Submission by the Australian Nursing and Midwifery Federation

To the Australian Commission on Safety and Quality in Health Care (ACSQHS) on the Standards for First Nations Cultural Safety Review

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Cultural Warning

1. Aboriginal and Torres Strait Islander readers are advised that this document contains material that may be culturally sensitive or distressing. This includes descriptions of historical and current events and attitudes that may cause sadness or trigger traumatic memories.

2. The term 'Aboriginal and Torres Strait Islander Peoples' has been used throughout this submission; however, it should be acknowledged that Aboriginal and Torres Strait Islander Peoples may also or instead identify as First Nations Peoples, First Nations Australians, and Indigenous peoples of Australia. It is further recognised that Aboriginal and Torres Strait Islander Peoples are not a unified or homogenous group, but comprise diverse nations, cultures, languages, and identities.

Key Points

3. 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. The ANMF thanks the Australian Commission on Safety and Quality in Health Care (ACSQHS) for the opportunity to provide feedback on the Standards for First Nations Cultural Safety Review.

4. It is the view of the ANMF that cultural safety is a fundamental component of healthcare quality and safety and must be embedded across all aspects of healthcare delivery, governance, and workforce, rather than treated as a separate or discretionary initiative.

5. Racism and cultural unsafety are significant contributors to preventable harm, reduced access to care, poorer health outcomes, and workforce attrition. Addressing these issues requires systemic reform.

6. Cultural safety must be determined by the experiences of Aboriginal and Torres Strait Islander Peoples. Aboriginal and Torres Strait Islander leadership, self-determination, and

shared decision-making must therefore be central to defining, implementing, measuring, and governing cultural safety.

7. Healthcare organisations should be accountable for creating culturally safe conditions through strong governance, clear standards, transparent reporting, meaningful community partnership, and mechanisms to identify, report, investigate, and eliminate racism.

8. National standards should recognise cultural safety as both a healthcare quality issue and a Workplace Health and Safety issue, requiring proactive identification, management, and mitigation of cultural safety risks and racism.

9. Measurement of cultural safety should be led by Aboriginal and Torres Strait Islander Peoples and include patient experiences, workforce outcomes, organisational performance, experiences of racism, and evidence of improvements in access, quality, safety and health outcomes.

10. Effective implementation will require sustained engagement with Aboriginal and Torres Strait Islander communities, health professionals, representative organisations, and community-controlled organisations.

Introduction

11. 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.

12. 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.

13. 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.

14. 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.

15. The ANMF thanks the Australian Commission on Safety and Quality in Health Care (ACSQHS) for the opportunity to provide feedback on the Standards for First Nations Cultural Safety Review.

Consultation Questions

What does culturally safe hospital care look and feel like for Aboriginal and Torres Strait Islander Peoples?

16. Despite some social progress in Australia, Aboriginal and Torres Strait Islander Peoples continue to experience discrimination, exclusion, racism, and cultural disrespect within healthcare settings.[1-3] These experiences contribute to delayed or avoided healthcare, poorer health outcomes, adverse mental health impacts, and reduced life expectancy.[3-16] Addressing these inequities requires healthcare services to provide care that is not only clinically safe, but also culturally safe. Cultural safety is inseparable from high-quality healthcare, as patients who experience cultural exclusion, discrimination, stereotyping, racism, or cultural incompetence are less likely to engage in healthcare, placing their health and wellbeing at risk.[3-6, 17] This means that markers of cultural safety must not be considered independently from clinical safety, but rather as an integral component of healthcare quality and safety standards.[18, 19]

17. While there is no nationally agreed definition of cultural safety,[20] there is broad consensus that it extends beyond concepts such as 'cultural awareness', 'cultural sensitivity', and

'cultural competence'. Whereas these concepts generally focus on increasing self-awareness and developing the knowledge and skills required to work across cultural differences, cultural safety requires individuals and organisations to examine the structures, assumptions, power relationships, and institutional practices that shape healthcare interactions with those with cultural differences. It must be recognised that healthcare is delivered within a broader context marked by the ongoing impacts of colonisation, systemic racism, and social inequities, and therefore practitioners and organisations must be required to actively identify and address these factors.

