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Australian Digital Health Agency

Agenda

Council for Connected Care: Meeting 14 – Virtual Care

Location: In person, South Australian Health and Medical Research Institute (SAHMRI), 870 North Terrace, Adelaide SA 5000.

Meeting: 8:00am – 4:45pm (ACDT) on Thursday, 3 December 2026

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Item	Timing		Topic	Presenter
1	2.5 hrs	8:00 am	SA Ambulance Service / State Emergency Operations Centre visit	Anne Duggan, Chair
	20 mins	11:00 am	Morning Tea	
	10 mins	11:20 am	Welcome to Country	Elder: Cliffy Wilson Didgeridoo artist: Jie Martin
2	3 mins	11:30 am	Meeting Opens, Conflicts of Interest, Apologies and Housekeeping	Anne Duggan, Chair
3	2 mins	11:33 am	Minutes of Previous Meeting, Action Items and Papers for Noting	Anne Duggan, Chair
4	5 mins	11:35 am	A Message from the Minister for Health and Wellbeing of South Australia	Blair Boyer
5	15 mins	11:40 am	Scene Setting	Keith McNeil
6	15 mins	11:55 am	Royal Flying Doctor Service - William Creek Clinic and Matilda AI	Ryan Klose, Exec GM, Chief Information Officer, Royal Flying Doctor Service
	10 mins	12:10 pm	CCC Feedback Session	

Item	Timing		Topic	Presenter
7	30 mins	12:20 pm	Child and Adolescent Virtual Urgent Care Services (CAVUCS)	Dr Priya Wilson, Paediatric Emergency Physician and CAVUCS Medical Unit Head, Gabby McCormack, CAVUCS Nurse Unit Manager and Ashish Sharma, Consumer/Co-designer SA Women's and Children's Hospital
	10 mins	12:50 pm	CCC Feedback Session	
8	30 mins	1:00 pm	Integrated Cardiovascular Clinical Network (ICCNet) - improving outcomes for regional patients to achieve equity with metro patients.	John Denton, Operations and Research Manager, ICCNet
	10 mins	1:30pm	CCC Feedback Session	
	45 mins	1:40 pm	Lunch	
9	50 mins	2:25 pm	National Safety and Quality Standards for Virtual Care Workshop	Gillian Giles, Exec Director, Clinical Governance & Paul Miles, Director, Digital Health
10	20 mins	3:15 pm	Commission on Excellence and Innovation in Health (CEIH) / SACCAN Data and Intelligence	Tina Hardin, Exec Director, Clinical Informatics and Innovation & Michael Osborn, Chief Cancer Officer
	15 mins	3:35 pm	Afternoon tea	

Item	Timing		Topic	Presenter
11	40 mins	3:50 pm	Panel discussion - “Virtual Care as Part of the System — Not a Side Channel”	Bret Morris - Chief Digital Health Officer (Facilitator) Panel members: David Morris – Interim Deputy Chief Executive, SA Health Dr Mel Smith – GP Consultant, Co-Clinical Lead, SA Virtual Care Service Jeanette Walters – Executive Director, Integrated Care Systems
12	10 min	4:30 pm	Roundtable Updates	
			Aus CVD Risk I Calculator	Lisa Kalman
13	5 mins	4:40 pm	Meeting Summary and Other Business	
			Meeting Close 4:45pm (ACDT)	

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Council for Connected Care

Agenda Item 1: SA Ambulance Service and State Emergency Operations Centre site visit

Meeting: Thursday, 3 December 2026

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Purpose

The purpose of the Council for Connected Care's site visit to the South Australian Ambulance Service (SAAS) Headquarters, Emergency Operations Centre, Adelaide Ambulance Station and State Health Coordination Centre (SHCC) is to provide members with an opportunity to experience firsthand how South Australia is using connected digital capabilities, operational coordination and information sharing to support patient care, service responsiveness and whole-of-system decision-making. Through a series of guided rotations and discussions, members will gain insight into the operational environments, technologies and care models that are helping deliver more connected care across the health system.

Detailed Station Overview

Station 1: State Health Coordination Centre (SHCC) Patient Flow & Performance Monitoring
Members will receive an overview of the SHCC's role in coordinating statewide patient flow, managing demand pressures and providing real-time visibility of health system performance. Discussion will explore centre operations, how shared information and system-wide coordination support more informed decision-making and improved patient outcomes and the technology that supports the centre's functions.

Station 2: Electronic Patient Care Record (ePCR) & Ambulance Operations
This station will showcase ambulance operations alongside the implementation of the Electronic Patient Care Record (ePCR) program. Attendees will learn how digital information capture, clinical documentation and interoperability are supporting more connected care and enhancing the flow of information between care settings.

Station 3: Emergency Operations Centre (EOC)
Members will visit the Emergency Operations Centre to gain insight into how operational intelligence, clinical coordination and decision-support capabilities are used to manage emergency responses and improve service responsiveness across South Australia.

Panel Q&A and Discussion
The visit will conclude with a facilitated discussion featuring representatives from SAAS, SHCC and related services. The session will provide an opportunity for Council members to ask

questions, reflect on observations from the site visit and discuss lessons learned, emerging opportunities and strategic considerations for connected care and interoperability.

Time			
8:30 - 8:40	**Conference Room: Welcome & Site Overview (All Attendees)**		
	Group 1	**Group 2**	**Group 3**
8:45 - 9:15	Station 1	Station 2	Station 3
9:15 - 9:20	Move	Move	Move
9:20 - 9:45	Station 2	Station 3	Station 1
9:45 - 9:50	Move	Move	Move
9:50 - 10:15	Station 3	Station 1	Station 2
10:15 - 10:20	Return to Conference Room		
10:20 - 10:40	**Conference Room: Panel Q&A and Discussion (All Attendees)**		

A more detailed timetable will be provided to members on the day.

Background

SA Ambulance Service (SAAS) is South Australia's statewide provider of emergency ambulance transport, pre-hospital clinical care, patient transport, and retrieval services. Its purpose is to save lives, reduce suffering and enhance quality of life through accessible, responsive and high-quality patient care. In addition to responding to emergency and time-critical incidents, SAAS delivers aeromedical and medical retrieval services, coordinates emergency management and major event responses, supports patient transport across the health system, and provides services to metropolitan, regional and remote communities through a network of more than 100 locations across South Australia.

The State Health Coordination Centre (SHCC) is South Australia's central integrated coordination hub for managing system-wide patient flow across the health system. Operating 24 hours a day, seven days a week from the SA Ambulance Service headquarters, the SHCC provides real-time visibility of patient journeys across metropolitan and regional hospitals. It supports coordinated decision-making by identifying and responding to system pressures and flow blockages, helping to ensure patients receive timely care and that healthcare resources are directed to where they are needed most.

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability

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Agenda Item 2: Conflicts of Interest

Meeting: Thursday, 3 December 2026

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Purpose

The purpose of the agenda item is for members to declare any new conflicts of interest.

Recommendations

It is recommended the Council for Connected Care:

1 **declare** any conflicts of interest

2 **note** that a conflict-of-interest declaration is required annually or sooner if there is a change of circumstances.

Summary of issues

Conflicts of interest

It is important that the Council and its members are free from perceived or real conflicts of interest with the business before them. The Chair will invite members to state any real or perceived conflicts of interest.

If you have been contacted by Secretariat Services, please provide your annual conflict of interest declaration as soon as possible.

Confidentiality

Members and proxies are asked to note that the meeting minutes, action list, and presentation slides are committee-in-confidence and are not to be shared or disclosed externally. Agenda papers and communiqués will be publicly available on the Agency website and can be shared externally.

Background

This is a standing agenda item.

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability

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Agenda Item 3: Minutes of Previous Meeting, Action Items and Papers for Noting.

Meeting: Thursday, 3 December 2026

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Purpose

The purpose of this agenda item is to seek endorsement of the meeting minutes from 23 July 2026, provide an update on the status of action items and note updates on the Interoperability Plan, Standards Advisory Group and the NCGC-DH.

Recommendations

It is recommended the Council for Connected Care:

1 **endorse** the 23 July 2026 meeting minutes at Attachment A

2 **note** the status of action items at Attachment B

3 **note** the Interoperability Plan progress update report for Q1 (July-September 2026) at Attachment C

4 **note** the Standards Advisory Group update

5 **note** the NCGC-DH update and future strategic direction.

Summary of issues

Minutes for the 23 July 2026 meeting are provided at Attachment A.

A list of action items is provided at Attachment B. The following actions are recommended for closure:

- Action 2026/12-01
- Action 2026/13-01
- Action 2026/13-02

Interoperability Plan Q1 Progress Report

The quarterly progress report for July to September 2026 is provided at Attachment C. Updates on status and progress have been received from Agency and non-Agency action leads, including state

and territory health departments, the Department of Health, Disability and Ageing, Services Australia and jurisdictions.

Of the 44 actions in the Interoperability Plan:

- 35 are complete
- 9 are on track – 4 ongoing actions and 5 short or medium-term actions.

Progress highlights include significant progress across Priority Area 1, supporting national efforts to strengthen identity foundations for connected care. Adoption of healthcare identifiers advanced across jurisdictions through clinical system integration, provider directory enhancements, conformance activities and broader digital health transformation programs.

This reporting period also marked the introduction of direct jurisdictional reporting within the quarterly progress report, providing increased visibility of implementation activities, challenges and opportunities across the health sector.

Progress was also made to strengthen healthcare identifier matching, provider identification and national directory capabilities, supporting more consistent and reliable health information sharing across Australia.

Two Healthcare Identifiers Roadmap activities, HIA-09 *Enhanced search considerations* and HIA-15 *HI Service architecture and future extensibility*, were completed during the quarter, further progressing the maturity, sustainability and future readiness of the Healthcare Identifiers ecosystem.

Standards Advisory Group update

The Agency appointed three new members to the Standards Advisory Group (the Group): Ms Sallyanne Wissmann, CEO, HIMAA; Ms Nicolle Marchant, Director, Digital Health, National Aboriginal Community Controlled Health Organisation (NACCHO); and Mr Jim O'Shea, Acting CEO, Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

The partnerships with NACCHO and VACCHO arose out of the consultation on the National Framework for Digital Health Standards and the need to ensure there are mechanisms for actively involving the voices of Aboriginal and Torres Strait Islander peoples in shaping the implementation of digital health Standards. The Group did not convene in the last quarter.

The Agency has commenced discovery work to understand the current environment and opportunities to support digital health standards' governance. This will be presented to the Group for their advice in the latter part of this year.

National Clinical Governance Committee – Digital Health update

The fourth meeting of the National Clinical Governance Committee for Digital Health (NCGC-DH) was held on 28 September 2026 and focused on providing strategic clinical governance recommendations across key national digital health reforms. Members discussed and provided recommendation on the continued implementation of Share by Default initiatives, including medicines information sharing and the National Medicines Record, with a strong emphasis on improving access to health information to maintain safety, quality, clinician and consumer trust. The NCGC-DH also provided advice on the national safety and quality standards for virtual care and the role of implementation levers in supporting adoption. The NCGC-DH considered advice

from the newly established Thriving Kids - Child Health Record Expert Advisory Group regarding the proposed national 3-year-old health check, including consumer and clinician access requirements and key privacy, safety and clinical governance considerations. Throughout discussions, members reinforced the importance of national consistency, consumer partnership, effective clinical governance, and a whole-of-system approach to implementing digital health reforms to maximise safety, quality and health system benefits.

Over the coming months, the NCGC-DH will focus on providing strategic clinical governance advice to support the safe, effective and nationally consistent implementation of key digital health initiatives, including the national safety and quality Standards for virtual care, enhanced health information sharing for medicines through Share by Default and the National Medicines Record, and the development and implementation of the Child Health Record.

Background

This is a standing agenda item.

Attachments

Attachment A: Minutes - CCC 23 July 2026

Attachment B: CCC Action List

Attachment C: Interoperability Plan progress update report for Q1 (July-September 2026)

Contact officer: Cass Timmermans, Assistant Director, Interoperability

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Action List

Council for Connected Care

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Action item #	Action item	Owner	Due date	Status
2026/13-03	All council members encouraged to provide useful case studies, user stories and examples to support connected care themes	All Council Members	On-going	Open
2026/13-02	Provide more information on virtual care standards, noting AIHW work on virtual care data standards for the Health Chief Executives Forum.	ACSQHC, AIHW & Agency	3 December 2026	Closed – discussed under agenda item 8 on 3 December 2026
2026/13-01	Explore opportunities to support culturally and linguistically diverse communities through accessible consumer communications and information resources.	Partnerships Team (Agency)	3 December 2026	Closed – Discussed with Comms and Partnerships team – Partnerships will reach out to FECCA & Mental Health advocates to understand what comms could be supported. No budget to do translations on video media in this FY
2026/12-01	Periodic updates reporting by the NCGC-DH to the Council, communiques from NCGC-DH and each EAG advisory group to be shared with CCC members. Membership lists of NCGC-DH and EAGs to be shared with CCC members.	Clinical Governance, Agency	3 December 2026	Closed – discussed under agenda item 3 on 3 December 2026 and further updates will be included as part of the CCC standing agenda items.

Closed Actions Items

Action item #	Action item	Owner	Due date	Status
2026/11-01	Council noted the update and that feedback will be synthesized and shared to inform future product and experience design work	Experience and Service Design, Australian Digital Health Agency (the Agency)	23 July 2026	Closed - shared in the annual report as part of March 12 2026 meeting summary.
2025/10-01	Interoperability team to incorporate suggestions on items for 2025-26 workplan collected from the Council members into meetings for next year	Agency	November 2025	Closed – discussed under Agenda item 3 on 12 Nov 2025
2025/09-02	Department of Health, Disability and Ageing to provide update on the progress of the Omnibus bill at the next meeting.	The Department	August 2025	Closed – discussed under Agenda item 6 on 21 Aug 2025
2025/09-01	Australian Commission on Safety and Quality in Healthcare to share draft clinical governance framework document when available with Council members	Commission	August 2025	Closed – discussed under Agenda item 9 on 21 Aug 2025
2024/08-01	Identify immediate opportunities to improve secure sharing of patient information and decrease the use of fax, email and mobile messaging	Agency, Department of Health and Aged Care, Healthdirect, MSIA, RACGP	November 2024	Closed – discussed under Agenda Item 4 on 14 Nov 2024.
2024/05- 01	Follow-up on the Agency's approach to supporting Priority Reform 4 of the National Agreement on Closing the Gap.	Agency	August 2024	Closed – discussed under Agenda Item 3 on 8 Aug 2024.
2023/10- 10	The Agency intends to increase focus on AI next year and will seek guidance from the Council on this early-mid 2024	Agency	May 2024	Closed – discussed under Agenda Item 5 on 22 Feb 2024.
2023/08 - 5	Agency and Department of Health and Aged Care to regularly review the governance 'mud map' and share with members when there are updates.	Agency, DOHAC	October 2023	Closed – discussed under Agenda Item 4 on 11 Oct 2023.
2023/08 - 6	Agency to share the 2023 Interoperability Benchmark Survey with member	Agency	October 2023	Closed – discussed under Agenda Item 4 on 11 Oct 2023.
2023/08 - 7	Agency to provide members with an update on its work on security conformance profiles.	Agency	September 2023	Closed – discussed under Agenda Item 4 on 11

Action item #	Action item	Owner	Due date	Status
				October 2023.
2023/08 - 8	Agency to provide an update on identity initiatives at the October 2023 Council meeting in the progress report.	Agency	October 2023	Closed – discussed under Agenda Item 4 on 11 Oct 2023.
2023/08 - 9	Agency to prepare an expression of interest for the clinical nomination for the Australian Digital Health Standards Advisory Group and circulate to members for distribution to their networks.	Agency	August 2023	Closed – discussed under Agenda Item 4 on 11 Oct 2023.
2023/06 - 1	Agency to share its communication and engagement plan with members.	Agency	August 2023	Closed – discussed under Agenda Item 4 on 10 Aug 2023.
2023/06 - 2	The Agency to confirm what meeting materials can be shared with non-members.	Agency	August 2023	Closed – discussed under Agenda Item 2 on 10 Aug 2023
2023/06 - 3	Secretariat to update draft terms of reference with member comments and circulate revised version out-of-session for endorsement.	Secretariat	July 2023	Closed – revisions were circulated with 7 June 2023 meeting minutes.
023/06 - 4	Agency and Department to develop a governance ‘mud map’ and circulate to members for information.	Agency, DOHAC	October 2023	Closed – governance ‘mud map’ circulated with 10 August 2023 meeting papers.

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Connecting Australian Healthcare

National Healthcare Interoperability Plan 2023–2028

National Healthcare Identifiers Roadmap 2023–2028

Quarterly Progress Report
July 2026 – September 2026

Issued 23 October 2026



Publication date: 23 October 2026

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Introduction

The Connecting Australian Healthcare – National Healthcare Interoperability Plan 2023–2028 (Interoperability Plan) is Australia's first national plan to deliver a connected healthcare system for more personalised holistic care and better health and wellbeing outcomes for all Australians.

The Interoperability Plan sets out a national vision to share consumer health information in a safe, secure and seamless manner and identifies 44 actions across five priority areas - identity, standards, information sharing (sending, receiving and finding the right information), innovation (initiatives that drive interoperability) and measuring benefits - and policy tools to support interoperability.

The Agency, in collaboration with the Department of Health, Disability and Ageing and Services Australia, has developed a National Healthcare Identifiers Roadmap 2023–2028 (HI Roadmap) that includes 20 activities to drive uptake of the HI Service.

The Australian Digital Health Agency (the Agency) established the Council for Connected Care (the Council) as the key governance body to provide strategic advice, oversee implementation of the Interoperability Plan, and report on progress.

The Interoperability Plan was published on the Agency's website on 11 July 2023. This is the thirteenth progress report against the 44 actions in the Interoperability Plan.



National Healthcare Interoperability Plan 2023–2028

80% actions complete

Quarterly progress

0
actions
completed in
Q1 2026–27

Identity

PRIORITY AREA 1
Total actions: 10
Complete actions: 5



Standards

PRIORITY AREA 2
Total actions: 14
Complete actions: 14



Information Sharing

PRIORITY AREA 3
Total actions: 12
Complete actions: 8



Innovation

PRIORITY AREA 4
Total actions: 3
Complete actions: 3



Benefits

PRIORITY AREA 5
Total actions: 4
Complete actions: 4



Open actions 2026–27 delivery

1.6 Develop deeper network structures

3.9 Information-sharing model agreement

Open actions 2027–28 delivery

1.1 Using healthcare identifiers
1.2 Promoting healthcare identifiers
1.4 Healthcare identifier matching
1.7 Using the National Health Services Directory (NHSD)

3.2 API Gateway information exchange
3.11 Consistent legislative health definitions
3.12 Harmonising legislation

Completed Actions

1.3 Healthcare Identifiers Roadmap
1.5 Review Healthcare Provider Identifier (HPI-I) conformance
1.8 Implementing the 2019 National Health Services Directory (NHSD) review
1.9 Provider Connect Australia™
1.10 Integrating the NHSD and the Health Provider Directory (HPD)

2.1 Terminology in digital health systems
2.2 Develop specifications and standards
2.3 HL7® FHIR® AU usage
2.4 International standards participation
2.5 Standards catalogue
2.6 National Digital Health Standards Program (NDHSP)
2.7 Standards guiding principles
2.8 Standards gap analysis
2.9 Engage standards stakeholders
2.10 Including terminology in datasets
2.11 National library of terminology Mapping
2.12 API information exchange
2.13 Develop a conformance framework
2.14 Standards development cooperative

3.1 Interoperability in procurement
3.3 Procurement guidance
3.4 Online interoperability toolkit
3.5 GP and aged care facility interoperability
3.6 Consent Management
3.7 Research international practice
3.8 Care Management Network
3.10 Publish-subscribe service

4.1 Interoperability innovation challenges
4.2 Interoperability workforce
4.3 Develop education content

5.1 Administer interoperability survey
5.2 Publish annual report
5.3 Assess digital health maturity models
5.4 GDHP interoperability maturity model
6.1 Review policy tools*

*This action item is included under Section 8 of the Interoperability Plan, Policy tools to support Interoperability.

Identity



Progress highlights

This quarter saw continued progress across Priority Area 1,with jurisdictions, the Australian Digital Health Agency (the Agency) and its partners advancing adoption of healthcare identifiers and strengthening the foundations required for connected care.

Jurisdictions reported progress through healthcare identifier integration, identity management initiatives, provider directory reforms and conformance programs. These activities continue to strengthen the use of healthcare identifiers within clinical workflows and support more consistent identification of healthcare consumers, providers and organisations.

Nationally, work continued to promote adoption of healthcare identifiers, improve data quality and matching outcomes, and support future healthcare provider organisation structures. Progress was also made to strengthen national directory services, with jurisdictions continuing to expand use of the National Health Services Directory (NHSD) and Provider Connect Australia (PCA) to support service discovery, referrals and provider information management.

Action status

5 actions have been marked as complete under the Identity priority area. The Agency will no longer be reporting against completed action items.

Priority Area 1 – Identity: Q1 2026 - 27 update

Action 1.1 Using healthcare identifiers	**Lead(s)**	**Timeframe**	**Status**
Jurisdiction health departments, the Agency and Services Australia will adopt and use national healthcare identifiers in future digital health initiatives involving health information sharing.	• The Agency • Services Australia • All Health Departments	Ongoing	On track

In the Q1 reporting period, progress towards national use of healthcare identifiers continues to develop.

The Department of Health, Disability and Ageing (the Department), Services Australia and the Agency have progressed work across a number of the activities in the Healthcare Identifiers Roadmap (HI Roadmap) over the reporting period. To progress the work agreed under the 2026–2031 Addendum to the National Health Reform Agreement (NHRA), the Department and the Agency has commenced initial discussions with jurisdictions to inform jurisdictional priorities, challenges and opportunities associated with the adoption of key digital reforms including adoption of healthcare identifiers. Discussions will also focus on priority areas of mutual benefit across jurisdictions that will support development of roadmaps and enable safe and timely health information exchange.

Services Australia's work during the quarter focused on progressing existing healthcare identifier capabilities and supporting implementation activities aligned with the HI Roadmap and broader interoperability objectives. Services Australia has commenced analysis and assessment for the prioritisation of enhanced monitoring of HI Service, improved ABN validation for organisation records, geocoding for provider and organisation addresses, support for health technology providers, and improvements to the Individual Healthcare Identifier (IHI) registration process for non-Medicare consumers.

The Agency continues to work closely with states, territories, and private health organisations to implement HPI-Is in clinical document uploads to My Health Record and provide temporary exemptions to some organisations while they transition to using HPI-Is. To date seven (7) organisations have successfully transitioned to uploading HPI-Is to the My Health Record and from December 2026, it is expected that most organisations will no longer require exemptions and will routinely include HPI is in uploads to my health record.

The Australian Capital Territory (ACT) has continued improving accuracy at public health services across the Territory by undertaking a project to ensure all Healthcare Provider Identifier – Individual (HPI-I) records stored within the Digital Health Record (DHR) have been validated and to retrieve HPI-Is for providers who have recently completed a discharge summary. This project is now in its final stages, with a Notice of Connection required to deactivate the relaxed discharge summary template. The ACT continues to use IHIs in its territory-wide EMR and is exploring investment opportunities to improve match rates and address issues relating to Department of Veterans' Affairs (DVA) number accuracy. During the quarter, DVA number validation was implemented, with existing incorrect DVA numbers now being flagged and corrected as part of a broader approach to improve data accuracy and IHI match rates.

