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Feedback: *Foundations of High-Quality Care - A national model for clinical governance* (July 2025)

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to comment on the ACSQHC draft *Foundations of High-Quality Care – A national model for clinical governance* (July 2025).

In lieu of a formal submission, we provide key considerations drawn from the RACPs positions on integrated care, physician workforce, regulatory governance, and broader system reform. We intend to support a model that enables practical implementation, fosters service innovation, and strengthens the wellbeing and resilience of the physician and trainee workforce.

Clinical governance and duplication: cautionary note

At least four ACSQHC consultations on clinical governance topics are currently open or have recently closed. Alongside the draft national model, these include the *Credentialing and Defining Scope of Practice: Guide for managers and clinicians* (on which we have commented), the *Australian Open Disclosure Framework*, and the *National Safety and Quality Health Service (NSQHS) Standards*.

With multiple overlapping reforms underway, there are risks of duplication, inconsistency, and unnecessary complexity. Clarification is needed to ensure each reform has a distinct purpose and clear role being guidance or mandatory material within the wider regulatory framework. Without careful oversight, health services and clinicians are vulnerable to change fatigue, particularly in existing pressured environments with psychosocial risks and workforce stressors. Ultimately, clinical governance tools should simplify and strengthen quality and safety systems. They must not, through complex design or unclear responsibilities, add to the risks they are intended to mitigate.

Building a healthy workforce culture

The draft guidance iterates workforce responsibilities for high-quality care with some oversight that this depends on a well-supported, resilient, and healthy workforce. Current references to safety and whistleblowing, and to leadership awareness of worker wellbeing, are important but not enough. To enable implementation, the model should clearly articulate the system levers of workforce safety, wellbeing, and risk mitigation within clinical governance by:

- Recognising the requirements for adequate staffing; protected supervision and teaching time; flexibility for cultural and individual needs, and culturally safe environments for First Nations and other diverse practitioners. Additionally, required access to pastoral care and support services, not only platforms for use at crisis point.
- Affirming that healthy clinical governance must include protections against institutional misuse or weaponisation. Core principles should include transparency, impartiality, equity, cultural safety, conflict mitigation, rights of appeal, independent review. And inclusivity across the scope of physician roles, and ways of working.

- Encouraging healthcare organisations to establish leadership, monitoring, and support mechanisms for workforce wellbeing, while addressing psychosocial risk management as a legal workplace duty.

Enabling high-quality and integrated clinical practice

We welcome the draft's recognition of integrated care, however note that it remains expressed at a broad level. To be effective, it must include specific criteria aligned with contemporary evidence-informed approaches that facilitate seamless integrated care in the patient care journey, including collaborative commissioning. Collaborative commissioning is recommended by the Productivity Commission's recent *Delivering Quality Care More Efficiently Interim Report*.r It remains underfunded, however can significantly improve patient safety, quality, and system sustainability. This needs reinforcing in the model to progress the overall national direction for quality and safety improvement in healthcare.

Drawing on the *RACP Model of Chronic Care Management (MOCC)*, we recommend that the following examples be promoted in the final to encourage innovation, reduce patient healthcare episodes and optimise use of the health workforce:

- Coordinated models of care for complex patients at intermediate risk of repeat hospitalisation with shared oversight by Primary Health Care Networks, Local Hospital Networks, Aboriginal Community Controlled Health Organisations.
- Robust, secure, and interoperable data systems to inform commissioning, reduce duplication, strengthen accountability and quality, and measure outcomes.
- Funding models that enable pooled or joint arrangements, incentive responsive value-based care and flexibility to respond to the realities of chronic, complex, and long-term conditions.

Leading culture and systems

This section of the model is overly general in its description of quality leadership in contemporary healthcare systems. It outlines the importance of culture and executive direction, however does not sufficiently identify the practical drivers of effective leadership in modern health services for current and future challenges. It should integrate the governance responsibilities of leaders in tackling low-value care and advancing environmental stewardship, which aretwo core challenges for modern health systems.

- This section should emphasise evidence-based, high-value care while reducing low-value and unnecessary tests, treatments, and procedures. Programs such as the RACP's *Evolve* initiative are central here. Evolve provides evidence-based physician-led specialty-specific recommendations for physicians, to support better decisions in high-pressure environments, reduce wasted expenditure, and normalise value-based care as part of professional standards. Citing RACP's *Evolve* and similar low value care initiatives within the model supports the shift away from institutional enabling low-value practices in healthcare.
- It should also promote decarbonisation and environmentally sustainable care to reduce health system contributions to Australia's emissions. reinforcing long-term system resilience. It should encourage health services to consider direct and indirect impacts of climate on health service demand to maintain continuous quality, while mitigating climate risks.

Using data for better care

This section takes a genericview of data which does not address emergent risks and safety issues of Artificial Intelligence (AI) as a current and emerging data source in health services.

While AI has potential in diagnostics and care, it also introduces unmitigated risks that governance standards must address. To position the model to reduce emergent data risks as AI use expands rapidly in healthcare we recommend key considerations from our recent submission to the Safe and Responsible AI in Health Care – Legislation and Regulation Review:

- Encourage formal certification of AI systems and oversight for safety, effectiveness, and accountability assurance for quality patient outcomes.
- AI tools should provide explainable decision-making that clinicians and patients can understand, particularly within health records and digital systems.
- AI-driven data use must align with existing governance frameworks, ensuring legal and ethical clarity as practices evolve.
- Safe and ethical AI adoption requires co-design with clinicians, patients, and carers, and is supported by workforce support in digital literacy and ethics, including use of AI to safely predict and prevent low-value care related harm.

The RACP trusts these comments will be helpful in finalising the model. We welcome further involvement in this important work.

Please contact Peter Lalli, Senior Policy and Advocacy Officer on policy@racp.edu.au for further engagement.