ALLIANCE AGAINST
ISLAMOPHOBIA

SUBMISSION · SEPTEMBER 2026

Seen as an Individual

Racism, Islamophobia and Patient Safety

Submission to the Australian Commission on Safety and Quality in Health Care
National Safety and Quality Health Service Standards · Third Edition

Acknowledgement from AAI

On behalf of the Alliance Against Islamophobia, I thank **Dr Mohamed Haroon Kasim** for his contribution to preparing this submission. His expertise in clinical leadership and management, clinical governance, quality improvement and health-system redesign has helped translate community concerns into practical recommendations for safer, more equitable care.

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About AAI

The Alliance Against Islamophobia (AAI) works to identify, prevent and respond to Islamophobia and its institutional, social and health consequences.

AAI welcomes the opportunity to comment on the initial draft of the National Safety and Quality Health Service Standards — Third Edition and consents to the full publication of this submission.

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Cover image

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Endorsements

The following organisations endorse this submission:

Australian Federation of Islamic Councils

Australian Muslim Advocacy Network

Islamic Council of Queensland

Islamic Council of Victoria

Islamic Society of South Australia

Muslim Votes Matter

Queensland Muslims Inc

Executive summary

AAI supports the third edition's emphasis on person-centred care, integration, continuous learning and outcomes.

The draft already contains important protections. Requirement 1.01(d) addresses systemic, structural and institutional bias, racism and discrimination. Requirement 1.03(c) establishes a zero-tolerance approach. Requirement 1.10(d) addresses patients' experiences of their healthcare rights, while Requirement 1.12 connects feedback, complaints and patient-reported experience with investigation and improvement.

AAI seeks to make explicit how these obligations apply to racism, Islamophobia and discriminatory treatment. Policies, training and representative committees cannot, by themselves, establish whether patients experienced equitable care.

This submission advances five propositions:

1. **Racism and Islamophobia are patient-safety concerns**. Stereotyping may affect whether patients are believed, involved in decisions and given appropriate care.
2. **Language access is essential but insufficient**. Interpreter provision does not discharge a service's responsibility to address discriminatory treatment, including experiences of fluent English-speaking patients.
3. **Patient experience must inform action**. Reports of discrimination should inform governance, incident review, Experience-Based Co-Design and evaluation.
4. **Measurement must protect patients**. Identity information should be voluntary and protected, and measures must capture discrimination connected with actual or perceived identity.
5. **Consultation must not be tokenistic**. Patients and communities must have demonstrable influence over priorities, decisions, implementation and evaluation.

AAI's principal proposal is to strengthen Requirement 1.01(d), supported by targeted amendments to existing requirements. The Commission should develop and validate a short supplementary module for the Australian Hospital Patient Experience Question Set (AHPEQS), with equivalent measures where AHPEQS is unsuitable.

Services should use existing feedback, complaints and incident systems while that module is developed. The obligation to listen, investigate and improve should not depend on completion of a new measurement instrument.

The proposed amendments are set out in Annexure A. Annexure B maps the submission to the Commission's six consultation questions.

Recommendations

AAI recommends that the Commission:

1. **Strengthen governance:** Amend 1.01(d) and 1.03(c) to explicitly address Islamophobia, racialised religious discrimination, caste discrimination and dehumanisation, and require evaluation of the response.
2. **Monitor experience:** Require governing bodies to monitor patient and workforce experiences of discrimination, stereotyping, dignity, cultural and religious safety, and confidence in reporting.
3. **Identify inequities:** Require appropriately disaggregated patient-experience, complaints, incident and outcome data, interpreted with attention to quality, context and privacy.
4. **Protect identity information:** Ensure that religion, ethnicity and cultural identity information collected for equity monitoring is voluntary, confidential, purpose-limited and protected against profiling and discriminatory use.
5. **Demonstrate participation and change:** Require evidence that patients and communities influence priorities, service design and evaluation, and that their contributions inform co-design and measurable improvement.
6. **Examine discriminatory patterns:** Strengthen 1.12(e) and associated safety processes to identify and examine possible racism, Islamophobia, dehumanisation, stereotyping and failures to meet cultural, religious or communication needs.
7. **Provide safe reporting:** Require accessible, culturally safe reporting and appropriate support and redress, with protection against retaliation or compromised care.
8. **Strengthen communication support:** Retain reliable interpreter access, recording of communication needs and continuity across transitions, while making clear that these measures do not replace action on discrimination.
9. **Develop a validated measure:** Co-design and validate a short AHPEQS module addressing discrimination, dignity and cultural and religious safety, with equivalent measures for other settings.
10. **Pilot with affected communities:** Test requirements, measures and guidance with Muslim patients, carers, families, clinicians, workers and community organisations.
11. **Demonstrate consultation influence:** Ensure consultation is not tokenistic. Publish submissions unless confidentiality is requested, subject to privacy protections, and explain decisions through a recommendation-level response matrix.
12. **Validate revised requirements:** Test the next draft with communities whose experiences informed the changes before the Standards are finalised.

