National Rural Health Alliance

Submission to the Australian Commission on Safety and Quality in Health Care: Consultation on the National Safety and Quality Health Service Standards (third edition)

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Healthy and sustainable rural, regional and remote communities across Australia.

National Rural Health Alliance

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Introduction

The National Rural Health Alliance (NRHA) welcomes the opportunity to contribute to the consultation on the National Safety and Quality Health Service (NSQHS) Standards (third edition).

As the peak body for rural, regional, and remote (hereafter rural) health in Australia, the NRHA represents 55 organisations dedicated to achieving equitable health outcomes for the over 7 million Australians or approximately 30 percent of the population, living outside metropolitan areas. Our diverse membership includes representation from health professional organisations, health service providers, health educators, researchers, the Aboriginal and Torres Strait Islander health sector and students. Our vision is to ensure healthy sustainable and productive rural communities across Australia.

People living in rural Australia generally have shorter lifespans, experience high incidence of disease and injury, and poorer access to health services compared to those in metropolitan areas. The poorer health outcomes in these areas can stem from various factors, including lifestyle differences, social and geographical isolation, educational and employment disadvantages and limited access to, and use of, health services compared those living in cities (NRHA 2025a).

The NRHA commends the Australian Commission on Safety and Quality in Health Care (the Commission) for initiating this review and for recognising the need to ensure that the NSQHS Standards remain responsive to the evolving landscape of healthcare delivery, particularly in rural settings where the context is markedly different from metropolitan health environments.

1. What existing and emerging safety and quality risks should the Commission be considering for the third edition?

Rural health services face longstanding, systemic challenges that impact the safety and quality of care. These must be more explicitly addressed in the NSQHS Standards (third edition) to prevent the further entrenchment of health disparities.

Workforce

Workforce shortages remain one of the most significant safety risks across rural areas (AMA 2025). Many services operate with minimal staffing, often with single clinicians, which limits opportunities for clinical supervision and delays in escalation of care, which can lead to gaps in service coverage (Cortie et al. 2024). High turnover and burnout further undermine continuity and quality improvement efforts. Recruitment and retention of general practitioners, nurses, allied health professionals, and administrative personnel remain ongoing challenges (Tan et al. 2025).

According to the Rural Doctors Association of Australia (RDAA), accreditation is often difficult for rural practices due to administrative burden, limited access to experienced practice managers, and technological constraints (RDAA 2025). Transient workforces further hinder engagement with quality and safety systems.

The Clinical Governance Standard (e.g., Actions 1.19 to 1.26, NSQHS Standards Second edition) recognises the importance of a skilled and supported workforce (ACSQHC 2021). However, this assumes a stable workforce that rural services often cannot rely on. The NSQHS Standards (third edition) should therefore strengthen these actions by explicitly recognising workforce continuity, wellbeing and sustainability as safety risks, with guidance on proportionate governance models for small and isolated teams.

Access to timely and appropriate care

Geographical isolation impedes access to timely diagnosis, treatment, and follow-up care. The Royal Flying Doctor Service reports that nearly 18,405 Australians cannot access primary healthcare within a 60-minute drive (Bishop et al. 2024). Even where services exist, long waiting times and workforce shortages hinder access. Access to allied health services is particularly limited, resulting in preventable morbidity and delayed rehabilitation (Russell et al. 2025).

The Comprehensive Care Standard (e.g., Actions 5.01 to 5.04, NSQHS Standards Second edition) requires health services to identify patient needs and provide coordinated care (ACSHQ 2021). Yet these requirements are difficult to meet where services simply do not exist. The NSQHS Standards (third edition) should expand these actions to require formal escalation pathways, outreach arrangements and partnerships between rural and metropolitan services, ensuring care remains safe and comprehensive despite local resource limitations.

Infrastructure and technology limitations

Many rural health services continue to operate with inadequate infrastructure, outdated equipment and unreliable technological systems (AMA 2025; NRHA 2025b). Limited or unreliable digital connectivity in some rural areas impairs access to electronic medical records, telehealth platforms, and digital prescribing. These limitations undermine the potential of emerging models of care and threaten patient safety.

