

Guide to credentialing and defining scope of clinical practice for medical practitioners and dentists in Queensland

A best practice guide

June 2014

Guide to credentialing and defining scope of clinical practice for medical practitioners and dentists in Queensland Health

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Foreword

A safe working environment is valued by every member of the Queensland Health workforce. The following document is the inaugural *Guide to credentialing and defining the scope of clinical practice for medical practitioners and dentists*. It replaces the Credentialing and defining the scope of clinical practice for medical practitioners and dentists in Queensland Health policy of 2012 and implementation standard and has been written to reflect changes that have occurred since the health restructure in 2012.

This comprehensive guide is a key risk management strategy to assist in the management of processes that underpin the maintenance of clinical governance at the service level and for the clinical workforce.

It provides support to the decision making processes of Hospital and Health Services and Department of Health divisions to appoint appropriately qualified, competent and experienced medical practitioner and dentist. It assists in clarifying and defining the practitioners' scope of clinical practice to ensure the provision of safe and high-quality care to patients. This best practice guide ensures that each practitioner working in Queensland Health only provides clinical services for which they have demonstrated competence.

This guide is a tool to assist Queensland Health and to support the principles in the *Blueprint for better healthcare in Queensland* that is the vision of the Minister for Health:

1. Health services focusing on patients and people.
2. Empowering the community and the health workforce.
3. Providing Queenslanders with value in health services.
4. Investing, innovating and planning for the future.

The participation and use of this guide by Queensland Health services will contribute to the improvement of patient safety and health outcomes for Queenslanders.

Dr Michael Cleary
Deputy-Director General
Health Service and Clinical Innovation Division

Acknowledgments

This guide is the result of extensive consultation with representatives from a wide range of organisations and professional groups throughout Queensland. It has been developed from the work of previous standards and policies published by Queensland Health and the valuable work of the Australian Commission on Safety and Quality in Health Care for the National *Standard for Credentialing and Defining the Scope of Clinical Practice* of Medical Practitioners, 2004.

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Particular thanks also to the following groups who have provided advice with specific matters related to the guide:

- credentialing representatives within the Credentialing Officers Network Group representing all Hospital and Health Services and divisions
- Premium Management Group, System Support Services
- Human Resource Services, System Support Services
- Directors of Medical Services, Hospital and Health Services.

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Introduction

This guide has been developed as a best practice risk management strategy. Implementation of the strategy fundamentally supports patient safety and improved health outcomes by all Hospital and Health Services (HHSs), Department of Health (DoH) divisions, and eligible medical practitioners and dentists working in Public Health facilities. It assists employees in understanding the complex and legal requirements surrounding credentialing and granting a scope of clinical practice (SoCP) to an eligible medical practitioner or dentist.

This guide supports and provides a framework for the development of local processes to meet the requirements of the National *Standards for Credentialing and Defining the Scope of Clinical Practice* and the Australian Commission on Safety and Quality in Health Care standards.

Information in this document is intended to guide the credentialing process, allowing an appropriate level of flexibility and discretionary professional judgement. It is not to be relied upon as a substitute for specific legal or professional advice.

Each HHS is an independent statutory body and therefore has differing business approaches. Regardless of the approach, health services are accountable under their Service Agreements for ensuring the *Credentialing and defining the scope of clinical practice* health service directive is implemented. The National Safety and Quality Health Service Standards outline that compliance must be monitored and reported and that any variations are investigated to support the delivery of safe, high-quality patient care.

There is an overarching responsibility on all those involved in the process of credentialing to act with due care and diligence, and to ensure procedural fairness at all times. The principles of procedural fairness, transparency and accountability underpin the process of assessment of credentials and delineation of SoCP.

The process of verifying credentials and defining SoCP for medical practitioners and dentists practising within Queensland Health aims to protect:

- patients, by ensuring medical and dental services, and treatments are provided by competent, qualified and skilled practitioners suitably equipped to deliver safe and quality care
- medical practitioners and dentists, by ensuring they take responsibility only for services and treatments for which they are skilled and experienced to perform in a given environment
- hospitals and healthcare public health facilities, the government and the Queensland community from unnecessary human cost and financial losses.

While every attempt is made to ensure the content of this document is accurate, reliable and up-to-date, the healthcare setting is a complex environment, and in a state of change, therefore all information should be cross-checked to ensure currency.

For further information, contact your relevant HHS/division:

- credentialing officer
- chair, credentialing committee
- executive director of medical services, or equivalent.

Credentialing officers and executive directors can seek advice from:

- HHS lawyers for any specific legal related matters
- Office of the Principal Medical Officer.

What do certain words used in this guide mean?

This guide adopts the same definitions of terms used in the *Credentialing and defining the scope of clinical practice* health service directive (QH_HSD_034:2013) and *Credentialing and defining the scope of clinical practice* Department of Health Policy (QH-POL—309:2013) and a full glossary of terms is provided (refer to Appendix 1). However, it is worth noting some particular points.

The term 'decision maker' is used in this guide to reflect the position of authority, the person who can approve the SoCP within the HHS/ DoH division. Delegation of responsibilities is outlined in Part 1, Section 4. Some delegations are specifically detailed within the document.

A 'health service directive' (HSD) is issued specifically for Hospital and Health Services (HHS). A 'policy' is issued specifically for the Health Service and Clinical Innovation (HSCI) and Health Service Support Agency (HSSA). For the purposes of this guide, both documents (HSD and policy) have the same statements of intent to achieve a particular outcome and therefore are used interchangeably.

The guide has been developed as a risk management strategy and while implementation is not mandatory, it is a best practice minimum standard document.

Policy and standards use words such as 'shall' and 'must' to express a level of significance to matters. These words have been used in this guide to strengthen matters where appropriate.

When referring to 'clinical practice' this also applies to practitioners employed in medical advisory roles that do not provide direct clinical services e.g. Chief Health Officer and Principal Medical Officer.

Part 1: Overview

1. Purpose

This guide is consistent with good clinical practice and provides recommendations to:

- minimise risk to patients by ensuring medical practitioners or dentists (collectively referred to as 'practitioners') have the right skills, qualifications and experience with the appropriate public healthcare facility for the clinical services being provided
- advocate a process for use throughout Queensland public health services for verifying and evaluating the qualifications, experience, professional standing and other relevant professional attributes of practitioners and defining their SoCP within specific organisational settings
- provide a robust, non-punitive and practical process which is consistent with the National Standard and the Australian Commission on Safety and Quality in Health Care Standards for Credentialing and SoCP.

2. Scope

This guide has been developed as a comprehensive reference tool to support practitioners providing services within a Queensland Health facility, including visiting medical officers (VMOs), contractors, consultants and volunteers in understanding the complexity and legal requirements surrounding credentialing and SoCP. In addition, this guide is also a reference tool for persons involved in the credentialing process.

It acknowledges that no practitioner may hold a SoCP unless they hold current registration with the Australian Health Practitioner Regulation Agency (AHPRA). Practitioners who practise in Queensland public healthcare facilities as independent practitioners or under supervision prescribed by their registration (other than those exempted under Part 1, Section 2.2), must be credentialed and have their SoCP defined as required by the *Credentialing and defining the scope of clinical practice* health service directive prior to commencing duties.

2.1 Inclusions or identified practitioners (not exhaustive list)

- Chief Health Officer
- Chief Dental Officer
- Principal Medical Officer
- visiting medical/dental officers
- senior medical officers
- staff specialists
- dental specialists/officers
- private medical and dental officers treating private patients in Queensland public health facilities
- medical directors of clinical and non-clinical medical departments
- general practitioners

- medical practitioners and dentists providing care in residential aged care facilities and nursing homes (see Part 1, Section 2.1.1)
- medical superintendents with a right of private practice (MSRPP)
- medical officers with a right of private practice (MORPP)
- dental officers with a right of private practice
- practitioners engaged through external contracted services – (refer to appendix 1)
- university joint medical and dental appointees
- honorary medical officers
- locum medical/dental officers
- directors of oral health
- medical administrators (e.g. executive director of medical services, director of medical services, medical superintendents and medical administrators within HSC/HSSA)
- any medical practitioners or dentists employed on the pay scales for senior medical officers (C, MO), medical officers right of private practice (MOR), medical superintendents right of private practice (MSR) and as a visiting medical officer (VMO) and dental officers (DO)
- government medical officers
- medical practitioners and dentists providing population health services
- medical practitioners and dentists who provide services at corrective service public health facilities
- medical practitioners providing retrieval services

2.1.1 Practitioners providing care to residents of Queensland Health residential aged care facilities and nursing homes

This guide applies to HHSs operating these public health facilities. They must ensure practitioners who provide services to residents are credentialed and have a defined SoCP.

2.1.2 Private practitioners providing care to public patients within Queensland Health facilities

This guide applies to private practitioners providing clinical services from within Queensland Health facilities to public patients. It applies to private practitioners (including off-site services) where the patient attended a Queensland Health facility to receive a service—for example, a teleradiology reporting service where the patient attended a Queensland Health facility for the medical imaging procedure. (With the exception of the scenario listed at the end of section 2.1)

2.1.3 Private practitioners providing care to private patients within Queensland Health public facilities

This guide applies to private practitioners providing clinical services to private patients who are receiving services within a Queensland Health facility.

2.2 Exemptions

2.2.1 Practitioners with appointments in non-medical and non-dental positions

Practitioners appointed against non-medical or non-dental officer positions are not required to have a SoCP approved as per this guide.

2.2.2 Dental students

This guide does not apply to dental students practising under supervision.

2.2.3 Resident medical officers

This guide does not apply to resident medical officers (RMOs) practising under supervision.¹ Queensland Health employs these medical officers in designated training positions, and their clinical work is supervised by senior medical practitioners. While this guide does not apply to these medical practitioners, it is nevertheless important that their senior managers and supervisors verify their qualifications, registration (including any conditions, notations or undertakings) and clearly delineate their clinical responsibilities.

2.2.4 Resident medical officers providing rural relief

RMOs who relieve as juniors in rural and remote locations have their SoCP defined for that position. Accordingly, individual credentialing and SoCP requirements do not apply.

2.2.5 Practitioners undertaking research and teaching

Where a practitioner's research and/or teaching involves no patient contact or responsibility, there is no requirement for the practitioner to have a SoCP.

2.2.6 Practitioners participating in college examinations

Practitioners, either taking exams or examining, are not required to have a SoCP at the Queensland Health facility in which the examination takes place.

2.2.7 Private practitioners providing care to public patients in a private health facility

This guide does not extend to practitioners providing a clinical service to public patients in private health facilities which are not located within Queensland Health public facilities—for example, private practitioners providing services from a co-located private hospital facility and a nuclear medicine service which is not located within a public health facility.

In the above circumstances, the terms of contract between a HHS and a private practitioner will define the standard expected for their credentialing and SoCP. This standard must be equivalent to the standard process outlined in this guide.

¹ Apart from where specifically referred to, the guide does not apply to RMOs and medical/dental students as it is expected the performance of their duties is formally supervised by a senior medical/dental officer. The term RMO includes interns, junior house officers, senior house officers, principal house officers, registrars and senior registrars.

2.2.8 Medical practitioners participating in supervised up-skilling

This guide does not extend to practitioners participating in supervised up-skilling, provided the practitioner's SoCP and clinical responsibilities do not exceed those of a principal house officer or registrar. Where a medical practitioner participates in a senior medical officer (SMO) on-call roster as part of the up-skilling, they must have a SoCP individually defined.

3. Principles

- Patient safety—ensuring practitioners practice within the scope of their education, training and competence, and within the capacity and capability of the service in which they are working.
- Consistency—aligning with National Standards and Queensland Health credentialing processes.
- Natural justice and procedural fairness— the credentialing and SoCP processes are underpinned by natural justice and procedural fairness.
- Due care and diligence—all parties act with due care and diligence to support natural justice and procedural fairness. Credentialing and defining SoCP processes are underpinned by transparency and accountability.
- Equity—applicants to be treated equally and without discrimination. All decisions shall be based on the professional competence of the applicant and the capacity of the relevant service.

4. Decision-making

The following are appropriate positions for the accountability of decision making for practitioners SoCP. These delegations must be clearly documented in the local human resource service delegations manual.

The decision maker with delegation to approve SoCP in Part 1, Sections 4.2, 4.4, 4.5 and 4.6, cannot participate in the credentialing committee process or its deliberations.

4.1 Approval² of the appointment of the chair to credentialing /scope of practice committees:

- Director-General, Queensland Health
- Health Service Chief Executive
- Chief Executive Officer, Health Services Support Agency (HSSA)
- Deputy Director-General, Health Service and Clinical Innovation Division (HSCI)
- Chief Health Officer, HSCI.

²*Hospital and Health Services Human Resource Delegations Manual*, HRM Functions of the Director-General, March 2014. Unless stated otherwise in the specific condition of a delegation, the delegation to 'approve' a function includes the power to approve, amend or refuse approval as the delegate thinks necessary or expedient to the proper exercise or discharge of the power. Decisions by the delegate are to be in accordance with specific conditions of the delegation and processes stated in relevant legislation, policies and procedures.

The chair of the committee appoints credentialing committee members (refer to appendix 8: 'credentialing committee model-terms of reference')

4.2 Approval³ of the scope of practice for individual practitioners:

- Director-General, Queensland Health
- Chief Executive Officer, HSSA
- Deputy Director-General, HSCI
- Chief Health Officer, HSCI
- Health Service Chief Executive
- Or other positions authorised under an Instrument of Delegation which may include positions such as:
 - executive directors of medical services
 - executive directors of clinical services
 - executive directors of nursing
 - chief operating officers
 - directors of oral health.

4.3 Approval⁴ of temporary scope of practice for individual practitioners:

- Director-General, Queensland Health
- Chief Executive Officer, HSSA
- Deputy Director-General, HSCI
- Chief Health Officer, HSCI
- Health Service Chief Executive
- Or other positions authorised under an Instrument of Delegation which may include positions such as:
 - executive team members
 - executive directors of medical services
 - executive directors of clinical services
 - executive directors of nursing
 - chief operating officers
 - directors of oral health
 - directors of medical services
 - suitable experienced/senior medical practitioners/dentists at director/managerial level.

³ ibid

⁴ Op.cit.

4.4 Approval⁵ of termination, suspension and reduction of scope of practice

- Director-General, Queensland Health
- Chief Executive Officer, HSSA
- Deputy Director-General, HSCI
- Chief Health Officer, HSCI
- Health Service Chief Executive

NB: As detailed in Part 4, Sections 4 and 5, the executive director of medical services/director of oral health (EDMS/DOH) has the authority to immediately suspend a practitioner SoCP to ensure the safety of patients.

4.5 Initiates the practitioners 'right to appeal' process to the appeal committee

- Director-General, Queensland Health
- Chief Executive Officer, HSSA
- Deputy Director-General, HSCI
- Chief Health Officer, HSCI
- Health Service Chief Executive.

4.6 Approval⁶ of the scope of practice of a practitioner at the conclusion of the appeal process

The recommendation of the appeal committee is provided to the following decision maker/s for a final determination on the practitioner's SoCP.

- Director-General, Queensland Health
- Chief Executive Officer, HSSA
- Deputy Director-General, HSCI
- Chief Health Officer, HSCI
- Health Service Chief Executive.

4.7 Authority⁷ to approve a statewide scope of practice for a practitioner

- Director-General, Queensland Health
- Deputy Director-General, HSCI
- Chief Health Officer, HSCI.

This delegated authority to approve a statewide SoCP for a practitioner may also rest with a Health Service Chief Executive if that Health Service Chief Executive has been granted the requisite delegated authority to approve statewide SoCP by the Director-General, Queensland Health.

⁵ Op.cit.

⁶ Op.cit.

⁷ Op.cit

Part 2: Standard process for credentialing and defining scope of clinical practice

1. Purpose

This part identifies best practice requirements within the standard process and the implementation of the *Credentialing and defining the scope of clinical practice* health service directive. It identifies and recommends individual position accountabilities and responsibilities in relation to managing the standard process.

2. Supporting documents

Appendix 4	Application for scope of clinical practice form
Appendix 5	General referee report template
Appendix 6	Multi-HHS/DoH division statewide authorising credentialing and SoCP practice list of services table
Appendix 7	Position responsibilities for credentialing the committee
Appendix 8	Credentialing committee model - terms of reference
Appendix 9	Practitioners guide to preparing a submission
Appendix 10	Rural public health facilities for general practitioner locum credentialing and SoCP

3. General requirements

During each stage of the credentialing and SoCP process, it is important that there is compliance with the principles of natural justice and procedural fairness and any perceived or real conflicts of interest are appropriately managed.

A prime requirement of a robust credentialing and defining the SoCP process, is ensuring clear accountability for establishing and managing an appropriately convened credentialing committee (the 'committee') which manages its business in a timely manner.

The committee has accountability for ensuring it checks all documentation and seeks relevant third party advice regarding each practitioner's application for SoCP. The committee will not consider any incomplete application, or make a recommendation about a practitioner's SoCP 'pending' further information.

The committee makes a recommendation on the practitioner's SoCP to the decision maker. The decision maker is accountable for communicating the decision to the applicant within 10 business days of the committee meeting date (refer to Part 2, Section 4.6).

Each SoCP granted must be in accordance with the *Clinical Service Capability Framework (CSCF)* for each service.

3.1. Applying the standard process

3.1.1 Practitioners working in a single Hospital and Health Service/DoH division

Where a practitioner works within a single HHS/DoH division, the standard credentialing process as set out in Part 2, Section 4 applies.

