather than something that ideally should be minimised in preference of a stable and sustainable workforce that can provide continuity of care. The ANMF recognises that reliance on casual staff is widespread across many health and maternity services and that many nurses, midwives, and other clinicians work in these roles and indeed might do so as a preference over full time or part-time work. These workers are critical to the operation of many services and support the safe delivery of high-quality care and certainly must be accounted for within the Standards. While casual, agency, locum, and rotating staff are vital members of clinical care teams that are often required. The over-reliance on agency staffing is a known driver of unsafe conditions. A standard that plans for accommodating a casualised workforce without clearly establishing requirements for a mandated minimum staffing standard with secure employment is not supported.

Strengthen the focus on culturally and linguistically diverse communities and other marginalised community members

25. There are significant opportunities to further strengthen the Standards. There must be a clear focus on culturally and linguistically diverse communities, and on the prevention and elimination of racism in healthcare. We also encourage greater consideration of the barriers and discrimination experienced by people who are marginalised based on gender, gender identity, sex characteristics, and sexuality, both as health and maternity care consumers and as members of the health and maternity care workforce. A stronger emphasis on equity, inclusion, cultural safety, and respectful care for all communities would enhance the document and support better health outcomes and experiences.

Incorporation of the Healthcare Sustainability and Resilience Module

26. With the recognition that the health and maternity care workforce plays an important role in driving change, we strongly recommend that the full *Healthcare Sustainability and Resilience Module*, that was developed through expert panel consultation must be included into the Standards in its entirety. The *Healthcare Sustainability and Resilience Module* must be included because it provides a framework of actions to support health and maternity service organisations to address healthcare impacts on the environment and the climate risks affecting human health and equitable access to high-quality care. Designing and redesigning health and maternity services or facilities, procurement, supply-chain management, waste management and continuous quality improvement are effective



ways for health and maternity service organisations to address their environmental impact and inclusion of the full Module in the Standards would be a prime opportunity to better achieving reform in this space.

Strengthen workforce safety as fundamental to patient safety

27. The Standards must explicitly recognise that worker safety and patient safety are interdependent and that health and maternity settings that pose or contain risk and harm to staff by that nature also pose a risk to patients. Workplace violence, workload, fatigue, psychosocial hazards, bullying, racism and discrimination, harassment, and unsafe working environments should be identified, monitored and managed as safety and quality risks, rather than treating workforce safety as secondary or unlinked to consumer safety. While inclusion of zero-tolerance workforce culture, psychosocial safety, and occupational violence (better termed workplace violence in consideration of the fact that violence in workplaces must not be considered part and parcel of a person's occupation) provisions resonates well with ANMF's priorities around combating workplace violence and our broader safe workplaces agenda, the Standards appear to frame these issues around patient-directed behaviour management (restraint, de-escalation, environmental design) rather than workforce protections from violence and aggression as a distinct, reportable risk category.

Require an organisational response when workforce risks are escalated

28. Requirements that direct individual clinicians to speak up or escalate concerns about workforce gaps and unsafe conditions should be accompanied by a clear obligation on the health and maternity service to respond, act, and provide feedback. The Standards cannot place responsibility on individual staff including, nurses and midwives, to identify systemic staffing risks without requiring organisations to address those risks. The Standards repeatedly place the obligation to "escalate concerns" about deterioration, workforce gaps, or unsafe conditions on individual clinicians (1.14c, 2.16, 2.17), yet they do not legislate for any guaranteed staffing or resourcing response when those escalations occur. This highlights that staffing is being treated as a "risk area" without including important details for addressing it beyond staff being obliged to raise it.
29. Without the mandated staffing levels and skills mixes, this risks functioning as a system that expects staff to flag risk without a corresponding obligation on the organisation to fix it. This essentially shifts accountability onto staff for structural problems that are the responsibility of the organisation.



