

25th September 2026

National Standards Program
NSQHS Standards (third edition)
Australian Commission on Safety and Quality in Health Care
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Dear Program team

I am pleased to provide this written submission on behalf of the Health Consumers' Council WA.

The Health Consumers' Council WA is the peak body for health consumers in WA, and the only peak body which is funded by government to provide an independent health advocacy service.

This submission was informed by our substantial and ongoing consumer and community networks, including insights from a network of consumer leaders. We also facilitated a workshop on our submission with our individual advocacy team.

We look forward to collaborating further with the Commission as this important work continues. Please don't hesitate to contact me if you require any clarification or further information on the submission.

Yours sincerely



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Health Consumers' Council WA response to the draft National Safety and Quality Health Service Standards, Third Edition

About Health Consumers' Council WA

Health Consumers' Council WA Inc. was established in 1994 as an independent voice for health consumers and the community in Western Australia. We work to improve health outcomes and experiences by championing and amplifying diverse consumer voices.

HCCWA is the only consumer peak body in Australia funded by government to provide an independent individual health advocacy service across all areas of health to support consumers to navigate the health system and seek redress when care has not gone to plan. This service operates across all areas of healthcare in WA except involuntary mental health admissions.

Our network includes more than 10,000 consumers and community members across Western Australia.

What has informed this submission

- HCCWA's organisational experience in consumer engagement and systemic advocacy
- insights from HCCWA's independent individual health advocacy service
- a deidentified workshop with HCCWA advocates and engagement staff
- HCCWA's previous submission on the Third Edition Standards
- a consumer leadership discussion paper developed with experienced consumer leaders
- broader engagement undertaken by HCCWA about the draft Standards.

The Advocacy Team workshop drew on the experience of staff who support consumers, families and carers when they are having difficulty accessing care, navigating the health system, raising concerns or seeking a response when care has not gone to plan. The workshop findings are qualitative. They illustrate recurring issues and experiences raised by workshop participants but should not be interpreted as prevalence data or as representing every consumer experience. Quotes have been deidentified and lightly edited only to remove repetition and improve readability, without changing their meaning.

Overall position

HCCWA supports the Third Edition's aim of ensuring high-quality care that is person-centred, safe, effective, accessible, integrated and equitable.

We welcome the stronger attention in the draft to:

- patient experience and outcomes
- clinical governance and leadership accountability
- communication and shared decision-making
- cultural safety
- eliminating racism and discrimination
- integrated care and transitions between services
- learning from feedback, complaints and incidents
- consumer-reported experience and outcome measures
- safe governance of digital systems.

The draft recognises that patients, families and carers are partners in care and governance. It also includes requirements about consumer partnership, patient rights, consumer feedback and complaints within the proposed Clinical Governance Standard. These are important foundations.

However, HCCWA is concerned that removing a distinct Partnering with Consumers Standard may reduce the visibility and authority of consumer partnership at a time when meaningful partnership is not yet consistently embedded across health services.

The current Partnering with Consumers Standard provides a clear statement that consumer partnership is a core condition of safe and high-quality care. Distributing these requirements across three larger Standards may be conceptually integrated, but it also creates a risk that consumer partnership becomes harder to identify, implement and assess.

This concern is grounded in HCCWA's experience. Consumers continue to describe feeling dismissed, rushed, poorly informed or excluded from decisions. Advocates continue to support people whose concerns have not been heard, whose care has been fragmented and who cannot see how their complaint or experience has contributed to change.

“Consumers should not need specialist knowledge, persistence, legal advice or access to an advocate before a health service listens, responds and acts.”

HCCWA therefore recommends retaining a distinct Partnering with Consumers Standard.

If the Commission proceeds with integrating consumer partnership across the three proposed Standards, the final Standards must establish an equally visible, assessable

and enforceable consumer partnership framework. This framework should make clear what meaningful partnership looks like at the level of individual care, service improvement, organisational governance and system leadership.

Priority areas for strengthening

1. Move beyond consumer participation to consumer leadership

Consumer leadership is different from engagement or consultation.