3.1.2 Practitioners working across a number of Hospital and Health Services/DoH divisions

Where a practitioner works across a number of HHSs/DoH divisions, the practitioner will undergo the standard credentialing process in their home HHS/DoH division and will use the mutual recognition process as set out in Part 2, Section 6 in the other HHSs/DoH divisions.

3.1.3 Practitioners working across the state

There are a number of practitioners working within services listed in Appendix 6 who provide those services across multiple HHSs or across the state. These practitioners may be granted a statewide SoCP, consistent with any conditions on the practitioner's registration. Once granted a statewide or multi-HHSs/DoH division SoCP by the 'home' HHS/DoH division, the practitioner must provide those clinical services consistent with the CSCF level(s) for each service within the public health facility(ies) where the practitioner will be engaged.

Refer to:

- Part 2, Section 7—Statewide and multi-HHS credentialing process.
- Part 2, Section 8—Off-site reporting (teleradiology) services.
- Part 2, Section 9—Rural procedural and non-procedural GP locums, for information of how to credential and grant a statewide/multi-HHS SoCP.

3.1.4 Co-located private and public health facilities

For HHSs which have co-located private and public health facilities, the Queensland Health facility and the other private facility may jointly accept evidence of credentials, however they should separately consider the SoCP of practitioners within each particular clinical setting.

4. Standard application for scope of clinical practice

The practitioner's application for SoCP accompanied by a complete set of documentation (credentials) is presented to the committee for consideration. The committee must not process incomplete applications, or make a recommendation about a practitioner's SoCP pending further information.

The committee may obtain advice from the applicable professional college (refer to Part 2, Section 4.1).

The committee checks and assesses the documentation and makes a recommendation to the decision maker regarding a practitioner's SoCP and the duration of that SoCP (refer to Part 2 Sections 4.4 and 4.5). The committee's recommendation(s) must mirror

any suspensions, conditions or undertakings imposed by the registration board on the applicant. In the event that the standard credentialing process cannot be completed prior to the date of commencing employment, a decision may be made regarding an interim SoCP (three calendar months) in accordance with Part 3, Section 4.

The decision maker must then communicate to the practitioner and relevant staff in writing within 10 business days of the committee's recommendation, a decision on SoCP which is consistent with the CSCF level(s) for each clinical service within the public health facilities where the practitioner will be providing clinical services (Refer to Part 2, Section 4.6).

4.1 Relevant considerations for the credentialing committee in the standard process

The committee MUST, as a minimum examine the following:

- a) A completed and signed application form⁸ for credentialing and SoCP (refer to Appendix 4).
- b) In checking the application for SoCP, should an applicant respond 'yes' to any questions under 'applicant's declaration and authorisation', principles of natural justice and procedural fairness must be applied before making an adverse decision against the applicant based on the information provided by the applicant. It is the obligation of the practitioner to advise the committee of the following:
 - limitation on SoCP by another public health facility;
 - any other matter the committee could reasonably expect to be disclosed in order for the committee to make an informed decision on credentials and SoCP.

Failure to fully inform the committee may result in suspension and a review of the applicant's SoCP (refer to part 4).

- c) Verification of the practitioner's registration status in the appropriate category with AHPRA. Any decision regarding a practitioner's SoCP must take into account any conditions, notations or undertakings on their registration. For example, if a practitioner has given an undertaking to AHPRA that they will refrain from performing a particular procedure, then their SoCP in every public health facility at which they work should reflect the exclusion of the procedure from their SoCP.

NB: It is the obligation of the practitioner to advise the committee of any conditions, undertakings, notations or other restrictions on their registration; or Failure to fully inform the committee may result in suspension and a review of the applicant's SoCP (refer to part 4).

- d) The applicant's current curriculum vitae, the preferred format being the AHPRA standard format for curriculum vitae

⁸ **NB:** under the *Electronic Transactions (Queensland) Act 2001*, "due to the applicant's signature on the Application for scope of clinical practice form being required to be witnessed by another person, an electronic signature is **not** able to be used for the form.

NB: any employment gaps greater than three calendar months require explanation.

- e) Evidence that the applicant holds the mandatory qualifications and has the training required for the appointed position (for example, specialist Fellowship). The committee may obtain advice from the applicants' professional college if required.
- f) Documented evidence of participation in relevant professional development activities (continuing professional development (CPD)/ continuing medical education (CME)/ professional development program (PDP)/ maintenance of professional standards (MOPS)) in the requested SoCP. This includes, but is not limited to a range of activities to meet individual learning needs, including practice-based reflective elements, such as clinical audit, peer-review or performance appraisal, as well as participation in activities to enhance knowledge, such as courses, conferences and online learning. It is expected, at a minimum, that applicants will meet the requirements established by AHPRA and the colleges. For applicants who have obtained a Fellowship within the past 12 months, the Fellowship certificate/letter from the college confirming fellowship will be considered to be sufficient evidence of professional development at the time of application only.
- g) For new applications, references are obtained from at least two professional peer referees who are independent of the applicant and who can attest to the applicant's clinical performance within the previous 12 calendar months. One referee report should be from the most recent place of employment (or, in the case of locums the most recent locum posting). A 'General referee report' template is provided (refer to Appendix 5).

NB: Referee reports must be taken into account, however, they should not replace the committee's duty to enquire and act with due care and diligence, which includes providing any adverse reports to the applicant and allowing the applicant an opportunity to respond.
- h) In determining SoCP, consideration should be taken in regards to resources and the needs of the public health facility (as provided to the committee by the HSCE/Director-General or delegate) consistent with the CSCF service level(s) to support the clinical work undertaken.
- i) Check and retain a copy of the 'internet search' conducted in accordance with the protocol in Recruitment and Selection Human Resources (HR) Policy B1.
- j) Verification of the applicant's identity in accordance with the protocol in Recruitment and Selection HR Policy B1.

4.2 Other factors to be considered by the credentialing committee

4.2.1 Medical practitioners with limited registration

Medical registrants who do not qualify for general or specialist registration under the *Health Practitioner Regulation National Law Act 2009* (Qld) and who apply for limited registration in an area of need or for renewal of limited registration must comply with all registration requirements, including supervision.

The committee must ensure recommended SoCP is consistent with the practitioner's Medical Board of Australia's registration requirements including all the conditions, notations and undertakings of the registration.

4.2.2 Dentist with limited registration under the public sector dental workforce scheme

Appropriately qualified overseas-trained dentists may be eligible for limited registration to work in the Queensland public healthcare sector in rural and remote areas. The committee must be satisfied as to the following:

- there is an appointed supervisor for the applicant
- the applicant is able to practice in accordance with the level of supervision approved by the Dental Board of Australia (to be confirmed by guidelines from the board)
- there is a verified board approved 'Supervised Practice Plan' in place, where appropriate.

4.2.3 Other information relevant to safe practice

The committee may consider any other material they believe is reasonably relevant to safe practice, including items not noted on the application form, and including but not limited to:

- reports from the Office of the Health Ombudsman, AHPRA and/or Medicare Australia
- patient and staff complaints
- medical indemnity history and status, including audits of litigation matters
- clinical review and audit
- information made available from Queensland Health investigations
- job position descriptions.

4.3 Requests for further information

If the committee does not believe there is sufficient information or requires clarification on any aspect of an application prior to making a recommendation, the application may be held over. A request seeking clarification or further information should be made in writing to the applicant. This information should be tabled at the next scheduled committee meeting.

On receipt of the additional information, the committee should reassess the application based on all available information and make a suitable recommendation.

4.4 Duration of scope of clinical practice

The committee shall recommend SoCP for a specified period with a defined end date. In all circumstances, this period should not exceed an interval of five years⁹.

The committee may recommend limiting the duration of SoCP if appropriate. Such reasons may include, but are not limited to:

⁹ National Standard for Credentialing and Defining the Scope of Clinical Practice 2004, page 32
www.safetystandards.gov.au/wp-content/uploads/2012/01/credenti.pdf

- a limited defined period of employment
- uncertainty about clinical competence in the practitioner's requested SoCP (the committee would make a recommendation to the decision maker regarding arrangements to assess practitioner competence, and subsequent review)
- a medical condition which has the potential to impair the practitioner's capacity to provide safe patient care.

4.4.1 Duration for locum practitioners

The duration of a standard SoCP for a locum practitioner shall be for no more than five years¹⁰, keeping in mind the length of the locum practitioner contract. Prior to commencing each subsequent period of re-engagement in a HHS, the following should occur:

- verification of the practitioner's AHPRA registration details
- verification that the practitioner has current and appropriate SoCP.

The following should occur at a frequency as determined by the EDMS/DOH:

- a satisfactory reference is obtained from the locum's previous place of employment (refer to Appendix 5)
- the practitioner signs the applicant's declaration and authorisation section of the 'Application for scope of clinical practice' form (refer to Appendix 4)
- ensure the practitioner's curriculum vitae is current.

4.5 Credentialing committee recommendation

When the committee has considered all aspects of the practitioner's application, the committee will make a recommendation in writing to the decision maker or delegate on the SoCP. The recommendation will include any limitations, such as supervision requirements, conditions or undertakings on registration and the period of the SoCP.

The committee may recommend that the practitioner not be granted any SoCP. A decision maker accepting the committee's recommendation, in essence rejects the practitioner's application for SoCP.

The committee must clearly document any reason(s) why the practitioner's SoCP has a limitation or why SoCP is not recommended.

4.6 Decision of health service chief executive/Department of Health division chief executive or delegate

4.6.1 The decision maker disagrees with the committee recommendations

Where the decision maker disagrees with the committee's recommendation the following applies:

- The decision maker will advise the committee, in writing, the reasons for not supporting the recommendation and request a further review of the application.

¹⁰ This duration of locum SoCP may be determined at the discretion of the local credentialing committee.

- The committee shall re-consider the application taking into account the decision maker's request for further review, which may include seeking further information from the practitioner.
- The committee makes a new recommendation or may reaffirm the previous recommendation.
- The decision maker has delegated authority to make the final decision on SoCP and can make that final decision irrespective of whether the decision maker agrees with the committee's recommendation.

4.6.2 The decision maker approves scope of clinical practice

Where the committee makes a recommendation on a practitioner's SoCP which aligns with their application the decision maker in effect approves the requested SoCP.

The following applies:

- The decision maker approves SoCP for the practitioner as per the committee's recommendation.
- The approved SoCP shall be communicated to the practitioner within 10 business days of the committee meeting.
- The decision maker communicates the practitioner's granted SoCP to the public health facility director of medical services/director of oral health, and the director(s) of the relevant clinical departments/units where the practitioner will be working.
- Add the practitioner's SoCP to the public health facility intranet web site, where available.

4.6.3 The committee does not recommend scope of clinical practice

Where the committee does not recommend SoCP, the following applies:

- The decision maker may elect to support the committee's recommendation that denies, withholds or significantly limits the practitioner's SoCP.
- The decision maker shall communicate the decision in writing to the practitioner within 10 business days of the committee meeting. Correspondence shall include reasons why the application was denied, withheld or limited and the process for the practitioner to make a submission requesting a review of the decision (refer to Appendix 9).

5. Process for a review of the decision at the Hospital and Health Service/Department of Health divisional level

A practitioner may apply for a review of SoCP at a local HHS/DoH divisional level. (NB: resolution of credentialing and SoCP matters should be exhausted at the HHS/DoH division level before progressing to the appeals process)

The steps for making a submission to the committee include:

1. The practitioner's submission must include specific grounds/reasons for lodging the submission and must be provided in writing to the decision maker within 20 business days of receipt of the decision.

2. The decision maker must consider the practitioner's submission and seek advice from the committee, where appropriate.
3. Within 20 business days of the receipt of the submission, the decision maker must then communicate in writing to the practitioner the decision on SoCP, including the reasons for that decision. The letter must also outline the process for the practitioner to lodge a formal appeal (refer to Part 5, Section 4)

NB: If relevant, the practitioner's current granted SoCP remains in effect while deliberations and consideration of any further submissions/appeals are in progress.

6. Mutual recognition of credentials and scope of clinical practice

Some practitioners undertake clinical practice at other HHSs or DoH divisions. The following mutual recognition process may be used when a currently credentialed practitioner seeks to provide clinical services at other HHSs/DoH divisions and the SoCP granted at one HHS/DoH division covers the SoCP required at the second HHS/DoH division. Where the practitioner's SoCP sought at the second HHS/DoH division is not covered by the SoCP granted at the first HHS/DoH division, the mutual recognition process is not used. A complete standard process checking all elements of the requested SoCP must be undertaken as per Part 2, Section 4.

6.1 Process for mutual recognition of scope of clinical practice

The steps in the process for obtaining mutual recognition include:

1. The second HHS/DoH division must obtain a copy of the practitioner's approved SoCP and the committee recommendation (which may be an extract from committee minutes).

The second HHS/DoH division may also obtain:

- references from an appropriate clinical line manager from the first health service who is able to attest to the applicant's current clinical performance in the first HHS/DoH public health facility
 - a copy of the application reviewed by the first HHS/DoH public health facility committee
 - the practitioner's current curriculum vitae.
2. The most senior medical/dental administrator within the second HHS/DoH division may undertake one of the following:
 - support the SoCP recommendation made by the first committee to the HSCE/DoH division CE or delegate. The SoCP granted must be consistent with the CSCF service level(s) of the public health facility(ies) in which the practitioner will provide clinical services
 - refer the request for mutual recognition to the local credentialing committee for recommendation
 - not support the recommendation from the first health service credentialing committee and may request a full application be processed through the local committee (refer to Part 2, Section 4).

3. The decision maker must consider the recommendation to support mutual recognition of the senior medical/dental administrator, and then communicate in writing to the practitioner the decision on SoCP within 10 business days of the date of their recommendation. The following may apply:
 - the expiry date can be no later than the expiry of the SoCP granted at the first HHS/DoH division
 - the duration and SoCP granted must be noted at the next meeting of the committee
 - the second HHS/DoH division must notify the first HHS/DoH division that the practitioner has been granted a SoCP under mutual recognition.
4. The first HHS/DoH division is responsible for the management of performance concerns.

Should the practitioner's SoCP at the first HHS/DoH division be terminated, suspended or reduced, the HHS/DoH division is to immediately notify HHS/DoH divisions who have mutually recognised the practitioners SoCP of the change and take appropriate action.

NB: Where a practitioner resigns from the first HHS/DoH division and continues to provide clinical services in a second HHS/DoH division, the second HHS/DoH division will undertake the renewal of SoCP prior to the expiry of the practitioner's current SoCP.

6.2 Renewal of mutual recognition

Provided the first HHS/DoH division undertakes a completed renewal of the practitioner's SoCP (refer to Part 2, Section 5.2) the second and subsequent HHS/DoH divisions may again use mutual recognition to grant the practitioner the same SoCP in their respective HHS/DoH division.

The SoCP at the second and other HHSs/divisions will have the same expiry date as the first HHS/DoH division. As the mutual recognition process is occurring at the same time as the renewal, at the discretion of the second HHS/DoH division, referee reports may not be required for mutual recognition renewals.

7. Statewide and multi-Hospital and Health Services credentialing process

It is important to note that delegated authority for statewide credentialing and SoCP rests with the Director-General Queensland Health, Deputy Director-General HSCI and the Chief Health Officer, HSCI. A HSCE may only approve a statewide credentialing and SoCP if that HSCE has been granted the requisite delegated authority to approve statewide credentialing and SoCP (refer to Part 1, Section 4, Decision-making).

Credentialing committees are able to make recommendations for both local and statewide credentialing and SoCP. However, a committee is only able to make recommendations for statewide credentialing and SoCP to a designation who has delegated authority to approve statewide credentialing and SoCP.

Accordingly, practitioners providing statewide services, such as those listed in Appendix 6, can only be granted a SoCP on a multi-HHS or statewide basis from a designation who has delegated authority to approve statewide credentialing and SoCP.

7.1 Process for statewide and multi-Hospital and Health Services credentialing and scope of clinical practice

Steps in the process for obtaining statewide and multi-HHS credentialing and SoCP include:

1. The practitioner's clinical service is identified to provide statewide or multi-HHS access (refer to Appendix 6).
2. The practitioner applies for SoCP or renewal of SoCP through a credentialing committee as per the standard application process in Part 2, Sections 4 and 14, identifying a requirement for statewide and multi-HHS credentialing and SoCP.
3. The committee will make a written recommendation to the decision maker regarding the appropriateness of the practitioner's SoCP to the multi-HHS /statewide clinical service.
4. The decision maker must notify in writing to all other relevant HHS's/DoH divisions of the practitioner's approved multi-HHS or statewide SoCP within 10 business days of approval.
5. Each committee notified must note the details of the practitioner's granted statewide/multi-HHS SoCP at the next committee meeting. This includes the practitioner's name, the committee which granted original SoCP, details of SoCP, including any conditions and the expiry date.

NB: Any SoCP review is to be undertaken by the committee recommending the practitioner's statewide/multi-HHS SoCP.

6. Each relevant head of facility, for example Medical Superintendent or Director of Nursing must ensure that when a practitioner with statewide/multi-HHS SoCP commences duty, they are informed of the CSCF service level(s) of the public health facility(ies) relevant to the practitioner's SoCP. The practitioner's granted SoCP must also be communicated to the public health facility/service of the relevant clinical departments/units where the practitioner will be working.
7. It is important to note that any concerns regarding the clinical performance of a practitioner must be formally notified to the decision maker who first granted the practitioner's SoCP (refer to Part 4, Section 9). This action does not preclude any other action being taken to protect the safety of patients.

Refer also to Appendix 6.

