Australian Government
Australian Digital Health Agency

Agenda

Council for Connected Care: Meeting 10 – Annual Review

Location: Virtual via Microsoft Teams.

Meeting: 11:00 am – 1:30 pm (Australian Eastern Standard Time) on Thursday, 21 August 2025

OFFICIAL

Item	Timing		Topic	Presenter
1	5 mins	11:00 am	Welcome, Acknowledgement of Country	Anne Duggan, Chair
2	5 mins	11:05 am	Conflicts of Interest, apologies and housekeeping	Anne Duggan, Chair
3	5 mins	11:10 am	Minutes of previous meeting and action items	Anne Duggan, Chair
4	20 mins	11:15 am	Interoperability 2024-25 achievements • 2024-25 Annual Progress Report (Interoperability Plan + HI roadmap) • Standards Advisory Group Annual Progress Update	Siobhan McFadden, Director Interoperability Lisa Murphy, Director Standards Strategy
5	30 mins	11:35 am	Council for Connected Care 2024-25 Annual review and 2025-26 Workplan • 2024-25 Annual Review • Annual Survey Results • 2025-26 Workplan	Sandra Cook, Branch Manager, Connected Care
	15 mins	12:05 pm	Tea Break	
6	20 mins	12:20 pm	HI Legislation	Kate Deere, Director, Digital Health Legislation and Policy, DoHDA

Item	Timing		Topic	Presenter
7	15 mins	12:40 pm	Share by Default update	Tracy Cook, Director, Digital Health, My Health Record Section, DoHDA Sheriel Hughes, Branch Manager, National Program Delivery, ADHA
8	15 mins	12:55 pm	Pathology Tests Explained (PTEx) in my health app	Jenny Sikorski, Chief Executive Officer, Public Pathology Australia
9	15 mins	1:10 pm	ACSQHC Clinical Governance Framework update	Gillian Giles, Director Clinical Governance, ACSQHC
10	5 mins	1:25 pm	Summary and other business	Anne Duggan, Chair & Peter Sprivulis, Deputy Chair
			Meeting close – 1:30 pm	

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Council for Connected Care

Agenda Item 2: Conflict of Interest

Meeting: Thursday, 21 August 2025

OFFICIAL

Purpose

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

Recommendation/s

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.

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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Council for Connected Care

Agenda Item 3: Minutes of previous meeting, action items

Meeting: Thursday, 21 August 2025

OFFICIAL

Purpose

The purpose of this agenda item is to seek endorsement of the meeting minutes from 12 June 2025, and to provide an update on the status of action items.

Recommendation/s

It is recommended the Council for Connected Care:

1 **endorse** the 12 June 2025 meeting minutes at Attachment A

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

Summary of issues

Minutes of the 12 June 2025 meeting are provided at Attachment A

A list of all action items is provided at Attachment B.

Action items recommended for closure at this meeting are:

Action Item #	Description	Owner	Due	Status
2025/09-01	Australian Commission on Safety and Quality in Healthcare to share draft clinical governance framework document when available with Council members	Chris Leahy	August 2025	Closed – document circulated to members
2025/09-02	Department of Health, Disability and Ageing to provide an update on the progress of the Omnibus bill at the next meeting.	Simon Cleverley	August 2025	Closed - Included in Item 6 on agenda today

Background

This is a standing agenda item.

Attachments

Attachment A: Meeting minutes of the 12 June 2025

Attachment B: Action List

Contact officer: Cass Timmermans, Assistant Director, Interoperability

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Council for Connected Care

Agenda Item 4: Interoperability and Standards Advisory Group 2024-25 achievements

Meeting: Thursday, 21 August 2025

OFFICIAL

Purpose

The purpose of the paper is to review and acknowledge key interoperability achievements from 2024–25, including progress on the Interoperability Plan and Healthcare Identifier (HI) Roadmap, and to receive the annual update from the Standards Advisory Group (SAG), highlighting advancements in digital health standards and alignment with national priorities.

Recommendation/s

It is recommended the Council for Connected Care:

1 **note** the Interoperability Plan and HI Roadmap annual progress report at Attachment A

2 **note** the SAG annual progress update.

Summary of issues

Interoperability Plan and HI Roadmap annual progress report 2024-25

The Interoperability Plan and HI Roadmap aim to create a connected and secure healthcare system in Australia. The plan outlines 44 actions across 5 priority areas including Identity, Standards, Information-sharing, Innovation and Benefits. The 2024-25 annual progress report reflects on key achievements and progress against the 44 actions items in the Interoperability Plan and 20 activities in the HI Roadmap. During the reporting period over 2024-25, 15 actions were completed, including:

- **Action 1.9** Provider Connect Australia™
- **Action 2.2** Develop specifications and standards
- **Action 2.4** International standards participation
- **Action 2.6** National Digital Health Standards Program (NDHSP)
- **Action 2.8** Standards gap analysis
- **Action 2.11** National library of terminology mapping
- **Action 2.14** Standards development cooperative
- **Action 3.4** Online interoperability toolkit
- **Action 3.6** Consent Management
- **Action 3.7** Research international practice
- **Action 4.1** Interoperability innovation challenges
- **Action 4.3** Develop education content

- **Action 5.1** Administer interoperability survey
- **Action 5.2** Publish annual report
- **Action 5.4** GDHP interoperability maturity model

In total, 24 actions (55%) have been completed in the Interoperability Plan, marking substantial progress. While some ongoing work will continue to support these completed actions, quarterly reporting will no longer be required for them.

17 actions are currently on track and 3 actions are scheduled to commence in 2025-26 with medium timeframes (2025-26 to 2027-28) and include:

- **Action 3.10** Publish-subscribe service
- **Action 3.11** Consistent legislative health definitions
- **Action 3.12** Harmonising legislation.

Under the HI Roadmap, 12 activities are on track, with 5 additional activities to commence in 2025-26, including:

- **Activity 3** Development of a simplified guide to the HI Act
- **Activity 4** Template policies and guidelines on HI use
- **Activity 9** Enhanced search considerations
- **Activity 10** Individual Healthcare Identifiers for newborns
- **Activity 15** HI Service architecture and future extensibility

Over 2024-25, significant progress has been made to improve connected care:

- The Sharing by Default Act passed in February 2025 which mandates the secure sharing of health information to My Health Record for a more connected healthcare system.
- Workforce capability in digital health was enhanced through the Capability Action Plan (CAP) 2024-25, in collaboration with the Australasian Institute of Digital Health (AIDH), the Digital Health Cooperative Research Centre (DHCRC), and education sectors.
- Published the Conformance Framework in July 2024, the Aged Care Clinical Information System (ACCIS) Standards in August 2024, the Health Connect Australia Strategy, Architecture and Roadmap and an early draft FHIR Implementation guide is in development to support Health Connect Australia,
- Published Interoperability education resources, including Introduction to My Health Record integration for software developers and Integration with the Healthcare Identifiers Service.
- Centralised resources, including in the Connected Care education resources library, Online Interoperability Toolkit, Digital Health Developer Portal, online forum capability and the Digital Health Standards Catalogue (including the National Terminology Mapping Library) provide a central place for collaboration and build a knowledge base.
- The Council for Connected Care met four times in 2024-25 covering themes such as aged care, health disadvantage and Aboriginal and Torres Strait Islander, rural and remote communities.
- The Australian Digital Standards Advisory Group met five times over 2024-25 and addressed topics such as clinical terminology adoption, inter-governmental collaboration, Health Connect digital health standards and terminology mapping.

- The FHIR® Accelerator program continued through Sparked (CSIRO, HL7 Australia, the Agency and the Department of Health, Disability and Ageing). Achievements included the draft AU eRequesting FHIR Implementation Guide and participation in Connectathons.
- The Agency completed a research study on consent management in 2024-25 and completed an Interoperability Survey in June 2025.

Standards Advisory Group annual progress update

The Standards Advisory Group met five times over the financial year through three meetings and two focused workshops to advise on projects supporting digital health standards.

One of the workshops held in May involved members of the Standards Advisory Group, jurisdictional representatives and terminology experts advising on the development of a national library of terminology maps (addresses Action 2.11 Interoperability Plan). The Agency used criteria from ISO 21564 Health Informatics – Terminology resource map quality measures (MapQual) 2019 to identify mature, established and clinical safe terminology maps. A selection of terminology maps were identified and reviewed and validated against ISO 21564 with key stakeholders. Their feedback was used to inform the final deliverable and assisted the identification of future maps that would be available in the terminology map library. The terminology mapping library is now available in the Digital Health Standards Catalogue.

The Standards Advisory Group also met to discuss the development of a National Strategy and Roadmap for Digital Health Standards to capture and share a vision for a coordinated approach to adoption and implementation of digital health standards. Members shared their advice on the barriers and enablers to strengthening adoption and implementation of digital health standards which informed the identification of five key areas where support is needed. By actioning each of these key areas, the Agency aims to create the foundational structure required to lead future work on supporting adoption and implementation of digital health standards. These key areas are:

1. Establishing a governance model for inter-government collaboration on Digital Health Standards
2. Strengthening the evidence and the benefits for adoption of digital health standards
3. Communication, collaboration, and engagement
4. Training, education, and workforce capability uplift
5. Providing support for implementation.

Further consultation with the Standards Advisory Group on the Draft National Strategy and Roadmap for digital health standards before commencing broader consultation with key stakeholders on the over the coming months.

Background

The Council for Connected Care was established in June 2023 to provide strategic advice on connecting care and support the national implementation of the Interoperability Plan in Australia. It comprises 37 leaders in digital health and aims to improve health outcomes through a more interoperable digital health system by reducing fragmentation and enhancing information sharing across the healthcare system. The council serves as a multi-stakeholder advisory group, guiding efforts to achieve better integration and efficiency in healthcare delivery.

The Standards Advisory Group was also established in June 2023 to provide strategic and technical advice to the Council for Connected Care and the Agency regarding the development, implementation and use of digital health standards. The group is pivotal in ensuring that Australia can achieve a more connected healthcare system through the use of standards that support safe, secure and seamless sharing of information to improve healthcare experiences and patient outcomes.

Attachments

Attachment A: Interoperability Plan and HI Roadmap annual progress report 2024-25

Contact officer: Cass Timmermans, Assistant Director, Interoperability

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Council for Connected Care

Agenda Item 5: Council for Connected Care 2024-25 Annual review and 2025-26 Workplan

Meeting: Thursday, 21 August 2025

OFFICIAL

Purpose

The purpose of the paper is to discuss the performance of the Council for Connected Care (Council) in 2024-25 and seek member feedback and agreement on the Council's 2025-26 meeting topics.

Recommendation/s

It is recommended the Council for Connected Care:

1 **note** the Council for Connected Care 2024-25 Annual Review report at Attachment A

2 **endorse** Council for Connected Care Terms of Reference 2.0 at Attachment B

3 **discuss** the 2025-26 Council for Connected Care meeting topics.

Summary of issues

The Council for Connected Care 2024–25 Annual Review report (Attachment A) outlines delivery against the Council's responsibilities and summarises findings from the Council's performance survey. The report will be published on the Agency's website on following the meeting on 21 August 2025

A total of 16 responses were received to the Council's performance survey, representing a 43% response rate from the 37 members external to the Agency. Feedback was overwhelmingly positive, with 93% of respondents rating the Council as somewhat or very effective.

Key findings from the survey include:

- **Purpose, objectives and responsibilities**: All respondents (100%) agreed or strongly agreed that the Council's purpose, objectives, and responsibilities – as outlined in the Terms of Reference - are clear and appropriate. This represents a 20% increase compared to the previous year.
- **Governance pathways**: 64% of respondents agreed that the current structure, with only the Standards Advisory Group reporting to the Council, was appropriate. This marks an improvement from 53% in the previous review.
- **Membership**: 79% of respondents agreed or strongly agreed that the Council has the right number of members, up from 60% previously. Additionally, 93% agreed or strongly agreed

that members possess the right skills and experience. While some respondents noted that the Council's size can make consensus challenging, others emphasised the importance of a diverse and inclusive membership.

- **Meeting frequency**: 93% of respondents agreed or strongly agreed that the quarterly meeting cadence was appropriate, and 100% agreed or strongly agreed that the time allocated and format of meetings were suitable.
- **Meeting papers and communiqués**: All respondents agreed or strongly agreed that Council agendas and meeting packs were relevant and clear, with 86% also agreeing or strongly agreeing that communiqués were appropriately detailed. Feedback included requests for earlier visibility of meeting papers and clearer documentation of meeting outcomes and future directions. Several respondents expressed support for the theme-based meetings and breakout sessions.

2025-26 topics – suggestions included:

Survey responses from Council members have provided valuable insights into priority areas for the 2025–26 workplan. These suggestions reflect a desire for deeper engagement, clearer implementation pathways, and a stronger focus on real-world impact. Key themes include:

- Monitoring and reporting on implementation progress of national interoperability initiatives, with a focus on identifying and addressing areas of slow progress
- Deepening engagement at the interface of health, aged care, and the broader care and support economy
- Highlighting what is working well, exploring the real-world impact of connected care for Australians managing chronic conditions outside of vulnerable groups. Focusing on Transitions of Care
- Strengthening alignment between Council work and major reforms in health and aged care, including:
    - Legislative reforms on consent and information sharing
    - Viable cross-sector and cross-jurisdictional use cases
    - Integration of foundational supports such as disability services
- Exploring the role of AI in interoperability - its opportunities, limitations, and implications for trust, safety, and productivity
- Advancing interoperability through workforce development, with a practical focus on identifying and overcoming barriers
- Increasing transparency and engagement in Council meetings, with more interactive discussions, dynamic panels, and opportunities for all members to contribute
- Continuing to showcase on-the-ground innovation through site visits as a feature of face-to-face meetings.
- Exploring the use of My Health Record in clinical settings, and expanding focus to include allied health, community care, and population health, in collaboration with external agencies.

2025-26 Workplan

It is proposed that the Council will meet every four months with the proposed meeting dates being: 12 November 2025 (face-to-face), 12 March 2023 (face-to-face), 23 July 2026 (Virtual).

It is also proposed that in 2025-26 the Council meetings will continue to deepen the focus on how members and the organisations and stakeholders they represent can work together to bring about real, meaningful change.