The Clinical Governance Standard (e.g., Action 1.16, NSQHS Standards Second edition) requires safe information system, and the Medication Safety Standard (e.g., Action 4.14) addresses safe and secure storage and distribution of medicines (ACSHQ 2021). However, neither recognise digital or infrastructure inequity as a patient safety risk. The NSQHC Standards (third edition) should include requirements for mitigation strategies where connectivity is limited, such as offline back-ups, hybrid system and risk planning.

Telehealth and virtual care risks

While the expansion of telehealth and virtual care has enhanced access for many rural communities, it also presents new safety risks. These include concerns around clinical appropriateness, privacy and consent, digital literacy, infrastructure reliability, and de-personalisation of care (NRHA 2025b). Inadequate systems for remote monitoring and follow-up may expose patients to delayed intervention of missed deterioration. Telehealth and digital health are an important addition to but not instead of quality safe care.

The Communication Standard (e.g., Action 6.08 to 6.10 NSQHS Standards Second edition) covers safe handover and transitions but does not address telehealth specifically (ACSQHC 2021). The NSQHS Standards (third edition) should strengthen these actions by requiring explicit guidance on virtual care, including consent processes, follow-up mechanisms and clinical appropriateness criteria. In addition, advocacy for reliable digital infrastructure would be of benefit.

Cultural safety

Aboriginal and Torres Strait Islander peoples continue to experience poorer health outcomes due to a lack of culturally safe care, underrepresentation in governance, and limited involvement in service design. Cultural safety must be more prominently embedded within the NSQHS Standards (third edition).

The Clinical Governance Standard (e.g., Action 1.21 and 1.33, NSQHS Standards Second edition) requires culturally safe and inclusive care (ACSHQ 2021). The NSQHS Standards (third edition) should elevate cultural safety as a cross-cutting principle applied to all Standards, with requirements for Aboriginal and Torres Strait Islander representation in governance, staff training and outcomes monitoring.

Climate change

Climate change also poses an increasing threat to rural health service delivery. Heatwaves, floods, bushfires, and cyclones can disrupt access to care, damage infrastructure, and increase demand for emergency and ongoing health services (NRHA 2025c) Rural areas are disproportionately affected due to their limited emergency management resources and fragile infrastructure.

The Clinical Governance Standard (e.g., Action 1.10, NSQHS Standards Second edition) requires services to identify and manage risks, however no actions explicitly reference climate change (ACSQHC 2021). The NSQHS Standards (third edition) should expand these to require environmental risk assessment, climate resilience planning and coordination with local disaster management agencies, given the disproportionate rural impacts.

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

To drive high performance across all settings, the NSQHS Standards (third edition) must explicitly account for the diversity of health service environment, particularly the realities of rural service delivery. Despite facing substantial resourcing challenges, many rural and remote services demonstrate high performance through innovation, community engagement, and adaptability.

Models such as Community Paramedicine and Rural Health Consumer Panels exemplify effective, place-based solutions (Kinsman et al. 2023). The NSQHS Standards (third edition) should reflect these contextual factors to ensure they are both meaningful and achievable across all settings.

Key opportunities to strengthen high performance

- Position equity and parity as a central pillar: The Partnering with Consumers Standard (ACSQHC 2021) requires inclusive care but does not position equity as a system-wide requirement. The NSQHS Standards (third edition) should embed equity as a core principle, requiring health services to identify and act on disparities affecting Aboriginal and Torres Strait Islander peoples and rural communities.
- Proportionate implementation: The Clinical Governance Standard (e.g., Actions 1.01 to 1.08 NSQHS Standards second edition) outlines governance structures but assumes large or resourced organisations (ACSQHC 2021). Rigid compliance frameworks often hinder smaller services. Proportionate, context-sensitive implementation guidance is essential to reduce burden and support quality improvement (ACSQHC 2012).
- Embed workforce as a core driver: Recognise workforce wellbeing, support and continuity as essential enablers of safe, high-quality care. The Stronger Rural Health Strategy highlights the importance of workforce investment (DoHDA 2021).