New South Wales (NSW) proceeds to expand healthcare identifier implementation across the system and has extended the NSW Health Provider Directory (NHPD) to include Australian Health Practitioner Regulation Agency (AHPRA) data to obtain provider HPI-Is. Challenges remain where provider names are not unique, resulting in difficulties obtaining appropriate HPI-Is, and NSW has developed a workaround while the Single Digital Patient Record (SDPR) is implemented. Strategic discussions have also been undertaken with the Health Connect Australia team regarding future provider adoption requirements. NSW has also modified pathology upload processes to leverage Healthcare Information Provider Service (HIPS), increasing the inclusion of HPI-Is in My Health Record uploads. Until SDPR implementation is complete, pathology uploads will include HPI-Is where possible.

Action 1.1 Using healthcare identifiers (Continued)	**Lead(s)**	**Timeframe**	**Status**
Jurisdiction health departments, the Agency and Services Australia will adopt and use national healthcare identifiers in future digital health initiatives involving health information sharing.	• The Agency • Services Australia • All Health Departments	Ongoing	On track

Queensland continues to strengthen adoption of Healthcare Identifiers (HIs) through key digital health initiatives, including ieMR Cloud enablement, the HIPS 9 Proof of Concept, enhancements to the Queensland Master Patient Index (QMPI), and development of the Transfer of Care Information (TOCI) solution. These initiatives are designed to support the use of HIs within clinical and administrative workflows and improve information sharing across care settings. In parallel, Queensland has progressed development of the draft Provider Information Management Blueprint and consultation on the Patient Identity Management Blueprint. Together, these strategic initiatives support development of trusted consumer and provider identity services and strengthen the foundations required for future interoperability outcomes. Queensland has also identified the need to evolve existing capabilities towards a broader Master Person Index model, including support for standards-based identity exchange and Fast Healthcare Interoperability Resources® (FHIR)-enabled identity services.

South Australia (SA) has progressed with inclusion of IHIs in Sunrise EMR and the SA Health Enterprise Master Patient Index (EMPI), with implementation currently underway in non-production environments. Development of a FHIR Practitioner Directory solution incorporating SA HPI-Is is nearing feature completion, while planning is underway for integration with the CGOV credentialling system to obtain AHPRA registration numbers. SA Health organisations are also being increasingly registered through the HI Service under a network structure aligned to Local Health Networks, with major hospital facilities now registered with discrete HPI-Os.

Victoria has made strong progress towards HPI-I conformance. As at 11 September 2026, 29 Victorian Public Health Services (VPHS) were fully HPI-I conformant, with a further 31 services expected to achieve conformance by December 2026. Twelve services are working towards implementation planning, while five services are expected to require an extension to June 2027 due to Laboratory Information System replacement and EMR rollout activities. Victoria is also progressing implementation of Schedule H reforms under the NHRA, including upgrades to HIPS 9.1 to improve IHI matching performance and continued implementation of HPI-O structures across health services.

Western Australia's (WA) significant interoperability investment, including expansion of ePrescribing and eDispensing capabilities, integration of Real Time Prescription Monitoring, and upgrades to HIPS 9.1 to improve IHI discovery using mobile phone number and email address information is ongoing. WA is also progressing use of healthcare identifiers across contracted provider integrations, transfer of care between hospitals and residential aged care, and digital front door initiatives.

Action 1.1 Using healthcare identifiers (Continued)	**Lead(s)**	**Timeframe**	**Status**
Jurisdiction health departments, the Agency and Services Australia will adopt and use national healthcare identifiers in future digital health initiatives involving health information sharing.	• The Agency • Services Australia • All Health Departments	Ongoing	On track

The Northern Territory advanced planning and preparation for implementation of IHI capability across existing clinical and administrative systems and progressed integration activities associated with the Acacia Electronic Medical Record program. While no technical system changes have yet been implemented, work remains focused on strengthening healthcare identifier compliance, supporting My Health Record integration requirements, improving consistency and quality of patient identification, and progressing EMPI planning to support Schedule H implementation activities under the NHRA.

Tasmania has progressed engagement with the Agency regarding approaches to HPI-I implementation and management, alongside preliminary consideration of jurisdictional barriers, opportunities and future priorities relating to HI adoption as part of the NHRA digital reform agenda.

Action 1.2 Promoting healthcare identifiers	**Lead(s)**	**Timeframe**	**Status**
Promote the use of IHIs, including creating IHIs for newborns as soon as possible after birth.	• The Agency • Services Australia	Ongoing	On track

Throughout the reporting period there has been a strong focus on the promotion of healthcare identifier education materials, including the HI webpage, the Digital Health Foundation video series and developer eLearning content, which is supporting broader awareness and adoption of healthcare identifiers.

Services Australia continued activities to support adoption and use of healthcare identifiers, including ongoing work related to IHI for newborns.

Services Australia has received funding under the 2026-27 Thriving Kids Budget measure to uplift the IHI for Newborn webservice to FHIR which will support the creation of a National Digital Child Health Record in My Health Record and ensure health records for newborns are seamlessly integrated into the healthcare system from birth. Collaboration with partner agencies supported consistent use of healthcare identifiers across the digital health ecosystem.

Action 1.4 Healthcare identifier matching	**Lead(s)**	**Timeframe**	**Status**
Develop and implement a program of improvements in healthcare identifier matching (especially IHIs), focusing on data quality, user interfaces, service improvements, enhancements and proactive efforts on IHI retrieval.	• The Agency • Services Australia	Short	On track

Progress on this action is being advanced through analysis and targeted activities to improve healthcare identifier matching and data quality.

Services Australia is conducting analysis of HI Service data to identify patterns associated with lower data effectiveness and test practical interventions with selected provider organisations.

Work remains focused on understanding matching performance, identifying opportunities for improvement, and supporting broader interoperability and information-sharing objectives.

The Agency directly engaged individual vendors to support HI Service data quality uplift in response to Services Australia's analysis.

Action 1.6 Develop deeper network structures	**Lead(s)**	**Timeframe**	**Status**
Develop deeper Healthcare Provider Identifier – Organisation (HPI-O) network structures, including revising published guidance, to support enhancing online HPI-O network registration, and work with vendors to address software limitations.	• The Agency • The Department • Services Australia	Short	On track

Discovery work is ongoing on the proposed HPI-O seed and network structures. Testing of proposed future HPI-O structures against a range of digital health and other use cases has been undertaken to inform future-state planning and broader stakeholder consultation activities expected to commence in Q2.

Services Australia is collaborating with the Department and the Agency on activities supporting future healthcare provider organisation structures. Work during the quarter remained focused on refining approaches that support consistent and sustainable use of organisational identifiers across digital health systems.

Action 1.7 Using the National Health Services Directory (NHSD)	**Lead(s)**	**Timeframe**	**Status**
Use the NHSD as the service directory for digital health programs. Where this is not possible (such as for a specialised directory), jurisdictions will work with Healthdirect Australia and the Agency to support the required flow of information.	• All Health Departments	Ongoing	On track

Implementation and use of the NHSD progresses across jurisdictions, supporting service discovery, referrals, provider information management and interoperability initiatives. Work during the quarter has focused on improving directory quality, strengthening integration with national provider directory services, and progressing future adoption pathways through PCA and broader interoperability programs.

The ACT is currently working with NHSD to improve service and provider delivery. Planning has commenced to discover requirements for integration with PCA to promote interoperability.

Victoria continues to use the NHSD as its primary directory service. In addition, many Victorian Public Health Services maintain local directory solutions that are regularly updated using information sourced from the NHSD. Victoria is working collaboratively with Healthdirect and health services to improve the currency, completeness and accuracy of information held within the NHSD to support interoperability outcomes and strengthen information available to healthcare providers and consumers.

South Australia (SA) is progressing foundational work to support broader adoption of the NHSD. A data analysis comparing NHSD Production with the SA-only directory known as Summit Health HPRy will inform a transition plan to establish the NHSD as the authoritative source for service and practitioner discovery external to SA Health. Healthdirect Service Finder has also been successfully embedded on the SA Health website to support Emergency Department avoidance programs.

WA is expanding the use of data sourced from the NHSD via PCA to support transfer of care between hospitals and external providers, as well as digital front door initiatives. This work has a specific focus on enabling secure real-time information sharing supported by effective consent management.

The Northern Territory maintained delivery of the Health Connect Australia Provider Directory Pilot in partnership with the Agency. Work progressed on provider directory design, governance arrangements and integration planning. Engagement with general practices, Aboriginal Community Controlled Health Organisations and other healthcare providers continued to improve the completeness and quality of information held within PCA and the NHSD.

Tasmania remains engaged with the Agency regarding the potential use of the HIPS Local Directory Solution during the pilot phase. The NHSD has been utilised to support recent eReferral program upgrades, while directory services continue to be considered through broader interoperability and target-state architecture planning activities.

Queensland is using the NHSD in targeted digital health initiatives, including Smart Referrals, the Open Hospitals Service Finder and Virtual Emergency Care pathways. These services leverage NHSD content to support consumer access to accurate health service information. Queensland has advised that broader adoption remains dependent on future digital health modernisation initiatives, investment decisions, alignment with enterprise identity capabilities and progression of the Provider Information Management Blueprint. Future adoption will continue to be guided through interoperability planning and collaboration with Healthdirect Australia and the Agency.

NSW has leveraged the NSW Health Provider Directory to support provider identification and referrals, including expansion of provider information and secure messaging capabilities. NSW Health continues to collaborate with PCA to support operational requirements and future testing activities. Following the Single Digital Patient Record Tranche A, go-live, several gaps in provider data were identified and the status of this action has changed from On Track to Delayed while these issues are investigated.

Information Sharing



Progress highlights

This quarter saw sustained progress in strengthening the legislative, policy and governance settings required to support nationally consistent health information sharing. The first Share by Default Rules for pathology and diagnostic imaging services commenced on 1 July 2026, supporting increased sharing of health information through My Health Record and laying the foundation for anticipated reductions in duplicate testing and associated Medicare Benefits Schedule claims.

Consultation was also undertaken on the proposed expansion of Share by Default requirements for medicines-related information generated through online prescribing services. Feedback demonstrated broad support for improved access to medicines information through My Health Record, with consultation outcomes and clinical advice now informing policy options and broader medicines information-sharing reforms, including development of a National Medicines Record.

Work progressed on reviewing the *My Health Records Act 2012* to ensure the legislative framework remains fit for purpose to support emerging information-sharing capabilities and cross-border exchange. In parallel, jurisdictions contributed to national discussions on legislative, policy and operational settings required to support future health information sharing, with a particular focus on privacy, governance and interoperability considerations associated with cross-jurisdictional care.

Action status

8 actions have been marked as complete under the Information Sharing priority area. The Agency will no longer be reporting against completed action items.

Priority Area 3 – Information Sharing: Q1 2026 - 27 update

Action 3.2 API Gateway information exchange	**Lead(s)**	**Timeframe**	**Status**
Promote the use of the API Gateway to support interoperable information exchange, including development of a service catalogue.	• The Agency	Ongoing	On track

The past quarter has been heavily focused on discovery and service design of the HealthConnect Marketplace concept. This involved running 5 workshops with Industry and 3 with jurisdictions to document problems and frame opportunities. The workshops tested Agency capabilities against theses challenges and opportunities. A research report has been generated, with findings being considered for the product roadmap and backlog.

Action 3.9 Information-sharing authorisation framework	**Lead(s)**	**Timeframe**	**Status**
Collaborate with jurisdictions and other stakeholders to develop a legislative and policy framework that sets out the authorisations and prohibitions for the collection, use and disclosure of health information through a national health information exchange. The framework will address healthcare provider roles and responsibilities, patient control and consent and a regulatory approach to standards, privacy, audit, compliance and security.	• The Department	Short	On track

The first Share by Default Rules for pathology and diagnostic imaging services commenced on 1 July 2026, supporting increased sharing of health information through My Health Record. Increased sharing of pathology and diagnostic imaging reports is expected to reduce duplicate testing and associated Medicare Benefits Schedule claims, resulting in indicative savings of $146.3 million over two years.

During the quarter, the Department, in partnership with the Agency, undertook public consultation on expanding Share by Default requirements for medicines-related information generated through online prescribing services. The Department also sought advice from the National Clinical Governance Committee for Digital Health and its Expert Advisory Groups.

Consultation feedback showed broad support for improving access to medicines information through My Health Record to support safer, more coordinated care and address gaps in medicines histories.

Consultation outcomes and clinical advice are now informing policy options and broader medicines information-sharing reforms, including development of a National Medicines Record.

Action 3.11 Consistent legislative health definitions	**Lead(s)**	**Timeframe**	**Status**
Collaborate with jurisdictions and key stakeholders to develop consistent definitions and legislative and regulatory settings to support cross jurisdictional health information sharing, leveraging Commonwealth legislation.	• The Department	Medium	On track

Work is progressing on the review of the *My Health Records Act 2012* to assess whether the current legislative framework remains fit for purpose to support emerging health information sharing capabilities and cross-border information exchange.

The review is expected to progress in phases over the next two years, with the initial phase focused on identifying targeted reforms to strengthen privacy, safety, governance, usability and appropriate health information sharing, while maintaining public confidence in the My Health Record system.

Action 3.12 Harmonising legislation	**Lead(s)**	**Timeframe**	**Status**
Undertake collaborative intergovernmental work on supporting and implementing national information sharing settings and framework, drawing on outcomes from Actions 3.9 and 3.11.	• All Health Departments	Medium	On track

Work to support nationally consistent legislative, policy and information-sharing settings continues across jurisdictions, informed by broader consultation and reform activities underway across the interoperability program.

During this reporting period the Department maintains to work on this action, subject to the consultation and analysis being undertaken in response to Actions 3.9 and 3.11.

Across jurisdictions, efforts are being made to better understand the legislative, policy and operational settings required to support future health information sharing.

Queensland is progressing foundational work to support improved cross-border health information sharing through stakeholder engagement, planning activities and alignment with national interoperability initiatives. Reviews undertaken to date have identified variation in digital maturity, interoperability capability, data standards and governance arrangements across Hospital and Health Services. Queensland's federated service delivery model adds further complexity, requiring a staged approach that supports information sharing across organisational boundaries while reflecting local operating arrangements. Queensland continues to work with jurisdictional partners to better understand the legislative, policy and operational changes required to support future interoperability. Current activities are focused on identifying implementation challenges, informing policy development and establishing a shared understanding of national reform priorities.

Queensland recognises that achieving longitudinal patient records and effective cross-jurisdiction information sharing will require not only legislative harmonisation, but also alignment of identity, governance and interoperability capabilities across participating organisations.

The ACT highlighted differing privacy legislation across jurisdictions as a challenge for cross-border information sharing. While the Territory-wide Digital Health Record supports interoperability and information sharing across jurisdictions, the ACT notes that greater national consistency in privacy and information-sharing legislation would support a more connected approach to care delivery across borders.

WA is working to further support national engagement on consistent cross-border information-sharing legislation and policy. WA has established several Information Sharing Agreements with Commonwealth agencies under existing legislative arrangements to facilitate reciprocal information sharing. The *Privacy and Responsible Information Sharing (PRIS) Act 2024* has also introduced provisions to support information sharing with Commonwealth and state agencies for permitted purposes, while providing greater consistency with comparable Commonwealth and state privacy frameworks. WA notes that while the PRIS Act is not a complete solution, it represents an important step towards promoting responsible information sharing.

Action 3.12 Harmonising legislation (Continued)	**Lead(s)**	**Timeframe**	**Status**
Undertake collaborative intergovernmental work on supporting and implementing national information sharing settings and framework, drawing on outcomes from Actions 3.9 and 3.11.	• All Health Departments	Medium	On track

NSW maintains momentum to support legislative reform where possible, noting its current strategic focus remains on implementation of the Single Digital Patient Record and review of policy settings where cross-jurisdictional legislation does not align. NSW also continues to participate in national discussions through relevant forums.

Victoria will consider the implications of national legislative reforms as part of future state legislative, policy and implementation activities.

Tasmania continues to monitor national information-sharing reform activities and has commenced preliminary consideration of policy, governance and information-sharing implications associated with implementation of NHRA digital reforms. Tasmania remains committed to participating in collaborative national work to inform local planning as the Bluegum program progresses.

The Northern Territory is actively working to identify opportunities to strengthen information-sharing arrangements between healthcare providers while maintaining appropriate privacy, security and clinical governance safeguards. Current work includes exploring legal options for sharing information with external providers within existing Northern Territory legislative frameworks and Information Privacy Principles. Outcomes from this work will inform future policy development and support participation in emerging national health information-sharing initiatives.

SA has advised that there is currently no activity underway relating to harmonising legislation.

Australian Government
Australian Digital Health Agency

National Healthcare Identifiers Roadmap

Quarterly Progress Report
July 2026 – September 2026



Delivered as part of the National Healthcare Interoperability Plan 2023–2028

Introduction

The Agency, in collaboration with the Department of Health, Disability and Ageing and Services Australia, has developed a National Healthcare Identifiers Roadmap 2023–2028 (HI Roadmap) that includes 20 activities to drive uptake of the HI Service.

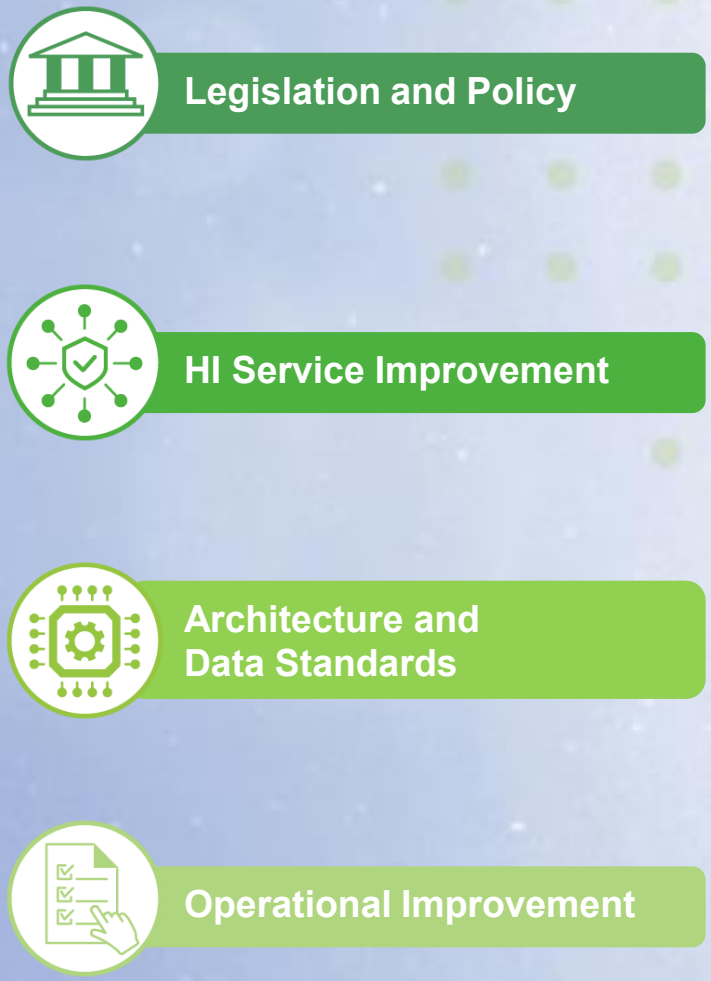
Healthcare identifiers are fundamental to a connected healthcare system. They support information sharing by accurately identifying the healthcare recipient, provider and organisation, ensuring information is shared for the right individual to the right provider. This improves the quality, safety and efficiency of care provided and puts Australians even more firmly at the centre of their own healthcare experience.

The HI Roadmap is an action in the Connecting Australian Healthcare – National Interoperability Plan 2023–2028 that is governed by the Council for Connected Care and is critical for progressing national digital health programs, including Share by Default for pathology and diagnostic imaging reports, electronic prescribing, electronic requesting, MyMedicare and Health Connect Australia.



Identity

Health information associated with the right people



Progress highlights

Implementation of the HI Roadmap advanced during the quarter, with work progressing across legislation, policy, governance and implementation support activities. This included ongoing sector engagement, refinement of guidance materials, and completion of foundational policy analysis to support greater consistency in the use and management of HIs across the health system.

Progress was also made to improve HI matching, data quality and service performance. Targeted engagement, research and analysis activities were undertaken to better understand identity matching challenges and identify opportunities to strengthen HI data quality, supporting more reliable and effective use of the HI Service.

Significant work progressed to support future interoperability and digital health capabilities. This included progressing future HPI-O structures, commencing the HI Service FHIR uplift, and advancing planning and design activities that will support modern, standards-based HI services.

Operational and governance initiatives also continued to mature during the reporting period. Cross-agency collaboration remained strong through established governance forums, with work underway to strengthen oversight arrangements, improve operational support models, and ensure the HI project remains well-positioned to deliver future roadmap outcomes.

Action status

6 activities have been marked as complete under the HI Roadmap. As HIA-9 and HIA-15 were completed in this reporting period, they have been included in this section. The Agency will no longer be reporting against completed HIAs.

National Healthcare Identifiers Roadmap 2023–2028

30% activities complete

Quarterly progress

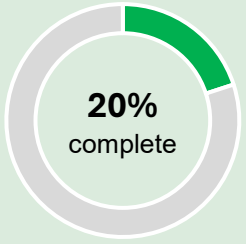
2 activities completed in **Q1 2026–27**

Activities completed in Q1 2026–27

HIA-09 Enhanced search considerations
HIA-15 HI Service architecture and future extensibility

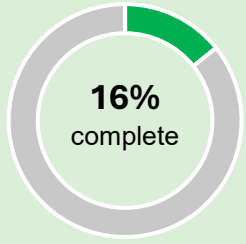
Legislation and Policy

Category 1
Total activities: 5
Commenced activities: 4
Completed activities: 1



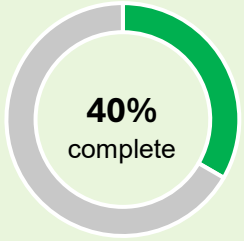
HI Service Improvement

Category 2
Total activities: 6
Commenced activities: 5
Completed activities: 1



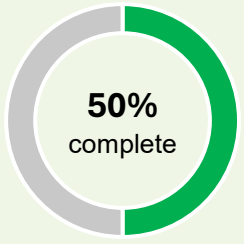
Architecture and Data Standards

Category 3
Total activities: 5
Commenced activities: 3
Completed activities: 2



Operational Improvement

Category 4
Total activities: 4
Commenced activities: 2
Completed activities: 2



Commenced Activities

Legislation and Policy
HIA-02 Australian Government policy position for HI Service adoption
HIA-03 Development of a simplified guide to the HI Act
HIA-04 Template policies and guidelines on HI use
HIA-05 HI use in consumer applications

HI Service Improvement
HIA-06 Data matching and data quality improvements
HIA-07 Review existing messages and responses
HIA-08 Improvements to data matching for Aboriginal and Torres Strait Islander people
HIA-10 Individual Healthcare Identifiers for newborns
HIA-11 Consumer empowered matching

Architecture and Data Standards
HIA-12 Healthcare Provider Identifier – Organisations: Guidance on appropriate structures
HIA-14 Update technical standards
HIA-16 Clinical systems architecture and design

Operational Improvement
HIA-19 HI support model and future operational requirements
HIA-20 Enhanced governance

Completed Activities

Legislation and Policy
HIA-01 Legislative reform program

HI Service Improvement
HIA-09 Enhanced search considerations

Architecture and Data Standards
HIA-13 HI Service conformance review and update
HIA-15 HI Service architecture and future extensibility

Operational Improvement
HIA-17 Develop and implement HI stakeholder engagement and communication plan
HIA-18 Development of education materials for HI Service

HI Roadmap – Legislation and Policy: Q1 2026 - 27 update

HIA 2 Australian Government policy position for HI Service adoption	**Lead(s)**	**Start date**	**Status**
	• The Department	2023–2024	On track
Work on this activity is on-going. The Department and the Agency are working to support the sector to update systems and workflows to enhance use of healthcare identifiers and strengthen connectivity across health and care sectors. Further updates will be provided in future reporting periods.			