The proposed meeting agenda structure is:

- Standing agenda items
  - Conflicts of interest, minutes of meetings and actions
- Governance
  - Updates from committees and other related government work
- Progress updates
  - Quarterly progress report summary
- Interoperability in action
  - Use cases, desired future states and members' contributions (consumer, healthcare provider, technology perspectives).

Proposed topics for the 2025-26 meetings are provided below.

Table 1: Proposed 2025-26 meeting topics

Date	Location	Key Topics/Focus Areas
12 November 2025	Canberra	• Transitions of care • Benefits of digital transformation (ACT Health) • Innovative workforce initiatives • HealthConnect Australia • Adoption and implementation of interoperability standards (Standards Week)
12 March 2026	Adelaide - Proposed (TBC)	• Virtual care • Cross-hospital data/reporting • Data and digital health advancements • Real-world impact of connected care • Ambulance Care
23 July 2026	Virtual	• Annual review • 2026/27 work plan

During the meeting members will be asked on Slido to consider:

- Are there any topics missing?
- Which organisations and stakeholder groups should present at each of the meetings?
- Which projects by the Council member organisations should be spotlighted at each of the meetings?

Background

The Agency established the Council on 7 June 2023 to support national implementation of the Connecting Australian Healthcare – National Healthcare Interoperability Plan 2023-2028 (Interoperability Plan) and provide strategic advice on matters related to connecting care.

The performance of the Council is to be measured at least annually through a self-assessment of its performance and opportunities for improvement. A survey was sent to members on 26 June 2025 to inform the Council's 2024-25 performance review and 2025-26 meeting topics.

Attachments

Attachment A: Council for Connected Care 2024-25 Annual Review report

Attachment B: Terms of Reference v2.0

Contact officer: Cass Timmermans, Assistant Director, Interoperability

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Australian Digital Health Agency

Council for Connected Care

Agenda Item 6: HI Legislation update

Meeting: Thursday, 21 August 2025

OFFICIAL

Purpose

The purpose of the paper is to provide members with an update on the Healthcare Identifiers (HI) legislative reform program.

Recommendation/s

It is recommended the Council for Connected Care:

1 **note** that changes to the *Healthcare Identifiers Act 2010* (Cth) (HID Act) and *the Healthcare Identifiers Regulations 2020* will be implemented in phases, with the first phase focusing on amendments to complement the aged care reforms.

2 **note** the changes to the HID Act that were introduced to the federal parliament in late July 2025.

Summary of issues

The Department of Health, Disability and Ageing (the Department) has been leading a review of the Healthcare Identifiers (HIs) legislative framework, with a view to ensuring the legislative settings are fit for purpose to support a more connected healthcare system and to underpin critical national reforms linked to Australia's National Healthcare Interoperability Plan (2023-2027) including Health Connect Australia.

Following significant consultation, a series of changes to the HID Act have been identified, which are proposed to be progressed in separate phases.

Proposed amendments will support broader, more flexible use of HIs, in order to realise the intended benefits of unique identifiers which will underpin digital health capabilities and an interoperable health system.

A summary of the first phase of reforms is set out below and the scope of future phases of reform will be discussed at the Council meeting.

Summary of Phase 1 changes

The first tranche of reforms is currently before the federal parliament. Key elements of these reforms are summarised below, with additional detail available on the Department's Healthcare Identifiers webpage.

- There will be a new type of identifier for healthcare support service providers, which will initially apply to aged care and disability service providers.
- Authorisations for new entity types to use healthcare identifiers (HIs):
    - Healthcare Support Providers (HSPs) (organisations)
    - Healthcare Administration Entities (HAEs).
- Authorisations for healthcare providers, HSPs and HAEs to use HIs for health and health administration purposes.
- Changes to the eligibility criteria and application process for self-regulating allied health professionals to be assigned an individual healthcare provider identifier (HPI-I):
    - Professionals must be credentialled and subject to oversight by a professional body.
    - Professional bodies may put in place arrangements with the HI Service Operator to facilitate the assignment and management of HPI-Is on behalf of the individuals they represent – this will streamline application processes, and allow professional bodies to apply in bulk for the assignment of HPI-Is to their professionals and advise where there are relevant updates (such as where a professional's credentials are suspended).
- The Department's HIs webpage also includes frequently asked questions on the amendments accompanying the aged care reforms.

Background

- The HI Framework stems from the 2009 National Partnership Agreement on E-Health in which the Commonwealth, and state and territory governments recognised that accurate identification of patients, providers and provider organisations is the key enabler of a safe, efficient and digitally connected health system.
- At the August 2023 meeting, the Council considered Priority area 1: Identity, of the National Healthcare Interoperability Plan.
- The Council expressed a strong commitment to using HIs to facilitate improved health outcomes and identified the need for HIs to be ubiquitous across all healthcare consumers and clinicians and extending to the disability and aged care sectors.

Attachments

Nil

Contact officer: Kate Deere, Director, Digital Health Branch, Department of Health, Disability and Ageing

Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 7: Share by Default update

Meeting: Thursday, 21 August 2025

OFFICIAL

Purpose

The purpose of the paper is to provide members with an update on the implementation of Share by Default for pathology and diagnostic imaging and the impact it has on the work of the Australian Digital Health Agency (the Agency).

Recommendation/s

It is recommended the Council for Connected Care:

1 **note** the update on the Share by Default reform in the pathology and diagnostic imaging sectors

2 **note** the implementation activities underway to support the delivery of this reform.

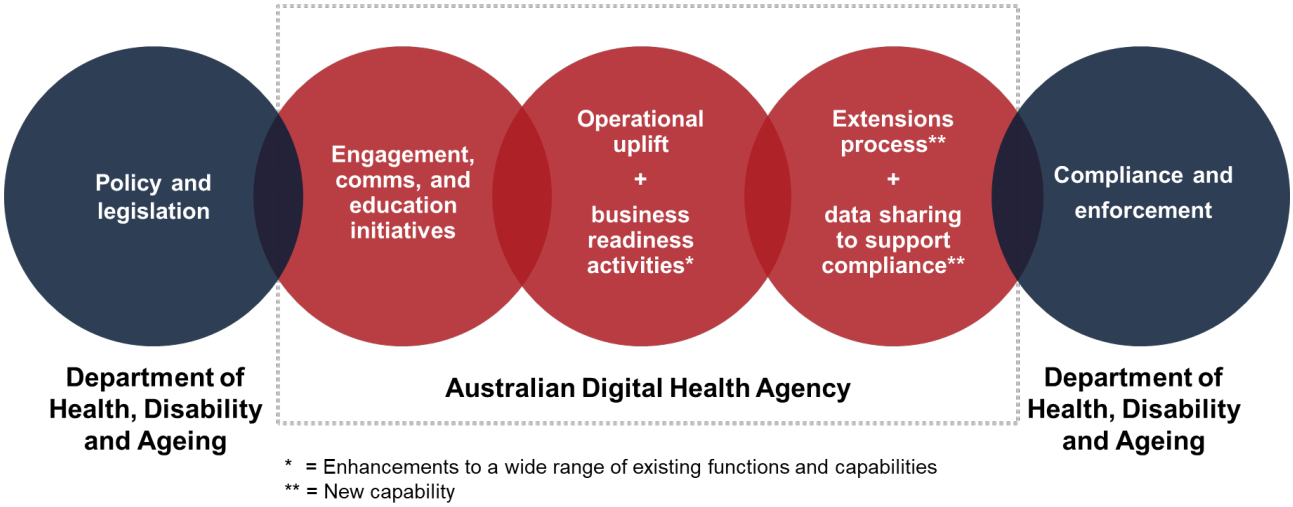
Summary of issues

In February 2025 the *Modernising My Health Record (Sharing by Default) Act 2025* (SBD Act) passed. The SBD Act allows government to make rules regarding what health information must be shared to My Health Record and by which healthcare providers. Pathology and diagnostic imaging providers will be the first required to share test results to My Health Record. Consultation with key stakeholders will inform the development of these Rules.

Exceptions will include consumer preference, as well as clinical discretion in cases where a healthcare provider believes there would be a serious concern for an individual's health, safety or wellbeing. Exceptions to manage technical issues will also be included.

Figure 1 outlines the respective areas of responsibility for the Department of Health, Disability and Ageing (the Department) and the Agency in delivering this reform.

Figure 1



The Agency is developing communications and education initiatives to support the introduction of the upload mandate, as well as the introduction of the related "faster access" reform. Faster access will see the removal or shortening of the 7-day delay that consumers usually encounter when viewing their test and scan results in My Health Record.

The Agency is also implementing a range of operational uplift and business readiness measures. These activities address matters such as the capacity of the My Health Record to accommodate a substantial increase in the volume of information being uploaded, the capacity of the call centre to respond to a likely increase in enquiries from consumers and healthcare providers, and the capacity to support developers in building connectivity between their clinical systems and My Health Record.

Finally, the Agency is standing up two new processes. The first is an extensions process whereby pathology and diagnostic imaging providers will be able to apply to the Agency for a time extension in complying with the mandate. The second is a process to provide data to the Department to inform compliance and enforcement activities associated with the mandate.

Exploration is underway for the future expansion of sharing by default to other types of key health information which would be valuable to share to My Health Record. Previous consultation consistently highlighted areas such as medication management and care planning. Further expansion of sharing by default will require consultation and government approval.

Background

The Strengthening Medicare Taskforce Final Report (December 2022) recommended modernising My Health Record in order to significantly increase health information available to consumers and their healthcare professionals, including sharing by default. In response the Australian Government announced in the 2023-24 Budget that it would implement sharing by default to My Health Record, commencing with pathology and diagnostic imaging reports.

Attachments

Nil

Contact officer: Simon Cleverley, Assistant Secretary, Digital Health Branch, Department of Health, Disability and Ageing and Sheriel Hughes, Branch Manager, Australian Digital Health Agency

Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 8: Pathology Tests Explained (PTEx) in my health app

Meeting: Thursday, 21 August 2025

OFFICIAL

Purpose

The purpose of the paper is to provide members with an update on the integration and implementation of the Pathology Tests Explained (PTEx) feature within My Health Record and the my health app.

Recommendation/s

It is recommended the Council for Connected Care:

1 **note** integration of PTEx into the My Health Record and my health app

2 **promote** use of pathologytestsexplained.org.au via My Health Record and the my health app as a way of digitally empowering patients about their pathology tests.

Summary of issues

Pathology Tests Explained (PTEx) provides evidence-based, plain-language explanations of pathology tests, reviewed by practising pathologists and scientists. PTEx is now actively integrated into the my health app and My Health Record platforms in Australia.

Recent developments include strengthened partnerships with pathology providers, whose practices are progressing towards sharing pathology results with the My Health Record by default. The integration of PTEx with my Health Record enhances the visibility and accessibility of PTEx content, allowing consumers to access trusted information directly about their pathology tests.

The PTEx initiative continues to evolve, with a focus on expanding content coverage, improving usability, and increasing consumer engagement. It plays a key role in supporting health literacy and empowering individuals to better understand their health data.

Background

Pathology Tests Explained (PTEx) is a consumer-facing resource developed to help individuals understand the purpose, process, and meaning of common pathology tests. PTEx content has been integrated into the my health app to support health literacy and empower users to engage more confidently with their health information

The integration allows users to access plain-language explanations of pathology tests directly from their test result summaries. Initial feedback has been positive, with users appreciating the clarity and accessibility of the information. However, usage analytics suggest that further promotion and

refinements are needed to maximise the feature's impact. It is planned to link the relevant PTEx test page directly from the patient's test report page in the My Health Record.

The PTEx initiative aligns with broader goals of digital health transformation, including improving transparency, supporting informed decision-making, and enhancing consumer trust in health data systems.

View PTEx here: www.pathologytestsexplained.org.au

Attachments

Attachment A: PTEx in My Health App PowerPoint slides

Contact officer: Jenny Sikorski, PTEx Director

PATHOLOGY TESTS
EXPLAINED

Pathology Tests Explained (PTEx) in My Health Record & my health app

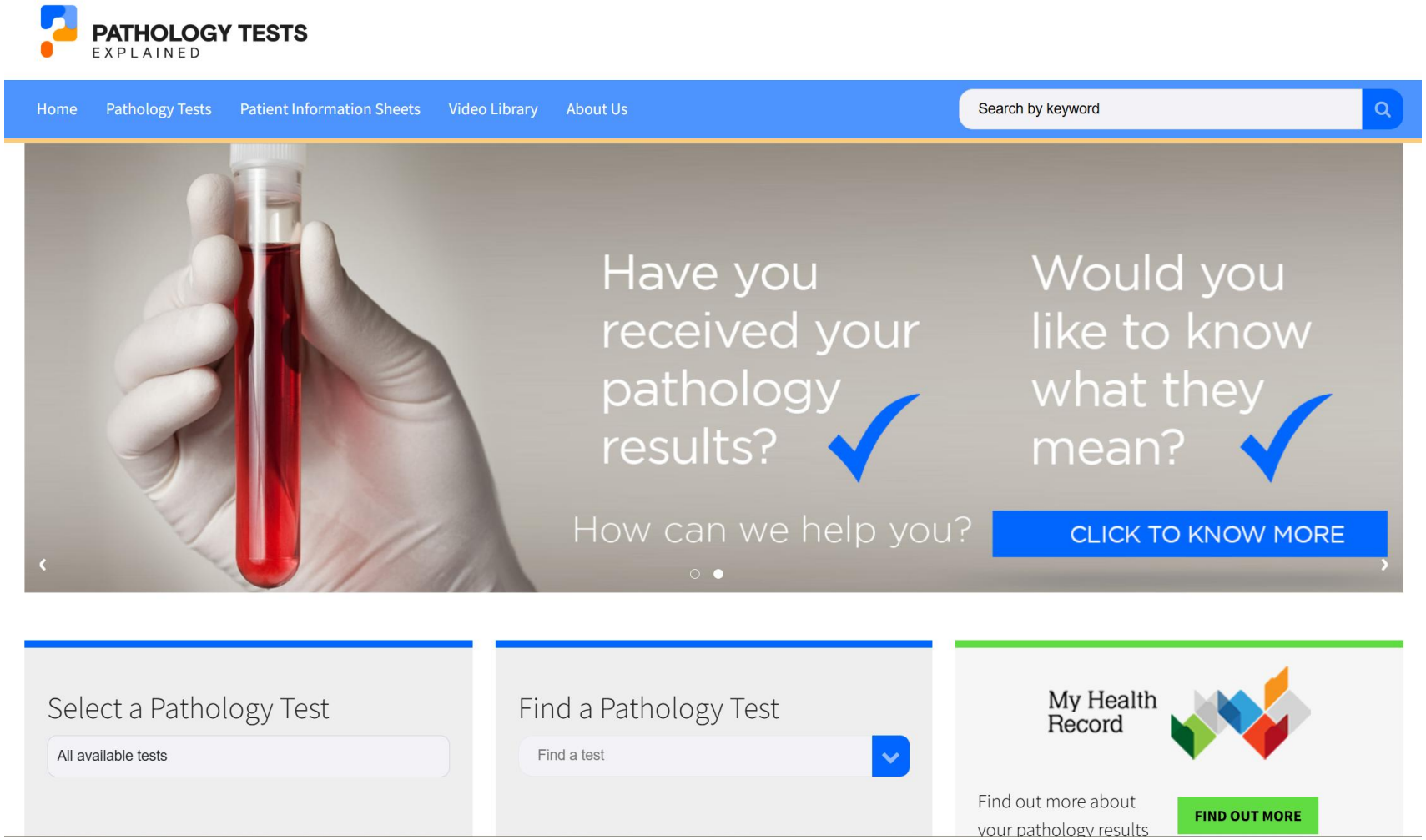
Jenny Sikorski, PTEx Director

Agenda

1. Background: User-friendly digital resource for consumers
2. Access: Better access to pathology info from My Health Record & my health app