1. The patient-safety case

Recognising the individual

Islamophobia may operate through religion, ethnicity, name, language, appearance or dress. Patients may experience it because they are Muslim or because others perceive them to be Muslim.

Assumptions that a patient is threatening, incapable of independent decisions, resistant to treatment or less credible may affect symptom assessment, consent, pain management, mental-health assessment, escalation and responses to family advocacy. Services need systems capable of detecting and examining these experiences.

Muslim Australians are culturally, ethnically, linguistically, religiously and socioeconomically diverse. Care should begin with each patient's expressed needs and preferences.

AAI recognises the distinct status, rights, histories and healthcare experiences of Aboriginal and Torres Strait Islander peoples. These proposals complement, without displacing or diluting, First Nations cultural-safety requirements.

Public attitudes and institutional perceptions

The Australian Muslim Advocacy Network's Dehumanisation Framework examines representations of groups as uniformly threatening, inherently dangerous, incapable of independent thought or collectively responsible.

It provides an explanatory foundation for considering how public narratives may influence institutional perceptions. AAI has previously supported this Framework. It protects people while preserving space for legitimate criticism of states, governments, militaries, political ideologies and religions. AMAN; Abdalla, Ally and Jabri-Markwell.

AAI proposes using the Dehumanisation Framework in complaint assessment and training (Section 2), with a focus on patient experience, possible bias, discriminatory treatment and quality improvement. Its application should be grounded in evidence and context, without assuming that public discourse automatically determines clinical decisions.

The ANU–Scanlon partnership's *Mapping Social Cohesion 2025* report found negative attitudes towards Muslims among **35 per cent** of Australian adults in 2025, compared with **34 per cent** in 2024 and **27 per cent** in 2023. The increase between 2023 and 2024 followed a period of declining negative attitudes. Muslims attracted the highest proportion of negative attitudes among the six religious groups compared. These findings describe public attitudes, not the prevalence of discrimination within healthcare. O'Donnell, Falkiner and Szachna, Figure 6(b), p. 14.

Australian evidence

A Victorian survey of 580 women from culturally and linguistically diverse backgrounds found that Muslim women had higher odds of **reporting racism** than non-Muslim participants: **OR 1.70**, **95% CI 1.02–2.83**.

Muslim women were also more likely to score above the threshold for high or very high psychological distress on the study's questionnaire measure, consistently across most types of racism examined. These findings concern self-reported racism and psychological distress; they do not establish a clinical diagnosis or the prevalence of healthcare discrimination. Yeasmeen, Kelaher and Brotherton.

Healthcare-specific qualitative research involving 15 higher-weight Australians of Arab heritage, all Muslim, identified appearance-based judgement, generalised advice and assumptions, cultural responsiveness and system constraints. This small study cannot isolate Islamophobia from other influences, but identifies mechanisms relevant to person-centred care. Hassan, Kerr and Begley.

Research involving interviews with 20 practising Muslims and a survey of 200 Australian Muslim participants identified religious and cultural influences on mental-health help-seeking and a need for appropriate treatment. Verwey.

Broader reports reinforce this context:

- *Isma — Listen* and *Sharing the Stories of Australian Muslims* document discrimination, distrust and barriers to reporting. Australian Human Rights Commission, 2004, 2021.
- *Islamophobia in Australia Report V* records 309 in-person incidents in its 2023–2024 reporting period. These are reported incidents, not a healthcare prevalence estimate. Islamophobia Register Australia.
- The health-inequities scoping review, FECCA consultations and *National Response to Islamophobia* support better data, accessible services, safe reporting and institutional responses. Demant et al.; FECCA; Special Envoy.

The evidence does not establish that every disparity is discriminatory. Its limitations support better measurement and investigation.

Communication and equitable treatment

The 2021 Census recorded approximately 5.8 million people using another language at home. Of that group, 15.1 per cent spoke English not well or not at all; most spoke English well or very well. ABS.