HIA 3 Development of a simplified guide to the HI Act	**Lead(s)**	**Start date**	**Status**
	• The Department	2025–2026	On track
The Department continues to maintain and refine resources supporting implementation of the Healthcare Identifiers legislative framework, including the simplified guide to the HI Act and supporting Frequently Asked Questions. Further updates will be provided in future reporting periods as work continues.			

HIA 4 Template policies and guidelines on HI use	**Lead(s)**	**Start date**	**Status**
	• The Agency • The Department	2025–2026	On track

During the reporting period the gap analysis of HI policy artefacts and legislative reforms has been completed and approved. This will strengthen the baseline assessment of existing resources and identifying opportunities to support greater consistency and alignment across the program.

This work provides a foundation for the development of template policies, guidelines and supporting resources to assist healthcare provider organisations in the appropriate handling of healthcare identifiers.

As work progresses, stakeholders will be engaged throughout development to ensure the materials are practical and usable, with consideration also given to training opportunities, implementation support, and ongoing maintenance and review arrangements.

This work will progress in line with development of the simplified guide to the Healthcare Identifiers Act 2010 (HID Act), taking account of recent legislative reforms.

HIA 5 HI use in consumer applications	**Lead(s)**	**Start date**	**Status**
	• The Agency • The Department	2026–2027	On track

This activity, jointly led by the Agency and the Department, commenced in July 2026. An activity plan has been developed, and work has commenced to identify settings that support the safe and secure use of healthcare identifiers in consumer applications.

During the quarter, a review of materials associated with the Health Technology Provider consultation, led by the Department, was undertaken to support development of potential safeguards.

The Department commenced work to identify settings to support the safe and secure use of healthcare identifiers in consumer applications.

Analysis and consultation planning has progressed, with broader consultation expected to commence in Q2.

Work is also continuing to identify future updates to the HI Service conformance profile to support the use of healthcare identifiers in consumer applications.

HI Roadmap – HI Service Improvement: Q1 2026 - 27 update

HIA 6 Data matching and data quality improvements	**Lead(s)**	**Start date**	**Status**
	• The Agency • Services Australia	2024–2025	On track

Work is progressing to support ongoing improvements in healthcare identifier data matching and data quality.

Services Australia has commenced activity for inclusion in the FY2026/27 plan of improvements, with a focus on data standards, conformance, data quality review analysis and targeted engagement.

The Agency has led direct engagement with individual vendors to support HI Service data quality uplift in response to analysis of HI Service data.

HIA 7 Review existing messages and responses	**Lead(s)**	**Start date**	**Status**
	• The Agency • Services Australia	2024–2025	On track

Services Australia continues to review and refine activities relating to HI Service messages and responses. Analysis of error messages within the HI Service has been undertaken to identify areas of improvement and inform discussions on future enhancements to error message handling.

Work remains focused on working collaboratively with all relevant stakeholders to determine the future approach, aligned with the broader interoperability and digital health agenda.

Feedback from the Agency on clinical safety considerations when updating messages and responses has also been provided.

HIA 8 Improvements to data matching for Aboriginal and Torres Strait Islander peoples	**Lead(s)**	**Start date**	**Status**
	• The Agency • The Department • Services Australia	2024–2025	On track

Stakeholder engagement activities with the Aboriginal Community Controlled Health Sector are nearing completion, with surveys and focus groups now delivered.

Outcomes from this work have informed understanding of sector-specific challenges and opportunities relating to HI use and IHI matching.

Services Australia is undertaking targeted analysis to better understand data quality issues and explore different avenues to improve matching outcomes for Aboriginal and Torres Strait Islander peoples.

In collaboration with the National Aboriginal Community Controlled Health Organisation (NACCHO), Services Australia is undertaking a targeted improvement program focused on analysing healthcare search data to identify practical opportunities for improvement and develop evidence-based recommendations for future action.

Ongoing engagement with the sector will remain ongoing to support collaboration and initiatives aimed at improving IHI match rates and healthcare identifier data quality.

HIA 9 Enhanced search considerations	**Lead(s)**	**Start date**	**Status**
	• The Agency • Services Australia	2025–2026	Complete

During the reporting period, the Agency and Services Australia have continued to progress this activity, with the completion of a report examining national and international approaches to individual identification to enhance HI record search results and improve match rate accuracy. The report has now been finalised, completing this activity.

Findings from the report will provide a reference point for future consideration of changes to the information used to establish and maintain healthcare identifiers, including potential enhancements to the identifying information used within the IHI matching process, should policy, operational or system changes be pursued in the future.

HIA 10 Individual Healthcare Identifiers for newborns	**Lead(s)**	**Start date**	**Status**
	• The Agency • Services Australia	2025–2026	On track

Progress on this activity continued during the reporting period, jointly led by the Agency, Services Australia and the Department, with an Activity Plan developed and agreed by the Healthcare Identifiers Working Group (HIWG).

The agreed Activity Plan establishes the approach and priorities for progressing improvements to the assignment and management of IHIs for newborns and aligns with broader work underway through the Thriving Kids initiative.

Services Australia furthered activities supporting future enhancement of IHI processes for newborns, with work during the quarter focused on progressing planned activities and supporting alignment with broader interoperability initiatives. Collaboration on data mapping to support the new FHIR IHI for Newborn webservice also continued.

Work is ongoing to identify future updates to the HI Service conformance profile to support IHI for newborns. In 2026-27, Services Australia will prioritise the build and deployment of FHIR-based APIs for IHI for newborns and IHI search as part of ongoing interoperability improvements.

HIA 11 Consumer-empowered matching	**Lead(s)**	**Start date**	**Status**
	• The Agency • The Department • Services Australia	2026–2027	On track

Jointly led by the Department, the Agency and Services Australia, progress on this activity commenced in July 2026. An activity plan was developed and endorsed by the HIWG.

The Activity Plan establishes the scope, approach and key deliverables for the activity. Work has commenced to map potential options for consumers to manage information associated with their healthcare identifier, including identifying benefits, risks and opportunities for improved matching while maintaining the integrity of the healthcare identifiers framework.

HI Roadmap – Architecture and Data Standards: Q1 2026 - 27 update

HIA 12 Healthcare Provider Identifier – Organisations: Guidance on appropriate structures	**Lead(s)**	**Start date**	**Status**
	• The Agency • The Department • Services Australia	2024–2025	On track

Throughout the reporting period, the Agency, Services Australia and the Department have worked closely to determine future healthcare provider organisation structures and associated healthcare identifier arrangements

Discovery on proposed HPI-O seed and network structures has progressed and testing of proposed future HPI-O structures against a range of digital health and other use cases has occurred to inform planning for broader consultation expected in Q2 FY26–27.

Activities remained focused on informing a future-state approach that supports interoperability objectives.

HIA 14 Update technical standards	**Lead(s)**	**Start date**	**Status**
	• The Agency • Services Australia	2024–2025	On track

Ongoing progress on this activity has been made during the reporting period. Services Australia has commenced activity on the uplift of the HI Service to FHIR, with the FY2026/27 scope consisting of a FHIR Facade and four HI search web services.

The Agency and Services Australia also maintained their collaboration on data mapping to support the new FHIR IHI for Newborn webservice. This work will inform the FHIR implementation guide.

HIA 15 HI Service architecture and future extensibility	**Lead(s)**	**Start date**	**Status**
	• The Agency • Services Australia	2025–2026	Complete

During this reporting period, Services Australia has completed current and future state infrastructure assessments and will monitor projected figures against actual transactions to ensure projections remain within acceptable boundaries.

HIA 16 Clinical systems architecture and design	**Lead(s)**	**Start date**	**Status**
	• The Agency	2026–2027	On track

This activity commenced during the reporting period, led by the Agency, with an activity plan developed to support delivery and provide a structured approach to achieving the intended outcomes. Work on this activity will continue to progress in line with agreed timeframes.

HI Roadmap – Operational Improvement: Q1 2026 - 27 update

HIA 19 HI support model and future operational requirements	**Lead(s)**	**Start date**	**Status**
	• The Agency • Services Australia	2023–2024	On track

The HI Service Services Schedule is undergoing further review to support the transition of the Healthcare Provider Directory to the Agency. Additionally, a review of existing Agency education resources was completed to inform development of a cross-Agency support model.

Services Australia has consolidated findings and is developing a recommendations report to inform future operational and reporting requirements.

HIA 20 Enhanced governance	**Lead(s)**	**Start date**	**Status**
	• The Agency • The Department • Services Australia	2024–2025	On track

The Agency, the Department and Services Australia continue to advance key governance and implementation activities across the Healthcare Identifiers reform program.

The HIWG continued to meet monthly, providing a consistent forum for operational implementation, technical alignment and cross-agency coordination of Healthcare Identifiers initiatives.

The group has supported the coordination and progression of roadmap activities, facilitated information sharing, and enabled the timely resolution of implementation issues.

Following completion of the current-state analysis, Services Australia is collaborating with the Agency and the Department to further develop and refine the governance framework. This work aims to strengthen oversight, clarify roles and responsibilities, and support effective governance of the HI Service into the future.

Thank you to the Council for Connected Care and to all governments and organisations who provided input to this report.

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Council for Connected Care

Agenda Item 5: Scene Setting – Virtual Care

Meeting: Thursday, 3 December 2026

OFFICIAL

Purpose

The purpose of this agenda item is to provide context and set the strategic tone for discussions focused on virtual care, as a core component of the connected care schema, with a focus on its increasing importance in health system reform, and to support the Council's consideration of integrating and scaling virtual models of care across the broader care ecosystem.

Recommendations

It is recommended the Council for Connected Care:

1 **note** the launch of the video - Virtual Care at Scale: Improving Patient Outcomes Through Digital Health

2 **note** the presentation by Dr Keith McNeil on how virtual care can be better integrated, governed and enabled through connected digital health.

Summary of issues

As healthcare systems continue to experience increasing demand and resource pressures, virtual care and digital health are emerging as important enablers of more accessible, efficient and patient-centred models of care. Experience within the South Australian health system highlights the potential for virtual care to support appropriate care delivery outside traditional hospital settings, helping to improve patient access, reduce unnecessary presentations to emergency departments and preserve capacity for patients requiring higher acuity care.

Key issues for consideration include:

- The growing demand on emergency departments and the need for sustainable approaches to managing patient flow and system capacity.
- The role of virtual care in providing timely access to care in alternative settings and supporting patients to receive care closer to home.
- Opportunities to improve patient experience and outcomes through more convenient, connected and responsive models of care.
- Embedding virtual care and digital health as core components of healthcare delivery and system design, rather than standalone initiatives.

- Leveraging digital integration to support a more connected, efficient and resilient healthcare system capable of responding to future demand and service challenges.

Main objectives and expected outcomes of the meeting

The main objectives of the meeting are to:

- Explore how virtual care can be embedded as a core component of the health system, rather than operating as a separate or supplementary service.
- Discuss opportunities to reduce avoidable emergency department presentations and preserve capacity for patients requiring urgent and high-acuity care.
- Identify the system, governance and digital foundations needed to support sustainable and scalable virtual care models.
- Share lessons from the South Australian experience that may inform broader national approaches to connected and digitally enabled care.

The expected outcomes of the meeting include:

- A shared understanding of the role virtual care can play in supporting a more connected, patient-centred and sustainable health system.
- Identification of opportunities, challenges and enabling conditions for integrating virtual care into routine healthcare delivery.
- Council perspectives on how national collaboration, alignment or further work may support the continued development of virtual care.

Background

Professor Keith McNeil is an internationally recognised respiratory physician trained in heart and lung transplantation at the world-renowned Papworth Hospital in Cambridge, UK. Keith established the Queensland Lung Transplant Service at The Prince Charles Hospital in 1996, and soon thereafter returned to Papworth where he was Lead Physician for the heart and lung transplant program. From there, Keith has occupied a vast array of positions in both senior clinical and senior administrative roles, including as CEO of tertiary hospital and health services (RBWH and Metro North HHS in Brisbane, and Cambridge University Hospitals in the UK), Head of IT and CCIO in the NHS, and Deputy Director General, CMO and CCIO in Queensland.

Keith currently works in the South Australian health system as the Commissioner for Excellence and Innovation in Health.

Keith presents across various sectors as a valued contributor to clinical and patient safety benefits associated with technology and digital transformation in the healthcare setting. His vision is to align research, precision medicine, and the data and information agenda with health system reform and transformation.

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability

Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 6: Royal Flying Doctor Service – William Creek Clinic and Matilda AI

Meeting: Thursday, 3 December 2026

OFFICIAL

Purpose

The purpose of the agenda item is to provide an overview of the Royal Flying Doctor Service's AI-enabled "Matilda" platform and its application in remote emergency care, and to discuss the implications for interoperability, virtual care, clinical workflows and trusted use of AI across Australia's healthcare system.

Recommendation

It is recommended the Council for Connected Care:

1 **note** the Royal Flying Doctor Service video featuring the William Creek virtual emergency centre. (https://www.youtube.com/watch?v=2Wd3MCDB-7U)

Summary of issues

The Royal Flying Doctor Service (RFDS) presentation showcases Matilda, an AI-enabled clinical support solution designed to enhance emergency care in remote and regional settings. Matilda seeks to address a key challenge in healthcare delivery: the time between a patient presenting for care and a clinician being able to assess them.

The discussion will also touch on the technologies underpinning Matilda, including multimodal AI, clinical decision support capabilities and integration with patient information sources such as My Health Record. RFDS will discuss its approach to digital trust, safety and governance, including the safeguards implemented to support the safe and responsible use of AI in healthcare.

The session will provide members with an example of how emerging technologies are being applied to support healthcare delivery in remote Australia and offer insights into the future potential of AI-enabled models of care.

Questions for Council for Connected Care Members to Consider

- What interoperability capabilities are required to enable AI solutions to safely access, exchange and utilise health information across care settings?
- How can AI-enabled virtual care services be integrated into existing healthcare pathways while maintaining continuity, quality and trust in care delivery?

- As AI-enabled virtual care solutions become more common, which clinical, operational and decision-making responsibilities should remain with healthcare professionals, and which may be appropriately delegated to AI-supported systems?

Background

Speaker Bio: Ryan Klose, Executive Chief Information Officer Royal Flying Doctor Service

Ryan Klose is an experienced executive leader specialising in technology transformation and digital and data-driven operating models. He brings more than 20 years of executive management experience and over 10 years of industry leadership across government and corporate boards, as well as 2 years as a university lecturer in AI and Medicine.

His experience spans wine, retail, law enforcement, pharmacy retail, health, aviation, manufacturing and production, and supply chain.

As Executive CIO of the Royal Flying Doctor Service, Ryan champions digital, cyber security and technology leadership nationally, supporting its quest for equitable and accessible healthcare for people who live, work, explore and play in the Australian Outback.

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability

Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 7: Child and Adolescent Virtual Urgent Care Services (CAVUCS)

Meeting: Thursday, 3 December 2026

OFFICIAL

Purpose

The purpose of this agenda item is to provide members with an overview of the Child and Adolescent Virtual Urgent Care Service (CAVUCS), including its development, operating model and impact on healthcare delivery.

Recommendation/s

It is recommended the Council for Connected Care:

1 **note** the presentation by Dr Priya Wilson, CAVUCS Medical Unit Head, Gabby McCormack CAVUCS Nurse Unit Manager and Ashish Sharma, Consumer/Co-Designer.

Summary of issues

The Child and Adolescent Virtual Urgent Care Service (CAVUCS) was established by the Women's and Children's Health Network in response to increasing demand on emergency departments and the growing need for alternative models of care that improve access to timely clinical advice and treatment for children and young people. Since commencing operations, the service has experienced significant growth and is now providing virtual urgent care consultations at scale, supporting families to access appropriate care while reducing unnecessary emergency department presentations. CAVUCS supports nurse led clinics and Extended Care paramedic staffed health centres, providing equity of access to rural and regional areas without a medical resource.

CAVUCS' evolution, growth and outcomes, highlight how virtual urgent care has become an important component of the paediatric healthcare system in South Australia. Members will hear how the service supports patients presenting with lower-acuity conditions through a combination of virtual clinical assessment, advice, follow-up and referral pathways, ensuring patients receive the right care in the most appropriate setting. The presentation will also demonstrate how the model supports continuity of care through partnerships with primary care providers, Priority Care Centres, outpatient services and hospital-based care when required.

A key focus of the presentation will be the service's integrated approach to care delivery and its collaboration with other healthcare providers. Members will hear how patients are referred to CAVUCS through a range of pathways, including Healthdirect and the South Australian Ambulance

Service, and how these partnerships support timely access to clinical assessment while helping to preserve frontline health system capacity. The presentation will also explore referral pathways out of the service and the role CAVUCS plays in connecting patients with ongoing care across the broader health system.

Questions for Council for Connected Care members to consider:

1. What innovative opportunities exist to improve Health Care in SA e.g. Statewide electronic radiology requests for patients receiving care through virtual models, particularly in rural and regional settings?
2. CAVUCS is a statewide service, benefiting all local health networks (LHNs), with 70% of consumers from outside Women's and Children's Health Network (WCHN) catchment area. Is there an alternative way to address current resourcing challenges associated with being block funded?
3. How can we expand or adapt CAVUCS' success to improve healthcare access and outcomes across other clinical settings and patient cohorts?

Background

Speaker Bios:

Dr Priya Wilson, Paediatric Emergency Physician and CAVUCS Medical Unit Head

Priya Wilson is the Medical Unit Head of CAVUCS and a Paediatric/ Neonatal Retrieval Consultant with MedSTAR Kids. As one of the pioneering Paediatric Emergency physicians in the world leading service CAVUCS, she has been part of its planning and implementation and continues to champion its expansion, growth and evolving capabilities.

Gabby McCormack, CAVUCS Nurse Unit Manager

The WCHN, Adelaide provides families with access to specialist paediatric emergency staff from the comfort of their own homes through CAVUCS. CAVUCS is an online video platform for parents/carers to engage with skilled emergency doctors and nurses who can assess children with non-life-threatening conditions, often saving families a trip to the emergency department. Gabby McCormack is the Nurse Unit Manager who has worked within the WCHN for 33 years. Gabby has spent most of that time in the Paediatric Emergency Department initially as a Nurse and then as the Nurse Educator. She was awarded the 2023 NMEA Excellence in Education. She has been involved with CAVUCS since its inception.

Ashish Sharma – Consumer/Co-Designer

A Fellow in Person Centred Care (FPCC) with Planetree International USA, Ashish has been involved with the healthcare sector since 2020 as a health consumer and advocate. With exposure across government health care networks, national and international boards, councils and committees, he has gained diverse experience in projects and assignments ranging from acute care to allied health, from strategy to implementation and planning to execution. Ashish has been part of award-winning high impact projects which have made a difference in lives of people in the health care space. With a strong lived experience of caring for disability, he has keen interest in

writing and speaking around the domains of person-centred care, consumer engagement and patient experience. Some key positions held by Ashish with WCHN, Adelaide, Australia include:

- Chair, Consumer and Carer Advisory Committee, Feb 2022 to Feb 2025
- Member, Person and Family Centred Care Steering Committee (Tier 1 committee), Mar 2024 until present
- Member, Patient Reported Experience Measures (PREM) Advisory team, Apr 2022 until present
- Member, Communications Advisory Committee, Dec 2020 until present
- Consumer Representative & Member - Child and Adolescent Virtual Urgent Care Service (CAVUCS) project, Jun 2021 until Jun 2025.

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability

Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 8: Integrated Cardiovascular Clinical Network (ICCNet)

Meeting: Thursday, 3 December 2026

OFFICIAL

Purpose

The purpose of the agenda item is to provide an overview of the Integrated Cardiovascular Clinical Network (ICCNet) and how it has improved access to specialist cardiovascular care for regional communities through connected models of care, data-enabled workflows and virtual service delivery. The session will also highlight key lessons from ICCNet's evolution, including the opportunities and challenges associated with scaling integrated and digitally enabled care across a geographically dispersed health system.

Recommendation

It is recommended the Council for Connected Care:

1 **note** the presentation by John Denton, Operations and Research Manager at Integrated Cardiovascular Clinical Network.

Summary of issues

The Integrated Cardiovascular Clinical Network (ICCNet) was established to address inequalities in cardiovascular outcomes between metropolitan and regional communities in South Australia. Over time, it has evolved from a clinician-led initiative focused on improving access to specialist cardiac expertise into a statewide network supporting integrated care pathways, virtual care models and more coordinated use of clinical information across care settings.

Members will hear how ICCNet has developed over time and the factors that have contributed to its success, including clinical leadership, collaboration across organisational boundaries and a focus on simplifying care for both patients and clinicians. The presentation will highlight how the network has improved access to specialist advice and supported more proactive and coordinated models of care across South Australia.

A particular focus will be the use of virtual care and data-enabled processes to improve participation in evidence-based care, especially for people living in regional and remote communities. The presentation will explore how these approaches have helped reduce barriers to access while supporting continuity of care beyond the acute treatment setting.

The discussion will also examine lessons learned from implementing integrated models of care at scale, including the opportunities and challenges associated with improving equity of access,

increasing participation in care, and sustaining virtual service models as demand for healthcare continues to grow.

Questions for the Council for Connected Care:

- How can the national interoperability program prioritise clinical uses for interoperability that help identify and close gaps in evidence-based care, including patients who are eligible for care but are not referred or reached?
- How should we evaluate connected care initiatives so that improved access and patient outcomes are recognised, including when appropriate healthcare utilisation increases? How do we ensure increased access delivers value and not excess consumption or moral hazard?
- Where connected information reveals a gap in care, how can the Council work with clinical governance bodies, jurisdictions and funders to make the risks of inaction visible and ensure identified gaps lead to timely, accountable action?

Background

Speaker Bio: John Denton, Operations and Research Manager at Integrated Cardiovascular Clinical Network

John Denton is the Operations and Research Manager at ICCNet SA, where he leads work to improve access to high-quality care for rural and regional communities. Combining clinical science, operational leadership and data analytics, he develops virtual care services and uses digitisation and service redesign to help clinicians reach more patients and deliver better outcomes.

John’s focus is on excellence in care, wherever people live. He sees improving healthcare productivity as essential to meeting rising demand and protecting access to public healthcare over the coming decades. He holds a Master of Data Science from the University of Adelaide.

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability

Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 9: Virtual Care Standards in Practice – Adoption, Impact and Emerging Models of Care

Meeting: Thursday, 3 December 2026

OFFICIAL

Purpose

The purpose of this agenda item is to seek Council members' feedback on the Australian Commission of Safety and Quality in Health Care's (the Commission) Virtual Care Standards, through a facilitated workshop discussion.

Recommendation

It is recommended the Council for Connected Care:

1 **participate** in workshop activities.

Summary of issues

The Council will participate in a 50 minute facilitated workshop focused on the Virtual Care Standards.

Council members will work in groups at their tables, with the Commission facilitating discussion and seeking members' feedback on the Virtual Care Standards. Further information and guidance for the workshop will be provided during the session.

Background

The Commission is developing national safety and quality standards for virtual care. This initiative aims to ensure that virtual care is delivered to the same high standards as in-person care, with the standards expected to be published by the end of 2027. The standards will apply across various healthcare settings, including hospitals, primary and community healthcare, and commercial providers, and will be structured around the National Model for Clinical Governance. The development of these standards follows a public consultation process and will be reviewed by the Commission's standing committees.

Attachments

Attachment A: Brief: Virtual Care Standards in Practice - Adoption, Impact & Emerging Models of Care

Attachment B: [Draft] National Safety and Quality Standards for Virtual Care.