PATHOLOGY TESTS EXPLAINED

Background: pathologytestsexplained.org.au



PATHOLOGY TESTS
EXPLAINED

Background: Guiding Principles to Help Consumers

- Easy access to information
- Presented in a manner that aids understanding
- Informs & enables consumers to converse with their caregiver about their healthcare
- Confidence that information is provided by reliable & authoritative source

PATHOLOGY TESTS EXPLAINED

Background: Sample Content

Deamidated Gliadin Antibody (Coeliac Disease Test)

DGP, Anti-deamidated gliadin, Coeliac serology, Celiac serology, deaminated gliadin peptide

Home / Tests / Deamidated Gliadin Antibody (Coeliac Disease Test)

Related Tests

Albumin, Calcium, Iron, Vitamin B12, Vitamin D

Printer Friendly

Lining of the intestines

Summary

- **Coeliac disease is a life-long, inherited condition in which your small intestine becomes inflamed when you eat gluten or other similar proteins.**
- **It occurs because your immune system, which is designed to protect you from harmful things, mistakenly attacks your small intestine when it detects gluten.**
- **It does this by producing antibodies.**
- **Testing for coeliac disease typically involves having blood tests to see if you have these antibodies.**
- **If your results are positive, you may be asked to have a biopsy in which a small section of your intestine is removed and examined. This can give a definite diagnosis.**
- **Genetic tests for coeliac disease are available but are limited in what they can do.**

PATHOLOGY TESTS EXPLAINED

Background: Sample Content

Deamidated Gliadin Antibody (Coeliac Disease Test)

DGP, Anti-deamidated gliadin, Coeliac serology, Celiac serology, deaminated gliadin peptide

Home / Tests / Deamidated Gliadin Antibody (Coeliac Disease Test)

Related Tests

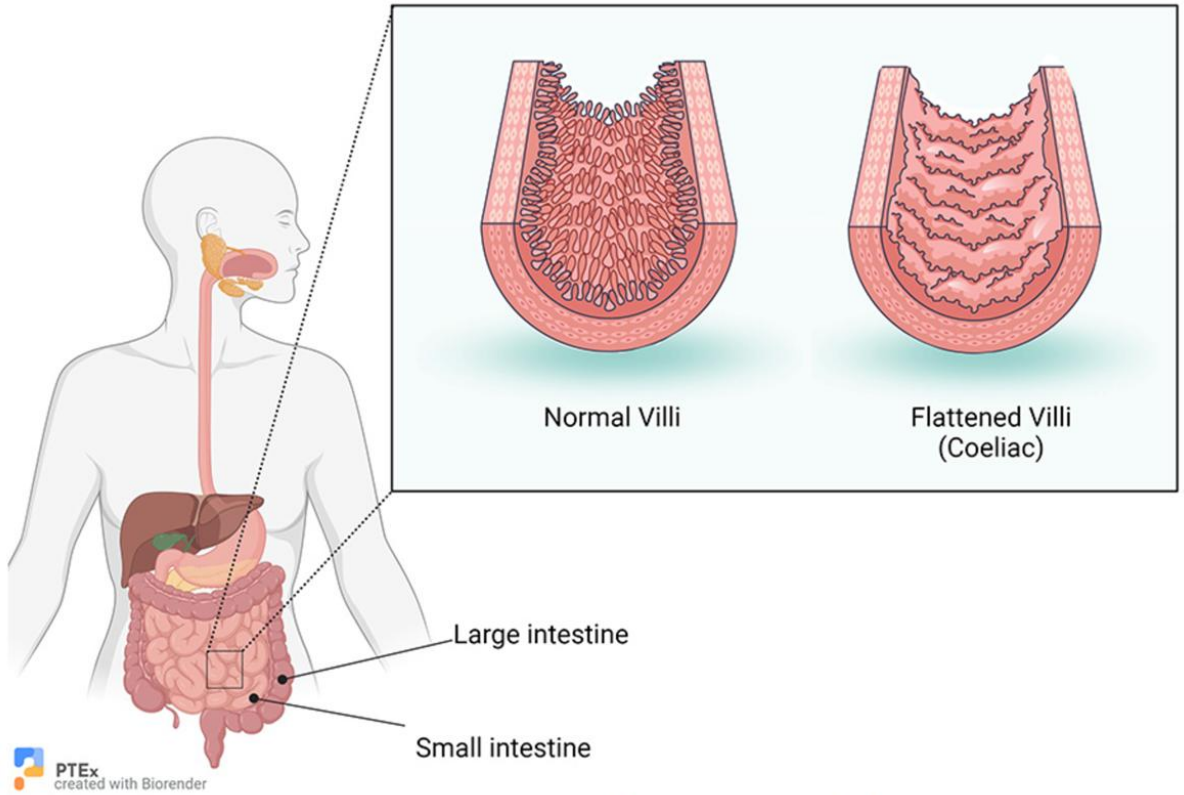
Albumin, Calcium, Iron, Vitamin B12, Vitamin D

Printer Friendly

YOUR TESTS

- Summary
- What is coeliac disease and how is it tested?
- Why get tested?
- Having the test
- Your results
- More to know?
- Questions to ask your doctor
- More information

MORE DETAILED INFORMATION

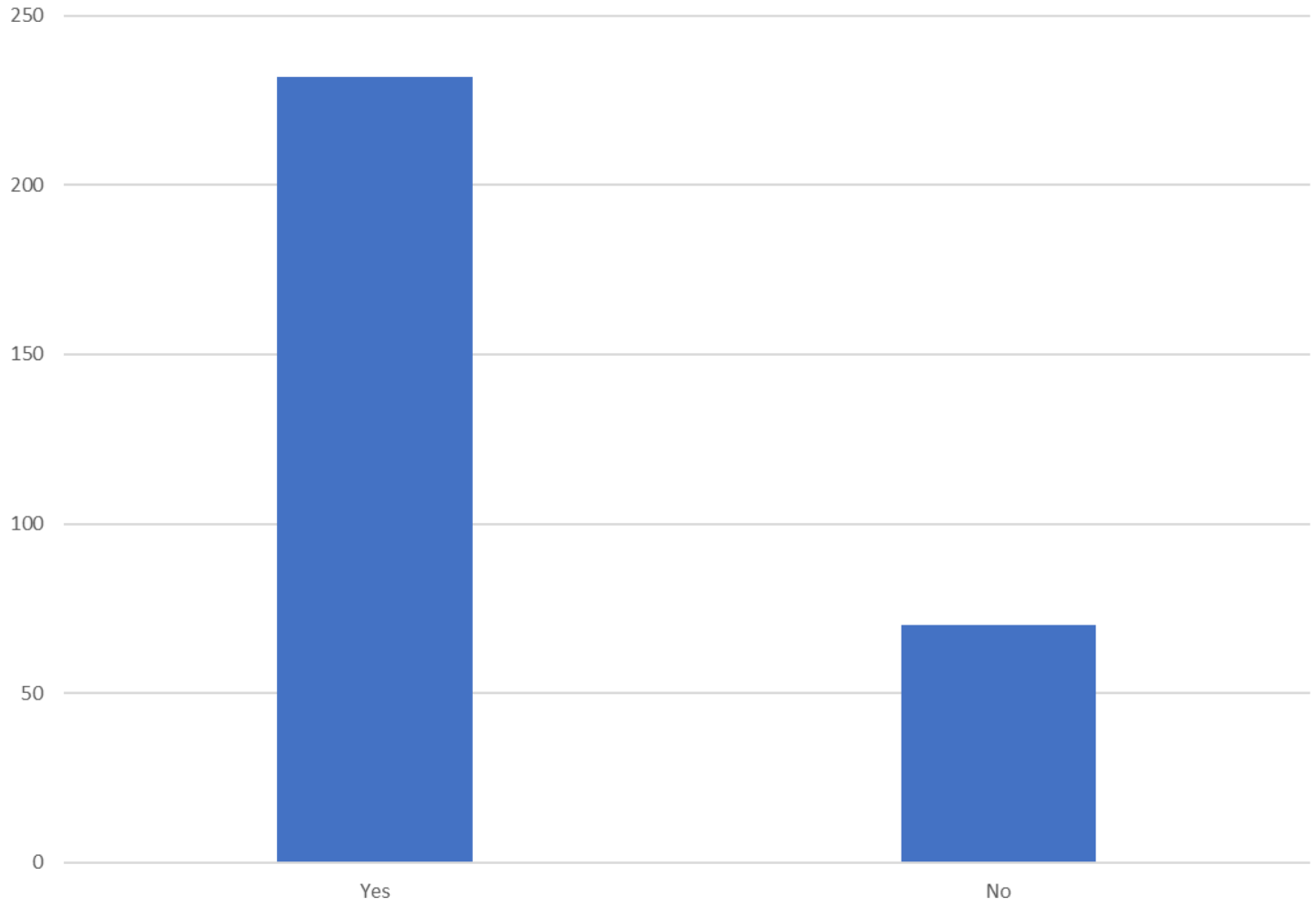


A healthy intestine compared with one affected by coeliac disease which has damaged the villi in the intestine wall.

PATHOLOGY TESTS EXPLAINED

Background:

Did you find the information you were looking for?

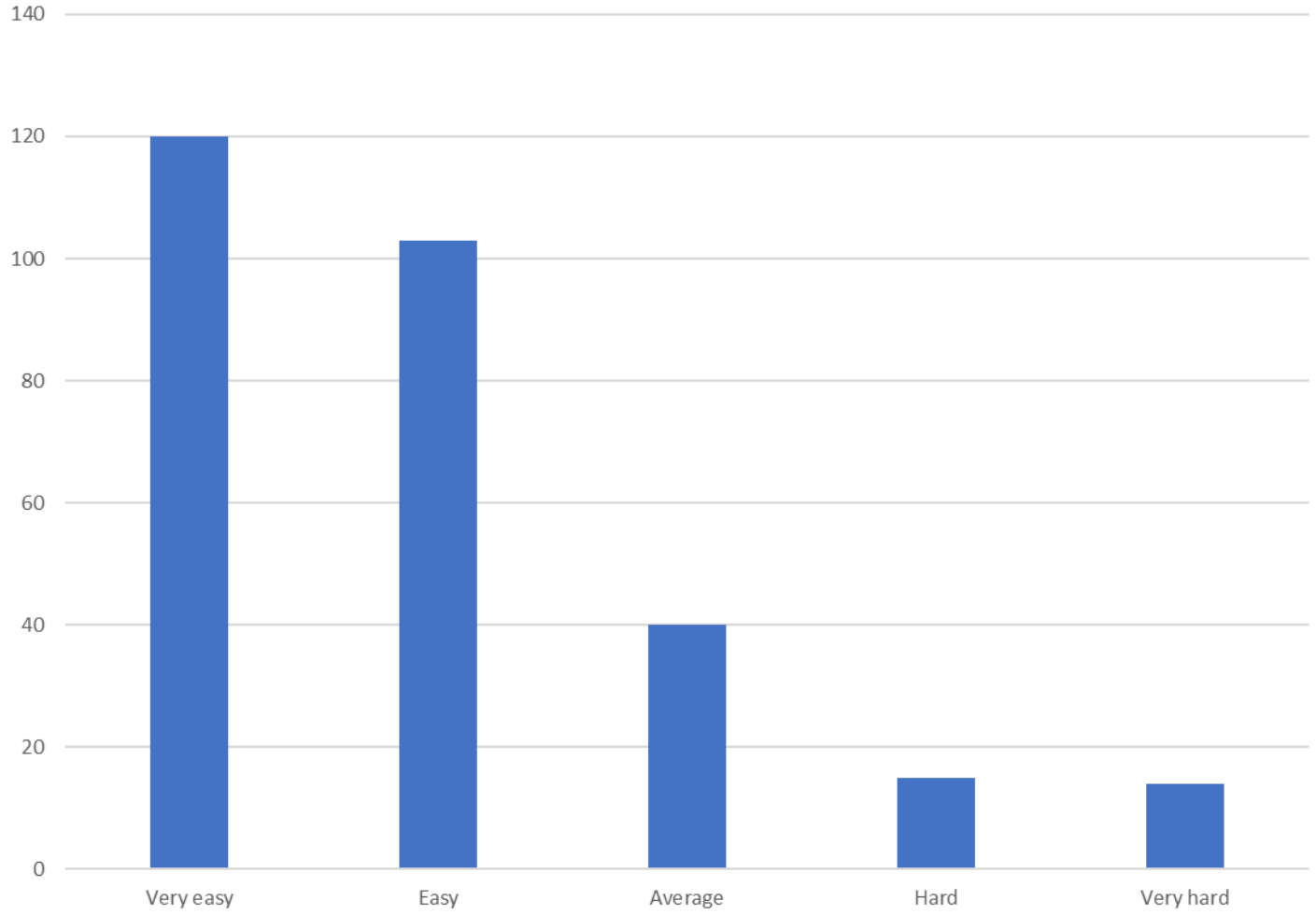


The majority of participants found the information they were looking for

PATHOLOGY TESTS EXPLAINED

Background:

Was the information easy to understand?