Interpreter access remains indispensable. However, English proficiency cannot explain discriminatory treatment based on a patient's name, appearance, dress or perceived religion. Services should assess both whether patients could communicate and whether they were heard, respected and taken seriously.

2. Applying existing obligations

Governance and patient rights

Governing bodies should receive evidence about discriminatory experiences, recurring patterns, corrective action and results. Low complaint numbers should not be treated as proof that discrimination is absent.

Requirement 1.10(d), concerning patients' experience of healthcare rights, should include whether patients experienced respectful care free from discriminatory treatment. This provides a direct connection between patient rights and the proposed discrimination measures.

Person-centred practice should assess whether patients were treated as individuals, involved in decisions, taken seriously and supported to raise concerns. Consumer partnerships should influence priorities, service design and evaluation.

Services should address discrimination based on actual or perceived caste, including its intersections with religion, race, ethnicity or descent. Evaluation should demonstrate whether action reduced discriminatory treatment and improved patients' experience, safety and equitable care.

Feedback and complaints

Requirement 1.12 connects patient feedback with incident management and improvement. Strengthening 1.12(e) would explicitly require examination of possible racism, Islamophobia, dehumanisation and discriminatory patterns.

The connection to **1.12(c)** is important: that provision integrates feedback, complaints and patient-reported experience with incident management, clinical review and credentialing.

Services should distinguish reported experience from investigation findings while taking both seriously. Patients should not have to prove discriminatory intent before concerns are examined.

Clinical systems and transitions

Incident review should examine whether bias, stereotyping or unmet communication, cultural or religious needs contributed to unsafe or unequal care. The focus should be the service's response to a person's needs, rather than treating identity itself as a cause of harm.

Services should record preferred language, interpreter need, communication preferences and relevant accessibility needs, and monitor whether support was provided. Relevant patient-defined cultural and religious needs should accompany patients across transitions with consent.

Clinical records and handovers should distinguish observed behaviour from interpretation, include the patient's account and relevant context, and provide a clear process for patients to challenge inaccurate or discriminatory descriptions.

Proportionate assessment

Implementation guidance should identify the evidence governing bodies and accreditors should examine. AAI recommends the Dehumanisation Framework as a tool to support assessment of complaints about racism and hatred towards patients, including dehumanising assumptions that undermine individual agency.

The Framework should also be used in training for clinicians, complaints staff and reviewers to help them recognise these patterns and apply the Framework in complaint assessment. The Commission should work with patients, communities and clinicians to test and refine its application in healthcare.

Its use should support examination of patient accounts, clinical records and service responses, with conclusions grounded in evidence and context.

A common approach across governance, person-centred practice and clinical systems can reduce repetitive documentation. Assessment should consider service size and setting while retaining clear expectations to detect, investigate and respond to discrimination.

3. Measuring experience and improvement

A short AHPEQS supplementary module

AHPEQS measures aspects of listening, individual needs, involvement, communication, pain relief, safety and overall care. Its 12 core questions do not explicitly identify racism, Islamophobia or stereotyping, and its specifications permit supplementary questions. AHPEQS technical specifications.

The Commission should co-design and validate a short module. Illustrative items for testing are:

1. Staff treated me as an individual rather than making assumptions about me.
2. My symptoms, pain and concerns were taken seriously.
3. During this care, I experienced unfair treatment that I believe was related to my background, identity or appearance.
4. I felt safe raising a concern about unfair treatment.
5. When I raised a concern about unfair treatment, the service responded appropriately.

An optional follow-up should ask what the unfair treatment related to, allowing multiple responses: religion or perceived religion, race or ethnicity, caste or perceived caste, language or accent, cultural background, name, dress or appearance, another reason, uncertainty and a preference not to answer.

Patients should be able to indicate treatment connected with being Muslim or being perceived as Muslim without declaring their own religious affiliation.

Routing must distinguish patients who experienced no unfair treatment, did not report, felt unable to report or preferred not to answer. The response-to-report item should apply only where a concern was raised.

These concepts require cognitive testing, accessibility and language testing, and validation. Equivalent measures should be used where AHPEQS is unsuitable.

Implementation and privacy

Services should act through existing feedback and safety systems while the module is developed. Unvalidated items should not be used prematurely to rank services. Increased reporting may reflect improved trust or detection.

Identity and experience information collected for equity monitoring should be voluntary and purpose-limited, with:

- assurance that declining will not affect care;
- restricted access, secure storage and defined retention arrangements;
- separation of identifiable case handling from aggregate monitoring where appropriate;
- community-informed governance;
- de-identification and suppression or aggregation of small numbers; and
- protection against profiling, surveillance and discriminatory use.