Contact officer: Cass Timmermans, Assistant Director, Interoperability

Australian Government
Australian Digital Health Agency

Council for Connected Care

Attachment A: Virtual Care Standards in Practice – Adoption, Impact and Emerging Models of Care

Meeting: Thursday, 3 December 2026

OFFICIAL

Purpose

The purpose of this paper is to inform members about the Australian Commission on Safety and Quality in Health Care's draft national safety and quality standards for virtual care, now released for public consultation, including requirements relevant to connected care.

The paper also identifies factors that will influence the adoption of the standards, the implementation guidance required, and future approaches to assessment and accreditation.

Recommendations

It is recommended the Council for Connected Care:

1 **discuss** the connected care requirements from the draft national safety and quality standards for virtual care, including the intended safety and quality outcomes
2 **discuss** the supporting guidance needed to prepare virtual care providers to implement the virtual care standards into everyday practice to achieve high-quality care
3 **discuss** potential approaches to adoption and implementation, recognising the responsibilities of multiple entities in achieving the objectives of the standards.

Summary of issues

The draft standards were developed to support high-quality virtual care, acknowledging that some virtual care providers have less experience with national safety and quality standards than others.

Virtual care encompasses a wide range of service models. Some are integrated with a person's broader care, while others are designed to provide more episodic care, choice, access, or efficiency. A key consideration is how future assessment approaches can apply the domains of high-quality care across these different models.

Standards alone will not improve the safety and quality of virtual care without effective adoption and implementation. Potential mechanisms include accreditation, licensing and legislation, which may need to be introduced in phases. Further consideration is required to determine how these approaches should be prioritised, sequenced and combined.

Emerging themes from the initial consultation are outlined below:

1. **Definition of a health service**
   Some virtual care providers state in their terms and conditions that they do not provide health care; they provide a platform that connects the patient and the individual clinician.

   Working position: If any organisation advertises a healthcare service, such as a consultation with a clinician and/or they remunerate that clinician, they provide health care and they have shared responsibility for the quality of that care.

2. **Operating clinical governance with a distributed clinical workforce**
   Many virtual care services employ clinicians who work across different locations, often individually. This structure requires tailored approaches to clinical governance and high-quality care across the workforce.

   Working position: Health services have responsibilities to ensure clinicians are engaged in clinical governance activities, including alignment with best practice, reporting adverse events and being involved in quality improvement activities. Clinicians need to understand the difference between professional obligations and organisational clinical governance.

3. **Asynchronous prescribing**
   Asynchronous prescribing occurs when a patient requests a prescription by email, through a portal or through another channel, and a clinician considers the request without a real-time consultation. It generally occurs in two contexts:
   a) A patient contacts their regular prescriber for a regular or one-off prescription. Generally, there has been a previous in-person consultation.
   b) A patient requests a prescription from an unknown prescriber often driven by urgency, unavailability of their usual prescriber, or a desire to keep this interaction private.

   Prohibiting asynchronous prescribing in the virtual care standards may have unintended consequences for patients' access to medicines and drive increased consultations and MBS costs in an already overloaded system.

   Working position:
   The decision to prescribe is one for the prescriber and they must satisfy themselves it is safe, appropriate and in the patient's best interests to do so. Health services should support prescribers to meet their professional responsibilities while ensuring that organisational arrangements do not improperly influence individual prescribing decisions.

4. **Achieving information exchange and continuity of care**
   There are virtual care providers who seek to share information generated through episodes of care with national digital health infrastructure, including My Health Record, and directly with members of the multidisciplinary care team.

   To ensure these practices are consistent, the virtual care standards reflect a range of interoperability, data quality and digitally enabled care requirements, based on the draft third edition of the National Safety and Quality Health Service Standards, such as:

Purpose	Requirements
Digital systems are optimised to improve continuity of care and integration	1.28 The executive and managers have organisational digital data systems that: a. Use national clinical terminologies and specifications b. Use interoperable data formats for seamless information extraction and exchange c. Monitor system performance to optimise the accuracy, completeness and quality of the data

		d. Support continuity of care, informed decision-making and quality assurance activities
Accurate, integrated patient information is available to reduce risk and improve continuity of care	3.06	The healthcare service has healthcare record systems that: a. Use national healthcare identifiers that are verified against the National Healthcare Identifiers Service b. Are interoperable with: i. National Digital Health Infrastructure (such as My Health Record) to support access, sharing and exchange of health information in accordance with national legislative and policy requirements c. Are able to share and exchange information in alignment with national requirements, specifications and infrastructure

Public consultation on the draft virtual care standards closes on Sunday 13 December 2026. Feedback can be made via an online survey or written submission. Members are encouraged to provide feedback and promote the consultation to their networks.

Background

The Commission's draft virtual care standards were released for public consultation on 3 November 2026. They use the draft third edition of the National Safety and Quality Health Service Standards as their basis, drawing on the primary and community care and digital mental health standards as well as state/territory, Standards Australia and peak body and industry guidance.

The standards are to cover all health services that provide care virtually including:

- Commercial direct-to-consumer, single disease/problem management services operating outside the Medicare Benefits Schedule (MBS)
- Telehealth (MBS) billed services currently provided for primary and secondary care. e.g. a GP or medical specialist telehealth consultation
- Allied health service in the community
- Virtual outpatient appointments and remote patient monitoring operating in the hospital sector
- Royal Flying Doctor Service and associated services that use remote monitoring and assessment in rural areas
- Ambulance/paramedicine virtual assessment and monitoring
- On-line/telephone triaging and referral to a health provider, e.g. Healthdirect
- Virtual hospitals (e.g. Victorian Virtual Emergency Department, Sydney Virtual).

Australian Commission on **Safety and Quality** in Health Care

Draft national safety and quality standards for virtual care

Initial draft FOR CONSULTATION

3 November 2026

safetyandquality.gov.au

The Australian Commission on Safety and Quality in Health Care pays respect to the Gadigal people as the Traditional Custodians of Country where the Commission's office is located. We extend that respect to all Aboriginal and Torres Strait Islander peoples, and their deep time connections to land, water and sky.

We recognise that knowledge about healthy Country, community and culture has been developed by Aboriginal and Torres Strait Islander peoples over tens of thousands of years and has been shared for generations. We are committed to partnering with and learning from Aboriginal and Torres Strait Islander peoples through the work that we do.

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Background

The Australian Commission on Safety and Quality in Health Care (the Commission) leads and coordinates national improvements in the safety and quality of health care to achieve better care, everywhere.

The Commission achieves its objectives by setting national standards for health care, providing evidence-informed guidance for health professionals, helping patients understand what they should expect from their care and publishing information reporting on the safety and quality of the Australian healthcare system.

The Commission's Strategic Plan 2025-30 focuses on:

- **high-quality care in an evolving environment** – so that high-quality health care is delivered consistently, reliably and equitably for all Australians
- **strong outcome focused clinical governance** – so that clinical governance, integrated standards and accreditation drive better patient outcomes
- **empowered patients, families, carers and communities** – so that health care is designed and delivered with patients and communities
- **an improvement-driven workforce culture** – because better health care is everyone's responsibility, every day.[1]

National Safety and Quality Standards are central to building an environment and culture where everyone in a health service works together with patients, families, carers and consumers to deliver high-quality care. The Commission is developing national safety and quality standards for virtual care (virtual care standards) to support Australian health services to manage risk, reduce preventable harm and continuously improve care delivered virtually.

Notes to Reviewers

The Commission has developed draft national safety and quality standards for virtual care to establish clear, consistent expectations to strengthen and ensure the quality of care delivered virtually.

Development of virtual care standards

Phased approach

The Commission acknowledges that virtual care is provided across the breadth of the health system by a wide variety of healthcare service types, understands that some healthcare services that provide virtual care are unfamiliar with safety and quality standards, and that the types of virtual care services available across Australia vary greatly.

To account for this breadth, the Commission is taking a phased approach to developing and implementing virtual care standards.

Phase 1 (this phase) focuses on the content of the draft virtual care standards.

Develop virtual care standards aimed at establishing a consolidated standards starting position based on the breadth of existing guidance and standards. The draft standards are aligned to the Commission's direction for safety and quality standards based on the draft third edition of the NSQHS Standards.

Phase 2 will focus on implementation. Building on the feedback received during Phase 1, the Commission will work with stakeholders to determine how the standards should be applied across different virtual care models and provider types, and to develop an implementation approach that supports consistent, practical and effective uptake of the standards across the health system.

Phase 1 – Virtual care standards development

The draft virtual care standards use the National Model for Clinical Governance as their foundation and are informed by the draft third edition of the National Safety and Quality Health Service (NSQHS) Standards currently under development, which are aimed at hospital and day procedure services.

In developing this document and acknowledging virtual care is delivered across the spectrum of healthcare services, the Commission has incorporated relevant components of the National Safety and Quality Primary and Community Healthcare Standards and the National Safety and Quality Digital Mental Health Standards to account for the broad range of healthcare services that provide health care virtually.

The Commission also acknowledges the significant work to develop safety and quality guidance in specific settings by other parties. The Commission has also reviewed, aligned and incorporated relevant components from guidance and standards developed by:

- State and Territory health departments
- Standards Australia
- Medical Colleges
- Industry groups such as the Australian Telehealth Standards Consortium and the Telehealth Sector Working Group.

As a result, the draft virtual care standards provide a single consolidated set of expected requirements for all healthcare services that provide care virtually. The Commission acknowledges that some requirements may not be applicable to individual healthcare services.

The virtual care standards provide the baseline safety and quality that should be expect when a clinician is not physically located with the patient.

Following public consultation on the draft requirements, the Commission expects to undertake targeted consultation with specific organisations and groups based on their feedback to understand and resolve issues raised.

Once the requirements have been finalised, the Commission will then determine the form the standards will take, considering the breadth of healthcare services and the types of virtual care that are provided. The final form of standards may be:

- a single document
- a virtual care module appended to core standards such as NSQHS Standards
- separate virtual care standards for the acute sector and standards for the primary and community sector

Feedback requested

The Commission is seeking feedback on whether the draft virtual care standards clearly articulate the key safety and quality requirements for virtual care, and whether they appropriately address the clinical risks, challenges and opportunities associated with delivering high-quality care virtually from healthcare professionals in all care settings.

Feedback is welcomed from business owners and managers of telehealth and virtual care services, health care professionals as well as consumers, carers, researchers and policymakers.

Feedback is specifically requested to determine whether the draft standards:

- capture the most important safety and quality issues
- need to be adjusted to meet the needs of patients receiving care from healthcare services of varying maturity and size – it's OK to say "this does not work for me".
- identify any gaps or areas requiring further refinement.

The Commission recognises there are large differences in the size, complexity and familiarity with national safety and quality standards in healthcare services that provide virtual care. To support healthcare services of all types, application of the requirements should be proportionate to the size, scope, complexity, clinical risk profile, service model and digital maturity of the individual healthcare service.

Relationship to draft third edition NSQHS Standards feedback

If you have previously provided feedback on the draft third edition NSQHS Standards, there is **no need to repeat that feedback**.

The Commission will review feedback received on the draft third edition NSQHS Standards in parallel with feedback on this document.

Deviations from the draft third edition NSQHS Standards have been highlighted in yellow (excl. deletions).

Feedback is requested via a survey.

Written submissions may also be sent to: ACSQHCdigitalhealth@safetyandquality.gov.au.

Introduction

The vision for the first edition of the National Safety and Quality Virtual Care Standards is to establish clear, consistent expectations for high-quality care delivered virtually, supporting nationally consistent and effective systems operating across the continuum of care.

The first draft virtual care standards recognise a major shift in how care is delivered, the realities of modern clinical practice in the Australian health system and supports healthcare services to adapt and evolve while ensuring care is consistently high-quality and improving over time.

Modern practice involves increasing demand, changing consumer behaviour in seeking health care, new models of care and an increase in the role and reach of digital technology. That is why the draft virtual care standards focus beyond the minimum safety requirements for health care delivered virtually so that healthcare services develop their systems and ensures a healthy workforce culture, culturally safe and responsive health care and continuous learning across the healthcare service to provide care that ensures optimal patient outcomes.

If implemented well, virtual care standards support healthcare services and clinicians to manage risk, use data for improvement and partner with patients, their family and carers at every step of the care continuum.

They are the standards of care that should be applied consistently when care is delivered virtually, every day.

Purpose

The draft virtual care standards:

- respond to recognised and emerging system pressures, including workforce sustainability, increase in the reach of digital technologies, the importance of equity of health outcomes and continuing system integration to ensure high-quality care and equity of outcomes
- reflect a maturing focus from specifying clinical processes to prioritising how patients experience care, measuring outcomes of care and acting on this information to improve care when required
- are tailored to the unique safety and quality risks when care is delivered virtually
- aim to build the culture of the whole organisation to support the consistent delivery of high-quality care
- establish the framework for any future accreditation scheme

Overview of the Standards

The draft virtual care standards are informed by the draft third edition of the NSQHS Standards to provide a consistent approach to safety and quality for healthcare services that provide both in-person care and care delivered virtually.

The virtual care standards comprise three discrete standards that are designed to work together as a single, integrated system driving safety and quality.

Compliance with the standards requires consistent, healthcare service-wide application, recognising that **everyone has a role to play in delivering high-quality virtual care**.

Clinical Governance Standard

This Standard outlines the responsibilities of the board, directors, executive and managers for ensuring that the healthcare service's clinical governance system supports the delivery of high-quality care.

Clinical governance is central to providing the best possible outcomes for patients. It is the combination of inclusive governance, organisational cultures that are psychologically safe and striving for continuous improvement and innovation, with effective systems and structures that enables everyone in a healthcare service to deliver care that is consistently high-quality and improving.

Effective clinical governance means that boards, directors, executives, managers and the workforce are clearly accountable to patients and the community for providing high-quality care - care that is person-centred, safe, effective, accessible and integrated, provided in a way that is equitable, efficient and sustainable.

Engagement and partnerships with patients, families, carers, consumers and community are also critical to achieving high-quality care and better patient outcomes.

This Standard creates the conditions for high-quality care carrying through the foundations from the National Model for Clinical Governance[2].

Roles in clinical governance

Governance models differ across Australia. Some public and private healthcare services do not have boards. Where a healthcare service does not have a board and executive, these roles fall to the key decision-maker and accountable person or group at the healthcare service.

- Boards and Directors set the strategic direction for the healthcare service and ensure processes and systems are in place to meet the healthcare service's objectives and for clinical governance. This role may also be performed by business owners.
- Executives define and oversee the required processes and systems.
- Managers operate and execute the required processes and systems.

Person-Centred Practice Standard

This standard outlines the systems that support clinicians to provide high-quality care so that patients receive care they need that is person-centred, safe, effective, accessible and integrated.

Person-centred practice is a model for providing healthcare services that focus on the provision of person-centred care. It is achieved through building effective collaborative relationships between clinicians who facilitate evidence-informed shared decision-making with patients and consumers.

Person-centred practice is a core safety and quality capability in clinical systems, communication processes, teamwork and shared decision-making. It supports healthcare services in providing individualised and culturally safe care and being adaptive towards the people they support. It also includes supporting staff with leadership modelling, reflective practice and training to demonstrate everyday person-centred practice.

This standard emphasises the importance of effective communication and collaboration between clinicians, within the multidisciplinary care team and with patients, their family and carers to tailor care to the needs of the individual and improve outcomes.

Safe Clinical Systems Standard

This standard outlines the priority systems, policies and processes that keep people safe while receiving care or working in a healthcare service, prevent avoidable harm and support the sustainable delivery of high-quality care.

Safe clinical systems are critical to ensuring the consistent application and use of evidence-informed practice to minimise risk of harm. This Standard includes requirements specific to virtual care, including infection prevention and control, medication safety, patient identification and digital systems.

This standard aims to make safe care the default.

The Clinical Governance Standard establishes the requirements and conditions for high-quality care by setting the healthcare service's culture, systems and structures. These requirements are carried through to the Person-Centred Practice Standard and Safe Clinical Systems Standard reflecting what needs to be in place to support the workforce and healthcare service to meet patient needs and provide high-quality care.

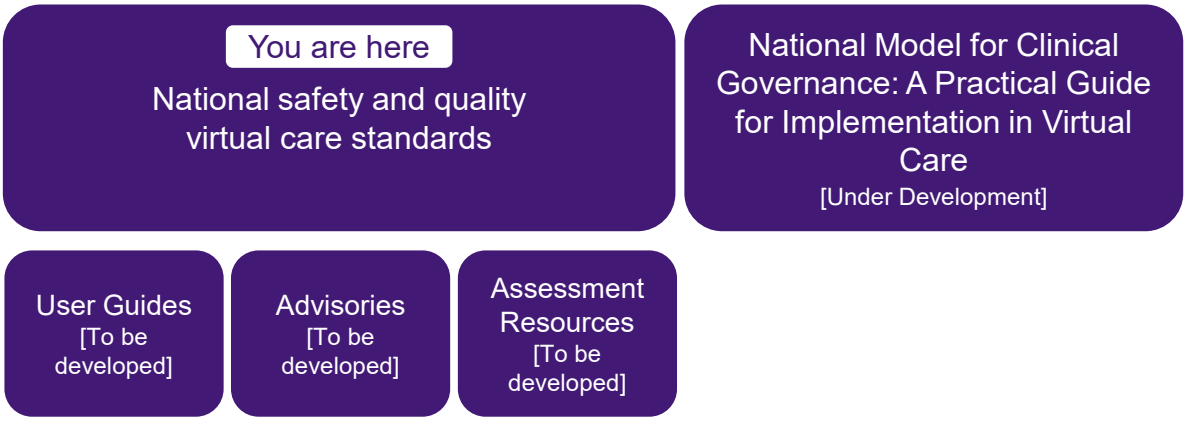
Consistent, healthcare service-wide application of the virtual care standards recognise that **everyone has a role to play in delivering high-quality virtual care.**

Structure of the virtual care standards

Document map

The draft virtual care standards provide the overarching requirements for the delivery of high-quality virtual care. The standards are supported by a range of companion and implementation resources to assist healthcare organisations to adopt the standards.

Figure 1: Document map

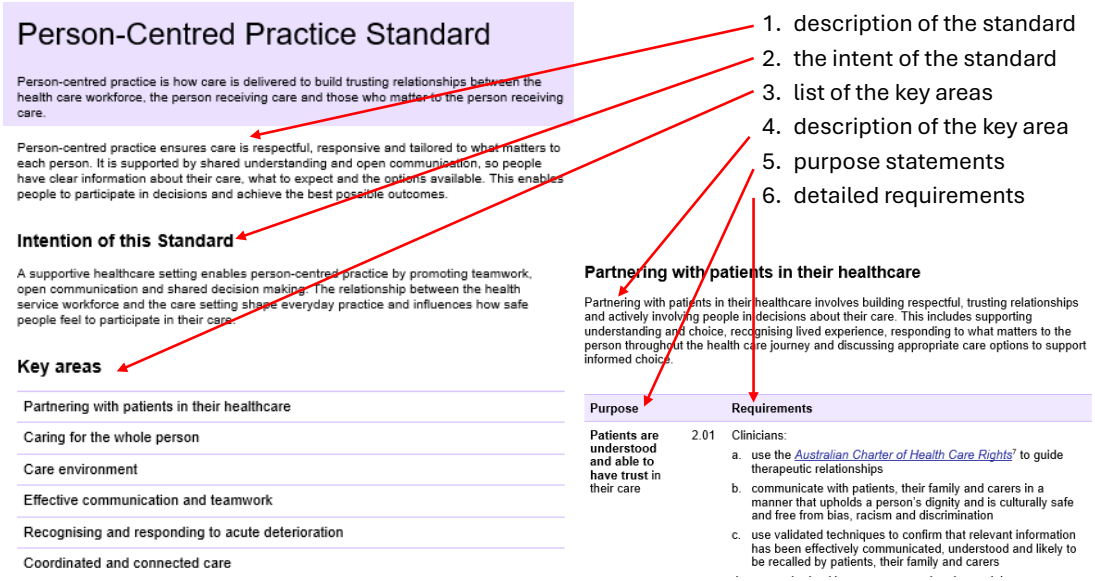


Standards structure

Each of the standards contains:

1. a description of the standard
2. the intent of the standard
3. a list of the key areas covered by the standard
4. a description of the key area
5. purpose statements which describe key elements of the standard
6. detailed requirements setting out what should be implemented to help achieve the stated purpose.

Figure 2: Standards structure



Application of the virtual care standards

The virtual care standards are applicable to services that deliver health care through virtual modalities such as:

- direct to consumer models including for a single condition
- online prescription requests
- primary and community care consultations via telephone and videoconferencing
- remote patient monitoring provided by hospitals
- outpatient appointments via telephone and videoconferencing
- virtual emergency department
- remote patient assessment such as those used by the Royal Flying Doctors Service
- paramedical services provided virtually.

Core elements underpinning the Standards

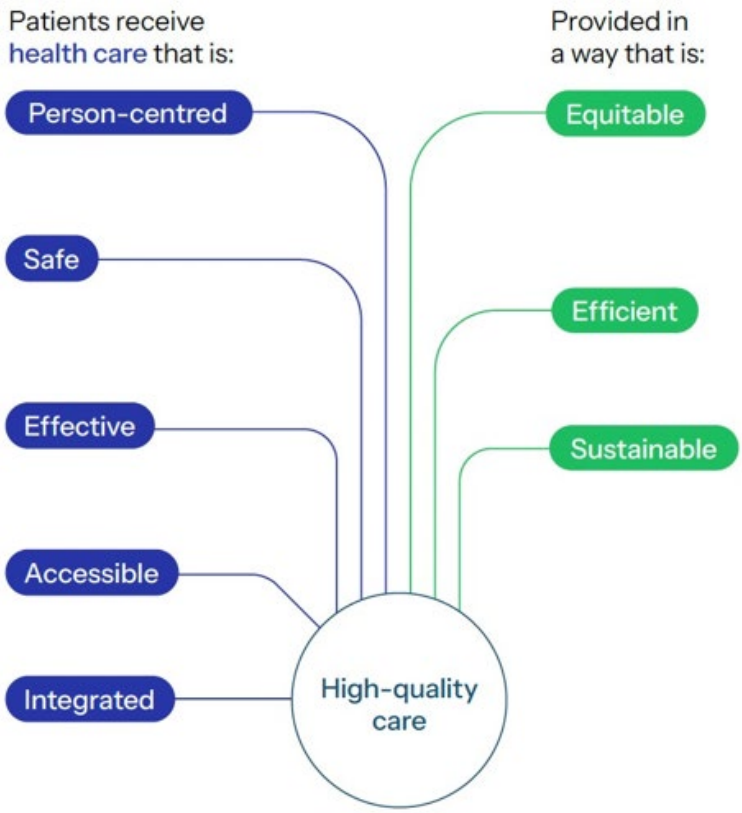
High-quality care

High-quality care, be that in-person, delivered virtually or a combination of both, is person-centred, safe, effective, accessible and integrated, provided in a way that is equitable, efficient and sustainable.

Cultural safety, as determined by Aboriginal and Torres Strait Islander peoples, is necessary for high-quality care. Cultural safety must be embedded in each domain of high-quality care to improve health outcomes for Aboriginal and Torres Strait Islander peoples[3]. A definition of cultural safety and its role in health care is discussed in the next section.

High-quality care consists of multiple interconnected domains, as shown in **Figure 3**. Each domain focuses on an important aspect of health care needed to achieve high-quality care. Together, the domains describe how care should be delivered to achieve the best outcomes for individuals and populations.[2]

Figure 3: Domains of quality



Cultural safety

Cultural safety is:

- 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.
- requires organisational change through critically analysing and addressing racism, biases, assumptions, stereotypes and prejudices expressed through the organisations structures, values, policies and procedures that create barriers to provide good health care and good health outcomes.