Overall, 223 of 292 respondents (76.4%) rated the information as “very easy” or “easy” to understand

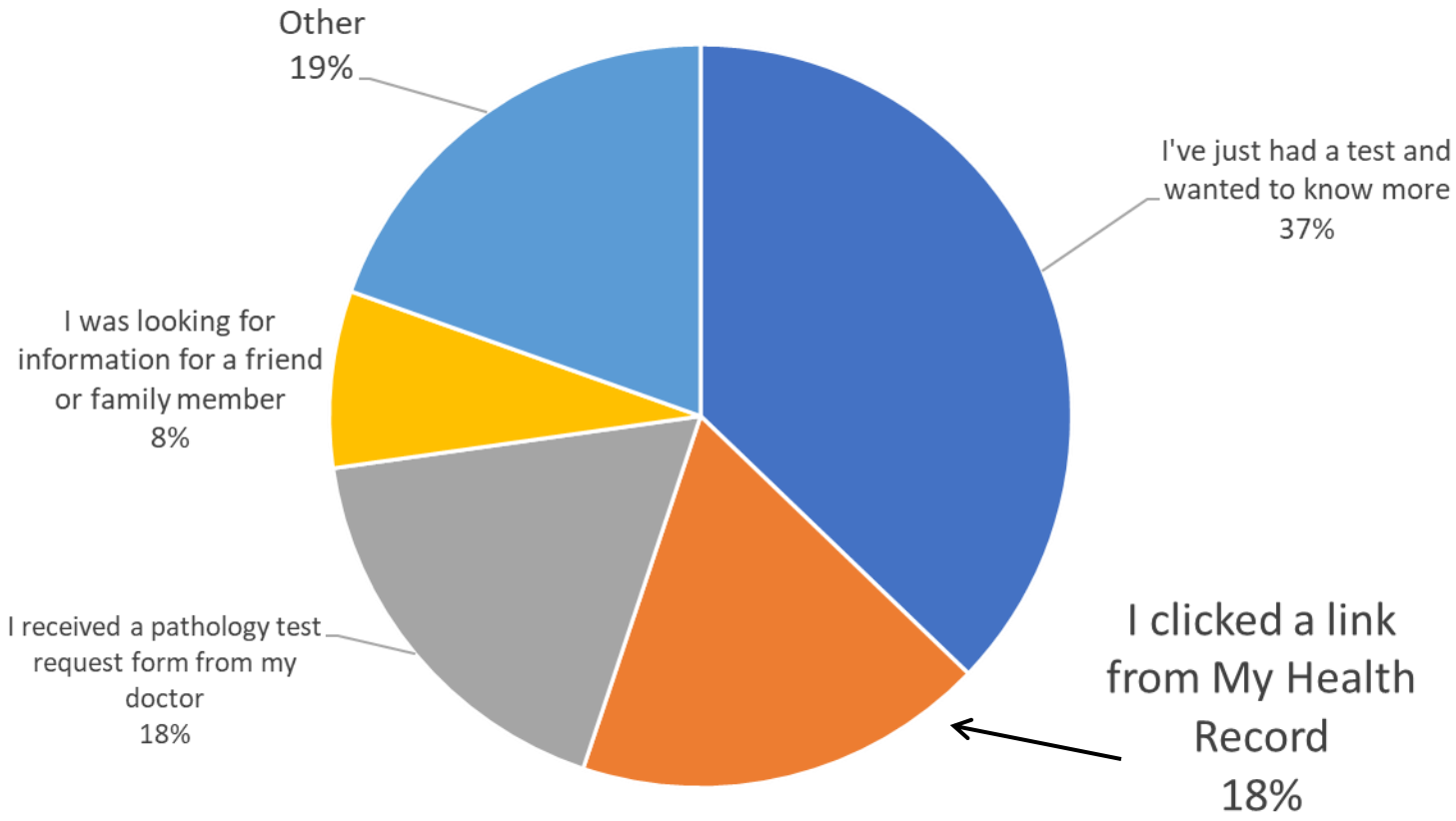
PATHOLOGY TESTS EXPLAINED

Access to PTEx

Last year the majority of consumers – 120,000 per month - reached PTEx via a Google search

PATHOLOGY TESTS EXPLAINED

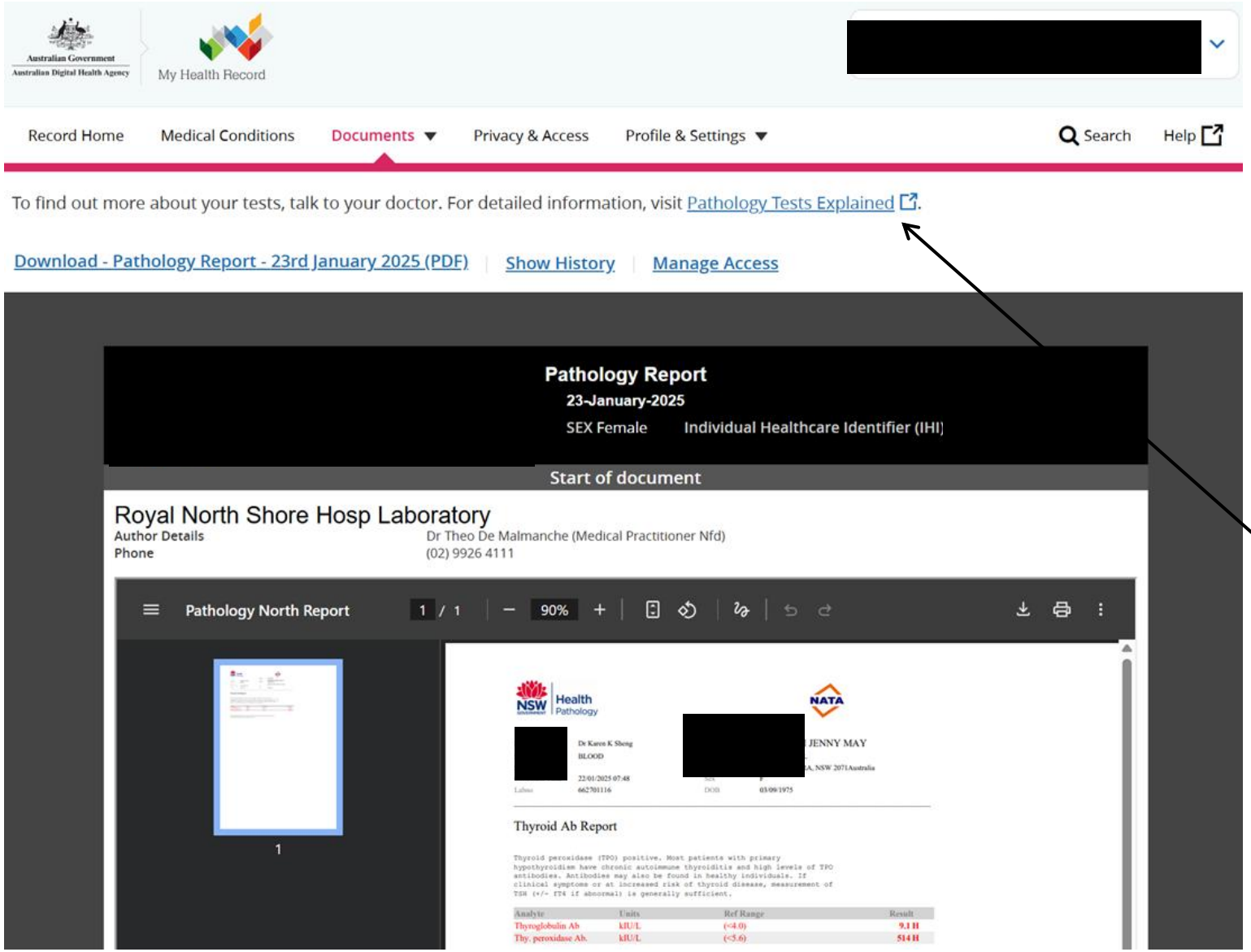
Access to PTEx



A recent consumer survey shows a significant number are coming now from MHR

PATHOLOGY TESTS EXPLAINED

Better Access to PTEx from MHR



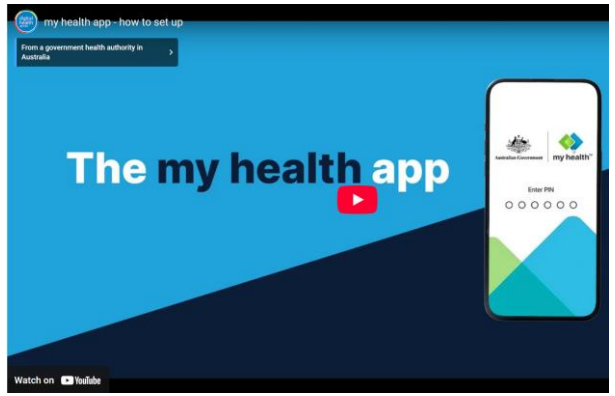
! Patient has high thyroid antibodies

Q: What does this mean?

A: Access PTEx here

PATHOLOGY TESTS EXPLAINED

Better Access to PTEx from my health app



! Patient has high thyroid antibodies

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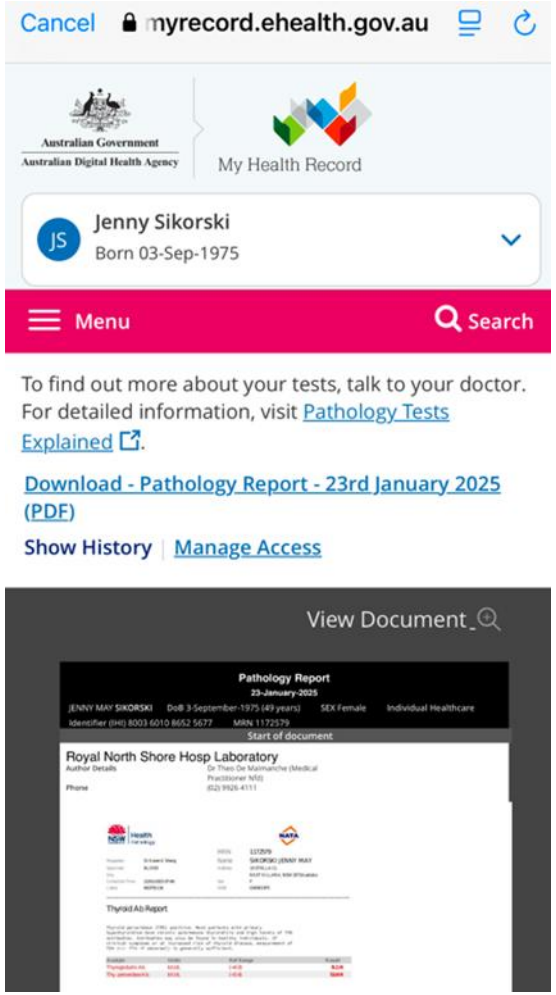
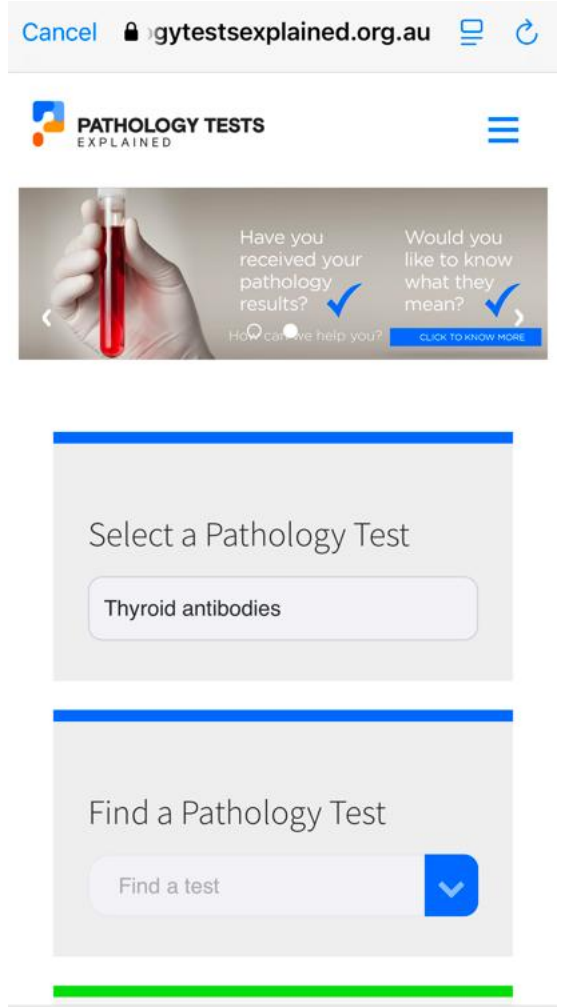


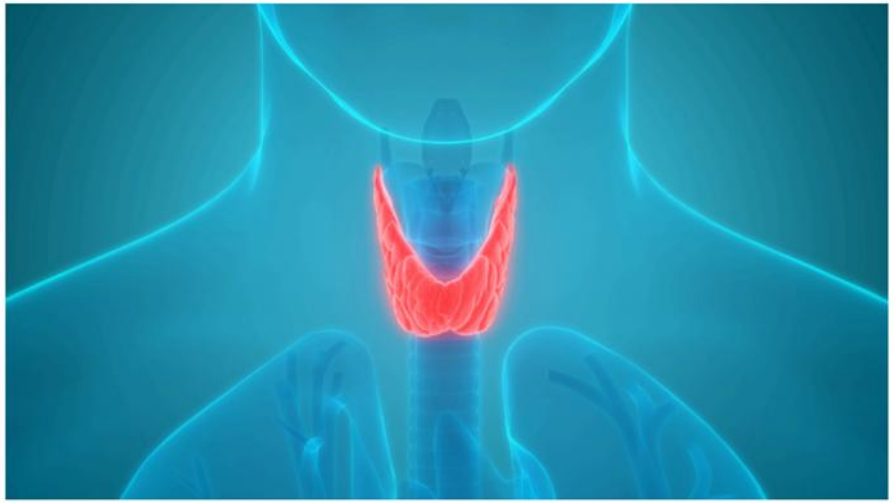


PATHOLOGY TESTS EXPLAINED

Better Access to PTEx from MHR

PATHOLOGY TESTS EXPLAINED

Thyroid antibodies



Summary

Thyroid conditions are common and can affect people of all ages from babies to the elderly. They can be caused by a range of underlying conditions. Your doctor will usually start by requesting a TSH test. This measures the amount of Thyroid Stimulating Hormone (TSH) in your blood. TSH is the hormone that stimulates your thyroid gland to make thyroid hormone. This is the only thyroid test covered by Medicare if you do not have a history of thyroid problems. Depending on your symptoms and your TSH result, you may need further testing of your thyroid hormones with measurement of FreeT4 and Free T3. If your doctor thinks you could have an autoimmune condition that is affecting your thyroid gland you may go on to have thyroid antibody tests. There are also tests that are used to monitor thyroid cancer following treatment. They include thyroglobulin and calcitonin tests which are used to detect and monitor some rare forms of thyroid cancer.

