SPECIALIST PRACTICE QUALITY FRAMEWORK

Domain 1: Clinical Governance and Leadership

We have clear accountability for the safety and quality of care in our practice.

Version 1.0 — First Edition

Published by the SPQF Editorial Group

Why This Domain Matters

In a hospital, clinical governance is a department. In a specialist practice, it is usually one person - often the principal practitioner - making decisions between patients. That is not a criticism; it is the reality of how specialist practices operate. But it means that governance arrangements need to be deliberate, documented, and understood by everyone in the practice, not assumed.

When something goes wrong - a missed result, a patient complaint, a staff incident - the first question any insurer, regulator, or coroner will ask is: who was responsible, and what systems were in place? This domain helps you answer that question clearly.

Quality Statements

1.1 — Governance Structure and Accountability

We have a defined governance structure that makes clear who is responsible for the safety and quality of care in our practice.

INDICATORS

1.1.1 The practice has an identified clinical governance lead. In a solo practice, this is the principal practitioner. In a group practice, one practitioner is explicitly nominated and this is documented.

1.1.2 The practice manager's role, responsibilities, and authority are documented. It is clear which decisions the practice manager can make independently and which require clinical sign-off.

1.1.3 The practice has a governance calendar or schedule that sets out when policies are reviewed, when team meetings occur, and when key compliance obligations fall due (registration renewals, insurance, equipment servicing, etc.).

1.1.4 In group practices, there is a documented arrangement for how clinical and operational decisions are made - whether through regular partners' meetings, a management committee, or another structure. Decisions and actions are recorded.

SUGGESTED EVIDENCE

- Organisational chart or simple accountability map
- Position descriptions for the practice manager and clinical governance lead
- Governance calendar or compliance tracker
- Minutes of governance or partners' meetings (if applicable)

1.2 — Clinical Policies and Procedures

We maintain current, relevant clinical and operational policies, and our team knows where to find them.

INDICATORS

1.2.1 The practice maintains a set of clinical and operational policies that is appropriate to the services it provides. At a minimum, this includes policies for infection control, clinical record-keeping, patient consent, complaints management, and incident reporting.

1.2.2 Policies are written in plain language, are relevant to the practice's actual operations (not generic templates that have never been customised), and include a review date.

1.2.3 All staff know where policies are stored and can access them during normal working hours. If policies are electronic, there is a backup arrangement for system outages.

1.2.4 Policies are reviewed at least every three years, or sooner when triggered by a change in legislation, clinical guidelines, or a significant incident.

SUGGESTED EVIDENCE

- Policy register with titles, version dates, and next review dates
- Evidence that policies have been customised (not untouched templates)
- Staff sign-off or acknowledgement records
- Evidence of policy review and update history

1.3 — Scope of Practice and Credentialing

We ensure that every practitioner working in our practice is qualified, registered, and working within an agreed scope of practice.

INDICATORS

1.3.1 The practice verifies AHPRA registration for all practitioners (medical, nursing, allied health) at initial engagement and at least annually thereafter. Records of verification are kept.

1.3.2 Where locums, visiting practitioners, or allied health professionals work within the practice, there is a documented arrangement covering their scope of practice, supervision requirements, access to records, and indemnity coverage.

1.3.3 For group practices, each practitioner's scope of practice is documented and understood. If the practice provides services that require specific credentialing (e.g., procedural sedation, injectable cosmetic treatments, laser procedures), evidence of that credentialing is held on file.

1.3.4 The practice has a process for onboarding new practitioners that covers clinical systems, practice protocols, emergency procedures, and medicolegal expectations.

SUGGESTED EVIDENCE

- AHPRA verification records with dates
- Credentialing documents and scope of practice agreements
- Locum and visiting practitioner agreements
- Practitioner onboarding checklist

1.4 — Incident Management

We identify, report, and learn from clinical incidents and near misses.

INDICATORS

1.4.1 The practice has a simple, accessible process for reporting clinical incidents and near misses. All staff - clinical and non-clinical - know how to report and feel safe doing so.

1.4.2 Every reported incident is acknowledged, assessed for severity, and investigated proportionately. Not every incident requires a root cause analysis, but every incident requires someone to ask what happened and whether it could happen again.

1.4.3 Findings from incident investigations are communicated to relevant staff and, where appropriate, result in changes to policy, process, or training.

1.4.4 The practice maintains an incident register that records what happened, the investigation findings, the actions taken, and whether those actions were completed.

1.4.5 Serious incidents - including those that could give rise to a coronial inquiry, a notification to AHPRA, or a medical indemnity claim - are escalated promptly to the clinical governance lead and the practice's indemnity provider.