30. Likewise, the Standards ask the workforce to "speak up," "escalate concerns" and report incidents/bias/discrimination repeatedly (1.13b, 2.09b, 2.16), but omits any mechanism to enforceable whistleblower legislation or anti-reprisal protections. This is particularly problematic as health and maternity care professionals operate under strict, multi-layered regulatory frameworks that mandate the proactive identification, assessment, and reporting of clinical risks and workplace hazards. These duties are dictated by the Health Practitioner Regulation National Law, work health and safety (WHS) legislation, and specific professional standards. If known risks are not properly addressed and acted upon, professionals are likely to be put in situations where they have a legal obligation to make a mandatory notification to Australian Health Practitioner Regulation Agency (Ahpra) or otherwise breach their own standards. Likewise, where workplaces or practices are unsafe, the healthcare professionals might themselves be at risk of breaching professional codes of conduct and standards by continuing to practice. Such situations also put staff at risk of errors, psychological and moral harm and increased risk of harm to others without clear implications or responsibilities on the organisation to address risk factors or concerns.

Strengthen workplace violence and psychosocial safety requirements

31. The current provisions on healthy workforce culture and behaviours of concern are welcome however they must set out how to explicitly address violence and aggression directed towards workers, including prevention, reporting, organisational response and monitoring. Worker and patient safety are interdependent, and both must be taken equally seriously in the Standards. Workplace violence and aggression must be elevated to its own Standard or key area. We recommend that this be modelled on the ANMF's 10-Point Plan which is already an enterprise agreement obligation in Victorian public health services. This would create explicit requirements for:

- funded security measures (duress alarms, secure zones, trained security staff);
- violence-specific incident reporting, investigation and trend analysis;
- post-incident trauma support, and;
- an explicit link between staffing adequacy and violence risk since ANMF's Pulse Check data shows workers that rated staffing "very poor" also report violence more often.



32. Burnt-out, injured or fearful staff cannot sustainably deliver person-centred care. Replacing the euphemistic "behaviours of concern" framing with explicit recognition of violence as a workplace hazard (not solely a clinical symptom to be managed) would also better align the Standards with work health and safety psychosocial risk obligations already in force elsewhere; "psychosocial safety" is in the glossary but gets barely a mention elsewhere in the document. Ideally the Standards must embed mechanisms to monitor and explicitly address psychosocial hazards arising from workload, job design, and workplace culture as critical factors that impact both the workforce and patient access, outcomes, and experiences.

33. Specific recommendations for requirements include:

- Requirement 1.03 should specify that boards, executives, and leaders must have systems to identify, assess, control and review psychosocial hazards in accordance with applicable work health and safety (WHS) legislation, including workload, occupational violence, aggression, bullying, sexual harassment, gender-based harassment, exposure to traumatic events, fatigue and poor workplace supports.
- Requirement 1.12 should specify that organisations must systematically identify and manage psychosocial hazards through risk assessment, worker consultation and implementation of control measures. Specific examples of hazards should list workplace violence, sexual harassment, gender-based harassment, bullying, excessive workloads, traumatic exposure, remote and isolated work.
- Requirement 1.13f refers to mandated validated psychosocial and cultural safety surveys. While this might be a good-faith mechanism, further clarity must be provided in terms of workforce surveillance and performance management (i.e., data governance (storage, use, use in performance contexts).
- Requirement 1.24 should stipulate that psychosocial hazards must be identified, assessed, controlled, and reviewed using a risk management process consistent with WHS legislation. This should specifically reference violence and aggression, sexual harassment, gender-based harassment, discrimination, bullying, excessive workload, fatigue, and traumatic events.
- Requirement 1.25 should be revised to ensure that along with the need to recognise, monitor



and report bias, discrimination, racism, sexual harassment and gender-based harassment as organisational risks, action must also be taken to respond to and eliminate these risks.

- Requirement 1.29 should be revised to incorporate psychosocial indicators and require Board reporting and review of workforce psychosocial safety indicators including bullying, sexual harassment, gender-based harassment, psychosocial injury claims, workers compensation for psychological injury claims and workplace violence incidents.
- Requirement 2.09 should be revised to reflect that the workforce should be protected from workplace sexual harassment, gender-based harassment, bullying and victimisation.
- Requirement 2.10 should be revised to go beyond cultural respect, discrimination, and racism to also include ensuring that the care environment standard also include a focus on avoiding assumptions, bias, discrimination, racism, sexism, sexual harassment and gender-based harassment in all interactions.
- Requirements 2.11 and 2.12 currently focus largely on patient behaviours. These should be revised to acknowledge that staff can also often experience behaviours of concern from visitors, family members, other staff, and managers.