Consumer leaders bring lived experience together with broader knowledge of the health system, community networks, governance and systemic advocacy. Their contribution is not limited to sharing an individual experience. Consumer leaders can identify patterns, understand the effect of decisions across services and provide a perspective that is often not visible from within a single organisation or clinical discipline.

A consumer leadership paper developed with experienced WA consumer leaders described consumer leadership as a legitimate and necessary part of health system governance, planning, design, delivery, measurement and evaluation. It also identified that consumer influence is strongest when consumers are represented at the highest levels of governance and recognised as people with expert skills and knowledge.

HCCWA's earlier submission similarly called for consumers to be involved at board and decision-making levels and for genuine co-design to replace processes in which consumers are consulted only after important decisions have already been made.

The Third Edition should distinguish clearly between:

- a patient participating in decisions about their own care
- a consumer representative contributing to a committee or project
- consumers partnering in service design and quality improvement
- consumer leaders influencing governance and strategic decisions.

These are related but different roles. Each requires different authority, support and accountability. Each also requires health service organisations to prepare differently to play their part as true partners.

HCCWA recommends that the Standards require health services to:

- include consumer leadership at the highest appropriate levels of governance – including where a health service provider's governance structure is part of another over-arching structure, for example, a state Health Department, or a private provider Group structure.
- involve consumers early enough to influence priorities and decisions
- demonstrate how consumer contributions affected the final decision or outcome
- involve consumers in planning, implementation, evaluation and improvement
- support a diverse pipeline of consumer representatives and leaders

- include sufficient funds in operational budgets to be able to provide appropriate payment, preparation, accessibility, mentoring and support
- avoid relying on one individual to represent the diversity of an entire community.

The test of partnership should not be whether a consumer attended a meeting. The test should be whether consumers had influence and whether their involvement contributed to better decisions, experiences and outcomes.

2. Retain clear and assessable accountability for consumer partnership

Consumer partnership can become tokenistic when health services are assessed on the presence of a committee, policy or consumer representative rather than on the influence of consumer participation.

The consumer leadership paper identified substantial variation in the authority and effectiveness of consumer advisory structures. It noted that their influence could depend heavily on organisational leadership, sponsorship and whether the group was genuinely empowered to contribute to decision-making. It also described how the formal presence of a consumer may satisfy an accreditation expectation even when the consumer is not adequately supported or able to influence the work.

This is consistent with concerns raised through the Advocacy Team workshop about systems appearing compliant while consumers continue to experience the same problems.

“It would be really good to get away from the tick-the-box approach that seems to have gone on in the past.”

Workshop participants called for health services to be judged by what changes for consumers, not only by whether policies, committees, training or reporting systems exist.

HCCWA is concerned that spreading consumer partnership requirements across the three proposed Standards could make them more difficult for health services, consumers and assessors to locate and follow. It could also weaken the accountability mechanisms to ensure the aim of consumer partnership in the standards is met.

If a separate Partnering with Consumers Standard is not retained, the Commission should provide:

- a clearly identified consumer partnership framework across all three Standards
- an index or cross-reference showing every consumer partnership requirement
- clear evidence expectations for meaningful partnership
- practical examples of consumer leadership and shared decision-making
- guidance that distinguishes genuine influence from consultation or attendance
- consistent assessment guidance for accrediting agencies.

3. Include consumers directly in accreditation

HCCWA has previously recommended that consumer reviewers be included on accreditation teams as subject matter experts, particularly when assessing consumer partnership. We continue to support this position.

Consumer involvement in accreditation should not be limited to health services showing assessors minutes, terms of reference, surveys or consumer feedback reports.

Accreditation should include direct engagement with a diverse range of consumers, carers, consumer representatives and independent consumer organisations. This should include people who have raised complaints or experienced difficulty accessing or navigating care, not only consumers selected by the health service. Consumers should also help develop, pilot and evaluate the assessment approach for the Third Edition.