- Enable data-driven improvement: Support services to use timely, locally relevant data for planning and quality improvement. Measurement and evaluation driven by place-based, outcomes-focused frameworks are effective in rural settings (AHHA 2025). Performance indicators must be appropriate to context, enabling fair and useful comparison across services of similar type and scale, and supporting benchmarking that leads to genuine improvement.

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

The NRHA strongly supports greater emphasis on integrated care in the NSQHS Standards (third edition), especially to improve service delivery and health outcomes in rural communities. For these communities, integration is not simply ideal but rather it is necessary. The geographic spread, limited local resources, and complex cross-jurisdictional arrangements require coordinated systems that ensure continuity, safety, and quality throughout the entire patient journey.

The NSQHS Standards (third edition) presents an opportunity to strengthen requirements for:

- Coordination across settings: encourage integration between hospitals, primary care, community health, aged care, mental health, paramedicine, RFDS and Aboriginal and Torres Strait Islander health services. This should include clearer expectations around care transitions, shared care planning, and linked service arrangements to reduce fragmentation and duplication of care; challenges that are particularly acute in rural settings.
- Digital interoperability: support digital infrastructure, interoperability and timely information sharing across providers and sectors, recognising the importance of telehealth and virtual care in rural areas. Strengthening shared governance and accountability across services will further embed integration into routine practice and ensure seamless care coordination (ADHA, 2023).
- Tailored support for rural models: allow for flexible implementation tailored to rural contexts, where service models often differ from metropolitan settings. Supporting existing integrated service models, such as multipurpose services and outreach programs, will be essential to ensure that safety and quality improvements are achievable and meaningful across all health services (Brown et al. 2025).

By imbedding integration into the NSQHS Standards (third edition), the Commission can help drive more connected, person-centred care, particularly for the rural communities that rely heavily on integrated, coordinated health services to meet their unique needs.

4. How can the third edition support a continuous learning approach and shift away from a compliance mindset.

The NRHA supports a shift in the NSQHS Standards (third edition) towards fostering a culture of continuous learning, reflection and improvement, particularly important for health services in rural communities. A learning-focused approach can drive genuine quality and safety improvements that are responsive to local needs and service realities, rather than encouraging reactive box-ticking compliance.

To support this shift, the NSQHS Standards (third edition) should be clearly positioned as an enabler of quality, not merely a framework for accreditation. Language throughout the NSQHS Standards (third edition) should emphasise outcomes, innovation and ongoing improvement over rigid prescriptive processes.

Rural health services, in particular, benefit from flexible, strengths-based and flexible approaches to continuous improvement. The NSQHS Standards (third edition) should actively encourage the use of local data, feedback from consumers and communities, and staff insights to identify priority areas and track progress over time. This aligns with evidence suggesting that rural quality improvement efforts are more successful when they are community-led, context-aware, and grounded in lived experience (Hamiduzzaman et al. 2025).

A stronger emphasis on peer learning, shared learning networks and collaborative improvement initiatives across services would help build a culture of trust, openness and learning across rural services. Critically, embedding a culture of learning requires practical support. Staff in rural areas often have limited access to training, professional development, and time for quality improvement activities (Campos-Zamora et al. 2022). The NSQHS Standards (third edition) should therefore explicitly recognise the importance of building capability in systems thinking, quality improvement methods, and culturally safe care, embedded into day-to-day operations rather than isolating them to accreditation cycles.

The current triennial accreditation model often creates an intense, resource-heavy workload in the lead-up to review periods. Reorienting the NSQHS Standards (third edition) around principles of continuous learning and improvement, rather than episodic assessment, would enable health services to deliver safer, more responsive, and locally grounded care, driven by a sustained commitment to improvement rather than short-term compliance.

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

The NRHA supports the efforts to simplify and clarify the structure and language of the NSQHS Standards (third edition), ensuring they are accessible and actionable for a wide range of services, including those delivery care in rural areas. In its current form, some elements of the NSQHS Standards (second edition) are overly technical or assume familiarity with large system quality-frameworks, which can present barriers for under-resourced or geographically isolated services.