Why get tested?

Your thyroid is a small gland at the base of your throat. It uses iodine from your diet to make hormones that regulate many of your body's metabolic processes – your body's processes for breaking down food and converting it into energy. How your thyroid is working affects how fast you burn calories, your heart rate, blood pressure and body temperature.

There are two main hormones produced by the thyroid. These are T4 and T3. They circulate in your blood, and it is important that levels stay constant to keep your metabolism running and in balance.

Tests for autoimmune conditions

Further tests may need to be performed if your doctor suspects that you have an underlying autoimmune condition – you have an enlarged thyroid or symptoms suggesting thyroid dysfunction. In this case you may need to have antibody tests.

Some of the antibody tests used are:

- Thyroid peroxidase antibodies (TPO)
- Thyroid-stimulating hormone (TSH) receptor
- Thyroid-stimulating immunoglobulin (TSI)

Often the laboratory performing your testing will automatically go on to perform a free T4 test or free T3 test on your original blood sample.

A 'free' T4 or T3 test refers to the fact that the type of hormone being tested is the part which is circulating freely and available to be absorbed by body tissues.

Thyroid antibody	Present in	When ordered	Other facts
Thyroid peroxidase antibody (TPO Ab)	Hashimoto's thyroiditis & Graves' disease	When someone has symptoms suggesting thyroid disorder; when a doctor is considering starting a patient on a drug therapy that may cause thyroid dysfunction when these antibodies are present (eg, lithium, amiodarone, interferon alpha or interleukin - 2).	Has been associated with reproductive difficulties, such as miscarriage, pre-eclampsia, premature deliver, and in-vitro fertilisation failure.
Thyroglobin antibody (TG Ab)	Hashimoto's thyroiditis; in some patients being monitored for thyroid cancer	Whenever a thyroglobulin test is performed to see if the antibody is present and likely to be interfering with the test results; at regular intervals after thyroid cancer treatment; when symptoms of hypothyroidism are present.	Not sensitive as TPO antibodies in diagnosing autoimmune thyroid disorder.

PATHOLOGY TESTS EXPLAINED

Better Access to PTEx from MHR

YOUR TESTS

- Summary
- Why get tested?
- Having the test
- Your results
- Questions to ask your doctor
- Any more to know?
- More information

MORE DETAILED INFORMATION

VIEW INFORMATION SHEETS

PATHOLOGY TESTS EXPLAINED

Information about pathology tests to help everyone take control of their health and make the right decisions about their care.

WHAT YOU SHOULD KNOW ABOUT YOUR **THYROID FUNCTION TESTS**

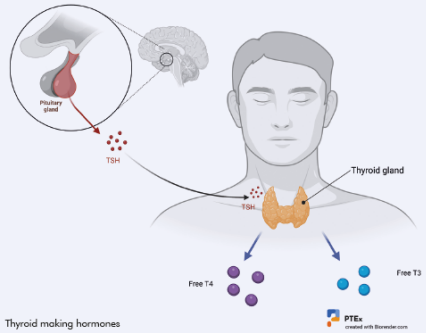
This is a group of blood tests that gives information about how your thyroid is working.

Your thyroid is a small gland at the front of the base of your neck. It is responsible for making hormones that travel around your body contributing to many functions, including metabolism – the way your body uses energy.

Your metabolism is a set of interconnected chemical processes that together regulates heart rate and body temperature among a host of other things. Making thyroid hormones requires iodine, which comes from your diet.

Because thyroid hormones are so important to the function of your entire body, if you have too much or too little you can feel very unwell.

- **Hypothyroidism** – when there is too little – sometimes referred to as an underactive thyroid.
- **Hyperthyroidism** – when there is too much – sometimes referred to as an overactive thyroid.



Thyroid making hormones

- Your thyroid makes the hormones T3 (Triiodothyronine) and T4 (Thyroxine).
- It is important to keep these in balance and a feedback mechanism makes sure levels don't get too high or too low.
- The levels of how much hormone your thyroid produces are controlled by your pituitary gland which sits at the base of your brain.
- The pituitary gland tells your thyroid gland how much to make by releasing more or less TSH - Thyroid Stimulating Hormone.
- If T3 and T4 production falls, TSH levels rises.
- If T3 and T4 become too high, TSH levels fall.

Testing for thyroid disease

If you have symptoms that suggest a thyroid problem you will most likely be assessed with a TSH test. This measures the level of TSH in your blood. If your TSH level is low or high, the levels of free T4 will next be measured to get a better understanding of what is going on.

The term 'free' thyroid hormones means the hormones are in the active form and can enter tissues when needed.

The levels of free T3 are not normally measured unless your symptoms and other test results suggest it could be useful. T3 is used mainly to help diagnose hyperthyroidism. It is not helpful if your doctor thinks you have hypothyroidism.

Because the FT3 level can become abnormal earlier than FT4 and return to normal later than FT4 it is often used to monitor your thyroid if you are having treatment.

What can your results tell you?

TSH	FT4	FT3	INTERPRETATION
High	Normal	Normal	Mild Hypothyroidism
High	Low	Low or normal	Hypothyroidism
Low	Normal	Normal	Mild Hyperthyroidsim
Low	High or normal	High or normal	Hyperthyroidsim
Low	Low or normal	Low or normal	Non-thyroidal illness: rare pituitary hypothyroidism

What are reference intervals (reference ranges)?

Your results are shown in your report as a comparison against a set of numbers called reference intervals or reference ranges. This is the range of test results considered normal for the general population. If a result in your report is outside this range, it can be flagged as high (H) or low (L). This does not necessarily mean that anything is wrong. It depends on your personal situation. Your results need to be interpreted by your doctor.

Autoimmune conditions

If it is possible that you have an autoimmune condition your doctor may order further tests. There are two main autoimmune conditions affecting the thyroid:

Hashimoto's thyroiditis – the immune system attacks the thyroid gland, causing inflammation which slows the production of thyroid hormones.

Graves' disease – the immune system makes an antibody that acts against TSH and causes the thyroid gland to produce too much thyroid hormone.

Some of the antibody tests used are:

- Thyroid peroxidase antibodies (TPO)
- Thyroid-stimulating hormone (TSH) receptor
- Thyroid-stimulating immunoglobulin (TSI)

What happens next?

Interpreting the many variations in test results is complex. An abnormal result from your thyroid tests may not mean you have anything to worry about. Other health conditions, extreme stress and pregnancy affect the levels of thyroid hormones, as well as some medications. Talking with your doctor about what your results mean for you is important.

Your doctor may want to repeat tests over time to monitor your thyroid. They may order an ultrasound of your thyroid. If you are prescribed treatment, thyroid tests will need to be repeated to monitor how well it is working. If you are being assessed for thyroxine treatment, you need only a T4 test. Rarely, your results may indicate a pituitary problem and you may need further, different tests for this.

Questions to ask your doctor

Why does this test need to be done?
Do I need to prepare (such as fast or avoid medications) for the sample collection?
Will an abnormal result mean I need further tests?
How could it change the course of my care?
What will happen next, after the test?

For more detailed information on these and many other tests go to **pathologytestsexplained.org.au**

PATHOLOGY TESTS EXPLAINED

www.pathologytestsexplained.org.au

Please use this QR code to access more information

Pathology Tests Explained is the primary national source of consumer information on pathology testing. Information is written and edited by practising pathologists and scientists, including leading experts. This ensures integrity and accuracy.

Pathology Tests Explained is managed by a consortium of medical and scientific organisations representing pathology practice in Australia. More details at: **www.pathologytestsexplained.org.au/about**

My Health Record

You'll find a direct link to the Pathology Tests Explained website embedded in the pathology results pages of your My Health Record and the my health app.

Click on the link to find information about what your tests are investigating or measuring and what your results can tell your doctor.

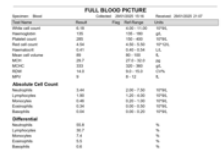
PATHOLOGY TESTS EXPLAINED

My Health Record

Current navigation

Via generic link on bottom of FBC report:
www.pathologytestsexplained.org.au
Takes visitor to PTEX landing page

Full Blood Count Report



Future navigation

Via FBC test code in report in MHR:
Takes visitor directly to
PTEx FBC test page

Pathology Tests Explained

PTEx Landing Page
Visitor searches for
FBC Test Page

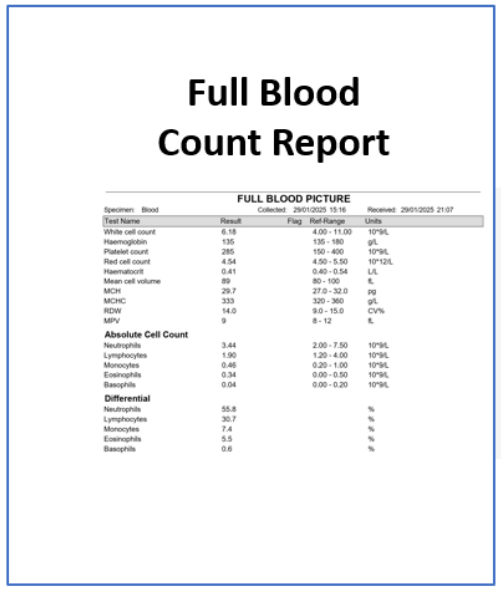
Full Blood Count Test Page

Full Blood Count Test Page

PATHOLOGY TESTS EXPLAINED

Direct link from MHR Test Report to PTEx

Test Result Page in MHR



Full Blood Count Report

FULL BLOOD PICTURE

Specimen: Blood Collected: 29/01/2025 15:16 Received: 29/01/2025 21:07

Test Name	Result	Flag	Ref-Range	Units
White cell count	6.18		4.00 - 11.00	10*9/L
Haemoglobin	135		135 - 180	g/L
Platelet count	285		150 - 400	10*9/L
Red cell count	4.54		4.50 - 5.50	10*12/L
Haematocrit	0.41		0.40 - 0.54	L/L
Mean cell volume	89		80 - 100	fL
MCH	29.7		27.0 - 32.0	pg
MCHC	333		320 - 360	g/L
RDW	14.0		9.0 - 15.0	CV%
MPV	9		8 - 12	fL
Absolute Cell Count				
Neutrophils	3.44		2.00 - 7.50	10*9/L
Lymphocytes	1.90		1.20 - 4.00	10*9/L
Monocytes	0.46		0.20 - 1.00	10*9/L
Eosinophils	0.34		0.00 - 0.50	10*9/L
Basophils	0.04		0.00 - 0.20	10*9/L
Differential				
Neutrophils	55.8			%
Lymphocytes	30.7			%
Monocytes	7.4			%
Eosinophils	5.5			%
Basophils	0.6			%

Test Page in PTEx

PATHOLOGY TESTS EXPLAINED

Home Pathology Tests Patient Information Sheets V

Full blood count

FBC, CBC (complete blood count), FBE (full blood examination), FBP (full blood picture), CBE, CBP, Antenatal screen

Will be able to provide similar direct links for many other commonly requested group tests – LFT, UEC, TFTs. Iron studies etc

PATHOLOGY TESTS EXPLAINED

Key Message: PTEx = Digital Empowerment

Visit pathologytestsexplained.org.au

from My Health Record in my health app for

consumer-friendly, reliable information about pathology tests

PATHOLOGY TESTS EXPLAINED

Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 9: Australian Commission on Safety and Quality in Health Care draft national model for clinical governance

Meeting: Thursday, 21 August 2025

OFFICIAL

Purpose

The purpose of the paper is to seek members' feedback on the Australian Commission on Safety and Quality in Health Care's (the Commission) draft national model for clinical governance.

Recommendation/s

It is recommended the Council for Connected Care:

1 **note** the draft national model for clinical governance and provide feedback.

Summary of issues

The draft Foundations of High-Quality Care (Attachment A) is a new national model for clinical governance designed to replace the Commission's original 2017 National Model Clinical Governance Framework.

The draft model aims to offer national consistency in how Australia defines and understands clinical governance, and to provide clear, relevant and up-to-date guidance for health services on aligning leadership, systems and culture to achieve high-quality care. The model is for public and private health service board members and executives in the acute sector, including day procedure services.

As a principles-based document, health service leaders can use the model to:

- review and strengthen clinical governance arrangements
- identify and monitor what their organisation needs to achieve consistently high-quality care
- guide their approach to applying safety and quality standards.

State and territory health departments and private hospital groups can use the model to inform new clinical governance systems and to shape detailed guidance for health services in their jurisdictions.

Once finalised it will be used to guide development of the clinical governance aspects of the 3rd edition of the National Safety and Quality Health Service (NSQHS) Standards. There is a separate consultation underway about the NSQHS Standards, more information can be found here.