Culturally safe practices for Aboriginal and Torres Strait Islander peoples include:

- acknowledging colonisation and systemic racism, and the social, cultural, behavioural and economic factors which impact individual and community health
- acknowledging and addressing individual racism, discrimination, biases, assumptions, stereotypes and prejudices and providing care that is holistic, free of bias, discrimination and racism
- recognising the importance of self-determined decision-making, partnership and collaboration in health care which is driven by the individual, family and community
- fostering a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander peoples and colleagues.[4]

The requirements for improving cultural safety and equity throughout the virtual care standards focus on embedding cultural safety in health care and addressing racism at multiple levels.

In the virtual care standards, cultural safety is applied in relation to Aboriginal and Torres Strait Islander peoples in recognition of their status as the First Peoples of Australia and the ongoing need to address the impacts of racism and inequity in healthcare. It is important to also acknowledge the need to ensure safe, person-centred and respectful care for people from all cultural and social backgrounds, while maintaining the meaning of cultural safety in the First Nations context.

National policy context

Recent reports have demonstrated that systemic and institutional racism remains across Australian healthcare structures, policies and practices, contributing directly to inequitable access and outcomes. The development of the virtual care standards is also within a broader national policy context, focused on improving health outcomes, system sustainability and consumer trust.

- The Priority reforms under the *National Agreement on Closing the Gap*[5] signed in July 2020, challenge all government organisations to 'embed and practice meaningful cultural safety' and 'deliver services in partnership with Aboriginal and Torres Strait Islander organisations, communities and peoples'.
- The *National Health Reform Agreement (NHRA) Addendum (2026-2031)*[6] states that the health system must recognise and embed Aboriginal and Torres Strait Islander holistic health and wellbeing, the cultural and social determinants of health and a life course

approach. Schedule B: Better Outcomes for Aboriginal and Torres Strait Islander peoples reinforces that health equity is a core responsibility of the entire health system.

- The *National Aboriginal and Torres Strait Islander Health Plan 2021-2031* calls for systemic action to eliminate racism across the health system and to ensure that mainstream healthcare services provide care that is culturally safe, as determined by Aboriginal and Torres Strait Islander peoples and communities.

The virtual care standards seek to embed cultural safety into everyday systems and processes within healthcare services to re-orient healthcare delivery to focus on models, practices and approaches that respect and prioritise First Nations ways of knowing, being and doing. The requirements have been informed by consultation with key Aboriginal and Torres Strait Islander stakeholders and are designed to contribute to the elimination of bias, discrimination and racism and the delivery of better health outcomes for First Nations peoples.

In parallel with the development of the virtual care standards, the Commission is coordinating a First Nations-led project to analyse evidence on standards for cultural safety (including associated measures and indicators) to inform recommendations for national standards for cultural safety for hospitals. The first stage of this project is currently underway and is focused on building the evidence and consulting with key stakeholders. The findings from this project and lessons from the co-design processes will be combined with feedback from the public consultation on virtual care standards, to help shape the requirements for the next draft of these standards.

Equity

In Australia, equity is a key priority for health leaders. Equity includes:

- reducing the gap in health outcomes between Aboriginal and Torres Strait Islander peoples and other Australians
- supporting other priority populations to receive high-quality health care
- tackling disparities between healthcare services in metropolitan, regional, rural and remote areas.

Health inequities relate to differences among groups of people whether those groups are defined socially, economically, demographically, geographically or by another dimension of inequality such as age, sex, gender, ethnicity, disability or sexual orientation. Social and cultural factors can contribute to health outcomes in ways that may be complex and interrelated.[7]

A person's participation in health care can be affected by cultural and historical factors including experiences of colonisation, imbalances in power, differences in language, historical or intergenerational trauma, a lack of cultural safety, bias, discrimination and racism.[8]

Equity means that the virtual care standards are applied consistently by your healthcare services every day across Australia, so every patient receives the right care, every time.

Patient preferences

Person-centred care is one of the domains of high-quality care, which respects the person receiving care, their family and carers, and responds to the person's preferences, needs and values.[2]

It's an approach to the planning, provision and evaluation of health care that is founded on partnership between clinicians, patients, families and communities, where care is tailored to the needs of the person, based on their expressed beliefs, hopes and expectations.

Person-centred practice has a broader lens, shifting the focus from what clinicians do to how healthcare services enable and sustain such behaviours through practitioner capability, care environments, and organisational culture.

It is a model for providing healthcare services that focuses on the provision of person-centred care. It is achieved through building effective collaborative relationships between clinicians who facilitate evidence-informed shared decision-making with patients and consumers.[9]

Where the virtual care standards refer to patients, their family and carers, this should be interpreted in accordance with the patient's preferences, wishes and consent. The involvement of family members, carers and support people should be guided by the patient's choices and occur only where appropriate. Healthcare services, their clinical and non-clinical workforce respect and support patient autonomy, ensuring that decisions about the participation of family members, carers and support people are determined by the patient wherever possible.

Clinical Governance Standard

Clinical Governance Standard

High-quality care means that patients have access to care that is person-centred, safe, effective, accessible and integrated, in a way that is equitable, efficient and sustainable. To do this, health care must be free from bias, racism and discrimination.

Intention of this Standard

The healthcare service's board, directors, executive and managers are accountable for ensuring that the healthcare service's clinical governance system supports the delivery of high-quality care. High-quality care is the shared goal for every member of the healthcare service's workforce, whether their role involves direct patient contact or contributes indirectly to patient outcomes.

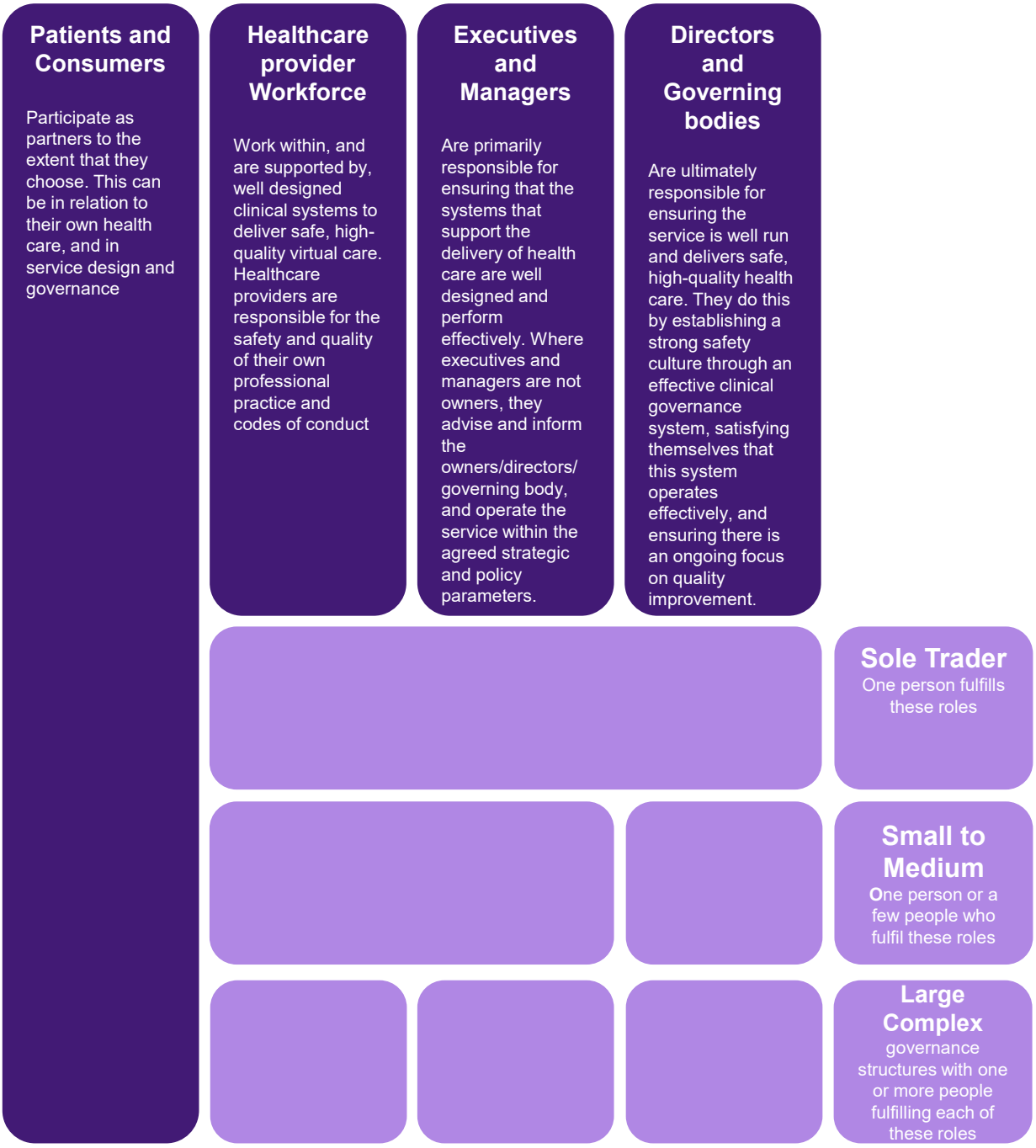
Everyone in a healthcare service contributes to leadership, working together to achieve results that could not be achieved working alone

Clinical governance roles and responsibilities

The types of healthcare services that deliver care virtually are many and varied extending, across the public and private sectors, from large acute care services, to smaller community based services, to short interaction virtual care services with national reach. Application of the clinical governance standards requires the most senior decision makers of the healthcare service to take responsibility for setting the culture and systems to enable the delivery of high quality virtual care.

Figure 4 below provides a framework to support healthcare services of different sizes to understand clinical governance roles and responsibilities.

Figure 4: Clinical governance roles and responsibilities



Key areas

Leading systems and organisational culture
Partnering with consumers
Building a healthy workforce culture
Enabling high-quality and integrated clinical practice
Managing and reducing risk
Using data for better care

Leading systems and organisational culture

The board, directors, executive and managers are accountable for the organisation's strategy and culture. They establish, maintain and continually improve organisational systems to achieve high-quality virtual care with better patient outcomes and experiences and an engaged, empowered workforce.

Purpose		Requirements
The board and directors are accountable for **high-quality care**	1.01	The board or director(s) govern organisational systems that: a. maintain a clinical governance framework aligned to the *National Model for Clinical Governance*[2], which is tailored to the size, scope and complexity of the services provided b. evaluate the organisation's performance against the clinical governance framework c. set the strategic direction and foster a culture that prioritises high-quality care d. identify and eliminate systemic, structural and institutional bias, racism and discrimination e. embed the *National Agreement on Closing the Gap Priority Reforms*[5] into governance systems
The board and directors are accountable for **organisation-wide culture, systems and structures**	1.02	The board or director(s) governs organisational systems to: a. build partnerships with consumers who reflect the diverse communities it serves, and incorporate their perspectives into strategic planning, priority-setting and decision-making b. align financial, operational and business decision-making with the organisation's strategic direction for high-quality care c. support the workforce to deliver high-quality care and monitor the effectiveness of clinical governance structures and activities d. embed a learning organisation approach to service, system and practice improvement e. use data insights to support decision-making and the delivery of high-quality care
The board, directors, executive and managers are accountable for creating a **healthy workforce culture**	1.03	The board, director(s), executive and managers have organisational systems to: a. enable a healthy workforce culture where members of the workforce feel safe to escalate concerns b. support the workforce to have leadership roles in establishing and maintaining the safety culture c. uphold a zero-tolerance approach to discrimination and racism, ensuring concerns and reports of risks, incidents, adverse events and complaints are investigated and required action is taken

The board, directors, executive and managers are accountable for **digitally enabled care**	1.04	The board, director(s), executive and managers have organisational systems to: a. ensure oversight of digitally enabled care, privacy and security, health information and digital tools and technologies used for clinical support and decision-making b. ensure the responsible use and maintenance of an information security management system for health information, including compliance with security and privacy jurisdictional requirements, including requirements for clinicians operating remotely c. detect, respond to and report on information security risks and incidents, including the use of unauthorised digital tools d. integrate digital tools and technologies downtime and cybersecurity planning and preparedness into governance systems including where virtual care services use consumer and remote patient monitoring devices e. maximise digital capabilities through the procurement, risk assessment, implementation, use, maintenance and replacement of all digital tools and technologies f. cultivate partnerships with the workforce, consumers and community in the design, implementation and governance of digitally enabled care g. uplift digital health literacy across the workforce with a focus on improving quality of care
The board, directors, executive and managers are accountable for **working with Aboriginal and Torres Strait Islander leaders to deliver cultural governance and systemic reform**	1.05	The board, director(s), executive and managers work with[5] Aboriginal and Torres Strait Islander leaders to establish accountability for: a. embedding a robust cultural governance framework recognising Aboriginal and Torres Strait Islander peoples' ways of knowing, being and doing as valid methodologies and integrating Aboriginal and Torres Strait Islander cultural knowledges b. undertaking system and business model reform to mitigate practices that limit Aboriginal and Torres Strait Islander peoples' empowerment, to share decision making and co-design to achieve high quality care c. implementing evaluation mechanisms, in partnership with Aboriginal and Torres Strait Islander peoples, that demonstrate monitoring, evaluation and system improvement
The board, directors, executive and managers are accountable for the **environmental sustainability** of health care	1.06	The board, director(s), executive and managers establish and maintain systems to adapt clinical practices to reduce their environmental impacts.

The board, directors, executive and managers are accountable for **minimising unwarranted variation and low-value care**	1.07	The board, director(s), executive and managers work with clinicians, the broader workforce, patients and consumers to: a. identify and reduce care that provides little benefit or disproportionate harms b. minimise waste in the delivery of care c. reduce inequities in the provision of care d. investigate reported instances of unwarranted clinical variation

Partnering with consumers

Boards, directors and executives lead systems that build a culture of person-centred care that empowers consumers as partners in governance at every level of the healthcare service. Organisational clinical governance structures and systems systematically engage consumers in planning, design, review and measurement to improve virtual care and contribute to better outcomes and experiences for patients, their family and carers.

The contribution that consumer leadership, skill and expertise bring to improvement, culture, delivery and evaluation of healthcare services is recognised and valued.

Partnering with consumers in governance systems is key to enabling patient empowerment and active participation in their own care.

Note: The requirements in this key area of the Clinical Governance Standard are key to providing person-centred practice.

Purpose		Requirements
Effective partnerships with consumers build a culture of person-centred care	1.08	The board, director(s), executive and managers have organisational systems to partner with consumers to: a. plan, design (including co-design), measure and review systems, services and models of care to support equitable experiences and outcomes of care b. support consumers in governance roles c. design, develop and review resources that are responsive to patients' needs, culturally safe and free from bias, discrimination and racism d. incorporate the views and experiences of consumers into training and education for the workforce e. measure and review the effectiveness of partnerships with consumers and the engagement of the healthcare service with the community and use this information to improve care
Patient rights underpin how health care is provided	1.09	The board, director(s), executive and managers have organisational systems to: a. adopt and make available a charter of rights that is consistent with the *Australian Charter of Healthcare Rights*[10] to patients, their family and carers, consumers and the workforce b. educate the workforce on patient rights consistent with the *Australian Charter of Healthcare Rights*[9] and embed these rights in the organisational culture and in the provision of care c. provide equitable access to health care for people with a disability and identify and action the need for reasonable adjustments d. measure patient experiences of how their healthcare rights are respected by the workforce and act to improve care

Purpose		Requirements
		e. embed open disclosure, consistent with the *Australian Open Disclosure Framework*[11], at all levels of the healthcare service f. monitor and improve the use and effectiveness of open disclosure
Partnerships with Aboriginal and Torres Strait Islander peoples and communities shape health care	1.9	The board, director(s), executive and managers have organisational systems to: a. build respectful and reciprocal partnerships with Aboriginal and Torres Strait Islander peoples, organisations and community-controlled healthcare organisations b. encourage involvement of Aboriginal and Torres Strait Islander peoples and community members in the co-designing of services, delivering and evaluating care
Health care is improved through **patient and consumer feedback**	1.10	The board, director(s), executive and managers have organisational systems for healthcare delivery to: a. encourage and support patients, their family and carers and consumers to speak up for safety and report when they have concerns b. embed a feedback and complaints system that is easy to access, transparent, culturally safe and free from bias, discrimination and racism c. integrate feedback, complaints and patient reported experience measures with incident management systems and the processes for clinical review and credentialing d. involve patients, their family, carers and consumers, and the workforce in the investigation and resolution of complaints and provide feedback on action taken e. analyse feedback, complaints and patient reported experience measures; use the findings to inform risk management and quality improvement activities; and provide feedback to consumers on the actions taken f. regularly review the effectiveness of the system for feedback and complaints

Building a healthy workforce culture

The workforce across all areas and teams in the healthcare service is supported, engaged and empowered to speak up about patient safety and quality or to raise concerns about workforce behaviours. There is a healthy workforce culture where people feel respected, valued and responsible for the care provided in their workplace.

Note: This key area applies to the entire workforce, including non-clinical staff and contractors. The next section on 'Enabling high-quality and integrated clinical practice' focuses on the additional clinical responsibilities of multidisciplinary care teams.

Purpose		Requirements
There is a culture where the **workforce is supported, engaged and empowered** to provide high-quality care	1.11	The executive and managers have organisational systems to: a. attract, recruit and retain a diverse workforce that reflects the community served and community needs b. foster psychological safety and support the workforce to speak up about concerns and report risks, near misses, adverse events and complaints c. respond to workforce concerns transparently; use these insights to reduce risks and improve the quality of care and monitor the effectiveness of actions taken d. provide tailored education and training programs that enable all members of the workforce to support and be accountable for virtual high-quality care e. provide regular training programs that enable the workforce to meet privacy, consent and occupational health and safety regulations f. respond to risks to patient care arising from workforce gaps or pressures g. measure and monitor workforce culture, including psychosocial safety and cultural safety, with validated surveys and use the findings to improve workforce wellbeing
The **workforce understands their responsibilities** for high-quality care	1.12	The executive and managers have organisational systems in place to: a. educate the workforce about the healthcare service's clinical governance framework and their shared responsibilities for providing or supporting high-quality care b. communicate responsibilities for providing or supporting high-quality care to each member of the workforce at orientation, when their roles and responsibilities change, and when planning and implementing new models of care c. support clinicians to meet relevant National Boards' professional obligations including when prescribing and providing care through digital and virtual care, and emerging models of care

Purpose		Requirements
		d. enable the workforce to escalate concerns about deterioration in a patient's condition e. review and discuss performance with the workforce routinely and when there are concerns about performance or behaviour and act to improve performance f. provide practical support and training to the workforce to select and integrate digital tools and technologies into their practice and evaluate their effects
Clinicians and teams are supported to be high-functioning	1.13	The executive and managers have organisational systems to: a. build and sustain diverse and inclusive teams with a clearly defined shared purpose, roles and responsibilities b. sustain a culture that focuses clinicians and teams on person-centred care c. support effective leadership, mentorship and coaching to build capabilities and enable effective communication, conflict management and teamwork d. monitor clinician and team performance and continuous improvement activities
The healthcare service is **culturally safe for the Aboriginal and Torres Strait Islander workforce**	1.14	The executive and managers have organisational systems in place to: a. enable the Aboriginal and Torres Strait Islander workforce to actively lead and meaningfully contribute to leadership decision making at all levels of the healthcare service b. effectively support strategies to enable the Aboriginal and Torres Strait Islander workforce's wellbeing c. eliminate bias, discrimination and racism in workforce recruitment and training programs, including in orientation, supervision and performance review

Enabling high-quality and integrated clinical practice

Clinicians are appropriately skilled, capable and supported to deliver high-quality care, and participate in the healthcare service's clinical governance systems. The healthcare service has robust systems to embed evidence-informed practice into clinical practice and models of care and to assess and review clinical performance and patient outcomes across the continuum of care.

Purpose		Requirements
Clinicians are supported, trained and developed to perform at their full capability to provide high-quality care	1.15	The executive and managers have organisational systems to: a. orient clinicians, including agency staff, locums and staff rotating from other sites to new workplaces b. tailor education and training programs to enable clinicians to provide, supervise and be accountable for delivering the virtual care services and the appropriate use of digital tools. c. provide clinicians with access to escalation pathways for senior clinician support and after-hours advice d. align the skills, capability and experience of clinicians with patients' care requirements e. conduct regular performance reviews and monitor and manage clinicians' professional performance and fulfilment of professional development requirements f. support clinicians to improve models of care by integrating digital tools and technologies with clear criteria for use, defined workflows and routine evaluation of clinical effectiveness, safety, equity and workforce impact g. ensure treatment decisions, including prescribing, align with best practice and are free from commercial influence
Clinicians actively contribute to clinical governance activities	1.16	The executive and managers have organisational systems to: a. involve clinicians from across the healthcare service, and where in place, different clinical groups in clinical governance roles b. report to the governing body on clinical perspectives of care quality c. support clinicians to implement and evaluate new clinical practice innovations, including those supported by digital tools and technologies
Clinicians are supported to undertake **quality improvement activities**	1.17	The executive and managers have organisational systems to: a. assist clinicians to conduct quality improvement activities b. engage clinicians in quality improvement activities c. consider evidence of engagement in quality improvement activities as part of credentialing and recredentialing requirements
Systems for **credentialling**	1.18	The executive and managers have fair and transparent systems for credentialing and defining scope of practice to:

Purpose		Requirements
and defining scope of practice protect patient safety		a. verify whether clinicians have the qualifications, expertise and professional standing to fulfil the performance requirements of their role and facility-specific scope of practice b. monitor and manage clinicians' adherence to the service-specific scope of practice c. review credentials and service-specific scope of practice regularly, when new models of care, procedures or technologies are introduced and when there are concerns about clinical performance or workplace behaviours d. use information from performance reviews when reviewing credentials and service-specific scope of practice e. monitor and improve the effectiveness of the credentialing process
Clinicians use **evidence-informed guidance and resources** to support clinical judgement and provide high-quality care	1.19	The executive and managers have organisational systems to: a. provide clinicians with access to Clinical Care Standards, evidence-informed guidelines, care pathways and decision support tools b. determine patient suitability to a virtual care service, using evidence informed patient inclusion and exclusion criteria, including confirming patients have an appropriately safe and quiet location. c. support clinicians to use the evidence-informed tools to provide high-quality care and in shared decision making with patients d. provide clinicians with timely, tailored information about the quality and outcomes of care they provide e. support clinicians to participate in clinical and peer review and quality improvement activities
Clinical Care Standards are effectively used for quality improvement	1.20	The executive and managers have organisational systems to: a. assess the relevance of Clinical Care Standards according to local service quality improvement priorities, clinical risks and data insights on clinical variation b. implement Clinical Care Standards that are relevant to service quality improvement needs and address healthcare service clinical risks, unwarranted variation, or other data insights indicating a need for quality improvement, or are required for implementation by a relevant authority c. collect, monitor and act on indicator data for relevant Clinical Care Standards
Health care is coordinated and connected across the healthcare service and with other providers and settings	1.21	The executive and managers have organisational systems to: a. collaborate with consumers and clinicians to design and improve integrated models of care within the healthcare service and across the continuum of care, including with care providers in other settings

Purpose	Requirements
	b. coordinate patient care across providers and settings, including sharing information at transitions of care and when a single instance of care is provided

Managing and reducing risk

The healthcare service has a systematic, transparent and strategic approach to risk that safeguards high-quality care and informs planning and resource allocation across all parts of the healthcare service.

Information from a variety of sources is used to prioritise risks to patient safety and quality of care, as well as risks to workforce culture and safety. The effectiveness of actions taken to reduce risk is monitored and reported.