Strengthen recognition of nursing and midwifery models of care

34. The Standards must explicitly recognise nurse- and midwife-led models and other evidence-based nursing and midwifery models of care, rather than relying exclusively on generic references to clinicians and multidisciplinary teams. Such inclusion will better reflect the contribution of nursing and midwifery to safe, high-quality care and their large share of the health and maternity workforce. While midwives are clearly covered by the Standards, the draft doesn't contain language that clearly covers maternity care (i.e., focus is on healthcare with nothing on continuity-of-care/caseload models, midwifery-led units, maternity care. Maternity care is folded into generic "clinician" and "multidisciplinary care team" language throughout which should ideally be addressed.

Strengthen focus on students on clinical placement, graduate transition, employment of registered undergraduate students, and internationally qualified staff

35. Beyond generic orientation/supervision language at requirements 1.17a–c, the Standards appear to



largely ignore the fact that many health and maternity services are sites that are both training places and worksites for large numbers of students on clinical experience placements, employed students (i.e., via undergraduate student employment models such as the Registered Undergraduate Student of Nursing/RUSON program), new graduates in transition to practice programs, interns, and internationally qualified staff, who work under supervision or mentorship by employed staff. The Standards must include greater attention and mention of these important groups in order to capture the valuable contributions they make to healthcare quality and safety; the fact that they are the pipeline of future staff across the sector, and the responsibility and workload that employed staff take on in overseeing, training, and mentoring these groups.

Ensure intersectoral and community care are explicitly covered

36. How the Standards should apply to, relate, and reflect community, primary care, mental health, aged care, and other settings across the health and maternity care continuum needs to be clearly explained. Here, requirements supporting continuity of care, interoperable information systems, and safe transitions between services must be acknowledged. This was a key recommendation in the ANMF's previous submission and remains important in the current draft.

Ensure implementation requirements are adequately resourced

37. The draft adds substantial new documentation and system requirements e.g., Best Possible Medication History (BPMH) processes, structured handover, care planning documentation, consent documentation, digital literacy uplift, tailored training programs. These are positive developments, however, there is no clear and corresponding commitment to ensure funded time, backfill, or staffing to deliver them. Our concern is that increased documentation load will displace direct care time and without a clear Standard regarding minimum staffing, this will have significant impacts on the workforce and the delivery of safe, quality care. The draft expands documentation loads considerably, so there must be clear and achievable expectations around the resourcing needed to accompany implementation, particularly for public and under-resourced services. The Standards should recognise that new requirements for documentation, training, digital literacy, handover, medication reconciliation, and care planning require protected time, staffing and resources. This is also an important rationale for why the Standards should include explicit requirements around staffing requirements. Implementation must not result in additional administrative work being



transferred to clinicians at the expense of direct patient care.

Performance review and credentialing as a disciplinary lever

38. Requirements 1.17(g) and 1.20 give executives broad scope to "monitor and manage clinicians' professional performance" and review credentials "when there are concerns about clinical performance or workplace behaviours." Here, Australia's national registration and regulation system already assures nurses' and midwives' competence and public safety, making additional credentialing unnecessary. Further, credentialing can create unnecessary barriers to employment, add costs, and duplicate existing regulatory processes.

Tying quality improvement engagement to credentialing (1.19c)

39. Requiring "evidence of engagement in quality improvement activities" as part of credentialing and recredentialing effectively makes quality improvement (QI) participation a condition of a clinician's ongoing ability to practice at a facility (see Requirement 1.19c). Here, our concern is that if it is not supported by employers during worktime, or if staffing levels are not sufficient to allow clinicians to engage effectively in QI, this would be relegated to unpaid, or out-of-hours work with employment and scope-of-practice consequences.

Personal care workers and unregulated/unregistered healthcare workers

40. The Australian Government has committed to supporting the regulation of currently unregistered personal care workers (PCWs) and Assistants in Nursing/Midwifery (as well as similar roles with other titles). The draft's glossary includes generic "clinician" and "workforce" definitions that don't differentiate or address PCW professionalisation and appear to consolidate registered and unregistered trained and qualified individuals all under the aegis of 'clinician'. This could create some confusion especially prior to PCW registration.

Additional recommendations

41. *Clinical Governance Standard*

- Requirement 1.04 should be strengthened to ensure health and maternity services have governance arrangements for the safe implementation, monitoring and evaluation of



emerging technologies, including consideration of safety, privacy, cybersecurity, equity and workforce impacts.