Seeking feedback on the draft model

The Commission is seeking members' feedback using this Key stakeholders survey by 29 August 2025.

Background

The Commission conducted a needs analysis to inform the development of the draft model. This included:

- Interviews with board chairs and chief executives from health services nominated by state and territory health departments as having high-performing clinical governance systems
- Meetings with Inter-Jurisdictional Committee (IJC) members, clinical colleges, clinicians, First Nations organisations and consumer organisations
- Focus group and meetings with private sector representatives
- Presentations and discussions at Primary Care Committee and Private Hospital Sector Committee meetings
- Analysis of NSQHS Standards accreditation outcomes data
- A rapid literature review on contemporary definitions of clinical governance and common themes and recommendations from safety and quality inquiries
- An environmental scan of clinical governance frameworks, policies and education programs across Australia.

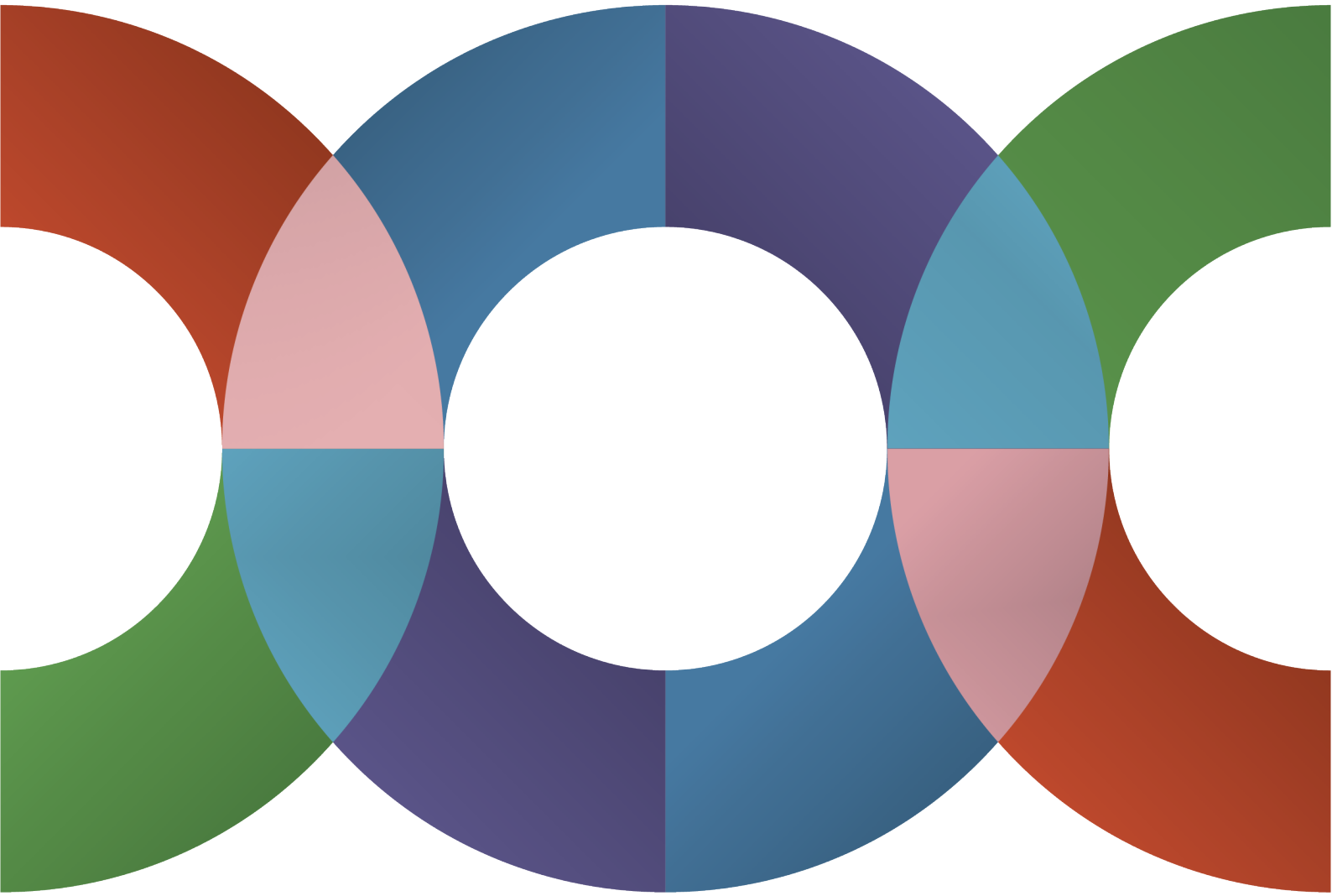
The six foundations of high-quality care in the draft model have been developed to respond to the key challenges identified in the needs analysis.

Attachments

Attachment A: Draft national model for clinical governance

Contact officer: Gillian Giles, Director, Clinical Governance, ACSQHC

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE



The Foundations of High-Quality Care

A national model for clinical governance

Consultation draft, July 2025

About this consultation

The Foundations of High-Quality Care is a new draft national model for clinical governance from the Australian Commission on Safety and Quality in Health Care. This model will replace the 2017 National Model Clinical Governance Framework.

The Commission is seeking your input. We would like to know how useful the model is likely to be in practice, what changes are needed, and whether there are gaps.

The final model will be released in early 2026.

Next steps

We will use feedback from this consultation to update the draft model and to develop practical resources that support health services to review and strengthen their clinical governance arrangements.

Questions

If you have any questions about the draft model or about participation in the consultation, please contact the team at clinicalgovernance@safetyandquality.gov.au

Overview

What is the model?

The draft model offers national consistency in how Australia defines and understands clinical governance, and provides clear, relevant and up-to-date guidance for health services on aligning leadership, systems and culture to achieve high-quality care.

This model is for boards and executives of public and private health services in the acute sector, including day procedure services.

Health service leaders can use it to review and strengthen their clinical governance arrangements, and identify and monitor what their organisation needs to achieve consistently high-quality care.

State and territory health departments and private hospital groups can use the model to inform new clinical governance systems and to shape detailed guidance for health services in their jurisdictions.

Why a new model is needed

New national guidance on clinical governance is needed to steer the health system to provide consistently high-quality care in the face of evolving challenges such as workforce shortages, growing demand for health care, the need for environmentally sustainable care, changing patterns of illness, and constrained resources.

Robust governance can harness the opportunities and manage the risks of other changes, such as the rise of artificial intelligence and emerging technologies, and the growth of community-based models of care.

While many health services have been able to embed strong clinical governance in this changing environment, some find it difficult to implement systems that engage the workforce and make a difference to the care that patients receive.

The evidence on what works has also evolved. The link between a positive workforce culture and high-quality care is now stronger and more widely accepted than when the first national model on clinical governance was released.

How the new model was developed

We reviewed the latest evidence to understand challenges in implementing effective clinical governance structures and systems and how to overcome them. We talked to leaders, clinicians, patients and consumers across the health system to understand how clinical governance is understood and applied, gaps in capability and delivery, and what high-performing organisations do differently.

We worked closely with state and territory health departments to design a model that meets the needs of diverse services and settings, and used a collaborative approach to test and refine the model with public and private health services across Australia.

Thank you

In developing this draft model, we have drawn on the collective wisdom and expertise of people across the health system, including in interviews with many health service board chairs and chief executives. We thank them for generously sharing their insights and enthusiasm for the crucial role of clinical governance in achieving and maintaining high-quality care and the best possible patient outcomes.

We also thank the Clinical Governance Advisory Committee (below) for their valued leadership and expert advice.

Name	Position
Mr Michael Gorton AM (Chair)	Consultant, Russell Kennedy Lawyers Chair, Monash Health, Wellways Australia and Holmesglen Institute Board member, Latrobe Regional Hospital, Victorian TAFE Association
Professor Christine Kilpatrick AO	Chair, Australian Commission on Safety and Quality in Health Care Board Professor (Enterprise), Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne Chair, Healthdirect Australia and The Royal Children's Hospital
Dr Cathy Balding	Adjunct Professor, James Cook University Board Director, RSL LifeCare Director, Qualityworks PL
Ms Elleni Bereded-Samuel AM	Executive Manager, Diversity and Inclusion, Great Care Pty Ltd. Board member, Royal Children's Hospital
Dr Peggy Brown AO	Consultant psychiatrist Chair, Mental Health Australia
Ms Suzanne Cadigan	Board member, Children's Health Queensland, Ronald McDonald House Charities and Karuna Hospice Board member, Nursing and Midwifery Board of Queensland
Ms Christine Gee AM	Chair, Australian Commission on Safety and Quality in Health Care Private Hospital Sector Committee Director, Ramsay Mental Health Australia
Professor David Greenfield	Professor of Health Leadership and Management, School of Population Health, Faculty of Medicine and Health, University of New South Wales
Mr Tony Kiessler	Chief Executive Officer, Australian Indigenous Psychologists Association Member, National Indigenous Health Leadership Alliance

Dr Audrey Koay	Chair, Australian Commission on Safety and Quality in Health Care Inter-Jurisdictional Committee Executive Director, Patient Safety and Quality, Clinical Excellence Division, Department of Health, Western Australia
Ms Louise McKinlay	Deputy Chair, Australian Commission on Safety and Quality in Health Care Inter-Jurisdictional Committee Chief Executive Officer, Safer Care Victoria
Professor Jennifer Martin	Chair of Clinical Pharmacology, School of Medicine and Public Health, University of Newcastle President, Royal Australasian College of Physicians
Associate Professor Aunty Carmen Parter	Chief Executive Officer, Girudala Community Cooperative Society Board member, Ahpra
Professor Judy Searle	Chair, Northern Adelaide Local Health Network Governing Board
Ms Maureen Williams	Consumer representative, Emergency Medicine Foundation Consumer consultant, Institute for Communication in Health Care, Australian National University Member, Consumer Leaders Taskforce, Health Consumers NSW

Contents

About this model

Purpose of the model

Clinical governance establishes the conditions for high-quality care. It builds an environment and culture where working together and with patients and consumer advocates to provide high-quality care is everybody's main goal.

This model aims to provide national guidance on clinical governance that is clear, relevant and effective in today's context and that helps health services build on the basics to strive for consistently high-quality care.

Health service leaders can use the model to review and strengthen their clinical governance arrangements, and identify and monitor what their organisation needs to achieve consistently high-quality care.

The model provides a definition of high-quality care and describes the six foundations of clinical governance required to achieve this care:

1. Leading culture and systems
2. Partnering with patients, carers and consumers
3. Building a healthy workforce culture
4. Enabling high-quality and integrated clinical practice
5. Managing and reducing risk
6. Using data for better care

Who this model is for

This model is for public and private health services in the acute sector, including day procedure services.

It is primarily intended for health service board members and executives or equivalent[1] who are responsible for directing and implementing clinical governance systems essential for high-quality care. At the same time, the model is designed to be understood by all of the workforce as everyone has a role in providing or supporting the delivery of high-quality care.

> *When board members, executives and clinical leaders champion clinical governance as fundamental to achieving high-quality care, it sets the tone for the rest of the organisation.*
> Health system leader (to be named with permission)

[1] Where an organisation does not have a board and executive, these roles fall to the key decision-maker and accountable person or group in the organisation.

How to use the model

Boards and executives (or equivalent) can use the model to govern[2], lead and plan for high-quality care through:

- designing systems and processes to achieve consistently high-quality care
- building a shared language and understanding across the workforce of the definition of high-quality care and the six clinical governance foundations required to support it
- enhancing accountability and clarifying roles and responsibilities
- guiding their approach to meeting safety and quality standards.

State and territory health departments and private hospital groups can use the model to inform clinical governance systems and to shape detailed guidance for health services in their jurisdictions.

This model is a principles-based document – it is designed so that health services can apply the six foundations in a way that meets the needs of their organisation, no matter their size, type or location. Practical resources and case studies will support health services to use the model.

How does the model fit with safety and quality standards?

Good clinical governance goes beyond accreditation. It is about building and maintaining the culture of the whole organisation to support delivery of high-quality care every day.

The model's six clinical governance foundations of high-quality care will shape the development of the next edition of the National Safety and Quality Health Service Standards.

Boards and executives should use the model's six foundations to check that their organisation's strategy, systems and culture are aligned to deliver care that is consistently high quality and improving.

The model will guide health services' approach to applying safety and quality standards in a meaningful way. By orienting every role and every system in the organisation to focus on high-quality care, everyone in a health service can be confident that standards are being met every day – not just during accreditation assessments.

Health care is constantly changing and new models of care are continually emerging. Applying the foundations of high-quality care in this complex environment will help health services to deliver the best outcomes for patients and prevent system failures even if there are not specific standards for new types of care.

[2] The model provides practical guidance for health service leaders and does not replace legal and regulatory requirements.

About clinical governance

What is clinical governance?

Clinical governance is central to providing the best outcomes for patients**.** It is the combination of culture, systems and processes that enables everyone in a health service to deliver care that is consistently high quality and improving.

It is the system by which boards, executives, clinical leaders and the workforce are accountable to patients and the community for providing high-quality care – care that is person-centred, safe, effective, accessible and integrated, in a health system that is equitable, efficient and sustainable.

Effective clinical governance builds trust across the health service. Patients experience care that better meets their needs. The workforce is confident that their organisation backs them with the right culture, structures, support and leadership to provide consistently high-quality care. Boards and executives have the oversight and tools they need to realise their strategy for achieving high-quality care.

Clinical governance is part of a health service's overall governance system and is closely integrated with corporate governance, such as financial and legal functions. The board sets the strategy to combine these systems to achieve the central purpose of a health service – providing high-quality care.

> *There is no corporate governance without clinical governance, because we are in the business of providing clinical care.*
> Health service CEO (to be named with permission)

More than compliance

Clinical governance activities are sometimes implemented primarily to comply with accreditation requirements. But clinical governance is not just about accreditation; it is vital to support leaders to make the right decisions, and to engage and enable the workforce to provide high-quality care. Clinical governance systems are most effective when the workforce sees that the purpose is to support high-quality care.

