

18 September 2026

Attention: National Standards Program
NSQHS Standards (third edition)
Australian Commission on Safety and Quality in Health Care
Via email: NSQHSSThirdEdition@safetyandquality.gov.au

**Draft National Safety and Quality Health Service (NSQHS) Standards (third edition)
consultation – Faculty of Pain Medicine feedback**

About the Faculty of Pain Medicine

The Faculty of Pain Medicine (Faculty of FPM) within the Australian and New Zealand College of Anaesthetists (ANZCA) is the professional body dedicated to the training and education of specialist pain medicine physicians. Our role is to reduce the burden of pain on society through education, advocacy, training, and research.

Overall position

The faculty welcomes the opportunity to comment on the Australian Commission on Safety and Quality in Healthcare's draft of the third edition of the NSQHS. The breadth of the draft standards is admirable, and FPM especially supports the focus on clinical governance, the patient-centred approach to healthcare delivery and the emphasis on a multidisciplinary approach to patient care. There are several sections that are relevant to our specialty. FPM's experience working in a complex clinical area, where multidisciplinary and interdisciplinary team care is the norm, can offer a particular insight into areas where some enhancements can be made to the draft standards. We offer the following recommendations to strengthen the clarity and implementation of the Standards across the whole healthcare sector.

Clinical Governance Standard - Enabling high-quality and integrated clinical practice

Section 1.17 highlights the role of "organisational systems" regarding a number of aims. The emphasis on the role of clinician educators to work with trainees in maintaining and improving standards is, of course, very appropriate. However, there is no recognition here of the significant burden that such training commitments place on senior clinicians, and furthermore, this appears to be at variance with statements from other organisations, particularly the NHPO, where there has been little consistency in defining any level of ratio between supervisors and trainees that might be judged as necessary to provide high level skills training. Effective supervision requires appropriately qualified and experienced supervisors who have sufficient capacity, protected time and organisational support to undertake this role. FPM recommends that these enabling requirements be made more explicit.

The emphasis on participation in morbidity and mortality (M&M) meetings is appropriate. However, there needs to be a simultaneous recognition of the significant difficulty in organising appropriate structures to run such meetings in the face of increasing legal supervision relating to privacy of records and discovery of what should be confidential discussions. There needs to be a clear pathway to improving access to M&M activities. Furthermore, there needs to be a recognition that participation in a variety of quality assurance processes, including M&M meetings, is an activity that requires both time and commitment if it is to be effective. Where the major emphasis remains on service throughput and management view quality assurance activities as separate to service activity, quality assurance and patient safety may suffer.

Section 1.18 emphasises the importance of clinicians actively contributing to governance activities, but once more, particularly with regard to section 1.18 (d), the legal implications of multidisciplinary review and discussion of complex clinical cases, particularly where an adverse outcome has occurred, need to be streamlined to allow clinicians to analyse such circumstances dispassionately and transparently. This same point is highly relevant to **section 1.19** regarding quality improvement activities.

FPM also recommends that **sections 1.18 and 1.19** more clearly recognise that meaningful participation in clinical governance, multidisciplinary review and quality improvement requires dedicated workforce capacity and should be treated as core clinical activity.

Section 1.18 also references the importance of implementing systems that support clinicians in the implementation and evaluation of new interventional procedures and clinical innovations. This is sound advice, but it would also seem important for there to be similar attention paid to clinical guidelines released by peak bodies to monitor the use of existing, complex interventions. The NSQHS could recommend explicit cross-reference to profession-specific clinical care standards for higher-risk interventions. FPM's PS11 (PM), the Procedures in Pain Medicine Clinical Care Standard is a good example of a reference source for specialty clinical governance.

Section 1.22 regarding clinical care standards includes an important section in note (c) where it is suggested that clinicians should be allowed to “collect, monitor and act on indicator data for relevant clinical care standards”. This is important, but specific mechanisms for doing this are currently compromised by limited access to appropriate database and registry resources. As noted in earlier sections, potential clashes with privacy law will also make this standard difficult to achieve without pathways that will permit the exchange of appropriate information.

FPM supports the emphasis in **sections 1.23 and 2.19 to 2.22** on coordinated and connected care. This is particularly important for people with chronic pain, whose care commonly involves specialist pain medicine services, primary care, pharmacy, allied health, mental health and other specialist services. The Standards should require clear documentation and communication of the multidisciplinary pain management plan, medication changes, treatment goals, risk-management arrangements and responsibility for ongoing prescribing and review at transitions of care.

Clinical Governance Standard - Using data for better care

In the section on using data for better care, **section 1.28** appropriately identifies that collection and analysis of data is vital to improving care. However, as noted in earlier sections, it is clear that the current clash with privacy legislation makes most of the aims of this section difficult to achieve. There needs to be clarity regarding when and how data can be used. For example, whilst deidentification of data is mentioned, even this does not protect against potential breaches of privacy legislation unless patients have given very specific written consent to permit this. There needs to be a clear emphasis on gaining consent for data collection from patients presenting to clinical services, and there needs to be better guidance for both clinicians and managers as to how this should be achieved.