From feedback to improvement

Services should demonstrate:

Collect experience → identify patterns → set priorities with patients → co-design change → implement → evaluate → report back.

Services should show both what they did and whether those actions improved patients' experience, safety and equitable treatment.

Evidence	What services should demonstrate
Resources and activities	Staff, funding, training, surveys, consultations and reviews
Patient experience	Whether patients experienced respect, involvement in decisions and freedom from discriminatory treatment
Changes to care and services	What changed in care pathways, practices or reporting systems in response to patients' experiences
Results	Whether those changes improved patient experience, safety and equitable treatment

Accreditation should examine completed improvement cycles and responses to unresolved concerns.

4. Community consultation must not be tokenistic and must demonstrate influence

AAI welcomes the Commission's invitation to participate. Community consultation must not be tokenistic. Its value should be demonstrated through patients' and communities' influence over priorities, drafting, implementation and evaluation.

Meetings, submissions and representation do not establish meaningful participation by themselves. Participants need an opportunity to shape decisions while options remain open and an explanation of how their contributions were considered.

Community organisations should complement direct engagement with diverse patients, carers and workers. A single representative should not be treated as speaking for every member of a community.

The Commission should:

- publish submissions unless confidentiality is requested, subject to privacy protections;
- identify participating communities and material gaps;
- publish a recommendation-level response matrix explaining proposals accepted, modified, deferred or rejected;
- show how community input affected drafting;
- invite communities to check the interpretation of their evidence; and
- involve affected communities in testing revised requirements and measures.

Influence does not require every proposal to be accepted. It requires genuine consideration, transparent reasons and evidence that participation can shape the outcome.

AAI does not assert that the current consultation is tokenistic. It asks the Commission to demonstrate substantive influence. The same expectation should apply to health services' consumer partnerships.

Conclusion

The third edition can make the application of existing patient-safety obligations to racism and Islamophobia explicit and assessable.

AAI asks the Commission to require health services to hear patients' experiences, examine possible discrimination, redesign services with affected communities and demonstrate whether care improved.

This requires explicit recognition of Islamophobia, reliable communication support, safe reporting, protected data and governing-body accountability. Community consultation must not be tokenistic and must demonstrate influence.

The test is whether patients are treated as individuals and services can demonstrate safer and more equitable care.

Signatory and contact

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Annexure A: Proposed drafting amendments

These amendments strengthen existing requirements. Recommendations 9–12 concern the Commission's measurement, piloting and consultation processes.

The safeguards below apply across all proposed data collection, analysis and reporting.

Source: NSQHS Standards — Third Edition: Initial Draft, July 2026.

1.01(d)—governance of racism and discrimination

Current requirement:

identify and eliminate systemic, structural and institutional bias, racism and discrimination

Proposed replacement:

identify, prevent and eliminate systemic, structural and institutional bias, racism and discrimination, including Islamophobia and racialised religious discrimination associated with actual or perceived religious identity, caste discrimination and dehumanisation; use patient-reported and workforce experience, complaints, incidents and outcome data to identify and address these experiences and related inequities; and monitor the effectiveness of action taken.

Supports recommendations: 1, 2, 3 and 6.

1.02(a)—consumer partnerships

Current requirement:

build partnerships with consumers, including those with lived experience, who reflect the diverse communities it serves, and incorporate their perspectives into strategic planning, priority-setting and decision-making

Proposed replacement:

build partnerships with consumers, including people with relevant lived experience and people from communities experiencing racism or discrimination, who reflect the diverse communities it serves; enable their participation while substantive options remain open; incorporate their perspectives into strategic planning, priority-setting and decision-making; demonstrate how those perspectives influenced decisions; and report decisions and reasons to participating consumers and communities.

Implementation clarification:

Consultation must not be tokenistic. Evidence should demonstrate participants' opportunity to shape decisions and the influence of their contributions, rather than rely solely on attendance, representation or consultation counts.

Supports recommendation: 5.

1.02(e)—use of data

Current requirement:

use data insights to support decision-making and the delivery of high-quality care

Proposed replacement:

use data insights, including appropriately disaggregated patient-reported experience, complaints, incidents and outcome data, to identify and examine inequities, racism, discrimination and culturally unsafe care, support decision-making and improve the quality of care.