How clinical governance applies to digitally enabled care

Robust clinical governance is needed for all types of care, whether delivered face to face or digitally enabled. Digitally enabled care includes virtual care, remote monitoring, and decision making supported by artificial intelligence.

As digitally enabled models of care evolve and clinical workflows change, governance structures and systems need to adapt.

Clinical governance systems and frameworks must continue to develop to harness the benefits of digitally enabled care – such as enhanced diagnostic accuracy, streamlined clinical workflows and support for personalised care – while safeguarding the safety and quality of care for patients.

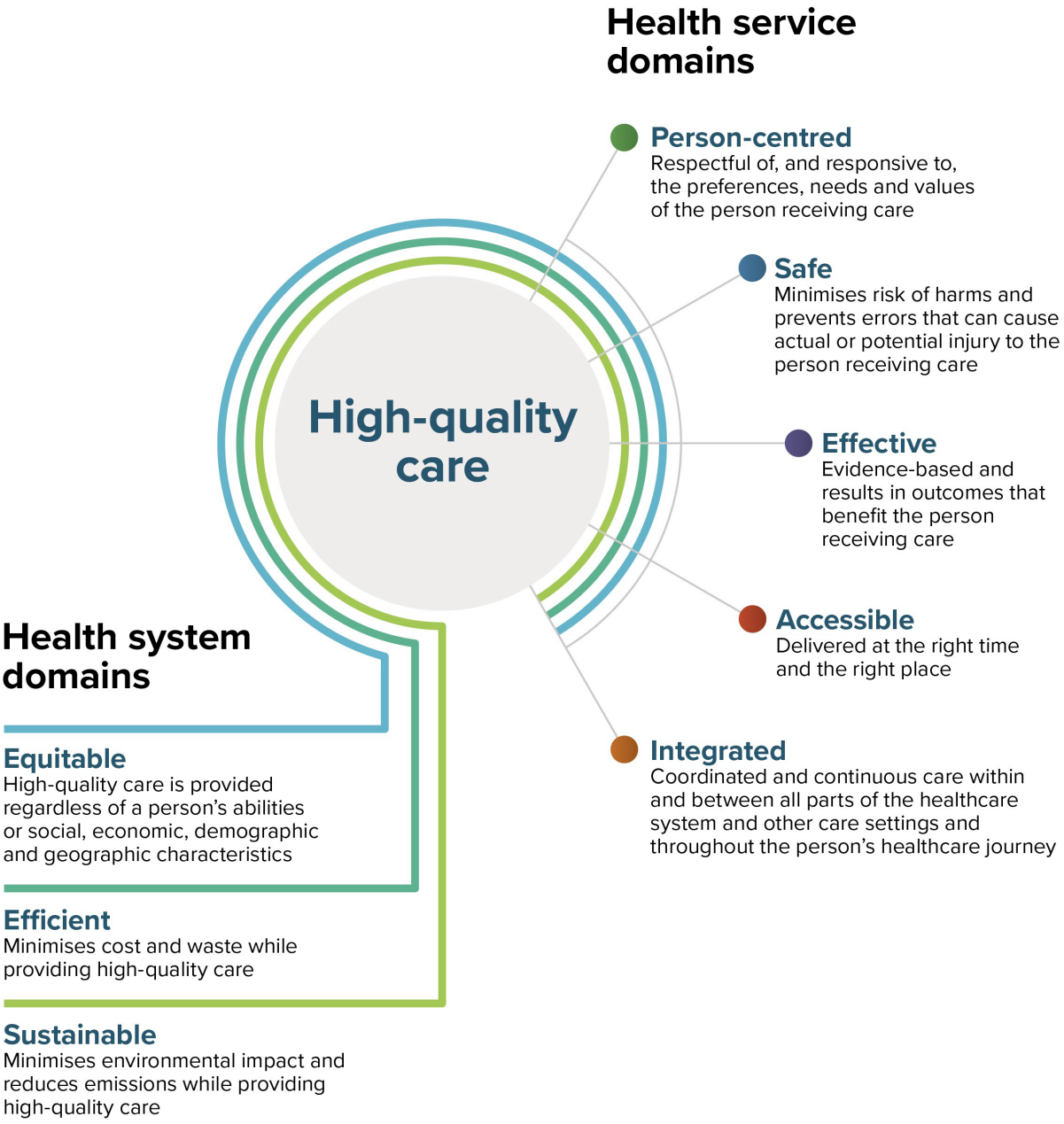
High-quality care

Defining high-quality care

The central aim of clinical governance is to deliver care to patients that is consistently high quality and improving. The Commission's domains of high-quality care (Figure 1) describe the quality of care patients should receive and that boards and executives are responsible for achieving through effective clinical governance.

> *There can be no safe health care without cultural safety. It must be embedded into every aspect of how we plan and provide the right care for our patients.*
> Health system leader (to be named with permission)

Figure 1: Domains of high-quality care



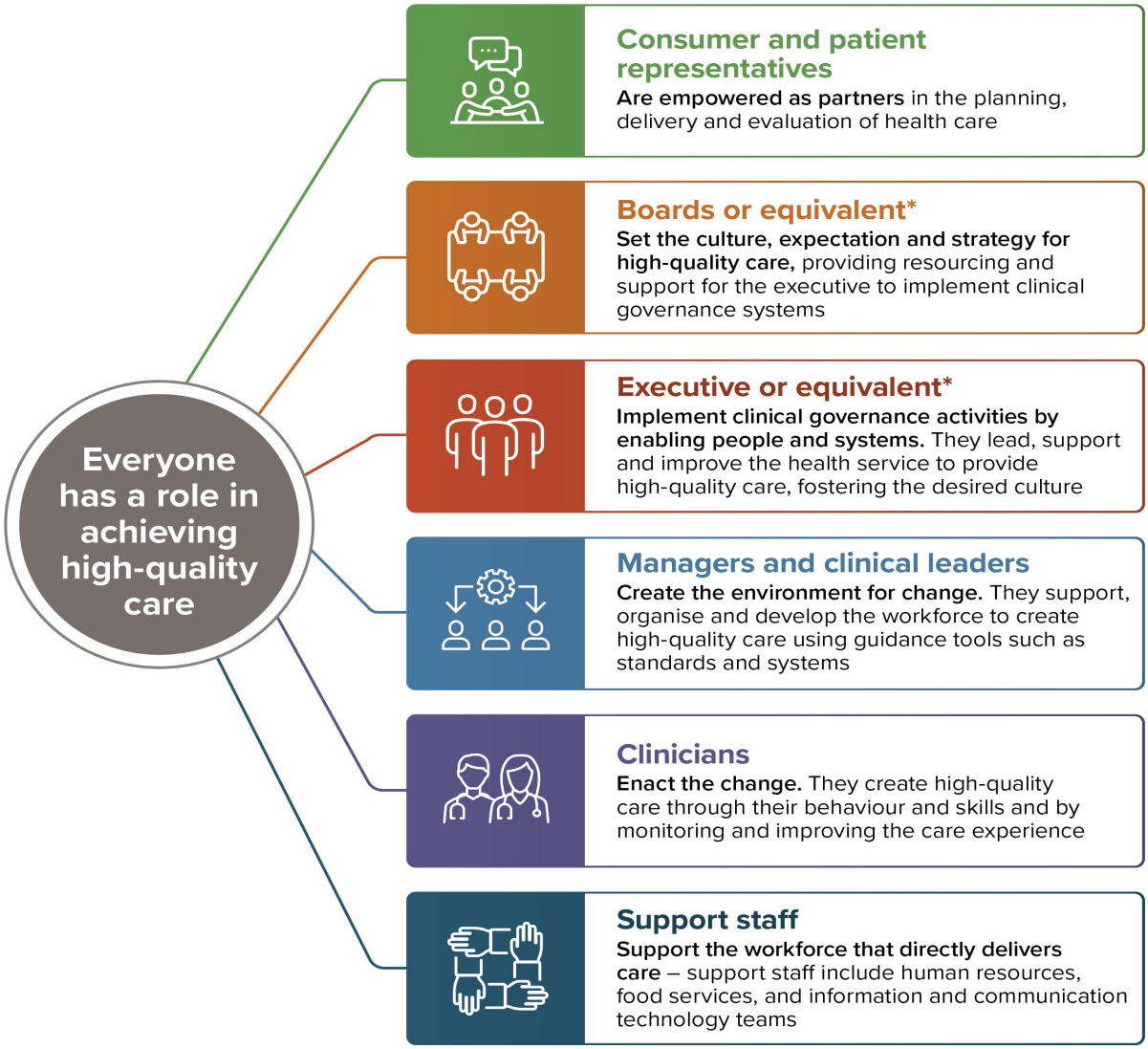
Roles in supporting high-quality care

Everyone in a health service – whether directly or indirectly involved in patient care – is responsible for achieving consistently high-quality care for every patient. To be effective, clinical governance needs to involve the board, executive and the workforce at all levels (Figure 2). Engagement and partnerships with patients, carers and consumers are critical to achieving high-quality care and better patient outcomes.

A note about patients and consumers

This model uses the term 'patient' for the person receiving care. It uses 'consumer' when referring to a consumer advocate or representative involved in clinical governance activities.

Figure 2: Roles in supporting high-quality care



This illustration has been adapted from an Australasian Institute of Clinical Governance (AICG) resource – 'I take responsibility'.

* Governance models differ across Australia – health services in some states and territories do not have boards. Where an organisation does not have a board and executive, these roles fall to the key decision-maker and accountable person or group at the organisation.

The six clinical governance foundations of high-quality care

Clinical governance is the set of organisational systems designed to support health services to deliver high-quality care. In this model, these systems are structured into six clinical governance foundations (Figure 3) that, when combined, underpin an organisational approach to delivering consistently high-quality and improving care.

The six foundations are connected and interdependent. The effectiveness of each foundation can vary as the environment changes. This means that continuous monitoring, evaluation and improvement are required to check that a health service's activities are aligned with each foundation and remain fit for context, culture and purpose – and achieve high-quality care as a result.

Of the six foundations, leadership is a critical enabler of effective clinical governance. The board and executive provide clear strategic direction while creating a culture in which there is leadership and accountability at all levels of the organisation for providing high-quality care.

This section sets out the key points of good practice for each foundation. It is not a complete list – rather it is designed so that health services can assess their work in each foundation area. Accompanying practical resources provide more detailed information on effective practice for each foundation.

Figure 3: The six clinical governance foundations of high-quality care

1. Leading culture and systems

Leadership and organisational culture (shared values and ways of thinking and acting) are central to how care is delivered and the outcomes of that care. Effective leadership at all levels of a health service is critical to achieving high-quality care, influencing and reinforcing all the foundations of high-quality care. The board and executive set the strategy and culture for high-quality integrated care, and collaborate with the workforce and patients, carers and consumers to achieve better care and patient outcomes.

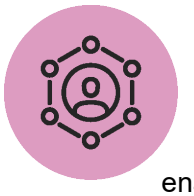
Safety and quality inquiries have highlighted that leadership actions – or lack of action – have a major impact on the operations and culture of a health service. Ineffective operations and negative culture contribute to poor staff morale, system failures and suboptimal care, while positive organisational culture and robust operations are associated with more satisfied and motivated staff and better patient outcomes.

What good practice looks like – key examples

1. The board and executive have a clear vision and strategy for providing high-quality care that is communicated and understood across the organisation. The clinical governance framework underpins and supports achievement of the strategy.
2. The structure and operations of the board, executive and committees are designed to enable collaboration and accountability for providing high-quality care.
3. Board decision-making considers the perspectives of people with personal knowledge and insights gained through direct involvement with a health condition.
4. Active engagement with Aboriginal and Torres Strait Islander people and communities prioritises their leadership and ways of knowing to provide culturally safe care that is free from racism.
5. Governance arrangements explicitly include and empower Aboriginal and Torres Strait Islander staff and community representatives.
6. There is systematic engagement with culturally and linguistically diverse patients, carers and communities as active partners in health service planning and delivery.
7. The board and executive collaboratively engage with the workforce, patients and community. For example, board members and executive regularly visit frontline services to talk with staff and patients, and staff present to board and executive meetings on quality of care.
8. Open disclosure reporting processes are valued, supported and embedded at all levels of the organisation.
9. The board and executive lead strategies to deliver environmentally sustainable health care through minimising unwarranted variation in care and wasteful care.
10. Leadership of digitally enabled care is rigorous and proportional to risk, just as it is for traditional care. There is effective oversight of digital health infrastructure and applications (including patient self-management platforms), data privacy and the ethical use of automated systems in clinical decision-making and patient care.
11. Safety and quality standards are implemented as enablers of effective clinical governance to achieve consistently high-quality care, not just to meet compliance requirements.

> *Leaders need to understand what it is like for both staff and patients. Talk with frontline staff first – that will give you an idea of why this is important. Sit with patients and pretty quickly you will realise that you need to do something about the point of care.*
> Health system leader (to be named with permission)

> *Culture is the hardest thing to sustain. Reputations are hard to earn and easy to lose. You need to stay vigilant.*
> Health system leader (to be named with permission)



2. Partnering with patients, carers and consumers

Partnering with consumers in clinical governance – and with patients in their own care – is critical to achieving high-quality care, contributing to better outcomes and experiences for patients, carers and families. Governance systems at all levels of the health service enable patients, carers and consumers to shape their care. The board and executive lead systems that build a culture of person-centred care so that everyone in a health service partners with patients, carers and consumers to provide or support the delivery of high-quality care.

What is person-centred care?

Person-centred care is health care that respects the patient, their family and carers, and responds to the person's preferences, needs and values. Person-centred care is equitable, culturally safe and free from racism.

What good practice looks like – key examples

1. Meaningful and active partnerships with patients, carers and consumers inform priorities and processes for providing high-quality care.
2. A consumer engagement strategy recruits, trains, supports and connects consumers to health service activities and projects and measures this engagement.
3. The board and executive act on patient outcome and experience measures alongside other performance measures and allocate resources to embed person-centred care.
4. The organisation partners with patients, carers and consumers who reflect the diversity of the wider community to design, measure and review health services. Insights from people with personal knowledge of a health condition strengthen clinical governance by informing policy development, quality improvement and education.
5. Formal and informal ways are used to gather feedback from a diverse and representative range of patients, carers and consumers.
6. Both positive and negative feedback is encouraged. There are clear processes to receive this feedback and to use it to improve care. Patients, carers and consumers know how to provide feedback and they receive information about outcomes.
7. Patients, carers and consumers are encouraged to speak up for safety and their concerns are acted on. There are culturally safe processes for patients and carers to voice concerns about deterioration during clinical care.