18. The ANMF adopts the national definition of cultural safety, developed through consultation with more than 200 Aboriginal and Torres Strait Islander organisations and individuals, and now embedded in the Nursing and Midwifery Board of Australia (NMBA) Code of Conduct and across the National Registration and Accreditation Scheme. Australian Health Practitioner Regulation Agency (Ahpra) defines cultural safety as "*… determined by Aboriginal and Torres Strait Islander individuals, families and communities … the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism*."[21]

19. The most important feature of this definition is that cultural safety is not determined by the perceptions of healthcare providers but by the experiences of Aboriginal and Torres Strait Islander Peoples. Cultural safety therefore requires healthcare services to move beyond individual practitioner competence and embed Aboriginal and Torres Strait Islander leadership and self-determination throughout systems of care. This means Aboriginal and Torres Strait Islander Peoples must be central to defining, designing, governing, implementing, and evaluating healthcare services to ensure they are culturally safe, responsive, and free from racism.[22,23, 24]

20. It is important to acknowledge that there is no singular monoculture shared by all Aboriginal and Torres Strait Islander Peoples. Aboriginal and Torres Strait Islander communities are culturally, linguistically, geographically, and socially diverse, with distinct identities, histories,

traditions, kinship systems, and connections to Country. Culturally safe care cannot be achieved through a one-size-fits-all approach or by relying on assumptions about cultural needs and preferences. Rather, culturally safe hospital care requires health services and practitioners to recognise, respect, and respond to the diversity of Aboriginal and Torres Strait Islander Peoples as individuals, families, and communities.

21. Prior research on Aboriginal and Torres Strait Islander Peoples' perceptions of culturally safe health care has described key components as respectful, culturally responsive communication; trusting relationships between patients and healthcare providers; a strong and well-supported Aboriginal and Torres Strait Islander workforce; and health systems that recognise, value, and respond to Aboriginal and Torres Strait Islander cultures, knowledges, beliefs, and ways of healing.[24-26] Further, research has described that culturally safe hospital care should be experienced as care that is respectful, welcoming, and free from racism and discrimination.[3-6] People should feel safe to express their cultural identity, confident that their values, beliefs, and preferences will be respected, and supported to involve family and community in care where desired. Patients should feel listened to, understood, and empowered to participate in decisions about their healthcare. Ultimately, culturally safe care should establish trust that healthcare providers will treat them with dignity and respect, and that their cultural needs will be recognised throughout their healthcare journey.[27-29]

22. Cultural safety will also include a review of systemic structures and Western medical models that disregard Aboriginal and Torres Strait Islander ways of knowing and being.[30] Research indicates that nursing in Australia has historically functioned within a race-centred society where practitioners are socialised into race-laden vocabularies.[31] A critical failure in this professional landscape is the tendency to view all patients the same under the guise of universal empathy. Evidence suggests, however, that Euro-American nursing frameworks often result in a hierarchy where non-Indigenous patients are perceived more favourably than Aboriginal and Torres Strait Islander People.[31]

23. The language used throughout healthcare systems provides a practical example of how these

biases become embedded in policy, practice and performance measurement. Terms such as "discharge against medical advice" place responsibility on the patient for leaving care, despite recognition that experiences of racism, cultural unsafety, lack of trust, and unmet social and cultural needs can contribute to self-discharge.[32] The label therefore frames a systems failure as an individual behavioural problem. Alternatives such as "incomplete episode of care" or "left prior to completion of treatment – system factors to be reviewed" shift attention from patient blame to service accountability. Importantly, cultural safety assessments and healthcare performance frameworks should measure not only patient outcomes, but also the underlying system factors that contribute to those outcomes, including culturally unsafe policies, practices, and documentation.

24. While existing evidence provides important insights into what culturally safe hospital care looks and feels like for Aboriginal and Torres Strait Islander Peoples, definitions and indicators of cultural safety must continue to be informed and determined by Aboriginal and Torres Strait Islander Peoples themselves. This includes meaningful Aboriginal and Torres Strait Islander leadership and participation in the development, implementation, monitoring, evaluation, and continuous improvement of cultural safety standards, policies, and performance measures across hospital systems.

What needs to change to reduce racism, cultural unsafety and preventable harm in hospital systems?