SAFEGUARDS APPLYING TO IDENTITY AND EXPERIENCE DATA

Where demographic or identity information is collected for equity monitoring, participation must be voluntary, with a transparent explanation of the purpose of collection and assurance that declining will not affect care. Any legally required collection must be distinguished from voluntary participation.

The organisation must apply purpose limitation, privacy and access controls, defined retention arrangements, community-informed governance, and de-identification and appropriate suppression or aggregation of small numbers in reporting.

Information must not be used for profiling, surveillance, discriminatory clinical decision-making or unrelated purposes. Identifiable information used to investigate and respond to an individual concern must be restricted to those who need it for that purpose.

These safeguards must apply to implementation guidance, minimum datasets and accreditation evidence developed to support the requirements.

Supports recommendations: 2, 3, 4 and 6.

1.03(c)—zero tolerance, reporting and response

Current requirement:

uphold a zero-tolerance approach to bias, discrimination and racism, ensuring concerns and reports of risks, incidents adverse events, and complaints are investigated and required action is taken

Proposed replacement:

uphold a zero-tolerance approach to bias, discrimination and racism, including Islamophobia, racialised religious discrimination, caste discrimination and dehumanisation; provide accessible and culturally safe reporting mechanisms for patients, families, carers and workers, with protection against retaliation or compromised care; ensure concerns and reports of risks, incidents, adverse events and complaints are investigated; provide appropriate support and redress; take required action; and evaluate the effectiveness of that action.

Supports recommendations: 1 and 7.

1.09(a)—co-design

Current requirement:

plan, design (including co-design), measure and review systems, services and models of care to support equitable experiences and outcomes of care

Proposed replacement:

plan, design, including through Experience-Based Co-Design, measure and review systems, services and models of care using patient-reported experiences and appropriately disaggregated data to identify and address inequities and support equitable experiences and outcomes of care.

Supports recommendations: 2, 3 and 5.

1.09(e)—evaluation of partnerships

Current requirement:

measure and review the effectiveness of partnerships with consumers and the engagement of the health service with the community and use this information to improve care

Proposed replacement:

measure and review the effectiveness and influence of partnerships with consumers and engagement with the community; demonstrate how participation shaped priorities, decisions and evaluation and what changed as a result; assess whether patient experience and outcomes improved; use the findings to improve care; and report findings and reasons for decisions to participating consumers and communities.

Supports recommendations: 2 and 5.

1.12(e)—analysis of feedback and complaints

Current requirement:

analyse feedback, complaints and patient reported experience measures; use the findings to inform risk management and quality improvement activities; and provide feedback to consumers on the actions taken

Proposed replacement:

analyse feedback, complaints and patient reported experience measures to identify and examine possible racism, Islamophobia, dehumanisation, discriminatory treatment, stereotyping and failures to meet cultural, religious or communication needs, including recurring patterns; use the findings to inform investigation, risk management and quality improvement activities; evaluate the effectiveness of action taken; and provide feedback to consumers on the actions and results.

Implementation clarification:

Analysis should connect with the incident management, clinical review and credentialing processes addressed in 1.12(c). Patients should not have to establish discriminatory intent before their concerns are examined. Implementation guidance should support use of the Dehumanisation Framework in assessing complaints about racism and hatred towards patients, and in training for clinicians, complaints staff and reviewers.

Supports recommendations: 2, 5 and 6.

1.13(f)—workforce culture

Current requirement:

measure and monitor workforce culture, including psychosocial safety and cultural safety, with validated surveys and use the findings to improve workforce wellbeing

Proposed replacement:

measure and monitor workforce culture, including psychosocial safety, cultural safety and experiences of racism, Islamophobia and religious discrimination, with validated surveys; analyse findings for patterns; report findings to the governing body, executive and workforce in accordance with privacy safeguards; and use the findings to improve workforce wellbeing and patient safety.

Supports recommendations: 1, 2 and 4.

2.01(d)—interpreters and communication support

Current requirement:

use authorised interpreters, translated materials, communication tools and culturally appropriate communication methods in line with the needs of the patient

Proposed replacement:

use authorised interpreters, translated materials, communication tools and culturally appropriate communication methods in line with the needs of the patient; monitor whether required support is provided; and ensure that communication support is accompanied by action to provide culturally safe care free from bias, racism and discrimination.

Implementation clarification:

Communication support does not, by itself, discharge obligations concerning culturally safe care, racism and discrimination.

Supports recommendations: 1 and 8.