Purpose		Requirements
There is a **strategic and systematic approach to manage risks** across the **healthcare service**	1.22	The board, executive and managers have organisational systems to: a. align the risk management strategy with priorities for high-quality care and address key factors and emerging risks that may impact its delivery b. provide robust oversight, identification and management of quality of care risks across all clinical and business functions, including digital tools and technologies c. combine information from incidents, risk reports, feedback, complaints and other data sources to inform risk assessments, mitigate risks, monitor trends and guide improvement activities d. support patients to self-report adverse events, deterioration and incidents to the healthcare service that provided the care or their usual health care provider(s) e. use governance structures to enable effective and transparent communication and reporting on risk and risk management across the healthcare service f. regularly assess the effectiveness of risk identification and management including review of priority areas of risk g. provide workforce education and training programs that identify, assess and manage risks h. use information from the risk management system to improve patient care, workflows, service design and policy i. direct patients to alternative care pathways as needed including where the provision of a virtual care service has been declined j. define parameters that identify when a patient's condition requires escalation tailored to the service being provided and the individual patient's risk profile
Effective risk management supports high-quality care	1.23	The board, directors, executive and managers have organisational systems to: a. identify and manage high-risk activities and common causes of harm b. recognise, monitor and report bias, discrimination and racism as a clinical and organisational risk and act to improve anti-racist practices and cultural safety.

Purpose		Requirements
The **incident management system** draws together findings from across the **healthcare service** to develop effective responses	1.24	The executive and managers have organisational systems to: a. maintain an incident management system with clear clinical governance roles and responsibilities b. transparently and promptly investigate and report all incidents, contributing factors and patient safety system failures, to governance or the director, including those related to digitally enabled care and the use of digital tools and technologies and to the TGA where the device is regulated c. use data to identify trends, recurring themes and systemic risks and act to make improvements and monitor effectiveness d. engage patients, their family and carers, consumers and the workforce to review incidents, actions taken to reduce harm and contribute to safety system improvements e. regularly review and improve the effectiveness of the incident management system
Health care provision is resilient and sustained during **service disruptions and emergencies**	1.25	The executive and managers have organisational systems to: a. oversee, review and improve emergency preparedness and response frameworks for maintaining healthcare delivery and services during disruptions, internal and external emergencies and disasters b. effectively communicate service changes or interruptions to consumers when the virtual care modality becomes unavailable c. incorporate climate-related risks, supply chain disruptions, digital downtime, utility outages, cyberattacks, outbreaks and pandemics into emergency preparedness and business continuity planning

Using data for better care

The board, directors, executive, managers and clinicians have the information to determine whether they are providing high-quality virtual care to patients and whether improvement efforts are effective.

Data are governed, analysed and used in a safe, accurate, timely and ethical way to strengthen decision-making, drive improvement and support high-quality virtual care.

Purpose		Requirements
Data governance supports a learning organisation to use data appropriately	1.26	The board, directors, executive and managers have organisational systems to: a. systematically collect, analyse, communicate and report on clinical quality and risk data to improve care b. maintain data governance systems to collect, use, store, share and retain data and de-identify data when shared or linked c. ensure data are accurate, consistent, fit for purpose and communicated to those people who need to use it d. protect data from unauthorised access
The right data are collected and used to assess and improve healthcare quality	1.27	The board, directors, executive and managers have organisational systems to review and use clinical quality and risk data that: a. recognise Aboriginal and Torres Strait Islander peoples and communities' right to own and govern the creation, collection, access, analysis, interpretation, management, dissemination and reuse of Aboriginal and Torres Strait Islander data b. collaborate with Aboriginal and Torres Strait Islander peoples and communities to interpret, respond to and act on data in culturally appropriate and safe ways c. encourage consumer involvement in analysing and reviewing data to improve care d. provide clinicians with concise and timely information about the quality of care they provide, including feedback, complaints, patient experience and outcomes, so that care can be improved e. assess the extent to which the healthcare service is delivering all dimensions of quality health care f. support clinicians to review and improve their performance, models of care and patient outcomes g. identify and manage key risks and inform organisational decision-making h. continuously assess, monitor and improve data quality
Digital systems are optimised to improve continuity of	1.28	The executive and managers have organisational digital data systems that: a. use national clinical terminologies and specifications

Purpose		Requirements
care and integration		b. use interoperable data formats for seamless information extraction and exchange c. monitor system performance to optimise the accuracy, completeness and quality of the data d. support continuity of care, informed decision-making and quality assurance activities
Data are analysed, monitored and reported to improve health care	1.29	The healthcare service: a. uses reports from its administrative, clinical and performance data to identify priorities for quality improvement b. acts on, reviews and monitors identified priorities for quality improvement c. measures changes in safety and quality indicators and outcomes d. provides timely information on safety and quality improvement and performance to the governing body, the workforce and patients

Person-Centred Practice Standard

Person-Centred Practice Standard

Person-centred practice is how care is delivered to build trusting relationships between the health care workforce, the person receiving care and those who matter to the person receiving care.

Person-centred practice ensures care is respectful, responsive and tailored to what matters to each person. It is supported by shared understanding and open communication, so people have clear information about their care, what to expect and the options available. This enables people to participate in decisions and achieve the best possible outcomes.

Intention of this Standard

A supportive healthcare setting enables person-centred practice by promoting teamwork, open communication and shared decision making. The relationship between the healthcare service workforce and the care setting shape everyday practice and influences how safe people feel to participate in their care.

Key areas

- Partnering with patients in their healthcare
- Caring for the whole person
- Care environment
- Effective communication and teamwork
- Recognising and responding to acute deterioration
- Coordinated and connected care

Partnering with patients in their healthcare

Partnering with patients in their healthcare involves building respectful, trusting relationships and actively involving people in decisions about their care. This includes supporting understanding and choice, recognising lived experience, responding to what matters to the person throughout the health care journey and discussing appropriate care options to support informed choice.

Purpose		Requirements
Patients are understood and able to have trust in their care	2.01	Clinicians: a. use the *Australian Charter of Health Care Rights*[10] to guide therapeutic relationships b. communicate with patients, their family and carers in a manner that upholds a person's dignity and is culturally safe and free from bias, racism and discrimination c. use validated techniques to confirm that relevant information has been effectively communicated, understood and likely to be recalled by patients, their family and carers d. use authorised interpreters, translated materials, communication tools and culturally appropriate communication methods in line with the needs of the patient e. implement reasonable adjustments to ensure equitable care
Patients understand their condition or treatment options and their potential benefits, risks and consequences for them	2.02	Clinicians: a. are trained by the healthcare service in person-centred care, shared decision making and consent b. comply with their legal obligations and recognise that consent is an ongoing process that is revisited or reconfirmed at key points in care delivery or when clinical changes occur c. use informed consent principles to guide their practice consistent with all relevant jurisdictional requirements and evidence-informed guidance d. tailor communication to the patient and provide information about the patient's condition, care options and what to expect e. use supports, reasonable adjustments and culturally responsive approaches where needed to enable participation in care decision-making f. inform patients of the right to decline or defer care or consider a second opinion g. support a patient's right to include their family and carers in decision-making h. ensure a suitably qualified clinician assesses a patient's capacity, supports patients to participate in decision-making and only uses substitute decision-makers where the patient is unable to make decisions despite these supports

Purpose		Requirements
Patients make **informed decisions** about their care	2.03	Clinicians: a. engage patients throughout the episode of care in establishing what matters to the patient in decisions about their care and documenting what matters in the healthcare record b. ensure patients have access to appropriate health information and decision support tools before discussions about investigations, interventions, treatment, and care decisions c. document the agreed decisions and relevant information about investigations, interventions, treatments and care in the healthcare record d. involve the patient's family and carers in discussions about the patient's care, investigations, treatments and care decisions

Caring for the whole person

Caring for the whole person involves understanding and addressing an individual's physical, cognitive, psychological, cultural and social needs that influence their health outcomes.

Person-centred practice is informed by ongoing clinical assessment and judgement to ensure care is appropriate, responsive and aligned with the person's needs and preferences.

Purpose		Requirements
Clinical assessment and evidence informed decision-making underpin the planning and coordination of care across the health-care team	2.04	The treating clinician or multidisciplinary care team: a. uses clinical information and assessment, evidence-informed guidance and decision support tools to inform clinical decisions b. considers the patient's cultural identity, personal circumstances and social context, including the social determinants of health relevant to the care setting when planning and coordinating care c. identifies and responds to risks of domestic and family violence, supporting safe disclosure, safeguarding patients, and appropriate care and referral d. uses relevant structured clinical assessment processes tailored to the patient's needs, care goals and preferences, including when there are changes in the patient's condition, risk and care setting e. uses clinical assessments, including relevant input from patients, their family and carers, to: i. identify patient clinical needs and functional ability including assessing inclusion and exclusion criteria for the specific virtual care service ii. inform clinical reasoning and diagnosis iii. identify and agree on treatments and therapy appropriate to the patient's condition, preferences and care setting iv. identify opportunities for interventions that optimise the patient's condition and functional ability before treatment or as care needs change v. identify and address patient-specific risks that may affect their safety, clinical outcomes or functional ability during care f. assesses the patient's ability to physically and cognitively participate in a virtual care service, including carers and advocates involved in the care g. assesses the patient's access to technical infrastructure e.g. internet connectivity and mobile devices, when considering use of virtual care service

Purpose		Requirements
		h. provide information to patients and their family on accessing alternate services where the scope of the service does not meet or is not appropriate for them
The **plan for care** is developed, documented, reviewed and used to guide and coordinate ongoing care	2.05	The treating clinician or multidisciplinary care team: a. documents the plan for care and clinical decisions in the healthcare record including: i. clinical assessment findings, provisional and confirmed diagnoses ii. care goals, patient healthcare needs, treatments and therapies iii. critical information, medication and allergy alerts and risks iv. time frames and the actions required by clinicians, the patient, their family and carers v. plans for transferring care to another health care provider b. assesses and updates the plan for care when there are changes in diagnosis, the patient's condition or setting and incorporate input from the patient, their family and carers where appropriate c. contemporaneously documents changes to the plan for care and the rationale for these changes in the healthcare record d. monitors the patient's condition and response to care to evaluate the effectiveness of the plan for care and acts on opportunities to improve outcomes and reduce harm e. supports health education and promotion, illness prevention and early intervention for patients, considering its patient population f. recalls patients for follow-up health care when appointments are missed or new information leads to a change in care or treatment
Care is delivered safely	2.06	The treating clinician or multidisciplinary care team: a. uses evidence-informed interventions to identify and mitigate patient risks at the start of the episode of care and whenever the patient's condition changes b. uses patient cohort and/or condition level data insights, including hospital-acquired complications, incidents, near misses, adverse events, complaints, feedback, variation in practice and other relevant data insights to improve outcomes c. communicates information about investigations, treatments and care options, including associated risks and benefits to support informed decision-making
Advance care planning is considered	2.07	The treating clinician or multidisciplinary care team use the healthcare service's policy and processes to initiate, consider or escalate and provide advance care planning when:

Purpose		Requirements
when appropriate		a. clinically appropriate b. requested by a patient c. a patient has repeated unplanned episodes of care within a 12-month period
End-of-life care is compassionate and coordinated	2.08	Clinicians: a. provide evidence-informed practice, coordinated care at the end-of-life in accordance with the *National Consensus Statement on end-of-life care*[12] b. reevaluate a patient's care preferences at each episode of care or when a patient's condition changes or deteriorates

Care environment

Care environments influence how people experience care. Respectful, inclusive and psychologically safe environments support dignity, wellbeing and effective interactions between patients, carers and the workforce.

Everyday behaviours and responses within care settings affect how concerns are raised, behaviours of concern are managed and how safety and effective care is delivered.

Virtual environments bring unique considerations where the written or spoken communications can be mis-understood with the loss of visual cues.

Purpose		Requirements
The workplace and care environments are respectful and psychologically safe	2.09	The clinical and non-clinical workforce: a. demonstrate respectful behaviours in day-to-day interactions with all people to support high-quality care and a positive and inclusive workplace culture b. promote a workplace environment where it is safe to ask questions, express concerns and speak up about care and safety issues and concerns c. respond to concerns in a timely and respectful manner
Practice is **inclusive and culturally respectful**	2.10	The clinical and non-clinical workforce: a. provide culturally safe care and environments for Aboriginal and Torres Strait Islander peoples b. demonstrate culturally respectful behaviours in everyday care c. avoid assumptions, bias, discrimination and racism in all interactions
Risk of behaviours of concern are minimised and managed	2.11	The healthcare service: a. builds workforce capability through training in evidence-informed practice strategies to prevent, recognise and manage behaviours of concern, including working with patients, their family and carers where appropriate b. identifies clinical specialties, operational settings and patient cohorts associated with a high risk of behaviours of concern to inform prevention, mitigation and response strategies c. provides access to appropriate care environments and evidence-informed practice interventions to prevent and support the safe management of behaviours of concern, including reducing environmental stimuli where possible and clinically appropriate d. supports workforce safety and wellbeing, including managing risks to staff when responding to behaviours of concern e. reviews and learns from behaviours of concern and related incidents, using data insights, feedback and analysis to identify contributing factors and implement improvements to reduce recurrence

Purpose		Requirements
Behaviours of concern are managed safely and effectively	2.12	The clinical and non-clinical workforce contribute to the safe and effective management of behaviours of concern by working in partnership with each other and with patients at risk, their family and carers to identify triggers and develop preferred de-escalation approaches

Effective communication and teamwork

Effective communication and teamwork underpin coordinated and safe care. Clear roles, shared understanding and the exchange of information support continuity of care and responsive decision-making.

Communication occurs between clinicians, with patients, their family and carers, and across the broader care and non-clinical teams and adapts as care needs change.

Purpose		Requirements
Effective communication supports person-centred care	2.13	The healthcare service has organisational systems to: a. develop and sustain the communication capability of the workforce including in digital and virtual care delivery, through training, credentialing and ongoing professional development b. monitor and evaluate the effectiveness of communication practices and use findings to drive continuous improvement c. use digital health communication technologies that are clinically appropriate and supported by training d. support communication and information sharing with patients, their family and carers, and across the clinical and non-clinical teams and other providers to enable coordinated care e. identify and respond to communication needs and preferences of patients across the episode of care, including accessibility needs, and provide communication resources and adapted methods to support shared decision making
Clinicians and multidisciplinary care teams support coordinated and high-quality care	2.14	The treating clinicians and/or multidisciplinary care team and non-clinical workforce working together as a team: a. foster trust and mutual respect within the team through recognising and valuing each member's contributions b. demonstrate behaviours that support a patient safety culture, including asking questions, escalating concerns and seeking assistance c. develop and maintain clinical and communication processes that support coordinated care d. understand team members' roles and responsibilities, including which clinician is responsible for coordinating care and overall clinical management e. communicate their role in care and responsibilities to the patient, their family and carers and all members of the team f. continuously review and improve their performance

Purpose		Requirements
Critical information about a patient is promptly communicated and effectively acted on	2.15	Clinicians understand and use the healthcare service's processes for responding to critical information, including processes to: a. ensure prompt recognition, timely communication and management of critical information b. ensure prompt notification, using an escalation procedure, of the critical information and associated risks to the patient, carers and family in accordance with their preferences and the clinician responsible for overall care c. ensure critical results are communicated, received, acknowledged and acted on d. document the escalation of the critical information and steps taken to ensure communication of the critical information

Recognising and responding to acute deterioration

Changes in a person's physical, cognitive or mental state require early recognition and timely response.

Person-centred practice includes clinical assessment, attention to concerns raised by patients, their family and carers, and appropriate escalation to prevent harm and deterioration.

Purpose		Requirements
Clinicians **respond appropriately to concerns raised** by patients, their family and carers	2.16	Clinicians: a. ensure that patients, their family and carers are informed and supported to escalate concerns about care and deterioration or changes in the patient's condition b. follow organisational systems to routinely ask patients, their family and carers to share key information and observations, including changes in condition or concerns, to support early recognition of deterioration c. ensure that concerns raised by patients, their family or carers are taken seriously, promptly and thoroughly investigated, clinically assessed, acted upon and documented as per the local escalation policy and process d. promote early recognition of physical, cognitive and mental health deterioration, and ensure appropriate monitoring, escalation and response using documented processes
Patient safety is supported by recognition and timely, appropriate **escalation of care**	2.17	The treating clinicians and/or multidisciplinary care team: a. is trained in recognising the early signs of physical and cognitive deterioration, in line with healthcare service policies and procedures b. implements physiological monitoring that is tailored to the care setting and adapted to the patient's condition, including where remote patient monitoring is being used c. uses and maintains documented monitoring and escalation pathways, protocols and agreed parameters for escalating care, and ensures these are embedded into clinical workflows and systems d. provides a timely clinical response to deterioration by clinicians with the skills required to manage the patient's condition, including rapid referral to services that can definitively manage sudden deterioration and/or provide information to patients on accessing alternate services where the patient's needs are beyond the scope of the service e. implements systematic review and continuous improvement of processes for identifying, documenting and managing clinical deterioration

Purpose		Requirements
Early recognition of **deterioration in a patient's mental state** is escalated in a timely and appropriate manner	2.18	The treating clinicians and/or multidisciplinary care team: a. recognises, assesses and manages sudden deterioration in a patient's mental state, including reported changes in behaviour, cognitive function, perception, physical function or emotional state, in the context of the patient's usual baseline b. monitors patients identified as being at risk of acute mental state deterioration c. includes the patient's known early mental health deterioration warning signs in the patient's individualised monitoring plan d. safely and effectively responds to patients experiencing suicidal distress or thoughts of self-harm, including those who have self-harmed or present a risk to harming others (including crisis intervention), and supports appropriate follow-up care e. documents and communicates observed or reported changes in a patient's mental state to other members of the multidisciplinary care team f. identifies and reduces the risk of harm from unmet needs or care fragmentation, including during transitions of care

Coordinated and connected care

Coordinated and connected care relies on clear communication of all relevant information during the transfer of responsibility between care providers. Safe transitions of care are supported by promoting a shared understanding of each patient's needs when moving between care settings or healthcare services. This approach ensures effective coordination, enhances patient safety and health care outcomes, and builds capability across care settings.

Purpose		Requirements
Patients receive **coordinated care**	2.19	Clinicians: a. implement and maintain strategies that support coordinated and connected care across the care continuum in partnership with patients, their family and carers b. use systems and tools to support timely and effective sharing of information, including shared plans for care and medication lists, between patients, their family and carers, clinicians, teams and healthcare services c. clearly define roles, responsibilities and points of contact for ongoing care, including explicit identification of who is accountable at the conclusion of the episode of care or transfer to another service, and where care is shared across clinicians, teams, healthcare services d. monitor and review risks and outcomes associated with care coordination and transitions of care, including recent episodes of care, emergency department presentations or hospital admission and use this information to facilitate continuous improvement
Risks associated with **transitions across services and care settings** are reduced	2.20	The healthcare service identifies and manages risks associated with transitions of care across services, settings and levels of clinical support, including: a. where there may be a mismatch between the patient's care needs and the level of clinical support, capability or resources available b. outside of routine operating hours and where access to clinical support or resources may be reduced c. where the patient is receiving care from multiple teams or services
Information exchanged at transitions of care is accurate, complete, timely and useful	2.21	The treating clinician and the multidisciplinary care team ensure that information exchanged at transitions of care at the end of the episode of care: a. is accurate, complete and transferred in a timely manner, with clear identification of the patient and relevant healthcare provider b. supports continuity of care and harm mitigation across services and settings by providing relevant care and treatment information such as episode of care summaries, medication lists, changes to medications, referrals and/or care plans

	c. provides patients, their family and carers with clear information about what to expect following the episode of care, what to look for, and what actions to take, including if their condition changes or does not progress as anticipated d. includes supporting information about a patient's cultural identity, obligations and practices and any relevant communication, accessibility or support needs e. is transmitted to the patient's regular care provider using digital systems and processes, including National Digital Health Infrastructure when available

Safe Clinical Systems Standard

Safe Clinical Systems Standard

Healthcare services implement and improve clinical safety systems and processes to maximise the quality of care.

Intention of this Standard

Priority systems, policies and processes keep people safe while receiving care or working in a healthcare service, prevent avoidable harm and support the sustainable delivery of high-quality care.

Key areas

The virtual care service
Safe environments
Patient identification
Health care record systems
Infection prevention and control
Medicines safety and quality
Medical devices and patient monitoring

Note: In Australia, healthcare services vary considerably in size, organisational structure and the scope and complexity of care they provide. Healthcare services reflect the diverse communities they serve. The clinical and the non-clinical workforce work as a team in a systematic way to provide health care to patients.

Healthcare services provide care so that safety and quality are not dependent on individuals, but are built into every system, process and environment ensuring every patient receives the right care, every time.

The virtual care service (new section)

The virtual care service(s) provided by the healthcare service is designed and managed to support clinicians in delivering high-quality virtual care and minimising patient harm

Purpose		Requirement
The virtual service(s) is designed for high-quality	3.01	The healthcare service: a. assesses the needs of the population it aims to service b. documents the purpose and intent of the service(s) and how it will operate c. documents the model(s) of care for each virtual care service offered d. identifies and provides the clinical and non-clinical workforce required to deliver the service e. identifies and provides the physical and technical resources required to deliver the service f. identifies and establishes a training program(s) for the workforce to cater for the unique aspects of virtual care accounting for: i. patient assessment where physical contact is not possible ii. the tools used to deliver the virtual care service including software platforms and monitoring devices (if used) iii. follow-up and escalation pathways for patient deterioration and emergencies assessing patient suitability for the virtual care service(s) iv. monitors and evaluates the delivery and performance of the service through the health care service's clinical governance framework v. documents the processes clinicians must use to provide input to monitoring and evaluation of the virtual care service(s)
Patients understand the scope and purpose of the virtual care service(s)	3.02	The healthcare service provides patients with access to information about the virtual care service(s) including: a. the purpose, intent, limitations and exclusions of virtual care services offered b. the terms of service including service costs to ensure the providers and consumers' obligations are clear c. privacy policy d. the patient characteristics suitable for the services offered and who can register for the services, including exclusion criteria

e. the service operating hours, how the service is provided and how to access the services including the technologies required from the patient

f. the information required for registration or requesting the service such as a referral

g. languages in which the service is provided

h. non-service costs such as estimated data usage

i. alternative health care options in an emergency when the virtual care service is closed

j. supporting patients with using technology required to access and use the virtual care service

k. providing virtual care service information in a range of languages aligned to their service's population

Safe environments

Care environments are safe and therapeutic through purposeful design and diligent maintenance of infrastructure.

Purpose		Requirement
Care environments are safe, culturally welcoming and therapeutic	3.03	The healthcare service maximises the provision of high-quality virtual care: a. through designing the environment in consultation with patients, consumers, communities, clinicians and relevant experts b. by testing and maintaining buildings, plant, equipment, utilities, services for water, electricity and gases, devices and other infrastructure to ensure they are maintained fit for purpose and safe for use c. by encouraging Aboriginal and Torres Strait Islander peoples and communities' participation in co-design, implementing and evaluating welcoming and culturally safe environments d. by providing a calm and quiet environment, free from background noise, for clinicians to provide care virtually e. by advising patients to be located in an appropriately private and quiet environment, free from background noise, for virtual care modalities f. by training clinicians in identifying and managing the risks of coercive control by unseen third parties during the delivery of virtual care

Patient identification

Patients consistently receive the intended care through provision of accurate, reliable and patient-involved identification and intervention matching.