- Requirement 1.17 should include reference to clear processes to support clinicians through continual change and development in digital tools and technologies.
- Requirement 1.17(h) should be strengthened to ensure that clinicians are supported to developed capability in the safe and effective use of emerging technologies in clinical practice.
- Requirement 1.23. Where health care is coordinated and connected across the health and maternity service with other providers and settings, sharing information must be also be contemporaneous and at the point of transition.
- Requirement 1.24 should explicitly require health and maternity services to identify, assess, and manage risk associated with emerging technologies throughout their lifestyle.
- Requirement 1.26. Timely feedback to incident reporters and actions taken must also be a requirement within an incident management system.
- Requirement 1.28 should be strengthened to require governance and oversight of health and maternity care data used by emerging technologies, including clear arrangements for data ownership, access, sharing, secondary use, privacy, security and ongoing monitoring of risks.
- Requirement 1.30. Safe patient and staff data storage and custodianship including stringent confidentiality requirements must be incorporated into digital systems that are optimised to improve continuity of care and integration.

42. *Person-Centred Practice Standard*

- Sexual violence should be included within the practice standard where clinical assessment and evidence informed decision-making should underpin the planning and coordination of care across the multidisciplinary care team.



"Reducing low-value care" and "unwarranted variation" language could be misinterpreted as a potential cost lever

43. Requirement 1.07 directs boards to "identify and reduce care that provides little benefit," "minimise waste," and investigate "unwarranted clinical variation." In principle this is sound and would be beneficial in terms of enabling reductions in unnecessary testing and interventions that are duplicative, provide little benefit, or disproportionate harm. Without clarity, however, it could be used by employers to justify short-staffing, service consolidation, or rationing under an "efficiency" and "waste reduction" banner rather than a genuine clinical-appropriateness banner which would not be congruent with the intention of the Standards.

Language around proportionality in implementation

44. The Standards state implementation should be "proportionate to the size, scope, complexity... and digital maturity" of the service. That idea might work well for small rural/remote services, but it could also be used to justify a lower bar in under-resourced settings which is where the worst staffing and safety problems tend to occur. Here, the ANMF would be keen to see this reconfigured in a way that sets a minimum expectation of services rather than an excuse for poor performance/quality.

Unexplained transition to 'evidence-informed' healthcare versus 'evidence-based'

45. Second edition (current) terminology focusses on 'evidence-based' healthcare and practice (8 mentions). The new (third edition) uses the term 'evidence-informed' 22 times (0 mentions in the current edition) and only 3 mentions of 'evidence-based'. This shift is unexplained and the term 'evidence informed' not defined. We recommend that this omission be made clear and a rationale provided for the terminological shift.

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

46. The initial draft well recognises the importance of coordinated and connected care across services, settings, and providers. Requirements 1.23 and 2.19-2.22 establish clearer expectations for integrated models of care, information sharing, defined responsibilities, structured clinical handover and management of risks associated with transitions of care. The explicit recognition of transitions across services and settings, including the use of national digital health infrastructure, is welcomed.



47. Further strengthening and piloting of the revised 3rd Edition Standards is required to ensure these requirements result in seamless continuity of care across the health and maternity care system, rather than placing responsibility for coordination primarily on individual clinicians who are limited in their capacity to effect systemic change.
48. Following a pilot, ensuring that implementation does not create additional unfunded administrative burden on staff, is also critical. The ANMF supports structured handover, improved documentation, and stronger information sharing as addressed in the Standards, but these requirements must be supported by appropriate staffing, digital infrastructure, education, and protected work time for staff. Additional documentation and coordination processes should not reduce the time available for direct patient care.
49. The ANMF supports the stronger emphasis on coordinated and connected care in the initial draft. The Standards could go further, however, by establishing clear organisational accountability, interoperable information systems, comprehensive cross-sector pathways, and genuine continuity of responsibility across care transitions. Safe coordination and interfaces between providers should be an inherent property of a safe, well-functioning health and maternity care system, not dependent on individual clinicians overcoming persistent gaps between services, settings and providers.
50. The effectiveness of the third edition of the Standards will ultimately depend on how well they function in practice across the diversity of the Australian health and maternity system. A representative pilot process should therefore be undertaken before implementation to assess whether the Standards are practical, applicable, and sufficiently clear across different service contexts, and to identify opportunities for refinement before they are finalised. This should include consideration of the interaction between requirements, the evidence and data needed to demonstrate compliance, the workforce and resources required for implementation, and the potential administrative burden for health and maternity services and clinicians.
51. The pilot should include a representative range of health and maternity services, including metropolitan, tertiary, rural and remote, public and private services. This is important to ensure that the Standards are workable across different models of care, organisational structures, workforce contexts, levels of digital maturity and available resources, rather than being primarily tested in well-resourced metropolitan settings.