To improve usability, the NSQHS Standards (third edition) should provide clearer guidance on how to interpret and apply each Standard in different settings. This includes practical examples, case studies, and contextual guidance tailored for rural services. A more consistent structure across the NSQHS Standards, with plain language descriptions of intent, expected outcomes, and links to practical tools, would support implementation and avoid misinterpretation.

Wherever possible, duplication should be reduced and language streamlined to highlight core principles. Grouping related actions more logically and using headings that reflect everyday clinical and operational concepts would further improve clarity. The inclusion of visual aids, such as summary tables, decision-making trees or implementation pathways, would help services understand how the Standards connect to their existing processes.

Crucially, the NSQHS Standards (third edition) must support flexibility without sacrificing clarity. Health services need to understand what is required, but also how they can meet the intent of each action in ways that are appropriate to their size, structure and local context. Clearer definitions, prioritised actions, and a tiered or scalable approach could assist in this regard.

By refining the format and structure of the NSQHS Standards (third edition), it can better support health services, particularly in rural Australia, to confidently engage with and act on the requirements, leading to more meaningful and sustained improvements in safety and quality.

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

The NRHA supports efforts to streamline the NSQHS Standards (third edition) by addressing areas of duplication and reducing unnecessary complexity. In rural settings where services are often small, multidisciplinary, and under resourced, duplication contributes to administrative burden and diverts time and energy away from meaningful quality improvement activities.

Several areas within the current NSQHS Standards (second edition) contain overlapping requirements, particularly in relation to governance, communication, documentation, and risk management. For instance, expectations around clinical governance structures and workforce responsibilities are repeated across multiple standards, often with only minor variations in wording or emphasis. Similarly, actions related to communication, such as during transitions of care, patient identification, and informed consent, appear across multiple NSQHS Standards without clear cross-referencing, creating confusion about accountability and effort duplication.

While all these elements are vital to patient safety, the repetition of similar content across different domains can dilute focus and create ambiguity. The NSQHS Standards (third edition) should consider integrating shared requirements into a core or foundational section that applies across all NSQHS Standards, thereby reducing redundancy while preserving safety-critical content.

The compliance burden is especially pronounced when health services must demonstrate the same evidence (such as policies, training records, or review processes) multiple times across standards. Services should be supported to demonstrate compliance once, with the evidence recognised across relevant standards. This would be particularly beneficial in rural areas, where staff often perform multiple roles and have limited capacity for administrative and accreditation-related tasks.

The scale of existing documentation further illustrates this challenge. For example, the **NSQHS Standards guide for Ambulance Health Services alone spans more than 400 pages,** an extensive document that underscores the growing complexity of NSQHS compliance, even for large and specialised services. For small rural providers, this level of detail can be overwhelming and counterproductive, especially when their focus must remain on frontline care.

By removing unnecessary duplication and adopting a more streamlined structure, the NSQHS Standards (third edition) can reduce compliance workload, improve clarity, and support all health services, particularly those in rural and remote area, to focus on the delivery of safe, high-quality, and locally responsive care.

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

The NRHA encourages continued consultation with rural health services, providers, consumers and communities throughout the review process to ensure that the NSQHS Standards (third edition) are practical, flexible and equitable across all geographic contexts.

In particular, the NRHA highlights the importance of ensuring that the NSQHS Standards (third edition) are implementable by smaller services, including those in rural and remote areas that operate with limited staffing, infrastructure and access to specialist expertise. While the safety and quality principles are universal, their application must be context-sensitive to avoid unintended consequences, such as increased administrative burden or barriers to accreditation.

The NRHA also encourages the Commission to invest in supporting materials and capacity-building initiative (such as implementation guides, training resources, and communities of practice) to assist services in understanding and applying the NSQHS Standards (third edition). Ongoing support will be essential to achieving the intended shift towards a learning-oriented, integrated and consumer-centred approach to care.

The NRHA appreciates the opportunity to contribute to this important review and looks forward to continuing to work with the Commission to ensure the NSQHS Standards (third edition) delivers improvements in safety, quality and health equity for all Australians, particularly those living in rural and remote communities.

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