8. Radiology Services

Radiology services includes on-site and off-site (teleradiology).

This credentialing process is restricted to the following:

- staff radiologists
- VMO radiologists
- honorary radiologists

- radiologists engaged by a private provider that is contracted to provide radiology services to Queensland Health patients in public facilities.

All radiologists with a current SoCP as 'specialist radiologist – diagnostic and/or interventional radiology' are to be deemed to have statewide off-site radiology reporting (teleradiology) as part of that SoCP unless explicitly excluded.

NB: For externally contracted services it is incumbent on the HHS to ensure that the provisions of the contract with the private provider of tele-radiology services cover off on appropriate credentialing processes for practitioners in alignment with the guide and the National Standards.

9. Rural and remote procedural and non-procedural general practice locums

The Remote and Rural Clinical Support Unit (RRCSU) credentialing committee is designated to examine all standard applications for statewide SoCP from rural General Practice (GP) locum medical officers practising in Queensland Health rural public health facilities (refer to Appendix 9). The committee's recommendation will be made to the HSCE of the Torres and Cape HHS.

For a practitioner to be eligible for statewide GP Locum SoCP the practitioner must have specialist registration in General Practice or evidence of significance experience in general practice.

General points to note:

- At all stages of the process, advice is available from the RRCSU Credentialing Unit, if required.
- Concerns regarding the clinical performance of a practitioner must be formally notified to the RRCSU Credentialing Unit. This action does not preclude any other action being taken to protect the safety of patients.
- The RRCSU will maintain and publish a locum GP register (to be available on the Queensland Health Electronic Publishing Site (QHEPS)) of all rural GP locum medical officers who have been credentialed and granted a SoCP.

Details captured on the RRCSU Credentialing Register include the practitioner's:

- surname, first name, middle name
- AHPRA registration details, including conditions, undertakings, notations or suspensions.
- details of SoCP granted, including any conditions or supervision requirements.

9.1 Process for credentialing and granting scope of clinical practice for rural and remote general practice locums

When a HHS considers the engagement of a rural and remote GP locum for a rural facility, refer to Appendix 10, the HHS will check the RRCSU credentialing register. One of the following two processes will be undertaken.

1. If the practitioner is listed on the credentialing register with a current relevant statewide SoCP (rural public health facilities only).

It is the responsibility of the HHS to:

- obtain a satisfactory reference from the locum's previous place of employment prior to commencement (refer to Appendix 5)
- ensure the practitioner's curriculum vitae is up-to-date
- verify the practitioner's AHPRA registration status, taking into account any conditions or undertakings on their registration, which may arise out of impairment, disciplinary or registration concerns
- ensure the granted SoCP is consistent with that of the position offered and any conditions on SoCP are met.

The decision maker must ensure the practitioner is informed of the CSCF relevant to the practitioner's SoCP on each placement at a new public health facility.

It is the responsibility of the RRCSU to:

- check documentation received from the HHS and update their records
 - update the credentialing register, as required.
2. If the practitioner is not listed on the credentialing register.

It is the responsibility of the decision maker to:

- make a decision regarding interim SoCP as per Part 3, Section 4 and forward the practitioner's approved interim SoCP, and all associated documents to the credentialing committee.

It is the responsibility of the RRCSU to:

- check the interim SoCP documents received from the HHS and update their records
- commence a standard SoCP application process using either Section 4—Standard application for SoCP or Section 6—Mutual recognition of credentials and SoCP

9.2 Scope of clinical practice renewal of general practice locums

Renewal applications for rural and remote procedural and non-procedural GP locums with approved statewide SoCP will be considered by the RRCSU credentialing committee to provide a recommendation to the decision maker.

10. Organ and tissue retrieval situations

A practitioner who is a member of an organ and tissue retrieval team must have SoCP from the HHS/DoH division where they are located. The HHS/DoH division where the patient is located needs to be satisfied that the practitioner has appropriate and current SoCP for the service provided to that patient in that HHS/DoH division. This could be by way of a temporary SoCP (refer to Part 3, Section 6)

11. Offender health

All practitioners providing clinical care to people in custody of correctional centres must be credentialed and have a defined SoCP. The HHS in which the correctional centre is located is responsible for credentialing these practitioners. The HHS is to consider the

correctional centre as a public health facility within the HHS (refer to Part 2, Section 4 for the standard process of credentialing).

12. Telehealth

A practitioner providing telehealth services must have SoCP from the HHS/DoH division where they are located when providing telehealth services. The HHS/DoH division where the patient is located needs to verify the SoCP in the practitioner's home HHS/DoH division and be satisfied that the practitioner has appropriate and current SoCP for the service provided to that patient in that HHS/DoH division.

13. Practitioner request to change scope of clinical practice

A practitioner may voluntarily request a review of their SoCP at any time. This is to be recognised and encouraged as appropriate professional conduct. Where the requested change of SoCP is incompatible with service delivery needs, this should be resolved using relevant human resource management procedures, but with the primary focus being on patient safety.

13.1 Voluntary reduction of scope of clinical practice

Practitioners may voluntarily, and by mutual agreement with their employer, limit SoCP. Examples of situations where this might occur include:

- phasing down of practice towards retirement
- case volumes are insufficient to maintain skills
- shift in practice emphasis/direction.

Voluntary reduction in SoCP will be noted and minuted at the next scheduled committee meeting, and confirmed in writing by the decision maker within 10 business days.

13.2 Review of conditions

Practitioners with any conditions imposed on SoCP by the committee may be reviewed on submission of evidence that the conditions of the review have been met.

Evidence will be tabled at the next scheduled meeting and the practitioner is to be notified in writing by the decision maker within 10 business days of the committee meeting.

13.3 Review of supervision

Practitioners with any supervision imposed on SoCP by the committee may be reviewed on submission of evidence to support changes in their supervision.

Evidence will be tabled at the next scheduled meeting and the practitioner is to be notified in writing by the decision maker within 10 business days of the committee meeting.

13.4 Introduction of new clinical service, procedures, technology or interventions

A practitioner may request additional SoCP where there is an introduction of new clinical services, procedures, technology or interventions.

These include new services, procedures or interventions that are being introduced into a HHS for the first time, even if they have already been established in other HHSs.

HHSs should have in place policies, structures (for example, appropriate committees) and procedures for determining whether such services should be introduced based on safety, cost, support services, staff training and other considerations. Such decisions should also be informed by service planning and capability-based planning.

When new services are introduced, practitioners wishing to incorporate such services within their defined SoCP must formally request an addition to their SoCP through the review process, for example:

- New/relevant qualifications or skills.
- The practitioner acquires or demonstrates enhanced skills or a new qualification and requests to have these recognised by the committee.

The practitioner is required to submit:

- an *Application for scope of clinical practice* form (refer to Appendix 4)
- evidence to support the additional requested SoCP (e.g. qualification)
- references from at least two professional peers who are independent to the applicant, with no conflict of interest and who can attest to the applicant's clinical performance in the additional requested SoCP.

13.5 A practitioner who has conditions suspensions or undertakings removed by AHPRA which affect the practitioners scope of clinical practice

The practitioner is required to submit documentation as per the standard *Application for scope of clinical practice* form (refer to Appendix 4).

13.6 A practitioner acquires specialist registration or additional skills or qualifications

A practitioner may request additional SoCP where they have acquired specialist registration or additional skills or qualifications.

The practitioner is required to submit:

- an *Application for scope of clinical practice* form (refer to Appendix 4)
- evidence to support the additional requested SoCP (e.g. specialist registration with AHPRA, qualification)
- references from at least two professional peers who are independent to the applicant, with no conflict of interest and who can attest to the applicant's clinical performance in the additional requested SoCP.

14. Renewal of credentialing and scope of clinical practice process

Scheduled re-credentialing and renewal of a practitioner's SoCP must occur as a part of an organisational strategy to ensure each practitioner's credentials remain current and relevant, and that the practitioner remains competent to provide the defined SoCP.

Renewal of SoCP must occur at a maximum of five-year intervals. There is no obligation on a particular public healthcare facility to maintain the SoCP previously granted.

The committee **MUST**, as a minimum, examine the following information:

- a) A completed and signed the application form¹¹ for credentialing and SoCP (refer to Appendix 4).
- b) In checking the application for SoCP, should an applicant respond 'yes' to any questions under 'applicant's declaration and authorisation', principles of natural justice and procedural fairness must be applied before making an adverse decision against the applicant based on the information provided by the applicant. It is the obligation of the practitioner to advise the committee of the following:
 - limitation on SoCP by another public health facility;
 - any other matter the committee could reasonably expect to be disclosed in order for the committee to make an informed decision on credentials and SoCP.

Failure to fully inform the committee may result in suspension and a review of the applicant's SoCP (refer to Part 4).

- c) Verification of the practitioner's registration status in the appropriate category with AHPRA. Any decision regarding a practitioner's SoCP must take into account any conditions, notations or undertakings on their registration. For example, if a practitioner has given an undertaking to AHPRA that they will refrain from performing a particular procedure, then their SoCP in every public health facility at which they work should reflect the exclusion of the procedure from their SoCP.

NB: It is the obligation of the practitioner to advise the committee of any conditions, undertakings, notations or other restrictions on their registration; or

Failure to fully inform the committee may result in suspension and a review of the applicant's SoCP (refer to Part 4).

- d) The committee may request the applicant's current curriculum vitae, the preferred format being the AHPRA standard format.
NB: any employment gaps greater than three calendar months require explanation.
- e) Documented evidence of participation in relevant professional development activities (CPD/ CME/ PDP/ MOPS) in the requested SoCP. This includes, but is not limited to a range of activities to meet individual learning needs, including practice-based reflective elements, such as clinical audit, peer-review or

¹¹ **NB:** under the Electronic Transactions (Queensland) Act 2001, "due to the applicant's signature on the Application for scope of clinical practice form being required to be witnessed by another person, an electronic signature is not able to be used for the form.

performance appraisal, as well as participation in activities to enhance knowledge, such as courses, conferences and online learning. It is expected, at a minimum, that applicants will meet the requirements established by AHPRA and the colleges. For applicants who have obtained a Fellowship within the past 12 months, the Fellowship certificate/letter from the college confirming fellowship will be considered to be sufficient evidence of professional development at the time of application only.

- f) If the practitioner is employed by the HHS/DoH division, at least one reference from their clinical line manager or their director is required. In all other cases (such as locums, medical practitioners treating patients in aged public health facilities etc) two references are required.

A referee should be independent of the applicant with no conflict of interest, and who can attest to the applicant's clinical performance within the previous 12 calendar months.

NB: Referee reports must be taken into account, however they should not replace the committee's duty to enquire and act with due care and diligence.

- g) In determining SoCP, consideration should be taken in regards to resources and the needs of the public health facility to ensure consistency with the CSCF service level(s) to support the clinical work undertaken.
- h) Check and retain a copy of the 'internet search' conducted in accordance with the protocol in Recruitment and Selection HR Policy B1.

14.1 Other information relevant to safe practice

The committee may consider any other material they believe is reasonably relevant to safe practice, including, but not limited to:

- reports from, the Office of the Health Ombudsman, AHPRA and/or Medicare Australia
- patient and staff complaints
- medical indemnity history and status, including audits of litigation matters
- clinical review and audit information
- information made available from any Queensland Health investigations.

14.2 Recommendation and approval of scope of clinical practice

The following processes and management for the renewal of credentialing and SoCP are the same as the standard application for credentialing and SoCP.

Refer to:

- Requests for further information (refer to Part 2, Section 4.3).
- Duration of scope of clinical practice (refer to Part 2, Section 4.4).
- Credentialing Committee recommendation (refer to Part 2, Section 4.5).
- Decision of HSCE/division CE or delegate (refer to Part 2, Section 4.6).

14.3 Position responsibilities for credentialing committees

Refer to Appendix 7 for position responsibilities for credentialing committees.

Part 3: Temporary credentialing and scope of clinical practice

1. Purpose

This part of the guide identifies best practice requirements for temporary credentialing and SoCP. There are four situations where this process will apply which include interim, urgent, disaster and emergency SoCP.

It also identifies individual position responsibilities in relation to the processes.

2. Supporting documents

Appendix 4	Application for scope of clinical practice form
Appendix 5	General referee report
Appendix 7	Position responsibilities for the credentialing committee

3. General requirements

At times the services of a practitioner without SoCP are required at very short notice, or in certain situations where it is not possible to complete the process set out in Part 2 (the standard process for credentialing and defining SoCP) prior to the time the practitioner should commence work. In these circumstances temporary SoCP may be granted.

This process strikes a balance between risks to patient harm which arise from a failure to provide an appropriately skilled practitioner in a timely manner versus the risks to patient harm arising from processes with reduced credentialing requirements and with less checks and balances in place.

4. Interim scope of clinical practice

All practitioners who are subject to the *Credentialing and defining the scope of clinical practice* health service directive/policy must have an approved SoCP prior to commencing duty.

It is recognised that in some circumstances a practitioner is required to commence work prior to completing a full application as set out in Part 2. In this situation an interim SoCP may be approved.

The following conditions apply to the granting of an interim SoCP:

- approval will not exceed three calendar months
- an interim SoCP cannot be renewed
- interim SoCP should not be used as a means of granting a time extension on formal SoCP
- should not be used to change or add to an existing formal SoCP
- must be noted at the next scheduled credentialing meeting

- a formal application as detailed, in Part 2, must still proceed and be checked by the appropriate credentialing committee following the granting of interim SoCP.

The RRCSU credentialing committee will note all interim SoCP awarded to procedural and non-procedural GP rural locum medical officers (refer to Part 2, Section 8).

4.1 Delegation

The decision maker may delegate the decision regarding interim SoCP arrangements. Refer to Part 1, Section 4—Decision maker.

4.2 Relevant considerations of the decision maker in the granting an interim scope of clinical practice

The decision maker should, as a minimum ensure:

- a) The applicant has signed the declaration and authorisation section of the Application for SoCP form (refer to Appendix 4).
- b) That in checking the applicant's declaration and authorisation section of the Application for SoCP form, should an applicant respond 'yes' to any questions principles of natural justice and procedural fairness must be applied before making an adverse decision against the applicant based on the information provided by the applicant. It is the obligation of the practitioner to advise the committee of the following:
 - limitation on SoCP by another public health facility;
 - any other matter the committee could reasonably expect to be disclosed in order for the committee to make an informed decision on credentials and SoCP.

Failure to fully inform the committee may result in suspension and a review of the applicant's SoCP (refer to Part 4).

- c) Verification of the practitioner's registration status in the appropriate category with AHPRA. Any decision regarding a practitioner's SoCP must take into account any conditions, notations or undertakings on their registration. For example, if a practitioner has given an undertaking to AHPRA that they will refrain from performing a particular procedure, then their SoCP in every public health facility at which they work should reflect the exclusion of the procedure from their SoCP.

NB: It is the obligation of the practitioner to advise the committee of any conditions, undertakings, notations or other restrictions on their registration; or

Failure to fully inform the committee may result in suspension and a review of the applicant's SoCP (refer to Part 4).

- d) That the applicant has provided a current curriculum vitae—the preferred format being the AHPRA standard format for curriculum vitae.

NB: any employment gaps greater than three calendar months require explanation.
- e) That the applicant has provided evidence that they hold the mandatory qualifications and have the training required for the appointed position (for example, specialist Fellowship), including documented evidence of relevant

professional development activities CPD/CME/ PDP/MOPS in the requested SoCP.

- f) At least one professional peer reference is provided from a referee who is independent of the applicant, with no conflict of interest, and who can attest to the applicant's clinical performance within the previous 12 calendar months (refer to Appendix 5).

NB: Referee reports must be taken into account, however they should not replace the committee's duty to enquire and act with due care and diligence.

- g) That they check and retain a copy of the 'internet search' conducted in accordance with the protocol in Recruitment and Selection HR Policy B1.
- h) Verification of the applicant's identity is undertaken in accordance with the protocol in Queensland Health Human Resource Policy B1: Recruitment and Selection.

In determining SoCP, consideration should be taken in regards to resources and the needs of the public health facility (as provided to the committee by the HSCE or DoH division CE or delegate) consistent with the CSCF service level(s) to support the clinical work undertaken.

4.3 Decision of health service chief executive/Department of Health division chief executive or delegate

The decision maker makes the decision to grant/decline a practitioner's interim SoCP which is consistent with the CSCF service level(s) of the public health facility(ies) in which the practitioner will be providing services.

The following steps must then be taken by the decision maker:

1. The decision maker is accountable for communicating the decision regarding interim SoCP to the practitioner within 10 business days of the decision.
2. When an interim SoCP is granted, the notification letter will contain or have attached the CSCF service level(s) of the public health facility(ies). The HSCE/DoH division CE or delegate must ensure the practitioner is informed of the capability of the services relevant to their area of practice. This may be accomplished during an orientation with the clinical director/line manager or EDMS.
3. Communicate the practitioner's granted interim SoCP in writing to the public health facility director of medical services and the director(s) of the relevant clinical departments/units where the practitioner will be working.
4. Add the practitioner's interim SoCP to the HHS intranet, where applicable.
NB: For rural GP locums—a copy of the granted interim SoCP and referee report must be sent to the RRCSU credentialing unit for noting by the RRCSU credentialing committee. Refer to Part 2, Section 9 of the standard process.
5. The decision must be noted at the next scheduled credentialing meeting.

5. Disaster medicine

Special provisions for credentialing and granting of SoCP may also be necessary in times of disaster or major emergency. This will be at the discretion of the EDMS and may not exceed fourteen days.

If time permits it may be more appropriate to approve formal SoCP through the mutual recognition process (refer Part 2, Section 6) or approve an interim SoCP (refer Part 3, Section 4).

5.1 Relevant considerations of the decision maker in the granting of a disaster scope of clinical practice

The decision maker should, as a minimum (where practicable) undertake the following:

- Verify the identity of the practitioner through inspection of photographic identification (e.g. current Australian passport, current Australian drivers licence or valid Queensland Health identification card).
- Immediate contact with a member of senior management of the HHS/DoH division at the practitioner's most recent place of appointment, to verify claimed employment history and good standing.
- Verify the practitioner's registration status in the appropriate category with AHPRA. Any decision regarding a practitioner's SoCP must take into account any conditions or undertakings on their registration, which may arise out of impairment, disciplinary or registration concerns. For example, if a practitioner has given an undertaking to AHPRA that they will refrain from performing a particular procedure, then their SoCP in every public health facility at which they work should reflect the exclusion of the procedure from their SoCP.
- Confirmation as soon as practicable by at least one professional referee of the practitioner's competence and good standing.
- Verify that the practitioner holds the mandatory qualifications and has the training required for the SoCP.

Enacting these provisions will also involve, where practicable, an assessment of the practitioner's available credentials by a senior medical practitioner/dentist who practises in the same speciality area as the applicant.

In granting a SoCP in disaster situations, determination in the above circumstances must not exceed fourteen days and should not be extended. This SoCP determination can be made verbally and must in every case, be subsequently confirmed in writing, and noted in the minutes at the next scheduled committee meeting.

6. Clinical emergency/urgent clinical situations

For the purpose of this guide, clinical emergency and urgent clinical situations are managed in the same context.

In the case of a clinical emergency, any practitioner is permitted, and is expected to do everything possible, to save the patient's life or save the patient from serious harm to the extent permitted by his or her registration and other relevant law. If, in such as emergency situation, there is no practitioner available with an appropriate authorised

SoCP, then the medical practitioner who is available may administer the necessary treatment outside his or her authorised SoCP.

If time permits with the identified emergency, the practitioner who is available should, if clinical circumstances permit, contact the EDMS/director oral health or their delegate to consider, and if appropriate, approve the emergency SoCP (this can be done verbally).

A temporary SoCP determination in this circumstance will not exceed 24 hours and may not be extended. Approval of this category of SoCP must be documented in the minutes of the next committee meeting.

It may be more appropriate to approve formal SoCP through the mutual recognition process (refer to Part 2, Section 6) or approve an interim SoCP (refer to Part 3, Section 4).

6.1 Relevant considerations of the decision maker in granting an emergency/urgent scope of clinical practice

The decision maker should, as a minimum (where practicable) undertake the following:

- Verify the identity of the practitioner through inspection of photographic identification (e.g. current Australian passport, current Australian drivers licence or valid Queensland Health identification card).
- Immediate contact with a member of senior management of the HHS/DoH division at the practitioner's most recent place of appointment to verify claimed employment history and good standing.
- Verify the practitioner's registration status in the appropriate category with AHPRA. Any decision regarding a practitioner's SoCP must take into account any conditions or undertakings on their registration, which may arise out of impairment, disciplinary or registration concerns. For example, if a practitioner has given an undertaking to AHPRA that they will refrain from performing a particular procedure, then their SoCP in every public health facility at which they work should reflect the exclusion of the procedure from their SoCP.
- Confirmation as soon as practicable by at least one professional referee of the practitioner's competence and good standing.

7. Position responsibilities for credentialing committees

Refer to Appendix 7 for position responsibilities for credentialing committees.

Part 4: Termination, suspension or reduction of scope of clinical practice

1. Purpose

This part identifies where HHSs/DoH divisions may terminate, suspend or reduce a practitioners SoCP. It also identifies organisational and individual requirements, accountabilities and responsibilities in relation to managing a reduction, suspension or termination of a practitioner's SoCP.

2. Supporting documents

Appendix 9

Practitioners guide to preparing a written submission

Appendix 7

Position responsibilities for the credentialing committee

3. General requirements

Suspension in part, or in full of the right to practice within a public health facility, particularly in response to concerns about competence and/or performance of a practitioner, has the potential to cause extreme detriment to the practitioner's clinical practice and/or reputation.

At all times and stages during the process, there is a paramount duty to ensure patient safety, while at the same time adopting the principles of natural justice and procedural fairness when considering any concerns about the practitioner's standard of care.

Natural justice and procedural fairness requires all persons involved in making a decision under this Part to:

- act fairly, in good faith and without bias or perception of bias
- ensure all relevant documents which are being considered by a decision maker or committee are disclosed in a timely manner to the parties concerned
- ensure practitioners know what allegations or claims are made against them
- give practitioners sufficient time to prepare their response to those issues or claims
- ensure practitioners are given the opportunity to adequately state their case and correct or contradict any statement prejudicial to their case
- declare any actual or perceived conflicts of interest. Where there is a conflict of interest, the person will withdraw from deliberations regarding the relevant application.

4. Immediate termination of scope of clinical practice

A practitioner's SoCP is immediately terminated and does not require discussion, investigation or specific action on the part of the decision maker when a practitioner's AHPRA registration is cancelled or modified in a way that precludes them from practising.

Within 48 hours of becoming aware of the circumstances, the decision maker must advise the practitioner in writing of the termination of SoCP and the reasons for the termination of SoCP.

The EDMS/DOH will:

- take the necessary action to ensure patient safety
- investigate and document, any patient harm and take appropriate action
- table the matter at the next committee meeting.

An affected practitioner may make a fresh application for SoCP to the committee once the circumstances that precipitated the immediate termination are no longer in effect. Refer to standard application for Part 2, Section 4.

5. Immediate suspension of scope of clinical practice

When the following circumstances occur, the practitioner's SoCP is immediately suspended and does not require discussion, investigation or specific action on the part of the decision maker:

- a practitioner's registration is suspended by AHPRA
- a practitioner's employment with the public health facility is suspended

Within 48 hours of becoming aware of the circumstances, the decision maker must advise the practitioner in writing, of the suspension of SoCP and the reasons for the suspension of SoCP.

The EDMS/DOH will:

- take the necessary action to ensure patient safety
- investigate and document, any patient harm and take appropriate action
- table the matter at the next committee meeting.

An affected practitioner may make a renewal application for SoCP to the committee once the circumstances that precipitated the immediate suspension are no longer in effect. Refer to Part 2, Section 14 — Renewal application for SoCP.

6. Other triggers for assessment for termination, suspension or reduction of scope of clinical practice

The following circumstances may trigger the assessment for termination, suspension or reduction of SoCP (this list is not exhaustive):

- a practitioner has conditions, suspension or undertakings imposed by AHPRA which affect the practitioner's SoCP
- the outcome of an investigation by the Office of the Health Ombudsman or AHPRA, or other investigation processes which indicate that a change to SoCP may be appropriate
- requests are received at any time from 'authorised individuals or bodies' (see 'authorised individual and /or bodies' definition in Appendix 1) for unplanned review of a practitioner's credentials or SoCP
- a practitioner has a mental or physical impairment affecting their fitness to provide safe patient care
- a practitioner is involved in an adverse clinical incident
- a practitioner has been convicted of a serious crime which could affect his or her ability to provide the defined SoCP safely and competently
- a practitioner has made a false declaration or provided false information regarding their SoCP application which materially impacts upon the validity of the SoCP having been granted
- the practitioner's performance review suggests to the practitioner's unit/division clinical director/line manager that a review of SoCP is necessary
- a practitioner presents a risk to the safety and wellbeing of patients
- a serious complaint is made regarding the practitioner's clinical practice
- a practitioner's employment is terminated

7. Assessing termination, suspension or reduction of scope of clinical practice

All requests for review must be referred in the first instance to the EDMS/DOH or their delegate and those requests must be documented.

In all cases, the EDMS/DOH is to immediately seek further advice and document the advice received. The purpose of seeking advice is to consider the available information and then determine if there is a need to urgently limit the practitioners SoCP in the interests of patient safety.

Advice may be sought from the appropriate clinical director, experienced college Fellow (medical/dental) or senior dentist with expertise in the same clinical domain as the practitioner under consideration. The Human Resource Services and Legal representative, where appropriate, should also be consulted.

Following consultation, if it is the preliminary view of the EDMS/DOH or delegate that the trigger may represent an immediate risk of patient harm, the process outlined in managing the immediate risk of patient harm is followed (refer to Section 7 of this Part) Where the EDMS/DOH or delegate is of the opinion that the risk of patient harm is not immediate and can await review by the committee, the approach outlined in Section 8 of this Part is followed.

If the trigger has previously been fully investigated, or been assessed as a vexatious complaint and no new information is available on this occasion, no further action is required.

8. Managing scope of clinical practice when there is an immediate risk of patient harm

Following the steps taken in Section 7 of this Part, at short notice and in emergency situations the EDMS/DOH can immediately reduce or suspend a practitioner's SoCP if there is reasonable belief that the practitioner presents a risk to the safety of patients.

The EDMS/DOH must immediately notify the decision maker of the temporary reduction or suspension until the credentialing committee has considered the matter. Such action is interim and pending review by the committee.

The action taken should be the least onerous (with regard to the practitioner's SoCP) action necessary for protection of patients. For example, where a practitioner has conditions or undertakings imposed on their medical/dental registration that are incompatible with the existing SoCP, the reduction or suspension of SoCP is to the extent necessary to ensure compliance with those conditions or undertakings and to ensure patients receive safe and acceptable standards of care.

8.1 Steps to be taken if there is an immediate risk of patient harm

The following steps are to be taken when there is an immediate risk of patient harm:

1. An interim decision is made by the EDMS/DOH or delegate to immediately reduce or suspend a practitioner's SoCP. The reasons for the decision are to be clearly documented.
2. The EDMS/DOH or delegate will formally advise the decision maker of their interim decision.
3. The decision maker will advise the practitioner verbally and in writing of the decision to immediately suspend or reduce their SoCP and the reasons for the decision within two business days of that decision being made, and that a review by the committee will follow.
4. The decision maker will request the committee to undertake a formal review (in accordance with Section 10 of this part) of the practitioner's SoCP within two business days of the SoCP being suspended or reduced. Reasons for the review must be clearly stated in the documentation.
5. The EDMS/DOH or delegate will advise the practitioner's line manager and other staff relevant to the provision of the affected service of the suspension or reduction of SoCP.
6. The EDMS/DOH or delegate should note that the *Health Practitioner Regulation National Law Act 2009* requires health practitioners to make a report to the health ombudsman if they form a reasonable belief that another health practitioner has engaged in notifiable conduct or has an impairment (Part 8 at Division 2, 'Mandatory notifications' under ss.141 and 142; and Part 8 at Division 3, under s.144 'Grounds for voluntary notification').

9. Managing when there is no immediate risk of patient harm

If there is no immediate risk to patient safety, or other factors which may result in requiring a review, then the following steps apply.

Refer to Part 4, Section 5 for a list of circumstances which may trigger the termination, suspension or reduction of SoCP.

9.1 Steps to be taken when there is no immediate risk of patient harm

The following steps are to be taken when there is no immediate risk of patient harm:

1. The EDMS/DOH or delegate will formally advise the decision maker of need to undertake a formal review of SoCP
2. The decision maker will request the committee to undertake a formal review (in accordance with Section 10 of this part) of the practitioner's SoCP. Reasons for the review must be clearly stated in the documentation.
3. The EDMS/DOH or delegate should note that the *Health Practitioner Regulation National Law Act 2009* requires health practitioners to make a report to the health ombudsman if they form a reasonable belief that another health practitioner has engaged in notifiable conduct or has an impairment (Part 8 at Division 2, 'Mandatory notifications' under ss.141 and 142; and Part 8 at Division 3, under s.144 'Grounds for voluntary notification').

10. Process for review of scope of clinical practice

This process follows from a request by the HSCE/DoH division CE to the committee that a practitioner's SoCP requires review (referred to as an *Unscheduled Review* in the previous *Credentialing and SoCP 2012* policy)

All parties, including the committee involved in this process, have a paramount duty to ensure the safety of patients, and to adopt the principles of natural justice and procedural fairness when considering any concerns about the practitioner's standard of care.

If applicable, the person raising a concern about the specific practitioner is not to be involved in any deliberations or decision-making regarding the practitioners SoCP.

10.1 Steps to be taken by the committee for a review

In response to a request for review of SoCP, the chair of the committee must undertake the following steps noting that matters and circumstances under review vary:

1. Advise the practitioner within ten business days in writing that a review has been requested and include the following in the written correspondence to the practitioner:
 - the subject of the review
 - all the reasons for the review

- copies of all available documents in the possession of the committee at that time that will be relied upon when considering the matter. Any further documents received by the committee, which will be relied upon, will be provided to the practitioner in a timely manner, which may in some cases include part or all of pertinent patient/s records. **NB:** Section 142 of the *Hospital and Health Boards Act 2011 (Qld)*¹² prohibits the disclosure of patient records by any *designated person*, which includes any current or former employee of Queensland Health or a HHS, to any other person, including another *designated person*. Obtaining patient records pursuant to s.160 of the *Hospital and Health Boards Act 2011* is a recommended option, which requires approval in writing by the relevant HHS CE or the Director-General Queensland Health **prior** to accessing and disclosing any patient records
 - the possible timeframes (including a date) preceding the proposed review meeting. If oral presentations are to be made this may require a second or subsequent review meeting
 - a request for the practitioner to provide a written submission within 20 business days of the date of the letter
 - inform the practitioner of the opportunity to make an oral presentation to the committee to support any written submissions provided. The practitioner may elect, at his/her discretion, to take up the offer of an oral presentation to the committee. Oral presentations will be heard by the committee at a second or subsequent review meeting.
2. Provide authorised individuals and/or bodies (see Appendix 1) who have made a request for the review with an opportunity to make a submission regarding the grounds for the request within 20 business days of the practitioner being notified of a review being undertaken. NB: if the request for the review was made by the decision maker, it would be appropriate for the role of the decision maker to be delegated to a member of the executive team for the purposes of this review
 3. Establish membership of the committee, which may be the existing committee and/or inclusion of the appropriate clinical director, experienced college Fellow (medical/dental) or senior dentist with expertise in the same clinical domain as the practitioner under consideration. The HHS/DoH division Human Resource Services and Legal representative, where appropriate, may also be included.
 4. Where required in order to ensure appropriate peer review, additional committee members should be considered. These additional committee members should have the skills and experience relevant to the SoCP being reviewed. For example, if a matter under review pertains to an urologist's clinical expertise, the composition of the committee should include at least two members that are urologists.
 5. Ensure no member has a conflict of interest (refer to Part 5, Section 3.2 for guidance) which prevents them being a member of the committee.

¹² <https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HHNA11.pdf>

The credentialing process is a risk management strategy for Queensland Health, but it is not a process specifically covered under legislation. The process is not a specific patient safety process (although there is indirectly a component of this deciding whether a practitioner should be granted SoCP/not)

6. Ensure the person who originally made the request for review, or raised the concern, is not a member of the committee. Any such members of the committee should be substituted. If this person was the EDMS/DOH/clinical director/chair of the committee then the holder of an equivalent position from a similar HHS/DoH division will be the substitute.
7. Ensure all members of the committee are familiar with the role and responsibilities of committee members in a review process.
8. Ensure all members of the committee and the practitioner are provided with all available documentation including the written submissions, at least five business days prior to the meeting.
9. Convene a committee within 20 business days after the closing date for the receipt of the practitioner's written submission.
10. At this meeting the committee will consider all available documentation and may request further information if necessary.
11. If necessary, convene a second or subsequent meeting of the committee to hear the practitioner's oral presentation or consider additional information submitted by the practitioner. Prior to each meeting ensure all members of the committee and the practitioner are provided with all available information at least five business days prior to the meeting.
12. Following the consideration of all the available relevant material (including the practitioner's oral presentation, if made) the committee must make a recommendation on the practitioners SoCP to the decision maker.. If the outcome of the recommendation is to terminate, suspend or reduce the practitioner's SoCP the subject, reason/s and recommendation/s of the review must be clearly documented.

10.2 Obligations of the committee when undertaking a review

Obligations of the committee when undertaking a review include the following:

1. The committee must conduct proceedings with the same powers and responsibilities as if it were determining an application for SoCP for the first time, including ensuring that accurate minutes are kept of the meeting.
2. The committee must ensure any recommendation to limit a SoCP is the least onerous action necessary for protection of patients.
3. The committee should note that the *Health Practitioner Regulation National Law Act 2009* requires health practitioners to make a report to the health ombudsman pursuant to notification obligations at Part 8 at Division 2, 'Mandatory notifications' under ss.141 and 142; and Part 8 at Division 3, under s.144 'Grounds for voluntary notification'.
4. Consideration may also be given to notification of the relevant professional college/society/association or Australian Medical Council if this disclosure is authorised at law.
5. The committee must gather sufficient information to allow an informed recommendation to the decision maker. For example:
 - seeking an opinion from the practitioner's clinical director or, if the relevant clinical director is him/herself the subject of the unscheduled review, seeking

an independent clinical opinion from an appropriately qualified practitioner or relevant college/society/association

- if there is a reasonable belief by the members of the committee that a practitioner may have a physical or mental impairment, disability, condition or disorder that detrimentally affects, or is likely to detrimentally affect, the practitioner's physical or mental capacity to provide safe patient care, the committee may recommend to the appropriate delegate under the Mental or Physical Incapacity of Employees HR E11 that, an applicant undergoes an independent medical examination and any ancillary testing to assess their physical and mental fitness to practice and to provide effective and safe patient care
 - if the practitioner does not consent to a clinical review, the committee may recommend to the decision maker to appoint a clinical reviewer under s.125 of the *Hospital and Health Boards Act 2011* (Qld) to undertake a clinical review. At the conclusion of the clinical review a report with recommendations will be submitted to the HSCE/DoH division CE and may be forwarded to the committee for consideration on authority of the HSCE/DoH division CE
 - where further information is required, temporary restrictions on SoCP may be recommended if appropriate, pending receipt and review of the further information.
- 6. The committee must provide an opportunity for the practitioner to make statements and/or present documents (but this does not include a right to be present for the entirety of the committee's proceedings).
- 7. Should the practitioner choose to attend the meeting for the purpose of making an oral statement based on the presented written submission, he/she can be accompanied by an adviser (who may be a barrister or legal practitioner). Legal representatives are present in an advisory capacity only, and may not advocate to the committee on behalf of the practitioner.
- 8. The committee must ensure at all times that the practitioner is provided with all documentation presented to the committee, including any clinical opinions, which are relevant to the practitioner's SoCP. The committee must ensure the practitioner has adequate time to respond to the documentation.
- 9. The committee must conclude the review in a timely manner.

10.3 Committee recommendations to the health service chief executive/DoH division chief executive or delegate

The committee shall make recommendation(s) in writing to the decision maker regarding the practitioner's SoCP, including reasons for the recommendation(s).

The committee's recommendation may include one or more of the following (list not exclusive):

- commissioning of a clinical review under s.125 of the *Hospital and Health Boards Act 2011*
- practitioner's SoCP amended to reflect AHPRA conditions undertakings or notations
- practitioner's SoCP terminated
- practitioner's SoCP suspended

- practitioner's SoCP reduced for example, ceasing certain procedures or interventions
- practitioner's SoCP limited to a specific public health facility/facilities
- impose conditions against a practitioner's SoCP
- a level of supervision may be applied to the practitioner's SoCP
- practitioner may be required to undertake additional training or a period of up-skilling
- no change to practitioner SoCP is required.

10.4 Decision of health service chief executive/DoH division chief executive or delegate

On receipt of the committee's recommendation, the decision maker must take the following steps:

1. Where the SoCP is recommended to be changed in a manner that is likely to be detrimental to the practitioner, the decision maker must give the practitioner an opportunity to make a submission to the decision maker about the proposed decision.
2. The recommendation must be communicated to the practitioner in writing within 10 business days of that recommendation being made. The communication also must nominate that the practitioner's submissions are to be provided within 10 business days after the receipt of the letter.
3. The decision maker must consider the practitioner's submission before finalising his/her decision about the practitioner's SoCP. In the course of considering the submission, the decision maker may request the committee to provide further advice. Such advice must be provided to the decision maker within 10 business days from the time of the request to the committee.
4. The decision maker must make a final decision on the practitioner's SoCP within 10 business days of receiving the practitioner's submission, or the committee's advice, whichever is the latter. This decision must be communicated to the practitioner in writing, within 10 business days of making the decision, including reasons for the decision, with copies to the 'authorised individuals/bodies' who requested the review if relevant and the chair of the committee.
5. The letter containing the final decision to the practitioner must inform the practitioner:
 - a) about his/her avenue of appeal through a credentialing and SoCP appeal committee; and
 - b) that a request for appeal is to be lodged within 20 business days of the date of receipt by the practitioner of the decision maker's letter advising of the final decision; and
 - c) to whom that request for appeal should be addressed.
6. If the practitioner does not submit an application for appeal of the final decision within the set timeframe, the decision maker will issue a new SoCP as recommended by the committee.
7. If SoCP has been reduced or revoked on the grounds of patient safety, the decision maker must advise in writing to the Medical/Dental Board of Australia through the state manager and AHPRA (Queensland office).

8. All decisions made by the decision maker and reasons for the decision must be documented at the first scheduled committee meeting after the decision was made.

11. Reduction of services bought about by the Hospital and Health Service and/or the public health facility

Following extensive consultation with the relevant practitioner(s) and other stakeholder(s), a HHS/DoH division may reduce or terminate a practitioner's SoCP at a public health facility due to:

- the public health facility no longer has the ability to clinically support the practitioner's SoCP
- the public health facilities CSCF has been redefined

When an HHS/DoH division considers redefining the CSCF or service delivery of a public health facility; consideration must be given to the impact on practitioners SoCP in consultation with the relevant credentialing committee.

The HSCE/DoH division CE must notify the credentialing committee of the impending reduction of services.

Prior to implementation, the committee will examine and redefine the SoCP of each practitioner working in the public health facility.

Within five business days of the change coming into effect, the decision maker, must advise the practitioner(s) of their amended SoCP and reasons for same.

12. Position responsibilities for credentialing committees

Refer to Appendix 7 for position responsibilities for credentialing committees.

Part 5: Appeal process

1. Purpose

This part identifies best practice with the appeal process and identifies the accountabilities and responsibilities of individual positions.

2. Supporting documents

Attachment A	Appeal Committee - model terms of reference
Appendix 9	Practitioners guide to preparing a written submission

3. Appeal process

The appeal process is instigated after all possibilities of resolution have been exhausted at the HHS/DoH division. These possibilities could include conducting an interim appeal phase such as an extraordinary credentialing committee meeting (at times previously referred to as an *Unscheduled Review*).

Where a practitioner is still aggrieved by the decision of the HSCE/DoH division CE under the health service directive/policy for *Credentialing and defining the scope of clinical practice*, the practitioner may appeal the decision.

The Office of the Principal Medical Officer conducts the appeal process and affords the aggrieved practitioner an independent review of the HSCE/DoH division CE decision only after all possible resolution processes have been undertaken at local level. The committee is time limited and sits only for the purpose of hearing an individual appeal.

This independent committee, established by the Office of the Principal Medical Officer has the expertise and support of specialised professionals such as the legal branch to assist with the appeal process in reaching a fair, transparent and non-biased decision when making their recommendation regarding the appeal to the appellant and the HSCE/DoH division CE

3.1 Applying principles of procedural fairness and justice

Practitioners are entitled to a fair hearing before any decision regarding their SoCP is made or implemented. Under the principles of natural justice and procedural fairness, all persons involved in making a recommendation under this part must:

- act fairly, in good faith and without bias or perception of bias
- ensure all relevant documents which are being considered by a decision maker or appeal committee are disclosed in a timely manner to the parties concerned
- ensure practitioners know what allegations or claims are made against them
- give practitioners sufficient time to prepare their response to those issues or claims that have been raised
- ensure practitioners are given the opportunity to adequately state their case and correct or contradict any statement prejudicial to their case

- declare any actual or perceived conflicts of interest and withdraw from deliberations regarding the relevant application.

3.2 Conflicts of interest

Examples of potential conflicts of interest in credentialing and defining the SoCP include, but are not limited to:

- situations where the committee member is a competitor with the practitioner under review and stands to benefit from any negative outcome for the practitioner under review
- situations where the committee member is related to a person in competition with the practitioner under review and that related person stands to benefit from any negative outcome for the practitioner under review
- situations where the committee member stands to benefit from a positive outcome for the practitioner under review, either because he or she hopes to obtain a similar positive outcome if his or her practice was under review, or because he or she will gain some benefit from the work of the practitioner under review
- situations where the committee member is related to, is in a relationship with or has a close personal friendship with, the practitioner under review.

4. Appeal

A practitioner whose SoCP has been terminated, suspended, reduced, denied or granted in a different form to that requested has the right to appeal against the HSCE/DoH division CE's final decision on their SoCP through a hearing of an appeal committee (refer to Part 1, Section 5.).

4.1 Appeal process

Steps in the appeal process to be followed include the following:

1. The appeal is commenced by the practitioner (appellant) making a request in writing to the HSCE/DoH division CE within 20 business days from the date of the receipt of the HSCE/DoH division CE's letter outlining the written decision regarding the practitioner's requested SoCP. The appellant must clearly articulate and individualise the grounds for his/her appeal and submit any associated evidence to support these grounds.
2. The HSCE/DoH division CE must, within 10 business days of receiving the written request, provide written notification to the Office of the Principal Medical Officer (chair of the appeal committee) that an appeal has commenced.¹³ The appeal committee must be convened by the chair within 20 business days of the date the notification is made by the HSCE/DoH division CE (see Attachment A for appeal committee terms of reference).

¹³ It is the responsibility of the HSCE/DoH division CE to ensure, where possible, reasons instigating an appeal including human resource and communication matters are resolved at HHS/DoH division level. The appeal option is only to be instigated when the local credentialing resolution options have reached an impasse.

3. If the appeal committee considers that, to assist in its decision-making it requires copies of patient records, then prior to accessing and disclosing any patient records, an 'Authority for Public Interest Disclosure of Information' pursuant to s.160 of the *Hospital and Health Boards Act 2011* is required to be approved in writing by the Director-General Queensland Health. NB: Section 142 of the *Hospital and Health Boards Act 2011* prohibits the disclosure of patient records by any designated person, which includes any current or former employee of Queensland Health or a HHS, to any other person, including another designated person, unless authorised under the Act.
4. If the appeal committee considers that, to assist in its decision making, it would be relevant to request a person to attend a meeting and present, or provide further information in writing, or ask that person questions as part of the process¹⁴ — whether that person be the appellant, the local credentialing committee chair, a EDMS, or one of the original decision makers—the appeal committee is able to make that request.

However, the following applies:

- Although the person may be requested by the appeal committee to provide information, either orally or in writing, to assist in the decision making process, there is no authority that compels the person to comply with the committee request.
 - To ensure natural justice, any information obtained by the committee must be provided to the appellant in a timely manner, for an opportunity to respond to that information, particularly if it is adverse information.
5. The appellant and the HSCE/DoH division CE must be advised at the same time (irrespective of the outcome of the appeal) and within 20 days of the appeal committee's last business day of the appeal hearing, which must include reasons for the decision and recommendations of the appeal committee.
The decisions and reasons of the appeal committee (the 'appeal committee') must be clearly documented and are reviewable under the *Judicial Review Act 1991 (Qld)*.
 6. At the completion of an appeal process the appeal will be closed. Ongoing matters that relate to the recommendations, for example, requirements for clinical supervision will be addressed by the HSCE for management.

5. Decision of the appeal committee

A decision of the appeal committee will be either:

- affirmation of the original decision regarding SoCP; or
- rejection of the original decision regarding SoCP; or
- alteration of the original decision regarding SoCP, which may include conditions.

¹⁴ Section 12(1)(g) page 61 of the *National Standard for Credentialing and Defining Scope of Clinical Practice*, July 2004, under the responsibility of the Australian Council for Safety and Quality in Health Care, recommends that an appeal committee:

'have available, for the purposes of providing information and clarifying the reasons for prior decision-making, the chairperson or another nominee of the committee responsible for credentialing and defining scope of clinical practice'

The appeal committee recommendation is then forwarded to the HSCE/DoH division CE for approval.

The appeal committee must provide reasons for their recommendation to the appellant within 20 business days of the last day of the appeal hearing.

If appropriate, the appeal committee may also make recommendations (providing reasons) to assist the practitioner to enhance their clinical competencies and enhance their prospects for a future successful application for an increased SoCP.

If the appeal committee holds in good faith a belief based on the evidence before the appeal committee, that the competence and/or current fitness to practice of the appellant is such that continuation of the right to practice in any circumstances would pose a significant risk to the life, health and safety of any person it must ensure that the matter is referred in a timely manner to the relevant HSCE/DoH division CE and professional registration board.

6. Position responsibilities for the appeal committee

Position	Responsibilities
Practitioner (Appellant)	<ul style="list-style-type: none"> • At all times act in good faith. • Ensure all information provided to the appeal committee is true and correct. • Ensure all requested information is provided to the appeal committee within the required timeframes to enable them to make an informed decision on credentials and SoCP. • Disclose the status of registration, including any conditions, past or present suspensions, reprimands or undertakings, limitation on SoCP by another public health facility or any other matter that the appeal committee could reasonably expect to be disclosed in order to make an informed decision on credentials and SoCP.
HSCE/DoH division CE	<ul style="list-style-type: none"> • Accountable for receiving notification and initiating the practitioners 'right to appeal' to the appeal committee. This accountability cannot be delegated. • Ensure all appeal processes within their HHS/DoH division are managed in accordance with local policy. • Ensure all relevant information is provided to the appeal committee. • Ensure the final recommendation of the appeal committee is formally communicated back to the HHS/division credentialing committee.
Chair of appeal committee	<ul style="list-style-type: none"> • Comply with the <i>Credentialing and defining the scope of clinical practice health service directive/policy</i>. • Abide by the terms of reference of the appeal committee. • Ensure appeal committee members conduct their responsibilities to a high standard and in a timely manner. • Ensure the appeal committee proceedings are conducted in private and members are advised they are compelled by strict confidentiality. • Ensure committee members remain on task and are not distracted by speculation or hearsay. • Ensure each appeal committee maintains complete records of the credentialing process for each decision and recommendation and ensures those records are available for audit and maintained as per the provisions of the 'General Retention and Disposal Schedule for Administrative Records'. • Ensure an 'Authority for Public Interest Disclosure of Information' pursuant to s.160 of the <i>Hospital and Health Boards Act 2011</i> is obtained in writing from the Director-General Queensland Health prior to accessing and disclosing any patient records that may be required for the appeal process. Section 142 of the <i>Hospital and Health Boards Act 2011</i> prohibits the disclosure of patient records by any designated person, which includes any current or former employee of Queensland Health or a HHS, to any other person, including another designated person. • Ensure each appeal committee member has completed training on the credentialing appeal process and understands their role and responsibilities as a member of the appeal committee. • Meetings of the appeal committee to be conducted as frequently as necessary to ensure timely progress of the appeal. • If appropriate, engage formal advice from the Legal Branch or Human Resource Services. • At the completion of the appeal, formally notify the appellant (and/or their legal representative if appropriate) of the final decision of the review.

- At completion of the appeal, formally notify the HSCE/DoH division CE of the final decision and recommendation/s of the review.

Appeal Committee members

- Comply with the *Credentialing and defining the scope of clinical practice* health service directive/policy.
- Complete training on the credentialing appeal process and understand the role and responsibilities of being a member of the appeal committee.
- Abide by the terms of reference of the appeal committee.
- Appreciate the consequence and gravity of the appeal process for the appellant and the HHS/DoH division.
- Recognise that the decision of the appeal committee is reviewable under the *Judicial Review Act 1991*.
- Provide independent advice regarding an application being reviewed by the appeal committee.
- Disclose any conflict of interest as per Part 5, Section 3.2.
- Disclose any present conditions or limitations with AHPRA.
- Must at all times act independently of the HSCE/DoH division CE.
- Fulfil responsibilities to a high standard and in a timely manner.

Attachment A: Appeal committee —model terms of reference

1. Membership of the appeal committee

The appeal committee is a specially convened independent committee. The committee is time limited and sits only for the purpose of hearing an individual appeal. The committee is established by the Principal Medical Officer, OPMO, and will have a minimum of five members from the following categories:

- principal medical officer, OPMO/delegate¹⁵(chair)
- a practitioner selected by the chair from a panel nominated by either the Queensland Branch of the Australian Medical Association or the Queensland Branch of the Australian Dental Association^{16 17} who:
 - is not an office-bearer, nor paid by that organisation
 - declares no conflict of interest in participating in the decision about the appellant
- a nominee fellow of the appropriate clinical college/area of speciality¹⁸ who practises in the field relevant to the SoCP being reviewed¹⁹
- an independent medical administrator (e.g. EDMS) from another HHS/DoH division
- a senior practitioner from another HHS who has no history of involvement in the initial process and brings to the committee specific healthcare expertise relevant to the appeal matter
- a relevant peer.

The chair will undertake such steps as necessary (including consultation where necessary) to be satisfied that each member of the appeal committee has the expertise, training and independence necessary to participate in the process and assess the decision being appealed. The chair has the sole discretion (after considering advice from appeal committee members) to determine whether a legal practitioner or a human resource manager is required to give advice to the appeal committee.

2. Length of appointments to the appeal committee

Members will be appointed for the duration of resolution of the matter under consideration in a timely manner.

¹⁵ Delegation would be enacted if there was a conflict of interest with the appeal application or if PMO was on leave and that leave may unnecessarily protract the appeal hearing.

¹⁶ This member may be a non-Queensland Health employee, and an application for indemnity would be considered on a case-by-case basis, subject to the same eligibility considerations that apply to a Queensland Health employee.

¹⁷ Indemnity for Queensland Health employees, HHS employees and other persons covered under Queensland Health or HHS Indemnity policies will be covered by the terms of those policies.

¹⁸ The Principal Medical Officer, OPMO, has the sole discretion to determine which clinical college is the most appropriate in any given appeal. As an example, when the committee considers an appeal for anaesthetic or surgical SoCP, the appropriate college would be the Royal Australian and New Zealand College of Anaesthetists or the Royal Australasian College of Surgeons respectively. In assessing a general medical practitioner's appeal for obstetric, anaesthetic, or surgical SoCP, the Royal Australian College of General Practitioners or the Australian College of Rural and Remote Medicine would also be invited to provide a nominee. For dentists, advice should be sought from dental schools.

¹⁹ As per above indemnity footnotes.

3. Frequency of meetings

The appeal committee will meet as necessary to ensure timely progress of the appeal to resolve the matter under consideration.

4. Role and function of the appeal committee

The appeal committee is responsible for considering appeals against decisions of the HSCE/DoH division CE, regarding matters of a practitioner's SoCP. The committee will consider appeal matters de novo.