52. The development and availability of implementation resources and guidance should also be addressed as part of the pilot process. Implementation guidance should be developed prior to, or in parallel with, the pilot and informed by stakeholder input. Supporting materials should be tested alongside the Standards to determine whether they provide sufficient clarity and practical support for health and maternity services to understand and implement the requirements. Early development and consultation on these resources will be important to building organisational readiness and ensuring that the pilot provides a meaningful assessment of implementation requirements.
53. Below, several further recommendations are made for how this could be achieved in a revised list of Standards and requirements.

Strengthen interoperability and information sharing across health and maternity systems

54. Fragmented digital systems must not create delays or safety risks during transitions of care. The Standards should require health and maternity services to use interoperable digital systems, standardised documentation, and agreed information-sharing processes that enable timely access to relevant patient information across public, private, primary care, community, mental health, and aged care settings. This should include real-time access to relevant records across the patient's care continuum, where appropriate. People receiving care or responsible care providers must also have clear, understandable, and accessible information about information sharing processes and their rights regarding these.

Coordination across systems regarding workplace violence and aggression risks

55. On workplace violence and aggression specifically, coordination is largely absent from the Standards with no shared coordinating framework. Violence risk information (e.g. a patient's known propensity for aggression) isn't addressed as something that should travel with a patient across transitions of care, admissions, or between services. Standardising a consistent violence-risk flagging and communication protocol usable across acute, sub-acute and community settings would improve both safety and continuity.
56. More broadly, the Standards would benefit from explicit expectations that safety-relevant information (not just clinical handover content) is coordinated across providers, including



family/carer input into behavioural management plans, which the current draft doesn't address at all.

Make continuity of care an explicit system-level responsibility

57. Requirement 2.19 appropriately requires clear identification of who is accountable following discharge or transfer. This requirement should be strengthened so that responsibility for safe coordination is clearly allocated between organisations and services, rather than relying on individual clinicians to navigate complex system gaps. The Standards should require receiving and referring services to have clear mechanisms for accepting responsibility, communicating relevant information, and following up identified risks; to strengthen the intent of requirements 1.23 and 2.19–2.22 and reduce risks associated with fragmented care. Furthermore, the Standards should extend the application of coordinated care requirements across all relevant settings. The Standards would better support seamless interfaces and interoperability between health and maternity care settings by explicitly recognising community, primary care, mental health and aged care interfaces, as well as hospital-to-hospital transfers. The ANMF previously recommended that each Standard apply across community as well as hospital settings, with continuity of care required across hospital, community and specialist services.

Ensure coordination requirements address mismatches in service capability and resources

58. The recognition in requirement 2.21 of risks arising where a patient's needs exceed the clinical support, capability, or resources available is important. The Standards should make clear that identifying such a mismatch must trigger an organisational response, including escalation, transfer or access to appropriate resources, rather than simply requiring clinicians to identify and manage the risk. This update would provide patients and clinicians with greater assurance that when such risks are identified, they are taken seriously and acted upon at an organisational level. This would also be a factor that would better enable learning health and maternity systems.

Support digital capability through education and resourcing

59. There could be further strengthening in the revised Standards on how digital care is enabled and sustained. The document says they are enabled, yet it is not obvious how this should or would occur. Likewise, language and considerations must be updated considering the fast-paced adoption and assimilation of artificial intelligence (AI) across health and maternity care. Ensuring that staff are



supported to access high quality opportunities to develop capability in digital health and interfaces underpin high quality, future-focussed digitised systems. Requirements for digital information sharing and interoperability should be accompanied by requirements for ongoing digital literacy, education, and support for staff.

Build feedback and learning across organisational boundaries

60. The Standards should encourage services to use information from incidents, complaints, readmissions, delayed discharges, and patient and workforce feedback to identify system-level failures in coordination and improve care pathways. Importantly, this should support a continuous learning approach in organisations and teams rather than a compliance-focused approach. This is another area where digital health and AI must be considered and acknowledged.