SUGGESTED EVIDENCE

- Incident reporting form or system
- Incident register (de-identified)
- Examples of completed incident investigations and resulting actions
- Evidence of staff communication following incidents
- Escalation records for serious incidents

1.5 — Complaints Management

We welcome feedback, take complaints seriously, and use them to improve.

INDICATORS

1.5.1 The practice has a documented complaints process that is accessible to patients. Patients are told how to raise concerns - this information is available in the waiting area, on the practice website, or provided at intake.

1.5.2 Complaints are acknowledged in a timely manner (within five business days as a benchmark) and the patient is told what will happen next.

1.5.3 Complaints are investigated fairly, with findings and any proposed resolution communicated to the patient. Where a complaint cannot be resolved internally, the practice informs the patient of external avenues, including the relevant state or territory Health Complaints Commissioner.

1.5.4 Complaints are recorded in a register that tracks the nature of the complaint, the investigation, the outcome, and any systemic changes made as a result.

1.5.5 Complaint trends are reviewed periodically (at least annually) to identify recurring themes and inform quality improvement.

SUGGESTED EVIDENCE

- Complaints policy and patient-facing information
- Complaints register (de-identified)
- Evidence of responses provided within timeframes
- Annual or periodic review of complaint themes
- Examples of changes made in response to complaints

1.6 — Open Disclosure

When something goes wrong in a patient's care, we are honest and transparent.

INDICATORS

1.6.1 The practice has a process for open disclosure that is consistent with the Australian Open Disclosure Framework. Clinicians understand the difference between open disclosure and legal admission of liability.

1.6.2 When a patient is harmed or experiences an adverse outcome related to their care, the treating practitioner (or clinical governance lead) initiates a conversation with the patient or their family that acknowledges what happened, explains what is known, describes what will be done to investigate, and offers an apology where appropriate.

1.6.3 Open disclosure conversations are documented in the patient's clinical record.

1.6.4 Staff receive guidance or training on how to conduct open disclosure conversations, including when to involve the practice's indemnity provider.

SUGGESTED EVIDENCE

- Open disclosure policy or guideline
- Evidence of staff awareness (training records, team meeting notes)
- Documentation in clinical records (de-identified examples)

1.7 — Legislative and Regulatory Compliance

We understand and meet our legal obligations as a healthcare provider.

INDICATORS

1.7.1 The practice maintains awareness of the key legislation and regulations that apply to its operations. At a minimum, this includes obligations under the Health Practitioner Regulation National Law, the Privacy Act, relevant state or territory health complaints legislation, workplace health and safety law, and any legislation specific to the procedures or services the practice provides.

1.7.2 The practice has a process for staying informed about regulatory changes that affect its operations - whether through college communications, industry associations, indemnity provider updates, or a designated responsibility within the practice.

1.7.3 Required notifications are made in a timely manner. This includes mandatory notifications to AHPRA, notifiable data breaches to the OAIC, workplace incidents to the relevant WHS regulator, and any reporting obligations specific to the practice's specialty.

1.7.4 The practice holds current public liability, professional indemnity (or confirms practitioner coverage), and workers' compensation insurance. Policy details and renewal dates are tracked.

SUGGESTED EVIDENCE

- Register of applicable legislation and regulations
- Evidence of monitoring process (e.g., newsletter subscriptions, compliance calendar)
- Insurance certificates of currency
- Records of any mandatory notifications made

Self-Assessment Summary

Ref	Indicator
1.1.1	Clinical governance lead identified
1.1.2	Practice manager role documented
1.1.3	Governance calendar in place
1.1.4	Decision-making structure documented
1.2.1	Core policies maintained
1.2.2	Policies customised and current
1.2.3	Staff can access policies
1.2.4	Policy review cycle in place
1.3.1	AHPRA verification current
1.3.2	Locum/visiting practitioner arrangements
1.3.3	Scope of practice documented
1.3.4	Practitioner onboarding process
1.4.1	Incident reporting process accessible
1.4.2	Incidents investigated proportionately
1.4.3	Findings communicated to staff
1.4.4	Incident register maintained
1.4.5	Serious incident escalation process

Ref	Indicator
1.5.1	Complaints process accessible to patients
1.5.2	Complaints acknowledged within 5 days
1.5.3	Complaints investigated and resolved
1.5.4	Complaints register maintained
1.5.5	Complaint trends reviewed periodically
1.6.1	Open disclosure process in place
1.6.2	Open disclosure conversations initiated
1.6.3	Disclosure documented in records
1.6.4	Staff trained in open disclosure
1.7.1	Key legislation identified
1.7.2	Regulatory change monitoring
1.7.3	Mandatory notifications made
1.7.4	Insurance current and tracked