HCCWA recommends that accreditation:

- include trained consumer reviewers on assessment teams
- examine the influence of consumer participation, not only whether structures exist
- include direct and accessible conversations with consumers and carers
- consider independent advocacy insights and recurring consumer concerns
- test whether consumers know their rights and how to raise or escalate concerns
- assess whether services report back to consumers about the changes made
- examine whether improvement activity has changed consumer experience and outcomes.

4. Make complaints, feedback and incidents visible drivers of improvement

HCCWA welcomes the proposed links between complaints, feedback, incident management, risk management and quality improvement.

However, health services should not be able to demonstrate compliance merely by showing that a complaint or incident management system exists.

Consumers may describe their experience as feedback, a concern, a comment or a request for help without realising that it must be formally classified as a complaint to receive a response. All concerns should be examined for possible risk, harm, discrimination or recurring system failure, regardless of the label applied to them.

Workshop participants also highlighted that a general acknowledgement creates an expectation that the information will be examined and used:

“If they say, “Thank you for your feedback, we will use this information to improve our services”, there is an obligation to monitor what is in those statements.”

The Advocacy Team workshop identified concerns about consumers receiving responses that did not clearly answer their questions, acknowledge identified gaps or explain how conclusions had been reached.

“Giving a bit of context about how they landed where they did would have helped. It would have shown accountability and that, yes, they were doing the work.”

Consumers and families should receive understandable information about:

- what was investigated
- what evidence was considered
- what gaps were identified
- how decisions were made
- what recommendations were made
- who was responsible for carrying them out
- whether recommendations were implemented
- whether the resulting changes improved care.

Low complaint numbers should not automatically be interpreted as evidence of good performance. People may not know how to complain, may fear consequences, may not find the process accessible or may not believe that speaking up will lead to change.

HCCWA recommends that the Standards require health services to:

- provide clear timeframes for acknowledging and responding to complaints
- provide regular progress updates during lengthy investigations
- offer accessible escalation when a matter is unresolved or involves ongoing risk
- analyse feedback and complaints for repeated and systemic concerns
- examine whether particular communities experience different barriers, treatment or outcomes
- involve consumers and affected communities in interpreting findings
- monitor the implementation and effectiveness of resulting actions
- report back to consumers and communities about what changed.

5. Involve consumers and families throughout incident review and encourage a restorative justice approach to incident management

The draft includes important requirements to involve patients, families and carers in the review of incidents and communicate investigation outcomes and subsequent actions. HCCWA supports this direction, but the final Standards should be clearer about what involvement means.

Consumers, families and carers may hold essential evidence about the person's health, usual behaviour, medicines, communication needs, care at home and events before, during and after an incident. This knowledge should be recognised and documented as evidence.

“The consumer and their family should be involved all the way through, including reviewing what needed to happen, whether the recommendations were carried out, and, if they were not, why not.”

With the consumer's agreement, involvement should include:

- helping to identify the questions the review needs to answer
- providing information and evidence
- receiving information about how the incident has been classified
- receiving an understandable explanation of the findings
- contributing to recommendations
- being told whether recommendations were implemented
- being informed about whether the changes were effective.

Trained consumer representatives should also participate in relevant incident investigation and review processes.

Taking a restorative justice approach would also go some way to addressing the secondary harm that consumers and families experience when a clinical incident is poorly handled. While clinical incident management will always be about improving future care, it is important that the needs of the people impacted by each incident are tended to.

6. Strengthen responsibility for coordinated care

Care fragmentation is one of the most consistent themes across HCCWA's evidence. The Advocacy Team workshop described consumers moving between hospitals, general practitioners, specialists, public services and private providers without anyone taking responsibility for the whole picture.

“There isn't somebody who overarches public, private and primary care and plays the communicator between them.”

HCCWA's earlier submission also identified safety risks when people move:

- between ambulance and hospital care
- between primary, secondary and tertiary care
- between hospital wards
- between regional and metropolitan services
- from paediatric to adult health services
- from hospital back to general practice and community care.