Purpose		Requirements
Robust **patient identification processes** ensure the right patient receives the intended care	3.04	The healthcare service ensures unambiguous, safe and traceable patient identification and intervention matching by: a. defining and using at least three approved patient identifiers in accordance with best-practice guidance, documenting the process for patient-intervention matching and communicating this to the workforce b. requiring the workforce to use at least three approved patient identifiers: i. on registration and at the start of the episode of care, on any shared information and at transfer of care ii. in health care records, care transfer documents and reports iii. before commencing any care, medication administration supervision, conducting interventions, transiting care, or providing patient advice or education c. taking prompt corrective action when a patient identification and matching discrepancy is identified d. checking the patient's photo ID where it is available when video-conferencing is being used
Aboriginal and Torres Strait Islander patients are respectfully identified and connected to culturally appropriate care	3.05	The workforce: a. understands the importance of appropriately identifying Aboriginal and Torres Strait Islander patients and their related care needs b. applies culturally safe practices when identifying Aboriginal and Torres Strait Islander patients by: i. routinely asking all patients using a standard identification question ii. asking the question in a respectful, non-judgmental way iii. explaining in a respectful, culturally appropriate, non-judgemental manner, and when asked, the purpose of the question iv. ensuring privacy when asking the question v. respecting that some patients may not wish to answer the question c. uses the patient's identification as an Aboriginal and Torres Strait Islander person to trigger culturally safe and appropriate models of care, to inform clinical decision-making and to support improved patient experiences, care and outcomes

Health care record systems

Patient care episodes are accurately documented, informed by and integrated into their health care record, which is accessible and connected through interoperable systems.

Purpose		Requirements
Accurate, integrated patient information is available to reduce risk and improve continuity of care	3.06	The healthcare service has healthcare record systems that: a. use national healthcare identifiers that are verified against the *National Healthcare Identifiers Service* b. are interoperable with: i. National Digital Health Infrastructure (such as My Health Record) to support access, sharing and exchange of health information in accordance with national legislative and policy requirements ii. diagnostic testing reporting systems, where used c. are able to share and exchange information in alignment with national requirements, specifications and infrastructure d. have alert systems that minimise alert fatigue, support decision-making and highlight patient risks to the clinical and non-clinical workforce e. are accessible to clinicians at the point of care f. contain accurate, integrated, comprehensive and up-to-date patient care information that can be used by the workforce to provide high-quality care, support continuity of care and improve patient experiences and outcomes

Infection prevention and control

Safe, high-quality care is supported and maintained by reducing infection risks through evidence-informed practice precautions, surveillance, workforce protection and providing a clean, well-managed environment.

Purpose		Requirements
Infection risks are effectively identified, managed and reported	3.07	The healthcare service: a. identifies and manages risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems b. applies standard and transmission-based precautions in accordance with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[13] c. complies with relevant profession-specific infection prevention and control guidance, jurisdictional legislation, requirements and policies, including work health and safety legislation d. assesses the workforce's competency in applying standard and transmission-based precautions and provides training and training updates e. has outbreak detection processes, response systems and governance mechanisms, including meeting jurisdictional reporting requirements
Infections are prevented through **evidence-informed use of medical device**	3.08	The healthcare service demonstrates processes for the use and management of medical devices in accordance with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*,[13] Therapeutic Goods Administration (TGA) regulations and manufacturers' instructions for use
Workforce infection transmission is prevented and managed	3.09	The healthcare service: a. aligns its processes with state or territory work, health and safety regulations, *Safe Work Australia Model Code of Practice: Managing the risks of biological hazards at work*[14] and the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*[13], including workforce screening and exclusion periods, and shared equipment such as keyboards, headsets and microphones b. supports non-attendance or remote attendance of the workforce when there is a suspected or known infection in the workforce, and implements additional controls to minimise transmission when absence is not possible
A **safe and hygienic environment** is maintained for the delivery of care	3.010	The healthcare service: a. identifies, evaluates and addresses infection risks associated with new and existing equipment, medical devices, products and the physical environment

Purpose	Requirements
	b. cleans, maintains, repairs and upgrades buildings, infrastructure, utilities, fittings, equipment, medical devices and furnishings to provide safe, appropriate and sustainable infection prevention and control

Medicines safety and quality

Safe, high-quality medication management across prescribing, dispensing and administration is delivered by maintaining accurate histories, managing allergies and reactions, reviewing medicines, communicating clearly, managing medicines sustainably and building collaborative stewardship to guide safe practice.

Purpose		Requirements
Accurate and safe **medication management** is provided throughout care	3.11	Clinicians use a structured approach to: a. take and document the Best Possible Medication History (BPMH) on a patient's presentation, or as early as possible when it is not practical at presentation b. verify and use the BPMH to reconcile the patient's medicines using multiple sources c. review and update the reconciled medicines in the patient's health care record d. communicate medication plans and medicine changes to the patient, their family and carers, all relevant clinicians, including their usual primary care teams
Harm is minimised through effective documentation, assessment, management and reporting of **adverse medicine events**	3.12	Clinicians: a. identify and manage medicine allergies and adverse events b. assess the accuracy and clinical relevance of reported allergies and adverse events c. document: i. known medicine allergies and adverse events on presentation, in accordance with BPMH requirements ii. new or suspected medicine allergies and adverse events during the patient's care and communicate these to the patient, their family and carers, all relevant clinicians including primary care teams d. report new or suspected medicine allergies and adverse reactions to an incident management system and the TGA
Medicines are optimised through ongoing reviews across the care continuum	3.13	Clinicians: a. review a patient's medicines throughout their care and at transitions of care b. perform and document patient medication reviews using a structured approach that: i. accords with evidence-informed practice ii. informs the appropriateness of initiating, continuing, modifying or deprescribing a patient's medicines based on their care needs

Purpose		Requirements
Medicines information is communicated clearly and accurately	3.14	Clinicians: a. provide patients with information about their individual medicine needs, risks and benefits b. routinely generate and update a patient's medicines list c. document why the patient's medication regimen has changed and inform the patient, their family and carers and all relevant clinicians including primary care teams of the change d. provide an updated medicines list and relevant information to the patient, their family and carers at transfer of care or at the end of the episode of care, in a form they understand and transmit the medicines list to the primary care teams at transitions of care
Medicines are safely procured, stored, distributed and disposed of	3.15	The workforce adheres to the manufacturers' directions of use, legislative and jurisdictional requirements and best practice guidance for the: a. safe and secure storage and distribution of medicines b. sustainable medicines procurement and usage practices c. disposal of unused, unwanted or expired medicines
Safe and consistent use of medicines, including antimicrobials, is supported through **effective stewardship**	3.16	The workforce demonstrates quality use of medicines practices that: a. identify medicines that pose a high risk to patients b. align with evidence-informed practice guidance c. apply surveillance methods to measure high-risk medicines use and reports the results to the workforce, board, director, executive, managers d. analyse and act on the results of the high-risk medicines use to demonstrate and promote quality improvement
Patients are prescribed medications safely	3.17	The healthcare service has processes and guidelines to: a. support clinicians in obtaining an accurate history and assessment of patients when prescribing b. provide alternate pathways to patients when virtual services cannot adequately assess a request for medicine(s).

Medical devices and patient monitoring

Medical devices are safely selected, used, maintained and monitored throughout their lifecycle in alignment with regulatory and manufacturer requirements.

Purpose		Requirements
Safe, compliant and reliable medical devices are provided	3.18	The healthcare service has organisational systems that: a. ensure applicable medical devices and software comply with regulations and are on the Australian Register of Therapeutic Goods b. ensure the selection of medical devices for use in the healthcare service is based on evidence of effectiveness and free from commercial influence c. ensure new medical devices go through a defined selection process, acceptance testing and commissioning to assess that the devices meet the manufacturer's stated specifications and requirements for patient care d. evaluate the implementation and performance of new medical devices and take appropriate action to address any issues identified
Medical devices are used as intended	3.19	The healthcare service has organisational systems that ensure: a. medical devices are used for their intended purpose in accordance with the manufacturer's instructions of use and communicate this to the workforce b. medical devices that are not listed on the Australian Register of Therapeutic Goods (ARTG) are used for their intended purpose in accordance with the clinical research protocol and product information sheet and communicate this to the clinicians and non-clinical workforce c. regular quality assurance of medical devices so the devices perform optimally during use d. medical devices undergo planned maintenance and repairs according to the manufacturer's instructions of use and have their performance tested after maintenance and repair e. medical devices that are not listed on the ARTG are serviced, certified and updated in accordance with the clinical research protocol and product information sheet f. active management of aging, obsolete and sub-optimally performing medical devices
Medical device incidents are reported	3.20	The healthcare service reports near missed and adverse events for: a. approved medical devices into the incident management system, to the manufacturer and the TGA b. medical devices that are not listed on the ARTG in accordance with regulation, into the incident management system and to relevant agencies

Purpose		Requirements
Remote Patient Monitoring (RPM) is used safely and appropriately resourced	3.21	Healthcare services use RPM safely by: a. Defining the type of monitoring to be provided and fit with the target patient population and the level of symptom severity and co-morbidities the service can support b. Determining the clinician and non-clinical resources and resource mix required to provide safe monitoring including hours of operation and staff-to-patient ratios c. Determining the technical resources required to support the service d. Identifying external healthcare services that can support the patient if they require care outside the virtual modality offered e. Developing patient assessment tools to determine the appropriateness of the RPM service for individual patients f. Designing RPM device delivery and pick-up systems including tracking notifications for the patient g. Identifying any costs to the patient including data transmission (internet), device hire, consumables required for the device delivery or pick up. h. Aligning RPM service disruption planning with the healthcare services emergency preparedness and response frameworks
Clinicians and patients are supported in obtaining accurate information from Remote Patient Monitoring	3.22	Healthcare services have processes and systems to support clinicians in: a. discussing RPM and alternative monitoring options with the patient b. confirming the patient's willingness and consent to engage with and learn how to use RPM. c. assessing the patient's cognitive and physical ability to use the proposed RPM device and read its outputs (where appropriate) d. training patients on the use of the RPM device including infection control and device cleaning considerations e. providing instructions for the use and care of the device to patients in line with the manufacturer's instructions f. providing guides to patients to assist in determining if the RPM system or device(s) are not operating and the steps to take to manage their health and reporting channels g. confirming any planned RPM solution downtime with patients including downtime monitoring, contact and escalation procedures

Glossary

The following definitions used by the Commission apply across the NSQHS Standards. Where appropriate, definitions from external sources have been adapted to fit the context of the NSQHS Standards and are referenced accordingly.

Term	Definition
Accessible[3]	Delivered at the right time and the right place.
Advance care planning[15]	A voluntary process that allows people to explore what they value most in life, to guide their current and future health and personal care.
Adverse event[16]	An incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event. See also near miss.
Allergy[17]	An immune response, in which a person's immune system reacts to foreign substances (allergens) that are harmless to most people.
Antimicrobials[18]	Medicines that kill or slow the growth of microorganisms (bacteria, fungi, parasites and viruses) that cause disease.
Antimicrobial resistance[17]	When microorganisms (bacteria, fungi, parasites and viruses) that cause infections resist the effects of the medicines used to treat them.
Approved patient identifier	Specific data items approved for use as patient identifiers, for example, patient name (family and given names), date of birth, gender, address including postcode, healthcare record number and individual healthcare identifier.
Behaviours of concern[19]	Behaviours of such intensity, frequency or duration that the physical safety or emotional wellbeing of the person, or others around them, is at significant risk.
Benchmark	A standard or point of reference by which others measure their performance or outcomes.

Term	Definition
Best Possible Medication History[20]	A Best Possible Medication History is an accurate and complete list of medicines the patient is currently taking. The list includes the name, dose, route and frequency of the medicine.
Bias	Refers to a systematic deviation from neutrality or fairness, where judgments, decisions or processes are influenced by personal beliefs, assumptions or external factors.
Board	The individual or group with ultimate responsibility for the governance, direction, oversight, performance, and compliance of a healthcare service. This may include a chief executive officer, healthcare service owner, partnership, board of directors, or other highest-level governing body responsible for strategic and operational decision-making and for monitoring the healthcare service's business, affairs, and operations. The individuals or group whose responsibilities include governing, directing and monitoring a healthcare service's business, affairs and operations, including overall organisational performance and compliance.
Care environment	The physical, social and organisational setting in which health care is delivered. It is designed to enable the delivery of high-quality care, be safe and welcoming, appropriately meet patients' needs and support their independence, function, interaction and overall well-being.
Care goals	What a patient wants to achieve during an episode of care within the context of their clinician situation.
Care pathway	A person-centred, structured, evidence-based, multidisciplinary approach that organises and coordinates care processes and clinical interventions for a defined group of patients over a specified period, mapping the sequence, timing, and expected outcomes of care.
Carer[21]	A person who provides ongoing, unpaid care and support to a family member, neighbour, or friend who needs help with their day to day living because they live with a disability, terminal illness, chronic illness, mental illness or ageing. A collective approach to carer responsibilities by those close to the person receiving care is also possible, particularly for Aboriginal and Torres Strait Islander peoples and people with different cultural or social identities culturally and linguistic diverse people there may be a collective approach to carer responsibilities.
Clinical assessment[22]	A systematic and dynamic process of collecting and analysing data about a patient's health. It involves an evaluation of a patient's symptoms and physical condition, information gathered from physical and diagnostic examinations, the patient's medical history and illness course, and the determination of a prognosis and treatment.

Term	Definition
Clinical Care Standards	Are quality statements in line with current best evidence that describe the care patients should be offered by health professionals and healthcare services for a specific clinical condition or defined clinical pathway.
Clinical governance[2]	The combination of organisational culture, systems and structures that enables everyone in a healthcare service to deliver care that is consistently high- quality and improving. It is central to providing the best possible outcomes for patients. Effective clinical governance means that boards, executives, clinical leaders and the workforce are clearly accountable to patients, families, carers and the community for providing high-quality care.
Clinical handover[23]	The structured transfer of professional responsibility and accountability for some or all aspects of care for a patient or group of patients, to another clinician or multidisciplinary care team on a temporary or permanent basis within a healthcare service.
Clinical leader[24]	A healthcare professional who works within a clinical setting and exercises leadership to improve the quality of patient care. They combine hands-on clinical expertise with the ability to guide and influence teams to shape workplace culture, drive positive behavioural change, and enhance practice and performance.
Clinical review[25]	A retrospective, structured, systematic process of examining health related evidence, medical care and treatment decisions to evaluate whether care met accepted standards of necessity, safety and quality. Reviews are used to regularly review a clinician's work, and they also occur in response to a defined list of clinical issues, and triggers, such as substandard performance or questionable care decisions.
Clinical trials[26]	A type of research that studies new tests and treatments and evaluates their effects on human health outcomes. People volunteer to take part in clinical trials to test medical interventions including drugs, cells and other biological products, surgical procedures, radiological procedures, devices, behavioural treatments and preventive care.
Clinician[27]	Refers to trained and qualified individuals, including registered and non-registered practitioners, who provide direct clinical care to patients. Clinicians include Aboriginal and Torres Strait Islander Health practitioners, allied health practitioners, ambulance officers and paramedics, medical and medical radiation practitioners, midwives, nurses, scientists, technicians and students who provide health care under supervision.

Term	Definition
Co-design[28]	A collaborative process in which stakeholders, including end users, work together as equal partners with experts to design structures, systems, policies, processes and services. It is collective creativity that is applied across the whole span of a design process.
Co-design (with Aboriginal and Torres Strait Islander peoples)	An equitably resourced partnership process that is Aboriginal and Torres Strait Islander-led and build on authentic relationships, communicating through agreed mechanisms, two-way understanding, cumulative evaluation and reflection to generate and sustain shared development pathways to outcome delivery and reform. To be described as co-design respective activities, arrangements and claims must: • ensure early and consistent involvement of Aboriginal and Torres Strait Islander peoples and communities through the design process for transparency and accountability • prioritise and respect the voices of Aboriginal and Torres Strait Islander peoples to determine and drive the agenda and design solutions for health reform; and address the interface between the health, disability and aged care sectors facilitate knowledge-sharing, power-sharing, shifts in control consistent with the National Agreement and capability building between the healthcare system, Aboriginal and Torres Strait Islander experts and patients
Community[29]	Refers to a group of people who share a common location, identity, culture, interests or experiences, and who are connected through social relationships, networks and a sense of belonging. In healthcare, communities play an important role in shaping health needs, experiences and outcomes.
Consumer	A consumer advocate or representative who provides a consumer perspective, contributes consumer experiences, advocates for the interests of current and potential healthcare service users, and takes part in decision-making processes.
Continuum of care	A person-centred, longitudinal conceptual framework that organises all healthcare services across a person's healthcare journey within an integrated system, providing coordinated, consistent care across discrete encounters while accounting for the individual's medical needs, personal context, and the integration of multiple services and teams.
Continuing professional development	The systematic maintenance, improvement and continuous acquisition and reinforcement of the life-long knowledge, skills and competencies of clinicians.
Continuity of care	The degree to which health care is experienced by a person as coherent, connected and consistent over time and across settings. It is achieved through ongoing relationships and seamless coordination across providers, teams, and care settings.

Term	Definition
Credentialing[30]	The formal process used by a healthcare service to verify the qualifications, experience, professional standing, behaviours, competencies and other relevant professional attributes of clinicians, so that the healthcare service can form a view about the clinician's competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.
Credentials[30]	The practical experience, qualifications, professional awards and statements of competency issued by an authorised and recognised body that attest to a clinician's education, training and competence and relevant practical experience.
Critical information	Information that has a considerable impact on a patient's health, wellbeing or ongoing care, and may require clinicians to reassess or change the patient's plan for care.
Critical medical device	An item that confers a high risk for infection if they are contaminated with any microorganism and must be sterile at the time of use. This includes any device that enters sterile tissue or the vascular system, because any microbial contamination could transmit disease.
Cultural safety	It is determined by individuals, families and communities. In healthcare service's culturally safe practice is the ongoing critical reflection of knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive health care, free from bias, discrimination and racism.
Cultural safety (Aboriginal and Torres Strait Islander peoples)	It is determined by Aboriginal and Torres Strait Islander peoples, families and communities. The healthcare service's culturally safe practices for Aboriginal and Torres Strait Islander peoples also include • acknowledging colonisation and systemic racism, and the social, cultural, behavioural and economic factors which impact individual and community health • acknowledging and addressing individual racism, discrimination, biases, assumptions, stereotypes and prejudices and providing care that is holistic, free from bias, discrimination and racism • Recognising the importance of self-determined decision-making, partnership and collaboration in health care which is driven by the individual, family and community Fostering a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander peoples and colleagues.
Cybersecurity	Measures and practices used to protect the confidentiality, security, integrity and availability of information technology and operational technology systems, data, computer systems, networks and devices.

Term	Definition
Data	Are measurements or observations that are collected as a source of information, and in the healthcare context, refer to clinical and non-clinical information such as patient records, test results, vital signs and service data that are collected to inform diagnosis, treatment, care planning and health system management and healthcare improvements.
Data governance	Ensures that data is accurate, accessible, secure and responsibly managed, while establishing policies, processes, structures, roles and responsibilities to enable effective management and use of data as a strategic asset for decision-making and service delivery.
Data insights	Meaningful interpretations of analysed data that explains patterns, trends, or relationships and can be used to inform decisions, policy, or action.
Data quality	Refers to the extent to which data is fit for purpose and meets standards for accuracy, reliability and usability.
Deprescribing	A planned and supervised process of medication reduction or withdrawal intended to achieve improved health outcomes through discontinuation of one or more medications that may be causing harm, no longer required or beneficial.
Deterioration	Refers to physiological, psychological or cognitive changes in a patient that indicate a worsening of the patient's condition.
Deterioration in mental state	Refers to negative changes in a person's mood or thinking, behaviour, cognitive function, perception or emotional state.
Digital downtime	Refers to a period when electronic systems are unavailable or only partially available or not functioning as intended, disrupting access to information and healthcare service delivery.
Digital maturity	Refers to the healthcare service's level of digital capability, including its ability to effectively adopt, use, integrate and improve its digital systems and data over time to support high-quality care.
Digital systems	Are information and communication technology-based systems, tools and services that support healthcare delivery and coordination by enabling the management, storage, sharing and access of information, facilitating patient care, and supporting the collection and exchange of health data.
Digitally enabled care	The appropriate use and integration of digital health tools and technologies in clinical settings to support the sharing of information, collaboration and to deliver connected, coordinated and high-quality healthcare.
Directions of use	The instructions provided with a medicine that enable it to be used safely and effectively.
Director[31]	A person responsible for overseeing the affairs of a company, who must comply with their legal obligations as a director under the Corporations Act 2001.

Term	Definition
Discrimination	Any distinction, exclusion or preference that impairs equality of opportunity or treatment and occurs when a person is treated less favourably because of personal characteristics.
Diversity	Refers to a range of social, economic and geographic differences among people and populations, including variations in cultural background, language, beliefs, experiences and disability status and personal characteristics.
Effective[3]	Evidence-based and results in outcomes that benefit the person receiving care.
Efficient[3]	Minimises cost and waste while achieving the best possible outcomes for people.
Environmental sustainability	Fulfilling the environmental needs of current generations without compromising the needs of future generations, while ensuring a balance between economic growth, environmental care and social wellbeing.
Episode of care	Refers to the period from a patient's initial contact with a healthcare service for a specific health problem through to the completion of treatment or final interaction for that specific health problem.
Escalation pathway	An escalation pathway is a structured process used to identify patient deterioration and initiate an increase in care to ensure a timely and appropriate response. The pathway can be activated by clinicians in response to abnormal physiological measurements or other observed deterioration or by a patient and their support people when they are concerned about a decline in the patient's condition.
Equitable[3]	Provides quality care to all people while responding to the needs of different groups to minimise differences in outcomes.
Equity	The absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability or sexual orientation).
Evidence-informed practice	An intervention that is based on best available evidence and experience to produce optimal patient outcomes and is established or proposed as a standard suitable for widespread adoption.
Executive	Refers to key decision-makers or accountable people responsible for providing strategic and operational direction of the healthcare service and ensuring the delivery of high-quality care.

Term	Definition
Facility-specific scope of practice	The extent of a clinician's approved clinical practice within a particular facility or healthcare service or setting, based on the clinician's credentials, competence, performance and professional suitability; the needs of the facility; the capacity of the facility to provide safe and appropriate care and the capability of the facility to support the clinician's scope of practice. It is specific to an individual, their role and the facility in which they work.

Formal partnership[5]	As defined in the clauses 28 to 33 of the National Agreement on Closing the Gap and enshrines agreed joint decision-making by setting out who makes decisions, how decisions are made, and what decisions will be about.
	
	Formal Partnerships provide Aboriginal and Torres Strait Islander entities with a level of power that is equal to or higher than other parties.
	
	Formal Partnerships:
	• require formal signed agreements between Aboriginal and Torres Strait Islander peoples, governments, and other parties that sets out how they will each work to together to achieve agreed goals and aims
	• allow Aboriginal and Torres Strait Islander peoples to choose their own representatives.
	• provide adequate funding to support Aboriginal and Torres Strait Islander parties to be partners in Formal Partnerships for activities to
	  ○ engage independent policy advice
	  ○ meet independently of governments to determine their own policy positions
	  ○ support strengthened governance between and across Aboriginal and Torres Strait Islander organisations and entities
	
	engage with and seek advice from Aboriginal and Torres Strait Islander peoples from all relevant groups within affected communities, including but not limited to, Elders, Traditional Owners and Native Titles Holders.

Governance	The exercise of authority, oversight and decision-making over an organisation such as a healthcare service to direct and manage its business affairs and operations, ensuring organisational performance and objectives are achieved while maintaining compliance with legislated regulatory requirements and legal, ethical and community expectations.
Healthcare-associated infections	Infections acquired in a healthcare service, during care or because of an intervention, that were not present or incubating at the time of admission. These infections may become apparent after discharge.