> *We start all board meetings with a report of a patient experience to set the context. It highlights the importance of patient care.*
> Health system leader (to be named with permission)

3. Building a healthy workforce culture

A supported and satisfied workforce is essential to delivering high-quality care and improving clinical outcomes. Many factors contribute to building and retaining an engaged workforce, including a physically, psychologically and culturally safe workplace, effective staff development and performance management systems, management of workload and adequate staffing, and supervision and support of junior clinicians. A positive organisational culture in which staff feel respected, valued and safe to speak up for safety is a critical factor in boosting workforce morale and enabling staff to provide or support consistently high-quality care.

What good practice looks like – key examples

1. The board and executive define the workforce's responsibilities for delivering high-quality care and provide appropriate and effective workforce planning and resourcing to meet them.
2. The board receives regular reports on workforce risks, pressures and gaps. Succession planning is proactive and occurs regularly for all key roles.
3. The board, executive, clinical leaders and managers understand the link between workforce health and wellbeing and the quality of care. They systematically measure and improve workforce safety, satisfaction and engagement, and manage and reduce risks and adverse events.
4. Operational systems and processes are designed so that the workforce can focus on patients and their needs, enabling them to provide high-quality care.
5. Education and training programs, competency frameworks and performance reviews enable the workforce to provide or support high-quality care.
6. The workforce feels safe to speak up for safety. The culture encourages identifying, monitoring and reporting risks, incidents (including near misses) and complaints without fear of blame, and promotes transparency and learning from mistakes.
7. The organisation attracts, recruits and retains a diverse workforce that reflects the community it serves. The workplace is safe and culturally responsive, acknowledging, respecting and accommodating difference.
8. The workforce receives practical support to develop and integrate new evidence-based technologies into their practice.
9. Clinical and corporate systems enable the workforce to provide and measure the quality of care through:
    - evidence-informed policies, procedures, clinical protocols and standards accessible at the point of care
    - clinical information systems and digitally enabled care
    - responding to feedback from the workforce about actions to address risks and improve care.

> *Clinical governance is important to all of the workforce – everyone should talk about patient care. You can't imagine the difference it makes to the finance department when they realise they're doing something meaningful – that they contribute to the patient experience at the point of care.* Health system leader (to be named with permission)

> *A clinical governance system enables every staff member to understand that we are here for patient care and how we all contribute.*
> Health system leader (to be named with permission)

> *We don't have a no-blame culture as this sends the message that there is no accountability. Instead we have 'just' decision-making – a restorative culture.*
> Health system leader (to be named with permission)

4. Enabling high-quality and integrated clinical practice

A key purpose of a health service is to provide clinical care to achieve the best patient outcomes. Patients are likely to have the best outcomes when their clinical care respects their needs and preferences, is informed by the best available evidence, and is integrated across clinical care providers and settings.

Clinicians have the skills and expertise to deliver care that is most likely to achieve the best outcomes for patients across the continuum of care. They work collaboratively to provide high-quality care and contribute to, and participate in, an organisation's clinical governance systems. Leaders and managers create the systems and environment that support clinicians to provide consistently high-quality care. Clinicians, the board, executive and managers are accountable for providing high-quality care.

What good practice looks like – key examples

1. There is regular review of a range of measures to determine whether the organisation is consistently providing all the dimensions of high-quality care. This information is used to improve care.
2. Quality improvement activities monitor and continuously refine care to ensure it aligns with best practice.
3. The organisation's responsibility for patients, their families and carers extends across the continuum of care, including improving care and managing risks at transitions of care. Collaboration and coordination of services promotes integration of care across providers and settings.
4. Clinicians and clinical teams actively participate in peer review and quality improvement activities, act to improve care and receive information on outcomes of actions.
5. The organisation reinforces and supports clinicians' dual roles – as healthcare professionals and stewards of system improvement – and develop their leadership skills to drive and support high-quality care.
6. There are robust and transparent systems to protect patient safety through credentialling, re-credentialling and defining scope of clinical practice, and the effectiveness of these systems is monitored.
7. A range of clinician groups is represented in clinical governance roles. The reporting system provides the board and executive with an accurate view of clinical perspectives on care quality.
8. There is strong collaboration between clinical and technical teams, ensuring quality, safety and accountability in the use of digitally enabled models of care.
9. Clear protocols guide when and how digitally enabled tools support clinical decisions, with defined accountability and human oversight.
10. Clinicians' leadership, teamwork and communication skills are developed to enable them to work in teams to deliver high-quality care.

> *Clinicians need to have time and space to lead on quality.*
> Health system leader (to be named with permission)

5. Managing and reducing risk

Health services are, by their nature, high-risk environments. Risk management frameworks need to be robust and adaptable as new technologies and digitally enabled health care continue to evolve. A strategic approach to risk management informs monitoring, planning and allocation of resources. It requires systems and a culture in which everyone in a health service is accountable for identifying circumstances in which patients or the workforce could be harmed and acting to prevent or control those risks. A safety culture allows people to openly share lessons from safety investigations, and to speak up when something is of concern.

What good practice looks like – key examples

1. The clinical risk culture aligns with the organisational purpose and strategic plan. The board agrees on the level of risk that the organisation is willing to tolerate to achieve the strategic vision for high-quality care.
2. A systematic approach to risk management involves every part of the health service. The organisation identifies, reports on and acts to minimise risk and harm, and proactively identifies causes of risks.
3. Data about risks, near misses and incidents are used to improve patient outcomes and experience, and to inform training and development – creating a learning organisation.
4. Investigations of safety incidents accurately identify root causes and draw together findings from related investigations to develop systematic and effective solutions.
5. Clinical incident and risk reports are analysed to look for trends to inform improvement efforts.
6. The safety culture is monitored, including patient and workforce perception of safety culture, and findings inform improvement strategies.
7. The organisational structure and reporting processes help to identify and address risk:
    - Committees are structured to increase communication about risk, for example, the chair of the safety and quality committee sits on the audit and risk committee.
    - The board understands risks to patient safety at the point of care, aligns the risk register with issues identified by patients and the workforce, and management addresses these issues.
    - The board receives distilled risk reports that enable a strategic response.

> *We spend a lot of time categorising and framing risks and setting appetite for risk. Our risk register is used as a reference for resource allocation and planning. We bring the risk register to life by including patient stories.*
> Health system leader (to be named with permission)

> *It's important to set a risk tolerance for the organisation. You can't eliminate risk. Health care is unavoidably high risk.*
> Health system leader (to be named with permission)

> *We have the flexibility to do deep dives into particular areas of risk and to respond to emerging risks.*
> Health system leader (to be named with permission)

6. Using data for better care

Collecting and analysing data about health service systems and performance, patient outcomes and experience – and acting on the findings – is fundamental to providing high-quality and continuously improving care. Effective use of data enhances health service management, including risk management. Responsive governance is needed to use findings across the health service to inform learning, improvement and accountability.

The board and executive champion a data-driven improvement culture by making data-informed decisions and providing information to all who need it. Data are used to identify areas for improvement and to provide feedback to the workforce to prompt behaviour change. Insights from multiple data sources (triangulated quantitative and qualitative performance, experience and outcome measures, and complaints) provide a deeper understanding of the quality of health care and the impact of efforts to improve care.

What good practice looks like – key examples

1. The board and executive use data to monitor all domains of high-quality care and to allocate resources to respond to key findings.
2. The board directs what data it receives and how it is presented. Quality and risk data are summarised and communicated so that trends and issues are clear to all, including managers and board members who do not have a clinical background.
3. The organisation reviews and uses multiple sources of trend and comparative data to reduce unwarranted healthcare variation, manage risk, measure performance, and drive innovation to promote high-quality care.
4. The organisation develops the capability of the executive, safety and quality team and workforce to use evidence-based improvement and change methods to achieve consistently high-quality care.
5. Clinicians receive timely information about the quality of care and care outcomes so that they can identify priority areas for improvement. These priority areas are reported to the board.
6. The organisation works with Aboriginal and Torres Strait Islander people and communities to interpret and respond to data in a culturally appropriate way and prioritises their right to data sovereignty (the right to govern the collection, ownership and application of data about their communities).
7. The organisation uses robust data governance, ensuring data sovereignty, and implements processes to continuously monitor and validate the performance of digitally enabled systems to ensure they remain high quality, accessible and effective.

> *Leaders need to be inquisitive about all types of data, including the soft signs that could have an impact on patient care. It's important to triangulate multiple data sources or perspectives. If you know that staff have high rates of sick leave and overtime, you need to dig further to find out what's happening with the workforce.*
> Health system leader (to be named with permission)

Clinical governance: what not to do

Health services are less likely to deliver high-quality care when they:

- delegate responsibility for clinical governance to a clinical governance or quality team rather than accepting that this is an organisational responsibility that must engage the board, executive and workforce across the organisation
- deal with incidents as they occur rather than anticipating and addressing potential risks
- focus more on complaints and errors than on celebrating and learning from success
- fail to recognise social and cultural diversity and do not adapt responses and service delivery to meet people's unique needs
- produce detailed reports with a lot of data but no insights
- inadequately monitor healthcare variation and do not know how clinical outcomes and patient experiences compare with similar organisations or trends over time
- make positive statements on quality and safety performance without evidence
- do not seek meaningful reporting on the quality of care and/or the clinical governance systems that support it
- accept poor outcomes with no clear actions for improvement or monitoring the effectiveness of these actions
- fail to set clear and shared aims for the desired quality of care
- conduct safety and quality meetings in isolation and do not report to the executive.

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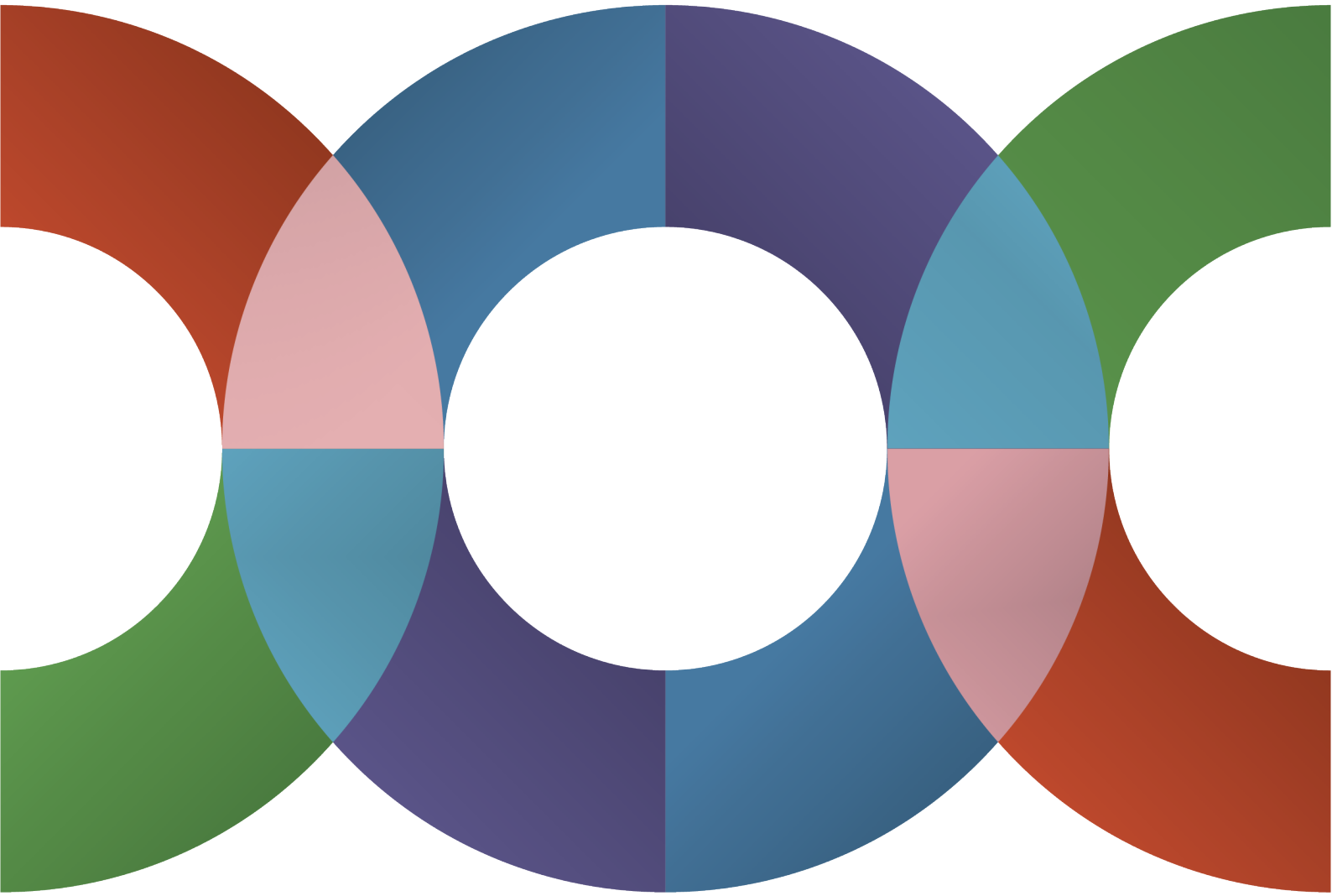
AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE



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Australian Government
Australian Digital Health Agency

Council for Connected Care

Agenda Item 10: Summary and other business

Meeting: Thursday, 21 August 2025

OFFICIAL

Purpose

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

Recommendation/s

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 in Canberra on Wednesday 12th November 2025.

Summary of issues

The next meeting will take place in Canberra at the QT Hotel on Wednesday 12 November 2025 and will focus on transitions of care, benefits of digital transformation and innovative workforce initiatives.

Background

This is a standing agenda item.

Attachments

Nil

Contact officer: Cass Timmermans, Assistant Director, Interoperability