An appeal conducted as an appeal de novo, means the appeal committee must re-consider the matter on appeal, including information provided by the practitioner for the original decision and information provided for the purpose of the appeal process, and not simply review the decision of the original decision maker. This may necessitate the committee extending beyond the bounds of the appellants stated grounds for appeal. The introduction of new information and/or material does not constitute a new application process.

During consideration of the appeal, the appeal committee must:

- invite the appellant whose credentials and/or SoCP are the subject of the appeal to submit any documents or information relevant to the appeal, and make written submission/s and have the option to support the written submission/s with an oral presentation to the appeal committee
- advise the appellant that should they wish to be accompanied by a legal representative or another support person during their presentation they must notify the appeal committee in writing at least five business days prior to the meeting. Legal representatives are present in an advisory capacity only, and may not advocate to the appeal committee on behalf of the practitioner
- if warranted, call for written or verbal comment from relevant practitioners and associations or colleges as to the clinical competence of the appellant.

In addition:

- the chair of the relevant HHS public health facility Credentialing Committee and relevant HSCE/DoH division CE may make written submissions for the purpose of providing information and clarifying the reasons for the prior decision-making. A copy of these submissions (and any other further information which may be submitted) is to be provided to the appellant by the appeal committee upon receipt of them by the appeal committee
- hearings of the appeal committee will be conducted in private and will be closed to persons not directly involved in the appeal hearing
- recommendations of the appeal committee will be by majority with the chair having the casting vote, if necessary
- the appeal committee has a duty of strict confidentiality
- presentations to the appeal committee may be recorded. Where this occurs, the presenter will be provided with a copy of the recording.

5. Recommendations of the appeal committee

A recommendation of the appeal committee will be either:

- affirmation of the original decision regarding SoCP;
- rejection of the original decision; or
- alteration of the original decision regarding SoCP, which may include conditions.

The appeal committee recommendation is then forwarded to the HSCE/DoH division CE for approval.

The appeal committee must provide reasons for their recommendation to the appellant within 20 business days of the last day of the appeal hearing. The appeal committee may also make recommendations (providing reasons) to assist the appellant to enhance their clinical competencies and enhance the prospects for a future successful application for an increased SoCP.

If the appeal committee holds in good faith a belief based on the evidence before the appeal committee, that the competence and/or current fitness to practice of the appellant is such that continuation of the right to practice in any circumstances would pose a significant risk to the life, health and safety of any person it must ensure that the matter is referred, in a timely manner, to the HSCE/DoH division CE, Director-General and relevant professional registration board.

6. Requirement to comply with principles of natural justice and procedural fairness

Appeal committee determinations and deliberations must be carried out in accordance with the principles of natural justice and procedural fairness. Any deliberations, determinations, decisions and reasons are reviewable under the *Judicial Review Act 1991 (QLD)*. Appellants are entitled to a hearing free of prejudice before any decision is made or implemented which affects the way in which they practice or are employed.

The committee in making its determination should also consider the length of time a practitioner may have 'not been practicing' due to the appeal process. If appropriate, this should be factored into the return to work decision.

NB: The appeal committee has an obligation to balance the needs of providing a timely, responsive appeal process and affording procedural fairness to the appellant. This includes providing all information to the appellant and providing the appellant sufficient time to prepare an informed response.

The principles of natural justice and procedural fairness are as follows:

- To act fairly, in good faith and without bias or perception of bias.
- To ensure all relevant documents considered by the appeal committee are disclosed in a timely manner to the parties concerned.
- To ensure the appellant is aware of all the allegations/claims made against them.
- To provide the appellant sufficient time to prepare their response to the issues or claims against them.

- To ensure the appellant is given the opportunity to adequately state their case and correct or contradict any statement prejudicial to their case.
- To ensure all members of the appeal committee declare any conflicts of interest and be excused by the chair from any deliberations regarding the relevant application.

Examples of where there are potential conflicts of interest in appeal process include:

- Situations where a committee member owns and/or manages a private practice/facility in which the appellant has a clinical practice.
- Situations where the committee member is in competition with the appellant and stands to benefit from any negative outcome for the appellant.
- Situations where the committee member is related to a person in competition with the appellant and that related person stands to benefit from any negative outcome for the appellant.
- Situations where the committee member stands to benefit from a positive outcome for the appellant, either because he or she hopes to obtain a similar positive outcome if his or her practice was under review, or because he or she will gain some benefit from the work of the appellant.
- Situations where the committee member is related to, is in a relationship with or has a close personal friendship with, the appellant.
- Situations where a member of the committee is in dispute with the appellant.

Processes for conflicts of interest:

- Declare conflicts of interest to the chair at the time of offer for an appointment to the appeal committee. The chair will determine whether to continue with the appointment. The chair may opt to seek legal opinion on the potential conflict of interest.
- When a member declares a real or potential conflict of interest after he/she has been appointed to an appeal committee, the member must not attend an appeal committee meeting until the appeal committee has determined whether a conflict of interest exists. The member must not take any action to influence the appeal committee's deliberations on whether a conflict of interest exists.
- Where a member becomes aware of a conflict of interest at an appeal committee meeting, he/she must physically leave the meeting. The member must not take any action to influence the appeal committee's deliberations on whether a conflict of interest exists.
- The reason for a member leaving the meeting must be clearly documented in the meeting minutes.
- If a member of the appeal committee is excused, the chair must determine whether the appeal committee can continue in discharging its functions without that member being replaced by an alternate. If an alternate is required, the chair has the authority to appoint another member.

7. Quorum

The quorum for the appeal committee shall be five members.

8. Documentation/written procedures

Any documents obtained or created by the appeal committee will be accessible under the *Right to Information Act 2009* (Qld) (subject to the exemptions specified in that Act) and other court processes, for example, subpoena.

The outcome of the appeal committee processes, including deliberations and minutes, will be stored and maintained and must be accessible as per the provisions of the General Retention and Disposal Schedule for Administrative Records.

9. Indemnity of appeal committee members

Members of the appeal committee are indemnified, or if a non-Queensland Health employee for example, a practitioner nominated by the Queensland Branch of the Australian Medical Association, may apply for indemnity in accordance with Queensland Health indemnity arrangements.²⁰

²⁰ Refer to appeal committee membership footnotes.

Appendix 1: Definition of terms

Term	Definition/explanation/details
Appellant	A practitioner appealing a decision of the HSCE/DoH division CE to the appeals committee
Applicant	An applicant is a medical practitioner or dentist who is not in an exempt category and is: <ul style="list-style-type: none"> • seeking to practise within a Queensland Health facility • subject to periodic or adhoc review of a pre-existing scope of clinical practice
Application	Application for granting of a SoCP, either new, review or additional/changed SoCP.
Appointment	The employment or engagement of a medical practitioner or dentist to provide services within a Queensland public health facility according to conditions defined by general law and supplemented by contract.
Approve	Unless stated otherwise in the specific condition of a delegation, the delegation to 'approve' a function includes the power to approve, amend or refuse approval as the delegate thinks necessary or expedient to the proper exercise or discharge of the power. Decisions by the delegate are to be in accordance with specific conditions of the delegation and processes stated in relevant legislation, policies and procedures. Refer to HR Delegation Manuals.
Authorised individual and/or bodies	Authorised individuals and bodies are defined as: <ul style="list-style-type: none"> • directors of medical services/oral health services • medical superintendents • directors of nursing • a relevant professional association • a medical staff association chair • head of the relevant clinical department • executive director • chief executive • Chief Information Officer • Deputy Director-General • HSCE • a regulatory authority (e.g. Medical/Dental Board, Office of the Health Ombudsman or Coroner). <p>Where a request for a review is made by a person other than such an 'authorised individual or body', that request will be considered and progressed as appropriate by the responsible executive director of medical services/director of oral health.</p>
Certification	Certification is a term that has been used to describe the process of verifying the truth of an individual's assertion or qualification.
Chief executive	The chief executive of a HHS or Queensland Health; or the following designations: <ul style="list-style-type: none"> • Deputy Director-General; • Chief Information Officer; • Chief Health Officer. For the purpose of this document, the terms are considered to be interchangeable.

Chief Health Officer	The person appointed as Chief Health Officer under Section 52 of the <i>Hospitals and Health Board Act 2011</i> .
Clinical governance	The systems by which the governing body, managers and clinicians share responsibility and are held accountable for patient or client care, minimising risks to consumers, and for continuously monitoring and improving the quality of clinical care. This is achieved by creating an environment in which there is transparent responsibility and accountability for maintaining standards and allowing excellence in clinical care to flourish.
Clinical practice	The professional activity undertaken for the purpose of investigating patient symptoms and preventing and/or managing illness, together with associated professional activities related to patient care.
Clinical privileges	Refer to definition of scope of clinical practice’.
Clinical Service Capability Framework	<p>The CSCF for public and licensed private health facilities provides a standard set of capability requirements for acute public health facility services provided by Queensland Health.</p> <p>Determination of clinical service capability is a process separate from credentialing that determines the minimum service, workforce and support service requirements and specific risk considerations that ensure clinical services are provided safely and are appropriately supported.</p>
Competence	The demonstrated ability to provide healthcare services at an acceptable level of safety and quality commensurate with the relevant profession. Competency is the combination of skills, knowledge, attitudes, values and abilities that support effective and/or superior performance in the professional’s practice role.
Continuing professional development (CPD)	<p>CPD and continuing medical education (CME) is the means by which medical practitioners and dentists maintain, develop, update and enhance their knowledge, skills and performance to ensure they deliver appropriate and safe care.</p> <p>CPD/CME includes, but is not limited to a range of activities to meet individual learning needs, including practice-based reflective elements, such as clinical audit, peer-review or performance appraisal, as well as participation in activities to enhance knowledge, such as courses, conferences and online learning.</p> <p>All colleges now provide CPD/CME programs. It is expected, at a minimum, that applicants will meet the requirements established by AHPRA and the colleges. For applicants who have obtained a Fellowship within the past 12 months, the Fellowship certificate will be considered to be sufficient evidence of CPD at the time of application only.</p>
Credentials	<p>Credentials are the documentation an applicant presents for consideration when applying for a job. This typically includes:</p> <ul style="list-style-type: none"> • professional education and degrees • professional registration and accreditation • work history • continuing professional development activities • references • health status.
Credentialing	The formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality healthcare services within specific organisational environments.

Credentialing committee	A committee whose members have the skills, knowledge and experience to determine an applicant's SoCP. The credentialing committee examines completed SoCP applications and accompanying credentialing documentation and recommends to the HSCE/Deputy Director-General or delegate an appropriate SoCP consistent with the individual practitioner's competence, training, performance and professional standing and within the CSCF of a public health facility.
Decision maker	The term 'decision maker' is used in this guide to reflect the position of authority, the person who can approve the SoCP within the HHS/DoH division. Delegation of responsibilities is outlined in Part 1, Section 4. Some delegations are specifically detailed within the document.
Dentist	For the purpose of this guide, a dentist is a practitioner engaged in independent practice or under supervision prescribed by registration. This includes the classes of dentists listed in Section 2.1.
Department of Health	Collectively the Office of the Director-General, System Policy and Performance Division, Health Service and Clinical Innovation Division, System Support Services Division, Health Services Information Agency and Health Services Support Agency.
Deputy director of medical services	Medical officer who reports to the executive director of medical services and carries out some of the executive director's functions on their behalf. The position may be variously titled as deputy medical superintendent, deputy executive director of medical services or other variant. For the purpose of this document, the terms are considered to be interchangeable.
Director of oral health	The director of oral health is the senior dentist within the management group of a HHS oral health service who is charged with the professional leadership of dental staff. The position may be variously titled as executive director of oral health, director of oral health, or in some cases, principal dentist. For the purpose of this document, the terms are considered to be interchangeable.
Director of clinical governance	This term refers to the officer, however titled, who has responsibility for clinical governance for that service.
Director of nursing	The senior nursing officer within a public health service facility who is charged with the professional leadership of nursing staff. The position may be variously titled as director of nursing, nursing director or other variant. For the purpose of this document, the terms are considered to be interchangeable.
Executive director of medical services	<p>The executive medical officer within the management group of a health service who has responsibility for the professional leadership and the clinical governance of medical services across a HHS.</p> <p>The position may be variously titled as medical superintendent, director of medical services or other variant. For the purpose of this document, the terms are considered to be interchangeable.</p> <p>In the case of the HSSA, this function is discharged by the senior pathologist, Pathology Queensland.</p>
Executive director of nursing	<p>The executive nursing officer within the management group of a health service who has responsibility for the professional leadership and the clinical governance of nursing services across a HHS.</p> <p>The position may be variously titled as executive director of nursing, director of nursing and midwifery or other variant. For the purpose of this document, the terms are considered to be interchangeable.</p>
External contracted service	Includes, but is not limited to, non-government organisations (NGO's), on-site or off-site radiology services and national and state programs.

Facility	Public sector health service facility means a facility at which public sector health services are provided.
Formal supervision	A supervision relationship that is formalised within an agreed document. For example, Medical Board of Australia— <i>Supervised Practice Plan</i> .
Governance	The set of relationships and responsibilities established by a HHS between its executive, workforce and stakeholders (including consumers). Governance incorporates the set of processes, customs, policy directives, laws, and conventions affecting the way a health service organisation is directed, administered or controlled. Governance arrangements provide the structure through which the corporate objectives (social, fiscal, legal and human resources) of the HHS are set and the means by which the objectives are to be achieved. They specify the mechanisms for monitoring performance. Effective governance provides a clear statement of individual accountabilities within the organisation to help align the roles, interests and actions of different participants in the health service organisation to achieve the organisation's objectives. In these standards, the term governance includes both corporate and clinical governance.
Hospital and Health Service	Hospital and Health Service means a Hospital and Health Service as defined within the <i>Hospital and Health Boards Act 2011</i> , and has legal status as provided for under s.18 of the <i>Hospital and Health Boards Act 2011</i> .
Hospital and Health Service chief executive	The manager of the HHS in which the medical practitioners and dentists are primarily engaged to undertake the clinical management of patients or to provide associated clinical services. Appointed under section 33 of the <i>Hospital and Health Boards Act 2011</i>
Health Service Directive	Division 2, Section 47 of the <i>Hospital and Health Boards Act 2011</i> authorises the Chief Executive of the Department of Health to issue Health Service Directives to HHSs—compliance is mandatory for all HHSs. Policy for the purpose of this document, the term is considered to be interchangeable. Refer to Policy definition.
Induction	The process by which employees are introduced to their new immediate work unit and environment, including local policies, standards, safe work procedures, administrative procedures, and training in relevant systems. It also includes mandatory training. Some topics may be common to orientation and induction, requiring both local and broader application.
Locum	An appropriately registered medical practitioner or dentist who is engaged on a temporary basis to meet a special need for a period of time.
Medical practitioner	For the purposes of this guide, a medical practitioner is a practitioner engaged in independent practice or under supervision prescribed by registration. This includes the classes of medical practitioner listed in Section 2.1.
Medical Superintendent	Refer to Executive director of medical services above.
National Safety and Quality Health Service Standards	National Safety and Quality Health Service Standards – September 2011: Standard 1.10. Australian Commission on Safety and Quality in Health Care.
Orientation	A formal process of informing and training staff on entry into a position or public health facility, covering the policies, processes and procedures applicable to that health service organisation. This includes the mission, strategic objectives, structure and scope of operations.
Peer consultation	Involves supportive and problem solving discussions between peers in which suggestions and information can be exchanged. While peers can

be in a formal supervision relationship, peer consultation typically implies bilateral or multilateral relationships for mutual support without formal processes for evaluation of practice skills.

Performance appraisal and development plan	A performance appraisal and development plan is used to help an employee meet the expectations of the organisation in terms of their work. It includes discussion of strengths and weaknesses, as well as strategies to improve these. This includes the identification of any training and personal development needs the employee may have to help him or her carry out their work effectively.
Policy	Policy, in this guide and unless otherwise specified, is the <i>Credentialing and defining scope of clinical practice</i> policy; a document that sets out the Department of Health's intent to achieve a particular outcome. Compliance with the <i>Credentialing and defining scope of clinical practice</i> policy is mandatory for all Department of Health staff in divisions and commercialised business units as specified in the document's scope.
Practitioner	For the purpose of this guide the term practitioner refers to a medical practitioner and or dentist.
Public health facility	A public health facility in this guide refers to a Queensland Health or HHS facility which provides definitive inpatient and/or ambulatory care to clients of Queensland Health. There are a range of names used which describe these public health facilities but are not restricted to: <ul style="list-style-type: none"> • hospital • hospice • multipurpose health service • healthcare centre/health service centre/community health centre • outpatients clinic • residential aged care public health facility/public mental health facility • fixed and mobile Queensland Health dental clinics.
Queensland Health	Queensland Health is the State department as named in the Administrative Arrangements Order (No.2) 2013 under the <i>Constitution of Queensland 2001</i> that administers legislation relevant to health in Queensland under the Minister for Health and the Director-General of Queensland Health.
Queensland public health system	Means: <ul style="list-style-type: none"> (i) the Department of Health, Queensland; and (ii) the Hospital and Health Services as detailed at section 8 of the <i>Hospital and Health Boards Act 2011</i> .
Registration	A medical practitioner's and dentist's professional registration is determined by AHPRA. The two applicable regulatory authorities are the Medical and Dental Boards of Australia.
Scope of clinical practice	Defining the SoCP (previously known as 'clinical privileges') follows on from credentialing and involves delineating the extent of an individual practitioner's clinical practice within a particular public health facility. This definition is based on the individual's credentials, competence, performance and professional suitability, and the needs, capability and capacity of the public health facility to support the practitioner's SoCP. <p>The SoCP is specific to the individual in that public healthcare facility, and necessarily relates to the resources, equipment and staff available at the public health facility. A practitioner's SoCP at various public health facilities and services may vary and needs to be defined specific to each health service as defined by the CSCF. Granting a SoCP to additional practitioners should not threaten the ability of existing staff to have the practice volume necessary to maintain clinical competence.</p>

Telehealth

The use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance.