Term	Definition
Healthcare Identifier	A unique number assigned to individuals, healthcare providers and healthcare services to accurately identify and match health information. For further information visit: https://www.health.gov.au/topics/health-technologies-and-digital-health/about/healthcare-identifiers
Health literacy	The personal knowledge and competencies that accumulate through daily activities, social interactions and across generations that enable people to access, understand, appraise and use information and services in ways that promote and maintain health and well-being.
Healthcare service	A separately constituted organisation that is responsible for implementing corporate and clinical governance, administration and financial management of a service unit or service units providing health care to a community at the direction of a board.
High-risk medicines	Medicines that have a high risk of causing significant injury or patient harm when they are misused or used in error.
High-quality care	Person-centred, safe, effective, accessible and integrated, provided in a way that is equitable, efficient and sustainable. Cultural safety, as determined by Aboriginal and Torres Strait Islander peoples, is necessary for high-quality care. Cultural safety must be embedded in each domain of high-quality care to improve health outcomes for Aboriginal and Torres Strait Islander peoples.
Incident[16]	An event or circumstance that resulted, or could have resulted, in unintended or unnecessary harm to a patient or consumer; or a complaint, loss or damage. An incident may also be a near miss.
Incident management system	An organisational system that supports the identification, reporting and investigation of incidents to enable learning, inform risk management, and drive continuous quality improvement.
Individual Healthcare Identifier	A unique number that ensures healthcare providers can accurately match records to the person they are treating.
Infection	When pathogens (germs) such as bacteria, viruses, parasites and fungi get onto or enter the body, multiply and cause disease.
Information security management system	An organisational system that includes controls to manage information security risks and protect the confidentiality, integrity and availability of health information.
Informed consent	When a person voluntarily agrees to a healthcare treatment, procedure or other intervention with accurate and relevant information about the health care and alternative options available, and adequate knowledge and understanding of the benefits and risks of the proposed health care relevant to that person.

Term	Definition
Integrated	Coordinated and continuous care within and between all parts of the healthcare system and other care settings and throughout the person's healthcare journey.
Interoperable	The ability of a system or product to transfer information within and between systems or products without special effort on the part of the user.
Intervention	Any action taken by a clinician to prevent, diagnose, treat, or manage a disease, injury, or health condition with the goal of improving or maintaining a person's health.
Interventional procedure	An invasive diagnostic or therapeutic procedure involving the use of instruments to directly act on the body.
Invasive medical devices	A device intended by the manufacturer to be used, in whole or in part, inside the body. This includes devices that enter a body orifice or that penetrate the surface of the body, or that enter the body in the context of a surgical operation.
Jurisdictional requirements	Encompasses legislation, regulations and policy instruments that govern what must be done within a jurisdiction in Australia. This includes (Commonwealth, state or territory jurisdictional requirements).
Leaders	The individuals who guide and influence teams within the health system to achieve high- quality care, irrespective of their formal role or title.
Medication reconciliation	A formal process of obtaining, verifying and documenting an accurate list of each patient's current medicines and matching the medicines the patient should be prescribed to those they are prescribed.
Medication review	A systematic assessment of a patient's medication management with the aim of optimising the quality use of medicines and minimising medicine related harm.
Medicine	Therapeutic goods that contain active ingredients intended to prevent, diagnose, cure, treat or alleviate symptoms of disease, injuries, and medical conditions or to change how the body works.
Medicines list	An up-to-date list of the medicines a person: a. is known to be taking and includes: i. prescription, non-prescription and complementary medicines ii. the medicine name, form, strength, intended use and directions for use b. should not be taking and includes: i. those causing allergies and adverse drug reactions the medicine name, the reaction type and the date the reaction was experienced.

Term	Definition
Models of care	Frameworks guiding how multidisciplinary care teams' function to deliver healthcare in different settings and contexts.
Multidisciplinary care team	A group of clinicians from different disciplines who work together to plan, deliver and review a patient's care.
My Health Record	The national secure consumer-controlled national electronic health record system that contains an online summary of an individual's key health information.
National clinical terminologies	Standardised collections of coded medical terms used across Australia's healthcare system to consistently record, communicate, and share clinical information in digital health systems.
National Digital Health Infrastructure	The nationally coordinated digital systems, platforms, standards and services that support the secure exchange, use and management of health information across healthcare services, providers and jurisdictions. Examples include: • My Health Record • Healthcare Identifier Service • Provider Connect Australia Health Connect Australia Provider Directory
Near miss[32]	An incident or potential incident that was averted and did not cause harm but had the potential to do so.
Open disclosure	An open discussion with a patient and their family or carers about an incident that resulted in harm to the patient while receiving health care. The criteria of open disclosure are an expression of regret, a factual explanation of what happened, the potential consequences and the steps taken to manage the event and prevent recurrence.
Organisational culture	A set of values, expectations, formal and informal practices and behaviours that define the unique organisational environment. 'The way things are done around here'.
Organisational systems	The resources, policies, processes, and procedures the healthcare service organises, integrates, regulates, and delivers to accomplish a stated goal.
Orientation	The formal process of introducing a new employee to a healthcare service and providing them with critical information and training that addresses workforce culture, organisational systems and expectations.
Patient safety culture	Focuses on the aspects of organisational culture that relate to patient safety. It is defined as a pattern of individual and organisational behaviour, based upon shared beliefs and values that continuously seeks to minimise patient harm, which may result from the process of care delivery.

Term	Definition
Person-centred[3]	Respects the person receiving care, their family and carers, and responds to the person's preferences, needs and values
Person-centred care[3, 9, 33]	An approach to the planning, provision and evaluation of health care that is founded on partnership between clinicians, patients, families, carers and communities, where care is tailored to the needs of the person, based on their expressed beliefs, hopes and expectations. Person-centred care is respectful of, and responsive to, the preferences, needs and values of patients, families, carers and communities.
Person-centred practice[9, 34]	A model for providing health care services that has its focus on the provision of person-centred care. It is achieved through building effective collaborative relationships between clinicians who facilitate evidence-informed shared decision-making with patients and consumers. Person-centred practice is realised in organisational cultures that are psychologically safe, embrace inclusive governance and strive for cultures of continuous improvement and innovation.
Physical environment	External surroundings and conditions including both natural and man-made elements. In healthcare the physical environment can include air space, water supply and buildings.
Plan for care	A plan for care is a collaborative process in which a patient, their family and carers work with clinicians to identify the patient's care goals and plan services to achieve them. The plan for care involves shared decision making about interventions and other aspects of care and is informed by the patient's values, needs and preferences, a clinical assessment, best-practice guidance, and the setting and service being provided.
Point of care	The time and location at which health care is delivered to a patient by a clinician.
Point of Care Testing devices[35]	Medical devices used at or near the patient to provide rapid results that support immediate clinical decision-making.
Procedure (medical)	A specific, structured clinical activity performed by a clinician that involves a defined technique or method to diagnose, treat, prevent, or manage a health condition.
Procedure (policy framework)	A set of detailed instructions describing how to perform a process or specific task.
Psychosocial safety	The proactive creation of a work environment that minimises risks to psychological and physical wellbeing, where people feel safe to speak up with ideas, questions, concerns or mistakes without fear of punishment, humiliation or negative consequences.

Term	Definition
Quality improvement	The combined efforts of the clinical and non-clinical workforce and consumers, patients, their family and carers, researchers, planners and educators to make changes that will lead to better health outcomes, better system performance and better professional development.
Racism	The unfair treatment or denial of equal opportunities based on race, skin colour or origin, and includes not only individual behaviours and attitudes, but also as well as systemic barriers that limit people's ability to experience dignity and equality.
Regularly	Refers to actions undertaken consistently and repeatedly over time at recurring intervals as part of an ongoing process, with the frequency informed by best practice guidance, a risk-based approach, and the nature of the activity.
Remote Patient Monitoring[36]	A way of delivering care that uses digital health technologies for the remote collection, transmission and analysis of consumers' health data.
Restraint	Any action, intervention or practice that restricts an individual's rights or freedom of movement, including the use of physical, mechanical or chemical means, to prevent harm or enable care.
Reusable medical device	An item intended for use on more than one patient for diagnostic or treatment purposes, which is designated by the manufacturer as suitable for reprocessing between uses to ensure it is safe.
Risk assessment	The systematic process of identifying, analysing, and evaluating risks to determine which events may lead to issues in the future and minimising their likelihood and consequences.
Risk management	The systematic application of risk policies, processes and practices to direct the application of resources to minimise, monitor and control the likelihood or consequences of events.
Routine operating hours	The planned scheduled hours during which a healthcare service provides its standard health care.
Safe[3]	Minimises risks of physical, psychological, psychosocial and cultural harms and factors that can contribute to actual or potential injury to the person receiving care.
Safety culture	The aspects of a healthcare service's organisational culture that relate to health and safety management. It is defined as a product of individual and group values, attitudes, perceptions, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of an organisation's health and safety management.
Screening	The systematic assessment of the workforce to identify those who may have, or are at risk of, an infection, enabling early detection and the timely implementation of infection prevention and control measures.

Term	Definition
Semi-critical medical device	A reusable item that comes into contact with mucous membranes or non-intact skin and is to be sterilised after each use. If sterilisation is not possible, high-level disinfection is to occur.
Shared decision making (with Aboriginal and Torres Strait Islander peoples)	Processes mutually described as shared between government and Aboriginal and Torres Strait Islander peoples. Activities characterised as shared decision making must adhere to the definition of shared decision making in the National Agreement on Closing the Gap, namely: By consensus, where the voice of Aboriginal and Torres Strait Islander entities holds as much weight as the governments Transparent, where matters for decision are in terms that are easily understood by all entities and where there is enough information and time to understand the implications of the decision Where Aboriginal and Torres Strait Islander representatives can speak without fear of reprisals or repercussions Where a wide variety of groups of Aboriginal and Torres Strait Islander peoples, including women, young people, Elders and Aboriginal and Torres Strait Islander peoples with a disability can have their voice heard Where self-determination is supported, and Aboriginal and Torres Strait Islander lived experience is understood and respected Where relevant funding for programs and services align with jointly agreed community priorities, noting governments retain responsibility for funding decisions Where all entities have access to the same data and information, in an easily accessible format, on which any decisions are made.
Shared decision making (with the patient)	A collaborative process in which a patient and clinician work together to make health decisions, using the best available evidence and considering the patient's values, preferences, and circumstances, including discussion of the benefits and risks of available options.
Social determinants of health	Encompasses the non-medical factors and wider social, economic and political forces that shape daily living conditions and influence health outcomes. It includes the circumstances in which people are born, grow, live, work and age, the social norms and policies, their education, sex and gender, food, resources, housing and climate.
Standard	A standard is an agreed, best practice statement that defines the agreed attributes, processes and expected performance levels that is used to ensure a service or method is delivered consistently at the required level.
Standard precautions	The minimum standard work practices for infection prevention and control for the care and treatment of all patients.

Term	Definition
Stewardship	The careful and responsible management of something entrusted to one's care.
Substitute decision-maker	A person who is authorised to make a health care or medical treatment decision for a person who has lost decision-making capacity.
Supervision	Structured oversight and guidance to support safe practice and reduce clinical risk.
Surveillance[37]	The ongoing, systematic collection, analysis, interpretation and dissemination of health-related data for the planning, implementation and evaluation of public health practice.
Sustainable[3]	Minimises environmental impact and reduces emissions while achieving the best possible outcomes for people
Team	A group of people who work together to achieve a common goal.
Timely	Coming early or at the right time; done or occurring at a favourable or useful time.
Trace	The ability to track and trace the history, location, and application of an item, person, or process throughout all stages of care.
Transition of care	When all or part of a person's health care is transferred between health professionals when a person moves between healthcare settings to receive care.
Transmission-based precautions[38]	The second tier of basic infection control and are used in addition to standard precautions for patients who may be infected or colonised with certain infectious agents for which additional precautions are needed to prevent infection transmission.
Unique Device Identifier[39]	A globally unique code assigned to a medical device that enables its identification and traceability throughout the supply chain and healthcare system. Only mentioned at 3.18 so may not need a definition if a reasonably common occurrence in healthcare services
Unwarranted variation[40]	Variation in the utilisation of healthcare services that cannot be explained by variation in patient illness or patient preferences.
Virtual Care	Any interaction between a patient and clinician(s), occurring remotely with the use of information technologies.
Workforce	Refers to all people working in a healthcare service, including employed or contracted, locum, agency, student, volunteer or peer workers. The health workforce is large and diverse and includes a wide range of professionals and operational staff who are all integral to providing high- quality care.

Term	Definition
Workforce culture[41]	The shared values, behaviours, attitudes and ways of working that shape how people interact, support one another, make decisions and deliver care. It influences staff wellbeing, teamwork, learning and the delivery of safe, high-quality care.

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Council for Connected Care

Agenda Item 10: Commission on Excellence and Innovation in Health (CEIH) and South Australian Comprehensive Cancer Network Data and Intelligence (SACCaN)

Meeting: Thursday, 3 December 2026

OFFICIAL

Purpose

The purpose of this agenda item is to provide an overview of the Commission on Excellence and Innovation in Health (CEIH) and the South Australian Comprehensive Cancer Network (SACCaN) Data and Intelligence initiative, which is developing a comprehensive cancer data ecosystem to support consumers, clinicians, researchers and health system planners.

Recommendation

It is recommended the Council for Connected Care:

1 **note** the presentation by Tina Hardin, Executive Director of Clinical Informatics and Innovation, CEIH and Dr Michael Osborn, Chief Cancer Officer, SACCaN.

Summary of issues

The South Australian Comprehensive Cancer Network (SACCaN) Data and Intelligence initiative, led in partnership with the Commission on Excellence and Innovation in Health (CEIH), is progressing the development of a comprehensive cancer data ecosystem to support consumers, clinicians, researchers and health system planners. By bringing together information from multiple sources and care settings, the initiative aims to provide a more complete understanding of cancer care, outcomes and patient journeys.

The presentation will use this work as a practical example to explore broader interoperability challenges and opportunities facing the health system. Members will be invited to consider the governance, privacy and legislative issues associated with sharing information across organisational, sectoral and jurisdictional boundaries, and discuss how trusted, secure and innovative approaches to data sharing could better support connected, whole-person care.

While focused on cancer, the issues and lessons arising from this work have broader relevance across the health system and may inform future approaches to interoperability, information sharing and health data reform.

Questions for the Council for Connected Care:

- What policy, legislative and governance changes would most effectively support secure and trusted sharing of health information across organisational and jurisdictional boundaries?
- How can Australia build connected data ecosystems that support whole-person care while maintaining appropriate privacy and community trust?
- What lessons from the development of a comprehensive cancer data ecosystem could be applied to other priority areas of healthcare and broader interoperability reforms?
- How can a national information strategy drive change that enables actionable decisions from point of care through system-wide policy?

Background

Speaker Bios:

Tina Hardin is Executive Director, Clinical Informatics and Innovation at the CEIH, with almost 25 years' experience across health data, information management, digital design, clinical quality registries, research translation, innovation and system improvement. She is also Program Sponsor for the SACCaN Data & Intelligence Program, where her focus includes bringing together data, digital capabilities and evidence to support more connected cancer care, better clinician experiences and the translation of research and innovation into practice.

A/Prof Michael Osborn is Chief Cancer Officer at SACCaN. He has been a consultant haematologist and oncologist at the Women's and Children's Hospital since 2010 and has led the Youth Cancer Service SA/NT since its establishment in 2011. Michael has contributed to national adolescent and young adult (AYA) cancer policy, service development, and leadership. His clinical and research interests include childhood and AYA leukaemias, living well during and beyond cancer treatment, and improving cancer care delivery

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability

Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 11: Panel Discussion: Virtual Care as Part of the System – Not a Side Channel

Meeting: Thursday, 3 December 2026

OFFICIAL

Purpose

The purpose of the agenda item is to explore the opportunities, challenges and enablers for delivering connected, person-centred virtual care at scale. Through a facilitated panel discussion, members will hear perspectives from health leaders and subject matter experts on how interoperability, information sharing and collaboration can support the future of virtual care across the health system.

Recommendation

It is recommended the Council for Connected Care:

1 **participate** in an interactive panel discussion to explore key considerations for delivering connected, person-centred virtual care at scale, and contribute perspectives on how interoperability, information sharing and collaboration can support improved health outcomes.

Summary of issues

Virtual care is playing an increasingly important role in improving access to care and supporting new models of service delivery across the health system. Realising its full potential requires seamless information sharing, trusted access to data and strong interoperability foundations to support connected, person-centred care.

This interactive panel discussion will bring together health leaders and subject matter experts to share practical insights on the opportunities, challenges and critical enablers for scaling virtual care, with a focus on improving care continuity and health outcomes across diverse care settings.

Background

The panel will be facilitated by Bret Morris, Chief Digital Health Officer, SA Health

Bret Morris is the Chief Digital Health Officer for SA Health, leading Digital Health SA and the digital services supporting South Australia's public health system.

With more than two decades of experience in digital transformation, technology leadership and public sector reform, Bret believes sustainable transformation is as much about people, processes and organisational change, as it is about technology.

Before joining SA Health, Bret co-founded digital consulting company Gyre Digital and was previously Chief Information Officer for the Government of South Australia, where he helped shape the State's Digital by Default, open data and cloud computing agendas. He also served as an independent Director of Education Services Australia from 2019 to 2025.

Bret chairs the National Health CIO Roundtable and the Australian Digital Health Agency's Jurisdictional Advisory Committee, contributing to national collaboration on interoperability, connected care and the digital foundations of Australia's health system.

Panellists include:

Dr Melanie Smith – GP Consultant, SA Virtual Care Service

Dr Melanie Smith is a GP working in private practice in Southern Adelaide and also as Co-Clinical Lead of the SA Virtual Care Service. She is a passionate advocate for primary care and general practice in particular. Melanie is a past president of General Practice Registrars Australia, current Council Member of the SA Faculty of the Royal Australian College of General Practitioners and Board Chair of the Adelaide Primary Health Network. From 2020 to 2023 she worked in public health in COVID response, initially in the USA and subsequently within SA Health.

As a clinician, Melanie has particular interests in urgent care, palliative care and digital health. Prior to commencing her medical studies, Melanie was a software engineer and continues to utilise her skills as a Certified Health Informatician Australasia advocating for digital clinical innovation and health systems improvement and as a Digital Health Adviser for the Australian Digital Health Agency. She is also a co-founder of Debrief Health, an AI powered clinical reflection tool designed to support continuous learning and improvement for clinicians in practice.

Jeanette Walters – Executive Director, Integrated Care Systems

Jeanette Walters is the Executive Director of Integrated Care Systems in SA government leading strategic planning, system redesign and key statewide reform projects to deliver new approaches to delivering care closer to home. This work includes the development of urgent care models to reduce demand on Emergency Departments, discharge support and transitional accommodation programs and hospital substitution models that use virtual and face to face care to reduce demand on hospital inpatient beds. Jeanette also holds key portfolios related to the interface with aged care and disability, supporting individual patient journeys, service development and system improvements.

Over her career Jeanette has worked as a clinician, in the public, private and university sectors, in SA, NSW and England; supported Intergovernment relations and negotiations in health; and led the development of social policy and programs related to ageing that address the needs and wants of older South Australians and engaged the community actively in that process.

Jeanette's operational and policy understanding and significant experience in hospitals, health, aged care and disability support has enabled her to develop productive relationships across sectors and build innovative, evidence informed care that delivers improved health experiences and outcomes for South Australians and supports broader system sustainability

David Morris – Acting Deputy Chief Executive, Clinical System Support and Improvement, Department of Health and Wellbeing

David Morris is the Interim Deputy Chief Executive, Clinical System Support and Improvement, and substantively Executive Director, SA Virtual Care Service and State Health Coordination Centre.

A nurse by background, David has held a range of senior clinical, operational, and executive leadership roles across SA Health, including Executive Director of Nursing and Midwifery and Chief Operating Officer at the Southern Adelaide Local Health Network.

David provides strategic leadership for virtual care across SA Health, shaping the development and implementation of digitally enabled models of care that improve access, strengthen system coordination, and enable more care to be delivered closer to home. His experience leading the development of statewide virtual care and system coordination brings a practical, system-wide perspective on the opportunities for digital innovation in healthcare.

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability

Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 12: Roundtable Updates

Meeting: Thursday, 3 December 2026

OFFICIAL

Purpose

The purpose of this agenda item is to understand current and upcoming initiatives undertaken by Council member organisations that focus on digital health reforms and interoperability with an emphasis on how virtual care can transform care delivery.

Recommendation

It is recommended the Council for Connected Care:

1 **note** update on the Aus CVD Risk i-calculator.

Summary of issues

The Aus CVD Risk-i calculator implementation demonstrates how coordinated digital health strategy, interoperability standards, and clinically endorsed, evidence-based guidelines can be operationalised to deliver measurable impact in healthcare, moving interoperability from concept to system capability.

The calculator application has now been deployed into its operational environment and is transitioning to live clinical use, embedding nationally endorsed cardiovascular disease (CVD) risk assessment guidance as a standards-based, interoperable solution within clinical workflow, addressing the long-standing gap between evidence-based guidance and its consistent application in clinical practice.

Key implications for the health system include:

- **National infrastructure value:**
  - Alignment with the Australian Digital Health Agency's interoperability roadmap and implementation program
  - Early adoption of standardised clinical data elements aligned with Sparked (Australian Core Data for Interoperability)
  - Demonstrates how clinical guidelines can be implemented as scalable, interoperable digital infrastructure.
- **Clinical and operational value:**

    - Supports delivery of national standards for early detection and prevention of CVD
    - Enables consistent, evidence-based decision-making at point of care
    - Reduces administrative burden and improves data quality through structured data capture and integration into workflow.
- **Patient and population value:**
    - Enables more meaningful clinician–patient interaction and shared decision-making
    - Supports uptake and efficiency of Heart Health Checks.

This initiative establishes a repeatable model for embedding future nationally endorsed tools into clinical systems, enabling scalable adoption of interoperability standards across vendors and care settings.

Background

Market Problem and Clinical Need

Cardiovascular disease (CVD) is a leading cause of death in Australia and continues to place a significant burden on the health system and community. Heart disease sends over **400 people to hospital every day**, accounts for **one in four deaths**, and costs the healthcare system more than **$16.9 billion annually.** It is also one of the most common reasons for general practice consultation, spanning preventive care (e.g. blood pressure and cholesterol management) through to complex management of established disease.

The existing Aus CVD Risk calculator is the most clinically accurate tool for assessing cardiovascular risk in the Australian population and is widely used by clinicians, with **more than 2 million calculations completed since its 2023 launch by the Health Minister**. Despite this strong clinical value, a gap remains between guideline recommendations and real-world clinical workflow.

Access the online Aus CVD Risk calculator here to view its current access and use.

In its current form, use of the calculator requires clinicians to access an external browser and manually enter patient data. This introduces workflow inefficiencies, including additional administrative steps, duplication of data entry, risk of errors, disruption to consultation flow, and **reduced time for meaningful patient interaction and shared decision-making.**

Previous integrations of CVD risk calculators into clinical software have been undertaken on an individual basis, resulting in **variability in implementation and outcomes**. This highlights the need for a consistent, standardised approach to digital implementation, one that supports structured data use, aligns to national standards, and enables scalable, interoperable deployment across clinical systems.

While the calculator itself delivers strong clinical value, its current mode of access limits its impact. A shift toward embedded, interoperable solutions is required to realise its full benefit across the health system.

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability

Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 13: Other Business

Meeting: Thursday, 3 December 2026

OFFICIAL

Purpose

The purpose of this agenda item is for members to raise any business items for consideration or discussion by the Council.

Recommendations

It is recommended the Council for Connected Care:

1 **raise** any other business items for consideration or discussion by the Council

2 **note** the next meeting will be held virtually on Thursday 6 May 2027.

Summary of issues

The next meeting is proposed to take place virtually on Thursday 6 May 2027 via Microsoft Teams and will have a focus on preparations for the Council for Connected Care Annual Review report to be published in June 2027 and future systems foundations.

Background

This is a standing agenda item.

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability