SPECIALIST PRACTICE QUALITY FRAMEWORK

Domain 3: Clinical Effectiveness

We provide evidence-based care and monitor our clinical outcomes.

Version 1.0 — First Edition

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Why This Domain Matters

Specialist practitioners are, by definition, experts. They have years of postgraduate training, fellowship examinations, and continuing professional development behind them. So it can feel uncomfortable - or even patronising - for a quality framework to ask whether a specialist is providing evidence-based care.

This domain is not about questioning clinical expertise. It is about the systems around clinical decision-making. Does the practice have a way of staying current when guidelines change? Is the consent process robust enough to survive scrutiny if a complication occurs? When a patient is referred on or discharged back to the GP, does the communication actually happen in a useful timeframe? Are clinical outcomes being tracked in any systematic way, or is the assumption simply that no news is good news?

Practice managers cannot and should not be auditing clinical decisions. But they can build systems that support good clinical decision-making, ensure medicolegal processes are sound, and make it possible for clinicians to see how their practice is performing over time. That is what this domain addresses.

Quality Statements

3.1 — Evidence-Based Practice

Our clinical care is informed by current evidence, clinical guidelines, and relevant college standards.

INDICATORS

3.1.1 The practice can identify the key clinical guidelines and college standards that are relevant to the services it provides. Clinicians are aware of these guidelines and can access them.

3.1.2 The practice has a process - whether formal or informal - for updating clinical practice when relevant guidelines change. This might be through college communications, journal alerts, peer discussion, CPD activities, or a designated clinician responsibility.

3.1.3 Where the practice's clinical approach departs from published guidelines (which is legitimate and sometimes appropriate), the rationale is understood by the treating clinician and documented in the patient record where it is clinically significant.

3.1.4 Clinicians within the practice meet their specialist college CPD requirements. The practice supports CPD participation through time, access, or funding arrangements.

SUGGESTED EVIDENCE

- List of key guidelines and college standards relevant to the practice
- Evidence of access to current guidelines (e.g., college membership, subscriptions, bookmarked resources)
- CPD records or college CPD compliance confirmation
- Examples of practice changes made in response to updated guidelines

3.2 — Informed Consent

We obtain valid, informed consent before providing treatment, and our consent processes would withstand external scrutiny.

INDICATORS

3.2.1 The practice has a consent process that is appropriate to the complexity and risk of the treatments it provides. A practice performing invasive procedures under sedation has different consent requirements from a practice providing medication reviews.

3.2.2 Consent is obtained by a practitioner who is qualified to perform the procedure or treatment, who can explain the material risks, benefits, alternatives, and expected outcomes, and who can answer the patient's questions. Consent is not delegated to administrative staff.

3.2.3 The consent process reflects the principles established in Rogers v Whitaker - specifically, that material risks are those that a reasonable person in the patient's position would want to know, not only those the clinician considers significant.

3.2.4 For significant procedures, consent is documented in writing using a consent form that records the procedure, the risks discussed, the alternatives considered, and the patient's agreement. The form is signed before the procedure, not retrospectively.

3.2.5 The practice has a process for obtaining consent from patients with additional needs, including patients from culturally and linguistically diverse backgrounds (using interpreters where necessary), patients with cognitive impairment, and patients who are minors. The practice understands the distinction between a person with authority to consent on behalf of another (such as a guardian, medical treatment decision-maker, or parent) and a family member without that authority.

3.2.6 Patients are given the opportunity to ask questions and take time to consider their decision. For elective procedures, patients are not consented and treated in the same encounter unless clinically appropriate and the patient's preference.

SUGGESTED EVIDENCE

- Consent policy or guideline
- Consent form templates
- Evidence of interpreter use where relevant
- Clinical record entries documenting consent discussions
- Process for managing consent for patients with additional needs

3.3 — Appropriate Use of Investigations

We request investigations that are clinically indicated, and we have reliable systems for managing results.

INDICATORS

3.3.1 Investigations are requested based on clinical indication, with consideration of current evidence, clinical guidelines, and the patient's individual circumstances. The practice avoids routine or protocol-driven investigations that are not supported by evidence for the clinical situation.