25. Reducing racism, cultural unsafety, and preventable harm in hospital systems requires coordinated action at individual, organisational, and system levels. While ongoing cultural safety and anti-racism education, training, and professional development should be made mandatory to support healthcare staff to deliver culturally safe care,[6, 33-37] this training alone is insufficient to achieve meaningful and sustained change, as it does not address the structural change required to make all aspects of care culturally safe.[6, 33-37] Racism and cultural unsafety are not solely the result of individual behaviours; they are also embedded within organisational cultures, policies, processes, practices, and structures that continue to reflect the ongoing impacts of colonisation, systemic racism, and social inequities. Addressing

these issues therefore requires a shift from individual responsibility towards shared organisational and system accountability.

26. Improving cultural safety requires health services to explicitly recognise and address institutional racism, remove barriers to equitable access and outcomes, and embed Aboriginal and Torres Strait Islander perspectives throughout clinical governance, organisational leadership, policy development, service planning, implementation, monitoring, quality improvement, and evaluation.[38, 39] Cultural safety should be treated as a core quality and safety priority, with the same level of organisational commitment, oversight, and accountability afforded to other patient safety risks.[19]

27. Healthcare organisations must establish clear accountability mechanisms to ensure racism and cultural unsafety are identified, reported, monitored, and addressed. This includes culturally safe pathways for reporting racism and transparent responses to complaints. The Gari Yala,[40, 41] Jumbunna, and Call it Out[42] reporting frameworks are good examples of identifying institutional, interpersonal and systemic racism. Further, organisations must ensure governance arrangements that enable Aboriginal and Torres Strait Islander Peoples to meaningfully contribute to decision-making, system reforms, and the ongoing evaluation and continuous improvement of healthcare in response to culturally safe care needs and expectations. Sustainable improvement will require a shift in organisational cultures that place delivering cultural safety as a core component of care rather than a discretionary or regulatory responsibility. More broadly, the ANMF recommends the adoption of the Australian Human Rights Commission Anti-Racism Framework 2024 across all health settings and workspaces and creation of actionable anti-racism documents with built-in accountability mechanisms.

28. At the practitioner level, culturally safe care requires ongoing self-reflection regarding personal values, assumptions, biases, and the power held within healthcare relationships.[43] Healthcare practitioners should demonstrate “cultural humility” by not only demonstrating an awareness and appreciation of cultural differences but also advocating against the

systemic barriers that Aboriginal and Torres Strait Islander Peoples.[44-46] "Cultural humility" does not assume that a practitioner must become an expert in all kinds of cultural values but, instead, that they demonstrate the humility and empathy needed to understand other people's values and experiences, avoid making assumptions, and treat everyone with the respect and consideration they deserve.[47] In practice, this involves culturally responsive communication, respectful partnerships with patients, families, and communities, shared decision-making, and advocacy for equitable systems of care.[48] However, responsibility for cultural safety cannot rest solely with individual practitioners. Healthcare organisations must provide the leadership, education, supervision, resources, and culturally safe workplaces necessary to support culturally safe practice and reinforce clear expectations regarding professional conduct. To embed cultural safety as a core component of healthcare quality, mandatory and ongoing cultural safety and anti-racism education should be implemented across all health settings. Such education should be accompanied by reflective practice, supervision, accountability mechanisms, and opportunities for organisational learning. Cultural safety is not a competency that can be achieved through a one-off training session and instead requires continual reflection, learning, and system-wide commitment to ensure that knowledge is translated into sustained changes.

29. Strengthening the Aboriginal and Torres Strait Islander health workforce is also a critical strategy for reducing racism, cultural unsafety, and preventable harm. Aboriginal and Torres Strait Islander health professionals bring unique cultural knowledge, expertise, lived experience, and community connections that strengthen healthcare delivery and improve the cultural responsiveness of services.[49, 50] Increasing Aboriginal and Torres Strait Islander representation across all professions, particularly in leadership, governance, education, and clinical roles, can improve access to healthcare, enhance patient experiences, and support the delivery of culturally safe care. This requires coordinated workforce strategies focused not only on recruitment but also on retention, career progression, leadership development, and culturally safe workplaces. For example, CATSINaM's *GENKE II – 'Gettin em n Keepin em n Growin em'* strategy outlines reforms to strengthen Aboriginal and Torres Strait Islander participation in nursing and midwifery education and employment.[51] Such initiatives should

be considered alongside broader health workforce reforms, such as the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031.[52]

30. Ultimately, reducing racism, cultural unsafety, and preventable harm requires health services to shift from viewing cultural safety as a workforce capability to recognising it as a core organisational and system responsibility. Lasting change will depend on strong Aboriginal and Torres Strait Islander leadership, shared decision-making, accountability for outcomes, and the embedding of cultural safety throughout governance, workforce development, service design, and healthcare delivery.