4. Are the Standards easy to understand and free from duplication? Where could they be clearer or simpler?

61. The initial draft third edition of the Standards is more streamlined than the current Standards. Condensing eight Standards down to three, however, has resulted in some areas of duplication and a lack of clarity in others. Several requirements repeat similar expectations relating to workforce capability, communication, teamwork, escalation, care coordination, data, risk and continuous improvement. This could result in uncertainty about where responsibility sits and what evidence health and maternity services will be expected to provide. The following amendments are recommended to reduce duplication and enhance clarity in the forthcoming draft.

Improve integration of workplace violence and aggression focussed content

62. While minimal, content around workplace violence and aggression-relevant content is clear, but its briefness creates ambiguity rather than simplicity. A single line ("managing risks to staff") gives health and maternity services no operational guidance on what compliance actually requires, unlike the more precise, criteria given for restraint minimisation or cybersecurity. This under-specification will likely produce inconsistent interpretation and weak assessment rigor at accreditation. Explicit, checklist-style criteria (as the ANMF Vic Branch 10-point plan uses) rather than a single aspirational clause should be implemented in the Standards, so assessors and services have a shared, auditable understanding of what "supporting workforce safety" means in practice.



63. Terminology should also be tightened: "behaviours of concern" is used to cover everything from mild agitation to physical assault, which blurs the line between clinical management of a patient and protection of staff from serious physical harm or even death. There are two related but distinct obligations that would be clearer if named separately.

Remove duplication between Clinical Governance and Person-Centred Practice requirements

64. Requirements 1.13-1.17 and 2.13-2.16 contain overlapping expectations around workforce capability, communication, teamwork, escalation and coordinated care. These should ideally be consolidated or clearly differentiated according to their purpose and accountability. For example; workforce education, supervision and capability would better sit primarily within Clinical Governance, while Person-Centred Practice should instead focus on how these capabilities support person-centred care and consumer outcomes.

Clarify the boundary between Requirement 1.23 and Requirements 2.19-2.22

65. There is overlap in requirements concerning care coordination, information sharing, transfers, discharge and clinical handover. Requirement 1.23 under the Clinical Governance Standard should establish the governance responsibility for integrated care, with Requirements 2.19-2.22 under the Person-Centred Practice Standard focused on the practical delivery of safe transitions.

Rationalise repeated workforce training and capability requirements

66. Training, education, supervision, communication capability, and professional development appear across multiple requirements. For clarity and ease of use, the Commission could consider avoiding requiring health and maternity services to demonstrate the same workforce capability through multiple Standards. Requirements should instead identify the specific capability or outcome required, with the governance system responsible for ensuring it is achieved.

Simplify repeated overarching concepts

67. Terms and expectations such as high-quality care, continuous improvement, evidence-informed practice, risk management, consumer partnership, cultural safety, and the 'use of data' (or a similar



term) occur throughout the Standards. These are important principles that should be clearly defined, however repeating them within multiple requirements can make the Standards unnecessarily complex. The Commission should establish these terms and expectations clearly at the appropriate overarching level and then specify their application only where this adds a distinct requirement.

Clarify accountability within each requirement

68. The Standards use different terms including boards, executives, leaders, health and maternity services, clinicians, workforce, multidisciplinary teams, and research teams. Each requirement should clearly identify who is accountable for establishing the system and who is responsible for implementation. This would reduce ambiguity, potential duplication, and prevent multiple groups being required to demonstrate essentially the same activity.

Simplify the structure and language of requirements

69. Purpose statements should explain the intended outcome, while requirements should state clearly and concisely what must be in place and what outcome must be demonstrated. Numbering the standards, key areas, and purposes of the Standards might improve ease of use. Requirements should avoid combining multiple systems, activities, and outcomes into lengthy provisions that can be challenging to follow and could result in misinterpretation.