Consumers provide a unique systems perspective because they experience the whole journey. Each service may act logically within its own boundaries while the overall experience remains disconnected, repetitive and unsafe.

The draft's focus on integrated care, multidisciplinary teamwork, clinical handover and transitions of care is welcome. However, requirements focused within individual health services will not be sufficient when the risk sits between organisations.

The workshop also described concerns being redirected between specialties without anyone taking responsibility:

"It was redirected to the next specialty, then the next specialty, then the next specialty. It continued for weeks. It wasn't until we got involved."

Delays are not merely inconvenient. As another participant noted:

"The longer it takes, the worse the outcomes can be."

HCCWA recommends that the Standards require:

- a clearly identified person or team responsible for coordination when needs are complex
- clear points of contact for consumers and carers
- defined triggers for multidisciplinary review and care navigation
- shared planning across services and settings
- active follow-up of time-critical referrals, tests and treatment
- clear responsibility following discharge or transfer
- stronger review when consumers or carers repeatedly raise an unresolved concern
- monitoring of fragmentation through complaints, delayed follow-up, readmissions and consumer experience.

Repeated requests for help should trigger review and escalation. They should not be treated as a problem with the consumer or carer.

7. Treat accessible communication as a safety requirement

Communication is not an optional feature of good care. Poor communication can contribute to delayed treatment, medicine errors, unsafe discharge, missed deterioration, uninformed consent and loss of trust.

Consumers may feel rushed, receive information filled with medical language or leave an appointment without understanding their options and next steps.

"Communication jargon is really difficult for consumers to understand. Things need to be broken down simply."

Providing information is not the same as achieving understanding. Safe communication should include:

- plain language explanations
- enough time to ask questions
- written follow-up where appropriate
- clear information about options, benefits and risks
- professional interpreters
- communication formats the person can use
- supported decision-making
- reasonable adjustments
- confirmation that important information has been understood.

Providing an interpreter without allowing enough appointment time does not create equitable access. Workshop participants described the practical inequity this can create:

“By the time you factor in an interpreter, it is too long, and then they are getting charged for a longer appointment. It feels uneven.”

Likewise, making information available digitally does not make it accessible to people who cannot confidently or safely use digital systems.

The Standards should require equivalent non-digital ways to access care, information, booking systems, complaints and escalation processes.

HCCWA also recommends clear consumer information for every Standard, including plain language, Easy Read, translated and non-digital formats. Our previous submission also recommended short explanatory videos to make the Standards more understandable for consumers and busy health practitioners.

8. Recognise independent advocacy as part of consumer safety

Independent advocacy often becomes involved when a health service’s usual processes have not responded adequately to a concern.

Advocates may help consumers communicate what is happening, identify possible risks, navigate complex systems and bring unresolved matters to the attention of senior staff.

“Individual advocacy and the need for it is probably most blatant here, because we fill the gap when it is not being caught by the health service.”

A safe system should not depend on whether a consumer has the knowledge, capacity or good fortune to find an advocate. At the same time, independent advocacy is an important safeguard when internal pathways are not accessible, responsive or trusted.

The workshop identified a need for independent, consumer or peer-led support and access to external review when people reach a barrier within the service:

“It would be good to see an independent or consumer peer-led service, and an external clinical service that somebody could go to for a review if they are hitting a brick wall.”

The Standards should require health services to:

- make information about independent advocacy and peer support readily available
- support consumers to access advocacy when requested
- allow advocates to participate with the consumer’s consent
- ensure urgent concerns are not delayed because a consumer needs assistance to navigate internal processes
- provide an escalation route when serious concerns remain unresolved.

9. Make equity practical

Treating everyone in exactly the same way does not necessarily result in fair or safe care.

People have different communication needs, levels of health literacy, support networks, financial circumstances and ability to navigate health services. Some people need more time, different information, reasonable adjustments or practical support to participate equally in their care.

“It would be nice to see it across the board as something automatic, with information so people know they can ask for something different according to their needs.”