What would meaningful accountability for cultural safety look like?

31. Accountability for cultural safety must be primarily located at the organisational and system level. While individual practitioners remain responsible for their professional behaviour and should be expected to demonstrate cultural competence and cultural humility, cultural safety itself cannot be achieved by any single practitioner. As such, accountability for creating and maintaining the conditions necessary for culturally safe care should rest with healthcare providers and health systems. This may involve embedding cultural competence and cultural humility requirements within professional registration standards, codes of conduct, and continuing professional development requirements, while cultural safety obligations are embedded in service accreditations, funding arrangements, and national quality and safety frameworks such as the National Safety and Quality Health Service (NSQHS) Standards.

32. Meaningful accountability requires more than statements of commitment, but also measurable obligations and consequences for non-performance. Too often, organisations publicly endorse cultural safety principles without implementing the structural changes necessary to achieve them. Cultural safety and anti-racism commitments should therefore be embedded within Hospital and Health Service agreements, organisational strategic plans, accreditation requirements, and the performance agreements of Boards, Chief Executives, and senior executives. Progress should be linked to regular reporting requirements and

independent review processes. Where organisations fail to meet agreed cultural safety standards or demonstrate sustained improvement, regulatory, accreditation, or funding consequences should be available.

33. Aboriginal and Torres Strait Islander leadership must be central to accountability mechanisms. Meaningful accountability cannot be achieved through consultation alone. Aboriginal and Torres Strait Islander Peoples must have genuine authority within governance structures and decision-making processes that determine how cultural safety is defined, measured, and enforced. This includes representation in leadership positions, participation in oversight and review mechanisms, and authority to influence organisational responses to identified concerns. Accountability frameworks should support self-determination by ensuring Aboriginal and Torres Strait Islander communities are partners in governance.

How should Aboriginal and Torres Strait Islander Peoples and organisations be involved in shaping, overseeing and improving cultural safety?

34. Aboriginal and Torres Strait Islander Peoples should be central to, and actively involved in, all aspects of initiatives aimed at improving cultural safety in healthcare. Cultural safety must be defined by Aboriginal and Torres Strait Islander Peoples, recognising that they are best placed to determine what culturally safe care looks and feels like in practice. Their perspectives, experiences, knowledge systems, and priorities must be meaningfully incorporated into the design, implementation, oversight, evaluation, and continuous improvement of policies, programs, and services intended to address cultural safety. This meets Priority Reform Three of the National Agreement on Closing the Gap.

35. Meaningful involvement should extend beyond consultation and include genuine partnership and shared decision-making. Aboriginal and Torres Strait Islander organisations, particularly Aboriginal Community Controlled Health Organisations (ACCHOs), should play a critical role in providing leadership, expertise, and oversight for the development of culturally safe systems of care. Health services should establish formal governance structures and processes that support Aboriginal and Torres Strait Islander leadership at all levels. Embedding self-

determination within healthcare systems is essential to achieving sustainable improvements.

What type of national standards model is most likely to create meaningful change?

36. Cultural safety should be embedded throughout the health system rather than treated as a discrete or optional requirement. A national standards model that incorporates cultural safety across all domains is more likely to drive meaningful and sustained change. Embedding cultural safety throughout the NSQHS standards framework reinforces that it is a core component of safe and high-quality healthcare.

37. Cultural safety should be recognised as a genuine Workplace Health and Safety (WHS) issue alongside physical and psychosocial hazards, in recognition of the significant and preventable harms that culturally unsafe care causes. Existing national and state-based legislative and regulatory mechanisms already recognise discrimination and harassment as psychosocial hazards, by which racism is a reasonable interpretation of these obligations, meaning the impacts of racism and cultural unsafety fall within an employer's duty of care to workers and patients.

38. Standards should be outcomes-focused and supported by proactive duties. As cultural safety is ultimately determined by the experiences of Aboriginal and Torres Strait Islander Peoples, any national framework must include mechanisms that capture these experiences while also establishing objective indicators that healthcare organisations can be assessed against. These measures should be developed in partnership with Aboriginal and Torres Strait Islander communities to ensure they accurately reflect culturally safe care.