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

70. The ANMF supports the stronger emphasis in the initial draft on quality improvement, clinical review, use of data, feedback, benchmarking and continuous improvement. The Standards (e.g., Requirements 1.19-1.22) provide a useful foundation for organisations to support clinicians and multidisciplinary teams to participate in quality improvement, access evidence-informed guidance, undertake clinical and peer review, and use data to identify opportunities for improvement. The requirements for monitoring coordination and transitions, including readmissions, delayed discharges, incidents and patient feedback, are also welcomed.
71. The Standards requires services to "review and learn from behaviours of concern and related incidents," however, the draft currently lacks the reporting infrastructure needed to make that learning meaningful in terms of practical impact. The New South Wales Nurses and Midwives Association's (NSWNMA) research has found under-reporting in health care is systemic; only around



a quarter of incidents are reported, and fewer than two in ten reporters believe any action follows.¹ This suggests organisational learning loops are currently broken at the front end, not just the analysis end.

72. The Standards could go further in supporting health and maternity services to shift from a compliance and incident-response mindset towards an embedded and sustained culture of learning, reflection, and continuous improvement. Overall, the ANMF supports the direction of the initial draft but recommends that continuous improvement should be treated as a characteristic of the way care is delivered, rather than another set of requirements to be demonstrated for accreditation. The third edition should explicitly promote learning from what goes well as well as what goes wrong, reflective practice, staff participation, psychological safety and appropriately resourced education and improvement activities. This would better position the Standards to drive sustained improvements in safety and quality over time.

The ANMF recommends:

Embedding a 'Safety-II' approach throughout the Standards

73. The Standards should encourage health and maternity services to examine not only what has gone wrong, but also the conditions, practices, and system factors that enable safe care to be delivered successfully. This would better support learning from everyday clinical practice, adaptation and resilience, rather than relying predominantly on retrospective incident investigation.

Streamlining incident reporting for workplace violence and aggression

74. The Standards should require accessible, low-friction incident reporting for workplace violence and aggression, mandatory feedback to staff on outcomes of reports (directly addressing the "nothing happens" perception), and board-level visibility of workplace violence and aggression trends analogous to the existing restraint-reporting requirement. Benchmarking against sector data (AIHW hospitalisation trends, union survey data) could also be referenced as an external check, since the current draft's learning loop is entirely internal to each service with no external comparator required.

¹ New South Wales Nurses and Midwives Association (NSWNMA). Occupational Violence: has no place in my workplace [Online]. NSWNMA. 2026. Available: <https://www.nswnma.asn.au/wp-content/uploads/2026/04/%E2%80%8B%E2%80%8BOccupational-Violence-Report-2026.pdf>



Strengthening acknowledgment of reflective practice as a core component of continuous improvement

75. Reflective practice should be explicitly incorporated into clinical governance and quality improvement processes as a mechanism for professional learning, supporting staff wellbeing, and improving care delivery that goes beyond solely compliance-driven approaches.

Ensuring that clinicians are actively involved in quality improvement

76. Requirement 1.19 appropriately requires multidisciplinary team participation in quality improvement. This should be strengthened by requiring organisations to provide staff with meaningful opportunities, time, and resources to participate in quality improvement activities and to contribute their clinical expertise and experience to service redesign. Quality improvement must also not become an individual compliance or credentialing obligation. The ANMF has concerns about the requirement in 1.19(c) to consider evidence of individual engagement in quality improvement as part of credentialing and recredentialing. Quality improvement should be supported as a collective organisational responsibility, with protected time and resources, rather than becoming an additional individual performance or credentialing requirement that may be undertaken outside paid working hours.

Providing protected education and learning time

77. Continuous learning cannot be achieved through mandatory online training or additional requirements alone. The Standards should require appropriate protected education and educator capacity, with learning integrated into clinical workflows and linked to identified service risks, clinical objectives, and outcomes.

Strengthening feedback loops between data, learning and practice

78. Health and maternity services should be required to demonstrate how information from incidents, complaints, consumer feedback, workforce feedback, clinical review, quality indicators, and clinical registries is translated into learning and changes to practice. The purpose should not simply be to collect or report data, but to demonstrate what has changed as a result. This would be a sound marker of a learning health and maternity care system. Further to this, the Standards must ensure improvement requirements are appropriately resourced. New requirements for documentation, data collection, training, review and quality improvement must be accompanied by sufficient



staffing, education, digital infrastructure and protected time. Otherwise, expanded Standards risk increasing administrative workload and reducing the time available for direct patient care.

Protecting a just and psychologically safe learning environment

79. Learning systems will not be effective where staff fear blame or reprisal for identifying risks, reporting incidents, or raising concerns. The Standards should reinforce psychological safety, speaking up and constructive learning from incidents, with clear organisational responsibility for responding to concerns and implementing improvements.