3.3.2 The practice has a reliable system for tracking requested investigations and ensuring that results are received. The system identifies when expected results have not been returned within a reasonable timeframe.

3.3.3 All investigation results - including normal results - are reviewed by the requesting or treating clinician (or a clinician who has accepted delegation) in a timely manner. Results are not filed without clinical review.

3.3.4 Abnormal or critical results are flagged, actioned, and followed up. There is a defined process for communicating significant results to the patient, including when results require urgent action.

3.3.5 The practice has a process for managing results that arrive when the requesting clinician is unavailable (on leave, departed the practice). Responsibility is assigned and understood.

3.3.6 The action taken on investigation results is documented in the patient's clinical record.

SUGGESTED EVIDENCE

- Results management policy or workflow
- Evidence of a tracking system (inbox, dashboard, log)
- Process for managing results during clinician absence
- Clinical record entries showing results reviewed and actioned
- Examples of follow-up actions for abnormal results

3.4 — Referral Management

We make and receive referrals effectively, and we communicate clearly with referring and receiving practitioners.

INDICATORS

3.4.1 Referrals received by the practice are triaged according to clinical urgency. The practice has defined categories (e.g., urgent, semi-urgent, routine) with target timeframes for each, and these are communicated to the referring practitioner or patient where appropriate.

3.4.2 The practice has a process for managing referrals where the clinical information provided is insufficient for safe triage. This includes a defined method for contacting the referrer to obtain additional information.

3.4.3 When the practice refers patients onward - to other specialists, allied health, hospitals, or diagnostic services - the referral includes sufficient clinical information for the receiving practitioner to provide safe and effective care.

3.4.4 Referral validity is tracked. The practice monitors Medicare referral validity periods and has a system for managing patients whose referrals are approaching expiry, including communication with the patient and the referring GP.

3.4.5 The practice monitors waitlist length and can identify patients who have been waiting longer than the target timeframe for their urgency category. There is a process for re-triaging patients on the waitlist when new clinical information is received.

SUGGESTED EVIDENCE

- Triage categories with target timeframes
- Evidence of triage process in operation
- Referral tracking system or waitlist management tool
- Process for managing insufficient or expiring referrals
- Examples of outgoing referral letters with adequate clinical information

3.5 — Communication with Referring Practitioners

We provide timely, useful reports to referring practitioners so they can continue the patient's care.

INDICATORS

3.5.1 The practice sends a report to the referring practitioner after every consultation. Reports are sent within a defined timeframe - within one week of a standard consultation and within 48 hours where urgent findings or management changes need to be communicated.

3.5.2 Reports include, at a minimum, the clinical findings, the diagnosis or differential diagnosis, the management plan, any medications prescribed or changed, any procedures performed, planned follow-up, and any actions required by the referring practitioner.

3.5.3 Reports are written in clear, structured language. They are useful to the referring GP, not just a record for the specialist's own file. Abbreviations specific to the specialty are explained or avoided.

3.5.4 When a patient is discharged from the specialist's care back to the GP, the discharge communication includes a summary of the episode, the current diagnosis, ongoing management recommendations, and any red flags that should prompt re-referral.

3.5.5 The practice has a process for ensuring that reports are actually sent - not just dictated or drafted. There is a check that confirms transmission, whether by secure messaging, upload to shared systems, or confirmed delivery.

SUGGESTED EVIDENCE

- Report turnaround time data or audit
- Examples of consultation and discharge reports (de-identified)
- Process for confirming report transmission
- Evidence of compliance with defined timeframes

3.6 — Continuity and Coordination of Care

We coordinate care within our practice and with other providers involved in the patient's care.

INDICATORS

3.6.1 When a patient is seen by more than one clinician within the practice (e.g., a registrar and a supervisor, multiple specialists in a group practice, or allied health professionals), there is a documented process for ensuring continuity. The clinical record is the primary tool, but handover processes and team communication also apply.