Telehealth may include such technologies as telephones, facsimile machines, electronic mail systems, live interactive video link and remote patient monitoring devices which are used to collect and transmit patient data for monitoring and interpretation.

Appendix 2: Acronyms used in this guide and its attachments

AHPRA	Australian Health Practitioner Regulation Agency
AMC	Australian Medical Council
CE	Chief executive
CME	Continuing medical education
CPD	Continuing professional development
CSCF	Clinical service capability framework
DOH	Director of oral health
EDMS	Executive director of medical services
FRACGP	Fellowship of the Royal Australian College of General Practitioners
GP	General practitioner
HHS	Hospital and Health Service
HSCE	Health service chief executive
HSD	Health service directive
MBA	Medical Board of Australia
MO	Medical officer
MOPS	Maintenance of professional standards
MORPP	Medical officer with right of private practice
MSRPP	Medical superintendent with right of private practice
PDP	Professional development program
RMO	Resident medical officer
RRCSU	Rural and Remote Clinical Support Unit
SMO	Senior medical officer
SoCP	Scope of clinical practice
VMO	Visiting medical officer
QHEPS	Queensland health electronic publishing site

Appendix 3: Supporting and related documents

Related or governing legislation, policy and agreements as amended or replaced

- *Anti-Discrimination Act 1991* (Qld)
- *Criminal Law (Rehabilitation of Offenders) Act 1986* (Qld)
- *Guardianship and Administration Act 2000* (Qld)
- *Health Ombudsman Act 2013* (Qld)
- *Hospital and Health Boards Act 2011* (Qld)
- *Hospital and Health Boards Regulation 2012* (Qld)
- *Judicial Review Act 1991* (Qld)
- *Public Service Act 2008* (Qld)
- *Public Service Regulation 2008* (Qld)
- *Right to Information Act 2009* (Qld)
- *The Health Practitioner Regulation National Law Act 2009* (Qld)
- *Witness Protection Act 2000* (Qld)
- Recruitment and Selection Human Resources Policy B1 (QH-POL-212)
- Citizenship, Residency and Visa Requirements for Appointment in Queensland Health Human Resources Policy B55 (QH-POL-112)
- Employees to Notify Supervisor if Charged with or Convicted of an Indictable Offence Human Resources Policy E4 (QH-POL-127)
- Mental or Physical Incapacity of Employees Human Resources Policy E11 (QH-POL-170)
- Indemnity for Queensland Health Employees and Other Persons Human Resources Policy I3 (QH-POL-152)
- Indemnity for Queensland Health Medical Practitioners Human Resources Policy I2 (QH-POL-153)

Supporting documents

- Australian Commission on Safety and Quality in Health Care, *Safety and Quality Improvement Guideline October 2012*, Standard 1: Governance for Safety and Quality in Health Service Organisations
www.safetyandquality.gov.au/wp-content/uploads/2012/10/Standard1_Oct_2012_WEB1.pdf
- National *Standard for Credentialing and Defining the Scope of Clinical Practice 2004*
www.safetyandquality.gov.au/wp-content/uploads/2012/01/credenti.pdf
- AHPRA, *Recency of Practice Registration Standard* relevant to the professions
www.ahpra.gov.au
- Clinical Service Capability Framework for Public and Licensed Private Health Facilities V3.1 2014. <http://www.health.qld.gov.au/cscf/default.asp>

Appendix 4: Application for scope of clinical practice form

Queensland Health



Application for Scope of Clinical Practice

NB: Information included on this application is for Medical Practitioners and Dentists requiring credentialing and Scope of Clinical Practice (SoCP). The information requested on this application form is additional to information contained within your current Curriculum Vitae (CV). Access to this information is limited to the credentialing committee, appeals committee, any level of decision maker within these processes and administration staff associated with the credentialing process.

Type of application: New Application Renewal Application
 Additional / Changed SoCP Application

Facility/ies or Hospital & Health Service/s where SoCP requested:

--

Specific facility/ies Multi Hospital and Health Services Statewide SoCP

Personal Details	
First name:	Middle name:
Last name:	
Preferred name:	
Previous name:	

(Please include your previous name if that appears on certificates)

Date of birth:	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
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Contact Details		
Home address: <input type="checkbox"/> Preferred address for correspondence	Practice address: <input type="checkbox"/> Preferred address for correspondence	
Phone:	Fax:	Mobile:
Email (1):		
Email (2):		

Professional / Medical Indemnity *(please attach)*

Current medical indemnity insurance? Yes No Queensland Health

Insurance company	Category of coverage	Expiry date

Continuing Education and Quality Activities

It is a requirement of the Medical and Dental Boards of Australia that all practitioners undertake Continuing Medical Education (CME) / Continuing Professional Development (CPD) activities as a condition of registration. You must provide evidence of participation in CPD programs and activities consistent with the Board approved standards. If you are not participating in a CPD program then current evidence (last three years) of participation in alternative CPD activities will be required.

NB: For applicants who have obtained a fellowship within the past 12 months, the fellowship certificate will be considered to be sufficient evidence of CPD.

Are you undertaking the requirements for continuing education, re-certification, etc required by the Medical / Dental Boards of Australia?

Yes – supporting documentation must be attached to this application ▼

College / Organisation / Program	Currently enrolled	Date completed <i>(if applicable)</i>

No – please explain ▼

Clinical Audit / Peer Review Activities

Do you subject your clinical work to quality activity mechanisms including clinical audit, peer review etc?

Yes – please describe ▼

Organisation	Type of activity	Frequency	Reports attached
<i>e.g. M&M Meeting</i>	<i>e.g. Quality and Clinical Peer Review</i>	<i>e.g. Monthly</i>	

No – please explain ▼

Applicant's Declaration and Authorisation

I, make the following declarations and authorisations.

I will ensure that my professional registration with AHPRA remains current, and acknowledge that failure to do so will lead to suspension of employment and SoCP until rectified.

I will actively participate in Continuing Professional Development (CPD) relevant to the SoCP to which I have applied.

In applying for SoCP I agree to abide by the:

- **Code of Conduct for the Queensland Public Service**
<http://www.psc.qld.gov.au/includes/assets/qps-code-conduct.pdf>
- **QH Health Service Directive/Policy**
<http://www.health.qld.gov.au/directives/html/c.asp>
- **Hospital and Health Services and Department of Health Policies and Regulations**
<http://www.health.qld.gov.au/ghpolicy/html/index-c.asp>
- **Terms and conditions which are attached to my SoCP.**

Please respond to each of the questions below by ticking the appropriate box.	Yes	No
1. Have you ever had an adverse finding/s made against you by a medical/dental registration authority or any other professional, disciplinary or similar bodies, including outside Australia?		
2. Have you ever had conditions or undertakings attached to your registration or had your registration suspended or cancelled by a medical/dental registration authority or similar body, including overseas?		
3. Are you currently under investigation by a medical registration authority, other regulatory authority or health facility in Australia or overseas?		
4. Has your right to practice and/or scope of clinical practice ever been denied, restricted, suspended, terminated or otherwise modified by any health care organisation, health facility, learned college or other official body, including in Australia or overseas?		
5. Has a medical defence insurer of which you have been a member ever applied conditions or refused to renew your cover or membership in Australia or overseas?		
6. Do you have any physical or other medical conditions, including substance abuse, which may limit your ability to exercise the scope of clinical practice for which you have applied?		
7. Do you have any disclosable criminal convictions i.e. convictions as an adult that form part of your criminal history and which have not been rehabilitated under the <i>Criminal Law (Rehabilitation of Offenders) Act 1986</i> ? If you are unsure about the status of any criminal convictions which you have you may wish to seek legal advice in responding to this question.		

★ If you responded 'Yes' to any of the above questions, please attach a statement with details, dates and include any relevant documentation.

Details:

I undertake to immediately notify a medical administrator (e.g. EDMS, DMS, DDMS, Clinical Director, Department Head or Medical Manager), Director of Oral Health and the Chair of the Credentialing and SoCP Committee:

1. If I become aware that I have developed a condition which would affect my ability to safely provide care to my patients.
2. Of any changes to my Australian Health Practitioner Regulation Agency (AHPRA) registration.
3. Of any current or new undertakings given or conditions, endorsements, suspensions, reprimands or notations imposed on my registration by AHPRA.
4. If I cease engagement with QH or cease private practice at a QH facility or service.
5. If I experience a restriction, withdrawal or alteration of SoCP at another health care facility or service, whether public or private.
6. Of my annual membership details for personal medical indemnity insurance (if applicable).
7. When any other changes occur to my clinical circumstances that may impact on my granted SoCP.
8. If my contact details (i.e. home/business/email/phone details) change.
9. In accordance with my obligations under the *Public Service Act 2008 QLD* and the Human Resources Policy E4 (QH-POL-127) employees are to notify supervisor if changed with or convicted of an indictable offence.

I authorise Queensland Health and its officers and/or agencies to:

- Obtain information from the Registration Body, Indemnity Insurance Organisation, Specialist College/s or Societies to which I am associated as nominated in this application, regarding the currency of my registration and/or membership of that body or organisation and regarding any other matter relevant to my application and ongoing SoCP.
- Verify details of this application with relevant individuals, external organisations, previous employer/s and to seek confidential references from nominated referees.

I declare that the facts and my response to this Application are accurate at time of application.

I fully understand that providing false information or documents may result in my SoCP not being granted, and may further result in my being subject to criminal charges and/or disciplinary action.

Print applicant name:	Print witness name:
Applicant signature:	Witness signature:
Date:	Date:

Application/Renewal Checklist

Attach a copy of your credentials (e.g. qualifications, CME/CPD, referee's reports, registration etc) which support your requested SoCP.

- Yes, photo identification attached
- Yes, current CV attached (signed and dated as true and correct – gaps in employment explained)
- Yes, base degree attached
- Yes, specialist qualifications attached
- Yes, training certification attached
- Yes, contacts for referees provided
- Yes, current CME/CPD evidence attached No, fellowship qualification less than 12 months old
- Yes, Professional Indemnity – certificate of currency attached (if applicable)

Scope of Clinical Practice Requested



- This list was compiled using current college reference sources, AHPRA specialties and fields of specialty practice not aligned with AHPRA registrations.
- Evidence of fellowship, training and currency of practice in the requested SoCP must be provided with the application.

AHPRA Registration Number:

- Specialist**
- General Registration**
- Limited Registration** (please state):

Addiction Medicine

Addiction Medicine

Anaesthesia

- Anaesthesia**
- Intensive Care for Anaesthetists
 - Diagnostic Perioperative Transoesophageal Echocardiography (TOE) in Adults
 - Extracorporeal Perfusion (ECP)
 - Neonatal
 - Transplant
 - Other (please state):

Breast Medicine

- Breast Medicine**
- Breast Imaging (interpretation of screening and diagnostic mammography)
 - Performance and interpretation of breast ultrasound
 - Image-guided interventional procedures

Dental Practice

- General Dental Practice**
- Treatment under general anaesthetic (in hospital operating theatre)
 - Relative Analgesia (using Nitrous Oxide and Oxygen)
 - Intravenous Sedation
- Specialist Dental Practice**
- | | | |
|--|--|---|
| <input type="checkbox"/> Endodontics | <input type="checkbox"/> Prosthodontics | <input type="checkbox"/> Oral and Maxillofacial Surgery |
| <input type="checkbox"/> Public Health Dentistry | <input type="checkbox"/> Oral Medicine | <input type="checkbox"/> Special Needs Dentistry |
| <input type="checkbox"/> Oral Pathology | <input type="checkbox"/> Forensic Odontology | <input type="checkbox"/> Oral Surgery |
| <input type="checkbox"/> Dento-Maxillofacial Radiology | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Paediatric Dentistry |
| <input type="checkbox"/> Periodontics | | |

Dermatology

Dermatology

Emergency Medicine

Emergency Medicine

Forensic Medicine

- Forensic Medical Officer**
- Government Medical Officer**

<p>General Practice</p> <p><input type="checkbox"/> General Practice <i>Unless otherwise specified, routine scope of clinical practice in General Practice includes all primary care areas including geriatrics, paediatrics, palliative care, antenatal care, psychiatry, internal medicine, closed orthopaedics, care of health service inpatients and patients in QH Residential Aged Care Facilities, emergency care, primary and outpatient care.</i></p> <p>Specify any exclusions:</p>
<p>General Practice Advanced Specialised Skills</p> <p>If requesting Scope of Clinical Practice in an Advanced Specialised Skill, please include for the Committee's consideration:</p> <ul style="list-style-type: none"> • Evidence of any certified post graduate training in the advanced skill. • Evidence of recent relevant experience e.g. log books. • Evidence of recent CME/CPD and upskilling in the advanced skill. • A reference commenting on recent competence in the advanced skill. <p>OR</p> <ul style="list-style-type: none"> • Without formal training – evidence of substantial recent relevant experience, evidence of CME, upskilling within the past 3 years and copies of relevant documents to support your requested Scope of Clinical Practice e.g. log books. <p><input type="checkbox"/> Obstetrics (DRANZCOG Advanced)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Perform normal deliveries, assisted deliveries (excluding Keilland's forceps) and caesarean sections <input type="checkbox"/> Perform basic elective and emergency gynaecological procedures including laparotomies in emergency gynaecological situations <input type="checkbox"/> Operative Laparoscopy (Level 1) <input type="checkbox"/> Colposcopy <p><input type="checkbox"/> Anaesthetics (JCCA)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Adults <input type="checkbox"/> Children – state minimum age or weight: <input type="checkbox"/> Epidural Anesthesia <p><input type="checkbox"/> Rural Generalist Surgery (24 months advanced skill training with ACRRM)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Attached list of specific procedures <p><input type="checkbox"/> Aboriginal and Torres Strait Islander Health (12 months advanced skill training with RACGP or ACRRM)</p> <p><input type="checkbox"/> Adult Internal Medicine (12 months advanced skill training with ACRRM)</p> <p><input type="checkbox"/> Child and Adolescent Health / Paediatrics (12 months advanced skill training with RACGP or ACRRM)</p> <p><input type="checkbox"/> Generalist Emergency Medicine (18 months post FACRRM training)</p> <p><input type="checkbox"/> GP Emergency Medicine (12 months advanced skill training with RACGP or ACRRM)</p> <p><input type="checkbox"/> Mental Health (12 months advanced skill training with RACGP or ACRRM)</p> <p><input type="checkbox"/> Population Health (12 months advanced skill training with ACRRM)</p> <p><input type="checkbox"/> Remote Medicine (12 months advanced skill training with ACRRM)</p> <p><input type="checkbox"/> Gastroscopy (GESA Certification)</p> <p><input type="checkbox"/> Colonoscopy (GESA Certification)</p> <p><input type="checkbox"/> Other (please state):</p>
<p>Intensive Care Medicine</p> <p><input type="checkbox"/> Intensive Care Medicine</p> <ul style="list-style-type: none"> <input type="checkbox"/> Echocardiography <input type="checkbox"/> Gastrointestinal Endoscopy <input type="checkbox"/> Extracorporeal Membrane Oxygenation (ECMO) <input type="checkbox"/> Other (please state):
<p>Medical Administration</p> <p><input type="checkbox"/> Medical Administration</p> <p><input type="checkbox"/> Clinical Administration in (please state):</p>

Obstetrics and Gynaecology
<input type="checkbox"/> Obstetrics and Gynaecology <input type="checkbox"/> Advanced Operative Laparoscopy Level 4 <input type="checkbox"/> Advanced Operative Laparoscopy Level 5 <input type="checkbox"/> Advanced Operative Laparoscopy Level 6 <input type="checkbox"/> Advanced Endoscopic Surgery <input type="checkbox"/> Lower Genital Tract Laser Surgery <input type="checkbox"/> Robotic Surgery Subspecialties <input type="checkbox"/> Gynaecological Oncology <input type="checkbox"/> Maternal-Fetal Medicine <input type="checkbox"/> Urogynaecology <input type="checkbox"/> Obstetrics and Gynaecological Ultrasound <input type="checkbox"/> Reproductive Endocrinology and Infertility Extra Training <input type="checkbox"/> Paediatric Gynaecology <input type="checkbox"/> Video Colposcopy of Children
Occupational and Environmental Medicine
<input type="checkbox"/> Occupational & Environmental Medicine
Ophthalmology
<input type="checkbox"/> Ophthalmology <input type="checkbox"/> Post Fellowship Training (please state):
Paediatrics and Child Health
<input type="checkbox"/> General Paediatrics and Child Health
<input type="checkbox"/> Child Protection <input type="checkbox"/> Level 2 – Medical staff working predominantly with children, young people and parents <input type="checkbox"/> Level 3 – Designated medical child protection practitioner
<input type="checkbox"/> Clinical Genetics (Paediatric)
<input type="checkbox"/> Community Child Health
<input type="checkbox"/> Neonatology and Perinatal Medicine <input type="checkbox"/> Echocardiography <input type="checkbox"/> Ultrasound <input type="checkbox"/> Other (please state):
<input type="checkbox"/> Paediatric Cardiology <input type="checkbox"/> Transthoracic Echocardiography <input type="checkbox"/> Transoesophageal Echocardiography <input type="checkbox"/> Fetal Echocardiography <input type="checkbox"/> Paediatric Cardiac Catheterisation – Level 1 Procedures <input type="checkbox"/> Paediatric Cardiac Catheterisation – Level 2 Procedures <input type="checkbox"/> Paediatric Cardiac Catheterisation – Level 3 Procedures <input type="checkbox"/> Paediatric Cardiac Catheterisation – Level 4 Procedures
<input type="checkbox"/> Paediatric Clinical Pharmacology
<input type="checkbox"/> Paediatric Emergency Medicine
<input type="checkbox"/> Paediatric Endocrinology
<input type="checkbox"/> Paediatric Endocrinology and Chemical Pathology
<input type="checkbox"/> Paediatric Gastroenterology and Hepatology <input type="checkbox"/> Liver Biopsy <input type="checkbox"/> Endoscopic Retrograde Cholangiopancreatography (ERCP) <input type="checkbox"/> Gastroscopy <input type="checkbox"/> Endoscopic Ultrasound (EUS) <input type="checkbox"/> Colonoscopy Balloon Enteroscopy <input type="checkbox"/> Capsule endoscopy <input type="checkbox"/> Other endoscopy (please state):