FPM also recommends that **sections 1.28 to 1.32** recognise the practical infrastructure and workforce capability required to collect, analyse and act on clinical quality and patient outcome data.

Person-Centred Practice Standard - Partnering with patients in their healthcare

Section 2.03 (a) recommends that clinicians should “engage patients throughout the episode of care in establishing what matters to the patient in decisions about their care and documenting what matters in the healthcare record”. This is indeed a very important aspect of this standard, and it would be appropriate to include this in earlier parts of the standard relating to data collection. Additionally, much medical research often fails to examine which outcomes

are particularly important for patients, resulting in important gaps in research resource allocation. This issue is of particular importance to **section 2.23** where research clinicians are advised on appropriate approaches to patients. However, the overall title to the section should be modified to include the importance of undertaking research into outcomes of prime importance to patients.

Person-Centred Practice Standard - Caring for the whole person

Sections 2.04 to 2.06 should recognise the importance of identifying patients at increased risk of developing persistent pain following surgery, trauma or acute illness. Care planning should include preventive strategies, appropriate follow-up and timely referral to specialist pain services where pain does not resolve as expected.

Where appropriate, these patient-prioritised outcomes should also inform the clinical quality and outcome data collected under **sections 1.28 to 1.32**.

Person-Centred Practice Standard - Recognising and responding to acute deterioration

Section 2.16 et seq draws attention to the important issue of recognising acute deterioration in a patient's status. FPM recommends that supporting guidance identify medication-related deterioration as an important clinical risk. An important example here is the scenario of opioid-induced ventilatory depression occurring in the postoperative and acute pain management setting. A recurring problem in this, and related areas is an underappreciation of the difficulty in assessing and interpreting findings of sedation and cognitive impairment. Improved training in assessing sedation and cognitive impairment, together with clearer pathways for escalation and intervention should be emphasised more strongly.

Person-Centred Practice Standard - Coordinated and connected care

FPM supports the focus on coordinated and connected care. People living with complex and persistent conditions may receive care across hospital, primary care, community and specialist services, with several teams involved over an extended period.

FPM recommends that **sections 2.19 to 2.22** explicitly recognise the risks experienced by patients with complex, persistent conditions as they move across services and care settings. This should include clear accountability for coordinating ongoing care, timely exchange of relevant information and active monitoring of outcomes associated with transitions and fragmented care.

Safe Clinical Systems Standard - Medicines safety and quality

Section 3.15 makes a very clear case for medication stewardship and is a welcome addition to the NSQHS. However, in addition to the specific reference to antimicrobial drugs, FPM recommends explicit recognition of opioids as a priority class of high-risk medicines requiring effective stewardship. This should extend across initiation, monitoring, review, transition and cessation of therapy. Stewardship systems should also consider other medicines used in pain management that may increase sedation, cognitive impairment or respiratory risk, particularly when used in combination with opioids.

The Pennington Institute has recently published Australia's Annual Overdose Report 2026. This confirms that as in all previous years, opioids remain the drug class most commonly implicated in fatal drug-induced poisoning in Australia. In 2024, opioids were involved in 1,083 drug-induced deaths and in 877 unintentional drug-induced deaths. Scheduled pharmaceutical opioids were involved in 370 unintentional opioid-related deaths, or 42% of the opioid total.

Additionally, in 2024, 428 Australians died from intentional drug poisoning, with opioids involved in 164 deaths; this represents approximately 38% of all drug-induced suicides. Available mortality data do not permit precise attribution according to whether the opioid was prescribed, diverted or illicitly manufactured. However, indirect analysis indicates that the great

majority of deliberate opioid poisonings (the great majority being suicides) involve the use of prescription opioids.

In total, these statistics suggest that in Australia, around 10 people die each week from overdoses involving prescription opioids. The Penington Institute's data further identifies that more than 80% of these deaths occur in patients under the age of 60 years whereas deaths occurring due to multiresistant bacterial infections are predominantly in people above the age of 70 years.

These figures support explicit recognition of opioid stewardship within national medication-safety standards. Health services should have systems to monitor opioid prescribing, dispensing and administration, identify and respond to opioid-related harm, support appropriate review and deprescribing, and use outcome data to improve practice.

Summary

FPM again recognises the important and comprehensive work that has resulted in the high-quality draft NSQHS standards. We recommend that consideration of the matters raised above could improve the standards further and offer important guidance to patients, clinicians and policymakers. We would be happy to discuss these issues further with the Australian Commission on Safety and Quality in Healthcare. Feel free to contact fpm@anzca.edu.au with any queries.

Yours sincerely,



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