3.6.2 The practice considers the patient's broader care context, including other treating specialists, allied health providers, and the GP. Where care is complex or involves multiple providers, the practice communicates proactively to avoid fragmentation, duplication, or conflicting management plans.

3.6.3 The practice has a process for managing patients who do not attend (DNA) scheduled appointments, particularly where non-attendance could result in clinical risk. The process includes a reasonable attempt to contact the patient and, where appropriate, notification to the referring GP.

3.6.4 When a practitioner leaves the practice or is absent for an extended period, there is a documented plan for continuity of care for their patients. Patients are informed and offered options.

3.6.5 The practice has a process for managing the transition of care for patients who require ongoing specialist follow-up but are relocating, changing practitioners, or being transferred to another service.

SUGGESTED EVIDENCE

- Handover or team communication process documentation
- DNA follow-up policy and examples of follow-up actions
- Practitioner departure/absence continuity plan
- Evidence of care coordination with other providers (e.g., multidisciplinary correspondence)
- Transfer of care documentation

3.7 — Clinical Outcome Monitoring

We track and review our clinical outcomes to understand how our patients are doing.

INDICATORS

3.7.1 The practice collects data on clinical outcomes that are meaningful for the services it provides. What is measured will vary by specialty - a surgical practice might track complication and revision rates, an oncology practice might track treatment completion rates, a rheumatology practice might track disease activity scores. The point is that something is measured, not that everything is.

3.7.2 Outcome data is reviewed periodically - at least annually - by the clinical team. The review considers trends over time, not just individual cases.

3.7.3 Where outcome data suggests an area for improvement, the practice takes action. This might include a clinical audit, a change in technique or protocol, additional training, or a referral for peer review.

3.7.4 The practice participates in relevant clinical quality registries, college audits, or peer review programs where these are available for the specialty. Where participation is mandatory (as with some college CPD requirements), compliance is tracked.

3.7.5 Outcome data is used constructively - to improve care, not to assign blame. The practice fosters a culture where reviewing outcomes is a normal part of clinical practice, not a response to a complaint or claim.

SUGGESTED EVIDENCE

- Description of outcome measures collected and why they were chosen
- Outcome data reports or dashboards (de-identified)
- Evidence of periodic review by clinical team
- Actions taken in response to outcome trends
- Clinical quality registry participation records
- College audit or peer review participation

Self-Assessment Summary

Ref	Indicator
3.1.1	Key guidelines identified and accessible
3.1.2	Process for updating practice when guidelines change
3.1.3	Departures from guidelines documented
3.1.4	CPD requirements met
3.2.1	Consent process appropriate to risk
3.2.2	Consent obtained by qualified practitioner
3.2.3	Material risks disclosed (Rogers v Whitaker)
3.2.4	Written consent for significant procedures
3.2.5	Consent for patients with additional needs
3.2.6	Time to consider given for elective procedures
3.3.1	Investigations clinically indicated
3.3.2	Results tracking system in place
3.3.3	All results reviewed by clinician
3.3.4	Abnormal results flagged and actioned
3.3.5	Results managed during clinician absence
3.3.6	Actions documented in clinical record
3.4.1	Referrals triaged by clinical urgency
3.4.2	Insufficient referral information managed
3.4.3	Outgoing referrals include adequate information
3.4.4	Referral validity tracked
3.4.5	Waitlist monitored and re-triaged
3.5.1	Reports sent within defined timeframes
3.5.2	Reports include minimum content
3.5.3	Reports written clearly for GPs
3.5.4	Discharge communication includes summary
3.5.5	Report transmission confirmed
3.6.1	Continuity within practice documented
3.6.2	Broader care context considered
3.6.3	DNA follow-up process in place
3.6.4	Practitioner departure continuity plan

Ref	Indicator
3.6.5	Transfer of care process
3.7.1	Meaningful outcome data collected
3.7.2	Outcomes reviewed periodically
3.7.3	Improvement actions taken from outcome data
3.7.4	Registry or peer review participation
3.7.5	Constructive culture around outcome review

This document is part of the Specialist Practice Quality Framework (SPQF). Visit spqf.au for the full framework, evidence guides, and self-assessment tools.