The Standards should require services to routinely ask people what they need to access, understand and participate in their health care. This should include:

- professional interpreters
- longer appointments where required
- accessible written information
- different communication formats
- disability adjustments
- support people
- navigation and wayfinding support
- non-digital access
- flexibility in how appointments and care are provided.

Equity should be assessed through what people can access and experience, not simply whether the same process was offered to everyone.

10. Recognise discrimination, racism, bias and stigma as factors that affect safety and quality and make these visible in governance structures and processes

HCCWA welcomes the draft's stronger attention to cultural safety, racism, discrimination and bias.

Consumers may not use formal terms such as racism, discrimination or stigma when describing what happened. They may describe not being believed, being treated differently, being unable to access an adjustment or having assumptions made about their behaviour, pain, capacity or health needs.

"Those things are not easy for most people to articulate."

Health services should not rely on consumers having the language, confidence or safety to classify their experience correctly.

Stigma can shape:

- whether symptoms are believed
- how distress or behaviour is interpreted
- which investigations are ordered
- whether other possible diagnoses are considered
- what is written in the health record
- how later clinicians understand and treat the person.

The workshop described the effect of an early assumption continuing to shape later clinical decisions:

"All the investigations are based on the first assumption. They reflect the stigma rather than asking what the actual issue is."

The Standards should require boards and executives to examine complaints, incidents, access, treatment, outcomes and consumer experience for patterns of racism, discrimination, bias and stigma.

Aboriginal people and communities must be involved in determining whether care is culturally safe and in interpreting and responding to information about racism and cultural safety. Cultural safety cannot be defined or assessed only by health services.

Communities affected by other forms of discrimination should also be involved in understanding the evidence and shaping the response.

11. Give consumers a voice in their health records

Health records largely document the clinical perspective, yet the information they contain can influence every future interaction with the health system.

The Advocacy Team workshop raised concerns about inaccurate, incomplete or stigmatising information being repeated across healthcare encounters.

“Medical records are relied on as, “The notes said this”. There needs to be an avenue for the patient’s perspective to be documented.”

Consumers should have an accessible way to:

- question information they believe is inaccurate
- request a correction or addendum
- have their perspective included
- identify information that is disputed
- ensure the findings of a later review are visible
- prevent unsupported assumptions from continuing to influence care.

These protections should be designed into electronic health record systems from the beginning. Consumers should not need legal knowledge or prolonged complaint processes simply to ensure that their perspective is visible alongside the clinical record.

Conclusion

HCCWA supports the direction of the Third Edition and welcomes its stronger focus on clinical governance, experience, outcomes, equity, cultural safety and continuous improvement.

Our central concern is that consumer partnership must become more visible, influential and accountable, not less.

HCCWA’s evidence shows a consistent pattern across organisational experience, advocacy work, previous submissions and consumer leadership thinking. Consumers continue to experience fragmented care, inaccessible communication, difficulty having concerns taken seriously and limited visibility of what changes after feedback, complaints or harm.

At the same time, consumers bring expertise that is essential to understanding whether care is safe and whether systems are working. Consumers experience health care across professional, organisational and sector boundaries. They can identify gaps that are not visible from within one service or discipline.

The final Standards should therefore make clear that:

- consumer leadership is part of good clinical governance
- consumer partnership must involve influence, not only attendance
- consumers should participate at the highest levels of decision-making
- consumers and families should be involved throughout incident review and improvement

- complaints and feedback must lead to visible action
- accreditation should include consumer reviewers and direct consumer evidence
- accessible communication, equity and cultural safety are core safety requirements, with an explicit requirement for health services to address and eliminate stigma
- independent advocacy is an important consumer safety safeguard
- health services must be accountable for what consumers experience, not only for the systems they document.

The practical test is whether consumers are listened to, understand their care and choices, receive the adjustments and support they need, know who is responsible, can raise concerns safely and can see what changed because they spoke up.

The Third Edition should ensure these experiences are routine and reliable, rather than dependent on an individual clinician, leader, consumer representative or advocate making them happen.