39. Cultural safety must also be experienced by the workforce. A healthcare service cannot be considered culturally safe for patients if Aboriginal and Torres Strait Islander staff continue to experience racism or culturally unsafe workplaces. National standards should therefore require health services to assess and address cultural safety for both consumers and staff. Workforce experiences should be viewed as a key indicator of cultural safety.

40. The ANMF supports a model in which cultural safety is both a standalone national standard, so that it is assessed in its own right and cannot be diluted across other requirements, and an explicit requirement embedded within each of the other standards, so that it is understood as integral to clinical governance, partnering with consumers, comprehensive care and communicating for safety. Whichever model the Commission adopts, hazard-based reporting, escalation and resolution obligations should be its spine.

What should hospitals and health services be required to demonstrate in relation to cultural safety?

41. Hospitals and health services should be required to demonstrate that cultural safety is embedded across all levels, including governance, service delivery, and quality improvement processes. Cultural safety should be recognised as a core component of healthcare quality and safety, with clear organisational accountability for preventing racism, reducing inequities, and improving the healthcare experiences and outcomes of Aboriginal and Torres Strait Islander Peoples. Organisations should be able to demonstrate how cultural safety considerations inform decision-making.

42. Health services should provide evidence of meaningful Aboriginal and Torres Strait Islander leadership and decision-making across all levels. This should include mechanisms that support Aboriginal and Torres Strait Islander self-determination, ensure community perspectives inform organisational priorities, and enable Aboriginal and Torres Strait Islander Peoples to define and assess cultural safety.

43. Hospitals should also demonstrate culturally safe workforce strategies, including ongoing education and development and initiatives to recruit, retain, develop, and promote Aboriginal and Torres Strait Islander workforce representation.

44. Healthcare organisations should be required to demonstrate mechanisms for identifying, preventing, reporting, monitoring, and responding to racism, discrimination, and cultural unsafety. This should include culturally safe complaints processes, transparent responses to incidents, and systems for monitoring patient experiences of cultural safety and racism.

Evidence should also be provided of how services use these data to inform quality improvement and accountability.

What would support or hinder effective implementation?

45. Effective implementation will be reliant on the level of meaningful engagement with Aboriginal and Torres Strait Islander Peoples, communities, organisations, and health professionals. Aboriginal and Torres Strait Islander Peoples must be provided with genuine influence over decision-making to ensure approaches reflect local community priorities, needs, and cultural contexts.

46. Consistent national standards, clear expectations, and practical implementation guidance will also support effective implementation. Healthcare organisations require clarity regarding what constitutes cultural safety, how it should be demonstrated, and how performance will be assessed. Nationally consistent standards and indicators can promote accountability, reduce variation across jurisdictions and services, and support a shared understanding that cultural safety is a core component of healthcare quality and patient safety.

47. Factors that may hinder implementation include a lack of clearly defined and developed systems for measuring cultural safety, limited collection and use of patient experience data, and a lack of mechanisms to identify, report, monitor, and respond to racism and cultural unsafety. Without robust monitoring and transparent reporting, organisations may struggle to assess progress, identify areas for improvement, or demonstrate accountability for outcomes.

What information, if any, should health services report publicly about cultural safety?

48. Public reporting on cultural safety is an important mechanism for transparency, accountability, and building trust among Aboriginal and Torres Strait Islander Peoples and communities. It should be understood as an application of Priority Reform Four of the National Agreement on Closing the Gap (shared access to data and information at a regional level) and be governed by Indigenous data sovereignty principles, with Aboriginal and Torres

Strait Islander peoples and community-controlled organisations determining how cultural safety data about them is collected, interpreted and released. Health services should publicly report the results of regular audits on cultural safety and racism, such as independently evaluated Marrie Matrix scores and an analysis of de-identified quantitative and qualitative cultural safety feedback. Workplaces should also publicise workforce statistics, including independent analysis of exit interviews for Aboriginal and Torres Strait Islander employees.