2.04(b)—individualised care planning

Current requirement:

considers the patient's cultural identity, personal circumstances and social context, including the social determinants of health relevant to the care setting when planning and coordinating care

Proposed replacement:

considers the patient's individually expressed cultural identity, religious or spiritual needs, personal circumstances and social context, including relevant social determinants of health, without relying on racial, cultural or religious assumptions when planning and coordinating care.

Supports recommendation: 1.

2.22(d)—transitions of care

Current requirement:

includes supporting information about a patient's cultural identity, obligations and practices and any relevant communication, accessibility or support needs

Proposed replacement:

includes relevant supporting information about the patient's individually expressed cultural identity, obligations and practices, shared with the patient's consent, together with relevant communication, accessibility and support needs; distinguishes observed behaviour from interpretation and includes the patient's account and relevant context; and supports continuity of respectful, culturally safe care.

Implementation clarification:

Patients should have a clear process to challenge inaccurate or discriminatory descriptions in clinical records and handovers. Information volunteered for equity monitoring should not automatically be transferred into clinical records or handover documents.

Supports recommendations: 1, 4 and 8.

Application within Safe Clinical Systems

Clinical Governance requirements concerning racism, discrimination, patient experience, incidents and improvement should apply across relevant Safe Clinical Systems requirements, including patient identification, infection prevention and control, medicines safety and quality, medical devices and blood management.

Accreditation guidance should require assessors to examine whether services investigate possible contributions of bias, stereotyping or communication failures to incidents, clinical variation or unequal outcomes, and whether resulting action improves care.

Supports recommendations: 1, 3, 5, 6 and 8.

Annexure B: Responses to the consultation questions

Questions are reproduced from the Commission's Health Sector Written Submissions fact sheet.

AAI's responses centre on demonstrable improvement in patient experience, safety and equitable care. Policies, training and consultation should contribute to these results. Their existence or completion should not, by itself, be treated as evidence that discrimination has been addressed.

1. How well do the Standards reflect key safety and quality priorities? What is missing?

The draft recognises racism and requires patient feedback and improvement. It should more explicitly require services to demonstrate whether their actions reduced discriminatory treatment and improved patient experience, safety and equitable care. Policies, training completion and low complaint numbers are insufficient evidence of success. Assessment should examine patient accounts, recurring patterns, action taken and the effectiveness of that action. See Sections 1 and 2 and amendments to 1.01(d), 1.02(e) and 1.12(e).

2. What changes would strengthen the Standards to support the delivery of high-quality care and better health outcomes?

Require services to demonstrate a clear connection between identified problems, action taken and results for patients. Patient-reported experience, appropriately disaggregated data and qualitative accounts should inform priorities, co-design and evaluation, supported by privacy safeguards and safe reporting. Governing bodies should examine whether changes worked, for whom, and what further action is needed where inequities persist. See Sections 2 and 3 and Annexure A.

3. How well do the Standards support care delivery and coordination across services, settings, and providers? How could this be improved?

Require evidence that communication support and relevant patient-defined needs are understood and acted on across transitions. Recording an interpreter requirement or completing a handover field should not, by itself, demonstrate effective support. Services should assess whether patients could communicate, whether their needs were met and whether inaccurate or discriminatory descriptions were challenged and addressed. See Section 2 and amendments to 2.01(d) and 2.22(d).

4. Are the Standards easy to understand and free from duplication? Where could they be clearer or simpler?

Clarify the distinction between evidence of activity and evidence of improvement. Guidance should identify what services need to demonstrate: the problem identified, patients' involvement, action taken, results and response to unresolved concerns. A common approach across governance, person-centred practice and clinical systems would make expectations clearer and reduce repetitive documentation. See Section 2.

5. How well do the Standards help health services learn, reflect and improve over time? What could strengthen this?

Require completed improvement cycles that show how patient experience led to changes in care and whether those changes were effective. Consultation should demonstrate patients' influence over priorities, design and evaluation. Where improvement is not demonstrated, services should explain what they learned and what they will change next. Increased reporting should be interpreted carefully, as it may reflect greater trust or better detection. See Section 3 and amendments to 1.09(a), 1.09(e) and 1.12(e).

6. What changes to the Standards would reduce the compliance burden, while maintaining safety and quality?

Reduce repetitive evidence collection by using existing surveys, complaints, incident review and governance systems to demonstrate action and results. Assessment should focus on the quality of services' responses and evidence of improvement, rather than the volume of policies, training records or consultation reports produced. A short validated AHPEQS module, equivalent measures for other settings and proportionate evidence expectations would support this approach. See Sections 2 and 3.

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