6. What changes to the Standards would reduce the compliance burden, while maintaining safety and quality?

80. Accreditation should focus on whether systems are achieving safe, equitable and high-quality outcomes, rather than the volume of policies, documents or evidence produced. The ANMF supports reducing unnecessary compliance burden, provided this does not reduce or undermine the safety and quality expectations of the Standards and requirements. The Standards should focus on clear, outcome-oriented requirements that strengthen safe care, rather than generating additional policies, procedures, documentation, and training requirements for their own sake. Overly burdensome Standards with duplication or lack of clarity risk organisations developing additional policies and administrative processes, increasing workload for clinicians, and reducing the time available for direct patient care. Our feedback against the consultation questions above provides recommendations that would reduce compliance burden while maintaining safety and quality. Further recommendations for minimising compliance burden where possible are provided below:
81. The Standards should specify the safety or quality outcome/s that must be achieved and allow health and maternity services reasonable flexibility in how they achieve it, provided they can demonstrate effectiveness according to appropriate and relevant measures. Requirements should not by default result in the generation of additional forms, policies, checklists, or documentation unless these are demonstrably necessary for safety or demonstrably better fit for purpose. Here, services should be able to use existing clinical governance, risk management, quality improvement, workforce, incident reporting, and digital systems to demonstrate compliance where those components are fit for purpose and effective. The Standards should not create parallel reporting or data-collection requirements where equivalent information is already available and already embedded.



82. The Standards should maximise the use of existing clinical, workforce, and quality datasets where these can reliably demonstrate safety and quality outcomes. Greater use of routinely collected clinical data has the potential to reduce the administrative burden associated with manual audits and additional data collection, while enabling health and maternity services to demonstrate performance through information that is already generated through routine care and governance processes. This could reduce duplication and enable nurses and midwives to spend more time delivering direct patient care.
83. The Commission should also consider the varying levels of digital maturity and analytical capability across health and maternity services when developing expectations for the use of clinical data. Not all health and maternity services will have the same capacity to collect, analyse, interpret and use datasets to demonstrate safety and quality. The implementation of the Standards should therefore be supported by appropriate guidance and resources that assist health and maternity services to use existing data effectively and consistently, while avoiding the creation of new or parallel data collection and reporting requirements.
84. The use of existing datasets should also be considered alongside the ANMF's broader recommendation that health and maternity services should be able to demonstrate compliance through existing governance, risk management, quality improvement, workforce and incident management systems wherever these systems already provide appropriate evidence of safety and quality. The Standards should focus on whether available evidence demonstrates the required outcome, rather than prescribing additional processes for collecting or presenting evidence where this does not add value.
85. Compliance with the Standards and requirements should be an organisational responsibility, with clear accountability for boards, executives, leaders, and health and maternity services. Individual clinicians should not be expected to compensate for organisational or system-level deficiencies through unrecognised additional individual documentation, escalation, or administrative work. As we have highlighted above, new requirements must be accompanied by appropriate resources. Where the Commission introduces new requirements for training, data collection, documentation, quality improvement or coordination, the Standards should recognise the need for sufficient staffing, protected time, education and digital infrastructure so that compliance activity does not displace direct patient care.



86. Adding a clearer, standalone workplace violence and aggression Standard would reduce burden rather than increase it. A single vague clause forces every health and maternity service to independently interpret and build its own approach to "managing risks to staff," which is inefficient and inconsistent. Adopting an existing, tested model, such as the ANMF (Vic Branch) 10-point plan, already embedded in Victorian public sector enterprise agreements, as the basis for a nationally consistent standard would give services a ready-made compliance pathway rather than requiring bespoke development, while giving assessors clear, comparable criteria. This is more efficient than the current approach, where ambiguity likely generates duplicated effort and inconsistent assessment across jurisdictions. Burden reduction should come from clarity and shared frameworks, not from continuing to minimise the volume of guidance on a growing risk.
87. Streamlining mandatory education requirements would enable education to better target towards addressing identified safety and quality risks and the integration of education and training into clinical practice, rather than creating additional generic and burdensome training modules. Education should support learning and capability of clinicians rather than becoming a tick-box compliance exercise. Likewise, clinician engagement in mandatory education and training should also be appropriately supported by health and maternity care providers as part of their responsibilities around delivery of safe and high-quality care.