49. Accessible and meaningful information about a health service's performance against cultural safety standards can help demonstrate its commitment to providing culturally safe care and addressing racism within healthcare settings. Public reporting should include information on cultural safety initiatives, Aboriginal and Torres Strait Islander workforce representation and leadership, consumer experience and feedback, complaints relating to racism and cultural safety, and progress against established cultural safety indicators. By demonstrating measurable action and continuous improvement, health services can enhance Aboriginal and Torres Strait Islander Peoples' confidence that they will receive care that is respectful, culturally responsive, and safe.

What should ACSQHC prioritise following this Review?

50. The ACSQHC should prioritise sustained engagement with Aboriginal and Torres Strait Islander health professionals throughout the design, implementation, and evaluation of any cultural safety reforms. This engagement should extend beyond formal consultation processes and include ongoing partnerships with Aboriginal and Torres Strait Islander nurses, midwives, doctors, allied health professionals, health workers, health practitioners, liaison officers, and frontline administrative staff. These professionals possess unique expertise as both providers and recipients of healthcare systems and often carry a significant responsibility for supporting culturally safe care for patients, families and communities, while also navigating racism and cultural unsafety within their own workplaces.

51. Consultation should include representative professional, industrial, and community-controlled organisations. These organisations provide critical insight into workforce

experiences, service delivery challenges, and barriers to implementation. They are well placed to identify practical strategies for embedding cultural safety within governance, accreditation, workforce development, quality improvement and health service delivery.

52. The Commission should prioritise the development of clear but flexible standards, measures, and accountability mechanisms for cultural safety. These measures should be developed in partnership with Aboriginal and Torres Strait Islander Peoples and should balance patient- and community-reported experiences with organisational, workforce and system-level indicators. Notably, standards should establish shared expectations and outcomes while allowing flexibility for locally determined governance, implementation, and accountability arrangements that reflect the diverse needs and priorities of different Aboriginal and Torrens Islander Communities.

53. Aboriginal and Torres Strait Islander nurses and midwives should be a particular priority within this work. As the largest Aboriginal and Torres Strait Islander registered health profession nationally, nurses and midwives work across the full continuum of care and are often the first and most consistent point of contact for patients, families and communities. Their experiences provide invaluable insight into the realities of healthcare delivery, the barriers to culturally safe care, and the practical changes required to improve health outcomes. Their leadership and expertise should be central to the development, implementation and evaluation of any national cultural safety framework.

How should cultural safety outcomes be measured and governed?

54. Cultural safety measurement must be led by Aboriginal and Torres Strait Islander Peoples. As there is no singular Aboriginal and Torres Strait Islander culture, cultural safety cannot be effectively measured using standardised tools developed independently of Aboriginal and Torres Strait Islander communities. Consistent with the national definition of cultural safety, what constitutes culturally safe care must be determined by Aboriginal and Torres Strait Islander Peoples.[21] The design of measures, the thresholds for performance, and the interpretation of results must all be led by Aboriginal and Torres Strait Islander Peoples.

Measurement frameworks should therefore prioritise the identification of culturally unsafe practices, policies and workplace cultures through Aboriginal and Torres Strait Islander-led tools, such as the Marrie Institutional Racism Matrix (MIRM).[53, 54] Additional measures should be co-designed with communities and staff to ensure they reflect lived experiences and meaningful outcomes, rather than relying on rigid compliance-focused processes or unrealistic evidentiary burdens.

55. Measurement should encompass patient, workforce and organisational outcomes. A comprehensive framework should assess patient and community experiences of care, perceptions of safety, experiences of racism and discrimination, trust in health services, and participation in healthcare decision-making. Workforce indicators should include recruitment, retention, attrition and workplace wellbeing among Aboriginal and Torres Strait Islander staff. These measures should be supported by both quantitative and qualitative data.

56. Continuous monitoring and accountability mechanisms are essential. Cultural safety complaints and feedback from patients, families, communities and staff should be systematically collected, analysed and reported to identify trends, address risks and drive service improvement.

57. Governance should be embedded within existing healthcare quality and safety systems. Cultural safety must be viewed as a core component of healthcare quality, not an additional regulatory requirement. Governance arrangements should therefore be integrated within existing quality and safety frameworks while ensuring Aboriginal and Torres Strait Islander leadership is embedded at all levels. Aboriginal and Torres Strait Islander Peoples must hold meaningful decision-making authority over cultural safety priorities, measurement, accountability processes and organisational responses to identified issues.

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