Paediatrics and Child Health continued
<input type="checkbox"/> Paediatric Haematology
<input type="checkbox"/> Paediatric Haematology and Pathology
<input type="checkbox"/> Paediatric Immunology and Allergy
<input type="checkbox"/> Paediatric Immunology, Allergy and Immunopathology
<input type="checkbox"/> Paediatric Infectious Diseases
<input type="checkbox"/> Paediatric Infectious Diseases and Microbiology
<input type="checkbox"/> Paediatric Intensive Care Medicine
<input type="checkbox"/> Paediatric Medical Oncology
<input type="checkbox"/> Paediatric Nephrology <input type="checkbox"/> Renal Biopsy <input type="checkbox"/> Acute Vascular Access <input type="checkbox"/> Peritoneal Access Placement
<input type="checkbox"/> Paediatric Neurology
<input type="checkbox"/> Paediatric Nuclear Medicine
<input type="checkbox"/> Paediatric Palliative Medicine
<input type="checkbox"/> Paediatric Rehabilitation Medicine
<input type="checkbox"/> Paediatric Respiratory and Sleep Medicine <input type="checkbox"/> Paediatric Bronchoscopy
<input type="checkbox"/> Paediatric Rheumatology
Pain Medicine
<input type="checkbox"/> Pain Medicine
Palliative Medicine
<input type="checkbox"/> Palliative Medicine <input type="checkbox"/> Paracentesis and Thoracocentesis
Pathology
<input type="checkbox"/> General Pathology
<input type="checkbox"/> Anatomical Pathology
<input type="checkbox"/> Anatomical Pathology and Cytopathology
<input type="checkbox"/> Chemical Pathology
<input type="checkbox"/> Haematology
<input type="checkbox"/> Immunology
<input type="checkbox"/> Microbiology
<input type="checkbox"/> Forensic Pathology
<input type="checkbox"/> Other Postgraduate Programs <input type="checkbox"/> Clinical Pathology <input type="checkbox"/> Genetic Pathology <input type="checkbox"/> Molecular Pathology <input type="checkbox"/> Paediatric Pathology <input type="checkbox"/> Neuropathology

Physician	
<input type="checkbox"/>	General Medicine
<input type="checkbox"/>	Participation in acute undifferentiated medical services
<input type="checkbox"/>	Echocardiography
<input type="checkbox"/>	Gastroscopy
<input type="checkbox"/>	Colonoscopy
<input type="checkbox"/>	Liver Biopsy
<input type="checkbox"/>	Bronchoscopy
<input type="checkbox"/>	Obstetric Medicine
<input type="checkbox"/>	Other (please state):
<input type="checkbox"/>	Cardiology
<input type="checkbox"/>	Adult Echocardiography
<input type="checkbox"/>	Level 1 – Transthoracic Echocardiography
<input type="checkbox"/>	Level 2 – Transoesophageal Echocardiography
<input type="checkbox"/>	Level 3 – Stress Echocardiography
<input type="checkbox"/>	Cardiac Implantable Electronic Devices (CIED) and Electrophysiology
<input type="checkbox"/>	Track 1 – Cardiac Implantable Electronic Devices
<input type="checkbox"/>	Track 2 – Cardiac Implantable Electronic Devices
<input type="checkbox"/>	Adult Cardiac Electrophysiology
<input type="checkbox"/>	Coronary Angiography
<input type="checkbox"/>	Diagnostic Cardiac Catheterisation and Coronary Angiography
<input type="checkbox"/>	Percutaneous Coronary Intervention (PCI)
<input type="checkbox"/>	Level 2 – Stress Echocardiography
<input type="checkbox"/>	CT Coronary Angiography (CTCA) Level A Specialist
<input type="checkbox"/>	CT Coronary Angiography (CTCA) Level B Specialist
<input type="checkbox"/>	Lead Extraction Certification
<input type="checkbox"/>	Clinical Genetics
<input type="checkbox"/>	Clinical Pharmacology
<input type="checkbox"/>	Endocrinology
<input type="checkbox"/>	Endocrinology and Chemical Pathology
<input type="checkbox"/>	Gastroenterology and Hepatology (attach GESA / Conjoint Committee Certificate if applicable)
<input type="checkbox"/>	Liver Biopsy
<input type="checkbox"/>	Endoscopic Retrograde Cholangiopancreatography (ERCP)
<input type="checkbox"/>	Gastroscopy
<input type="checkbox"/>	Balloon Enteroscopy
<input type="checkbox"/>	Colonoscopy
<input type="checkbox"/>	Capsule Endoscopy
<input type="checkbox"/>	Endoscopic Ultrasound (EUS)
<input type="checkbox"/>	Other endoscopy (please state):
<input type="checkbox"/>	Geriatric Medicine
<input type="checkbox"/>	Haematology
<input type="checkbox"/>	Haematology and Pathology
<input type="checkbox"/>	Clinical Immunology and Allergy
<input type="checkbox"/>	Clinical Immunology, Allergy and Immunopathology
<input type="checkbox"/>	Infectious Diseases
<input type="checkbox"/>	Infectious Diseases and Microbiology
<input type="checkbox"/>	Medical Oncology
<input type="checkbox"/>	Nephrology
<input type="checkbox"/>	Renal Biopsy
<input type="checkbox"/>	Peritoneal Access Placement
<input type="checkbox"/>	Acute Vascular Access

Appendix 5: General referee report

Queensland Health



General Referee Report

Referee Report for Credentialing and Scope of Clinical Practice Application

Referee's name:	
Referee's position:	
Applicant's name:	
Scope of Clinical Practice requested:	
1. Professional Relationship	
How long have you known the applicant?	
In what professional capacity have you known the applicant?	
When was your last professional contact with the applicant?	
Can you comment on the nature of the practice and patient population (gender, age, range of presentations) encountered in the professional practice of the applicant?	
2. Clinical Skills and Knowledge Base <i>(please rate the applicant's skills, as listed below)</i>	
History-taking, physical examination and presentation of findings:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor <input type="checkbox"/> Not observed
Clinical judgement and decision-making skills:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor <input type="checkbox"/> Not observed
Medical record-keeping skills:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor <input type="checkbox"/> Not observed
Procedural skills (considering applicant's level of experience):	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor <input type="checkbox"/> Not observed
Additional general comments on clinical skills and knowledge base in the applicant's requested scope of clinical practice.	
Please comment on the applicant's participation in CPD activities related to the requested scope of clinical practice.	
3. Work Ethic / Reliability / Punctuality <i>(please rate the applicant's skills, as listed below)</i>	
Punctuality and reliability (completion of set tasks on time):	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor <input type="checkbox"/> Not observed
Organisational skills:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor <input type="checkbox"/> Not observed
Initiative:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor <input type="checkbox"/> Not observed
Additional comments on work ethic, reliability and punctuality.	

4. Communication & Interpersonal Skills <i>(please rate the applicant's skills, as listed below)</i>	
Promptness and clarity of discharge summaries and letters:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor <input type="checkbox"/> Not observed
Communication and rapport with patients and families:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor <input type="checkbox"/> Not observed
Relationships with other health professionals:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Poor <input type="checkbox"/> Not observed
Additional comments on interpersonal skills.	
5. Employability	
Are you aware of any medical condition, mental or physical (including substance abuse or dependence), which might adversely affect the applicant's ability to competently and safely practice medicine or dentistry?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, please note the actions taken to address concerns e.g. referral to Medical / Dental Board</i>
Are you aware of any formal complaints, disciplinary or legal action against the applicant?	<input type="checkbox"/> Yes ▶ <i>provide details</i> <input type="checkbox"/> No
Would you consider this applicant for another position?	<input type="checkbox"/> Yes <input type="checkbox"/> No ▶ <i>provide details</i> <input type="checkbox"/> N/A
Would you entrust the clinical care of a family member to the applicant?	<input type="checkbox"/> Yes <input type="checkbox"/> No ▶ <i>provide details</i> <input type="checkbox"/> N/A
6. Conflict of Interest and Other Comments	
Do you have a personal relationship with the applicant or any conflict of interest in providing this reference?	<input type="checkbox"/> Yes ▶ <i>provide details</i> <input type="checkbox"/> No
Other comments you may wish to make (optional).	
7. Signature	
Name (please print):	Signature:
Position:	
Date:	

Appendix 6: Multi-Hospital and Health Service/DoH division statewide credentialing and scope of clinical practice list of services

Service	Entity/designation responsible for obtaining state wide SoCP approval	Applicable HHS/DoH division
BreastScreen Queensland Breast Imaging includes: radiologists, medical practitioners and senior medical practitioners providing state-wide services – SoCP Medical Imaging (Breast Screen, Breast imaging)	Chief Health Officer (Health Service and Clinical Innovation Division - HSCI)	State-wide
Cardiology	Metro North HHS, The Prince Charles Hospital	Statewide
Cardiac Indigenous Outreach Services	Metro North HHS, The Prince Charles Hospital	Statewide
Deadly Ears Program – paediatric ears, nose and throat, plus paediatric anaesthesia	Children’s Health Queensland HHS	Statewide
Flying obstetrician and gynaecologist, surgeon or anaesthetist	South West HHS, RRCSU	Central Queensland, Central West, Darling Downs, South West
Forensic medical officers, government medical officers	HSSA	Statewide
Forensic odontology	HSSA	Statewide
Forensic psychiatry	Metro North HHS, Royal Brisbane and Women’s Hospital	Statewide
General paediatrics	Children’s Health Queensland HHS	Statewide
General practice locums	Torres and Cape HHS, RRCSU	Statewide
General psychiatry associated with a statewide disaster response	Chief Health Officer, HSCI	Statewide
Genetics, adult (see Children’s Health Queensland for paediatric)	Metro North HHS, Royal Brisbane and Women’s Hospital	Statewide
Medical administration	Chief Health Officer, HSCI	Statewide
Medicine (including geriatrics), Medical Specialists Outreach Assistance Program	Metro South HHS, Princess Alexandra Hospital	Statewide
Nuclear medicine	Metro North HHS, Royal Brisbane and Women’s Hospital	Statewide

Off-site radiology reporting (teleradiology) services	HSCE/DoH division CEs	Statewide
Otolaryngology – ENT	Metro North HHS, Royal Brisbane and Women's Hospital	Statewide
Orthodontic advisory service and rural and remote dental services	Metro-South HHS	Statewide
Paediatric allergy and immunology	Children's Health Queensland HHS	Statewide
Paediatric anaesthesia	Children's Health Queensland HHS	Statewide
Paediatric dermatology	Children's Health Queensland HHS	Statewide
Paediatric endocrinology	Children's Health Queensland HHS	Statewide
Paediatric gastroenterology	Children's Health Queensland HHS	Statewide
Paediatric genetics	Children's Health Queensland HHS	Statewide
Paediatric haematology	Children's Health Queensland HHS	Statewide
Paediatric infectious diseases	Children's Health Queensland HHS	Statewide
Paediatric metabolic medicine	Children's Health Queensland HHS	Statewide
Paediatric nephrology	Children's Health Queensland HHS	Statewide
Paediatric neurosciences	Children's Health Queensland HHS	Statewide
Paediatric neurosurgery	Children's Health Queensland HHS	Statewide
Paediatric oncology	Children's Health Queensland HHS	Statewide
Paediatric ophthalmology	Children's Health Queensland HHS	Statewide
Paediatric orthopaedics	Children's Health Queensland HHS	Statewide
Paediatric otolaryngology – ears, nose and throat	Children's Health Queensland HHS	Statewide
Paediatric plastics and reconstructive surgery	Children's Health Queensland HHS	Statewide
Paediatric psychiatry	Children's Health Queensland HHS	Statewide
Paediatric radiology	Children's Health Queensland HHS	Statewide
Paediatric rehabilitation and cerebral palsy Health	Children's Health Queensland HHS	Statewide

Paediatric respiratory and cystic fibrosis	Children's Health Queensland HHS	Statewide
Paediatric rheumatology	Children's Health Queensland HHS	Statewide
Paediatric surgery	Children's Health Queensland HHS	Statewide
Pathology	HSSA	Statewide
Psychiatry provided through Medical Specialists Outreach Assistance Program	Metro-South HHS (PA Hospital)	Statewide
Retrieval services including Pre-hospital and Retrieval Medicine, Medical Coordination, Medical Coordination (Paediatric), Medical Coordination (Neonatal) and Retrieval Medicine (Grandfather Status)	Chief Health Officer, HSCI	Statewide
Queensland Ambulance Service performing retrieval services	Chief Health Officer, HSCI	Statewide
Royal Flying Doctor Service and non-government organisations – primary healthcare	Torres and Cape HHS, RRCSU	Statewide
Telehealth	HSCE/DoH division CEs	Statewide
Thoracic medicine	Metro North HHS, The Prince Charles Hospital	Statewide

Appendix 7: Position responsibilities for the credentialing committee

Position	Responsibilities
Applicant	<ul style="list-style-type: none"> • At all times act in good faith. • Information provided to the committee is true and correct. • Ensure all requested information is provided to the committee within the required timeframes to enable them to make an informed decision on credentials and SoCP. • Disclose the status of registration, including any conditions, past or present suspensions, reprimands or undertakings, limitation on SoCP by another public health facility or any other matter that the committee could reasonably expect to be disclosed in order to make an informed decision on credentials and SoCP.
Decision maker (refer to Part 1, Section 4)	<ul style="list-style-type: none"> • Ensure all practitioners within a HHS/DoH division are credentialed and granted SoCP in accordance with the <i>Credentialing and defining the scope of clinical practice</i> health service directive. • Establish a suitable number of credentialing committees which meets the needs of the HHS/DoH division. • Ensure committees conduct their responsibilities to a high standard and in a timely manner. • Ensure each committee maintains complete records of the credentialing process for each recommendation and ensures those records are available for audit. • On receipt of the recommendation/s from the committee, the decision maker should take into account any other relevant factors prior to making a decision regarding a SoCP. • Ensure a decision on SoCP is made within 10 business days of receipt of the committee's recommendation. • Ensure the letter advising the applicant of a decision made is sent to the applicant within a timely manner of the decision being made. • An interim SoCP approval will be for a period of not more than three calendar months and is not renewable. • Formal SoCP must be for a period not greater than five years. • Ensure the practitioner is informed of the capability of the services relevant to the practitioner's area of practice. • A SoCP granted by the decision maker is only valid within their HHS/DoH division. Exception being for certain services listed in Appendix 6.
Chair of credentialing committee	<ul style="list-style-type: none"> • Comply with the <i>Credentialing and defining the scope of clinical practice</i> health service directive/policy (refer to what do certain words used in this guide mean? page 8). • Abide by the Terms of Reference of the credentialing committee. • Provide independent advice to the decision maker. • Ensure committee members conduct their responsibilities to a high standard and in a timely manner. • Ensure each committee maintains complete records of the credentialing process for each recommendation and ensures those records are available for audit and maintained as per the provisions of the 'General Retention and Disposal Schedule for Administrative Records'.

- Ensure each core committee member has completed training on the HHS/DoH division credentialing process and understands their role and obligation as a member of the committee.
- Meetings of the committee should be conducted as frequently as necessary to ensure practitioners are reviewed on a timely basis.
- Convene an extraordinary meeting where a matter requires review prior to the next scheduled meeting of the committee.
- Distribute recommendations to the decision maker in a timely manner.

Credentialing committee members

- Comply with the *Credentialing and defining the scope of clinical practice* health service directive.
- Abide by the Terms of Reference of the committee.
- Provide independent advice regarding an application being reviewed by the committee.
- Fulfil responsibilities to a high standard and in a timely manner.
- Recommend an appropriate SoCP based on the information provided.
- Members will complete training on the HHS/DoH division credentialing process and understand their role and responsibilities as a member prior to sitting on the committee.

Appendix 8: Credentialing committee model— terms of reference

Terms of reference credentialing and defining the scope of clinical practice committee (the ‘Committee’)

1. Membership of the committee

The committee is responsible for considering an applicant’s credentials and requested scope of clinical practice (SoCP) and recommending to the decision maker (refer to Part 1, Section 4) a SoCP for the applicant. It is recommended that the committee should, as a minimum, be comprised of at least five members including:

- executive director of medical services (or their nominee) (EDMS), (director of oral health for dentist applicants) or an appropriate medical administrator on a non-hospital committee
- two other medical practitioners from separate clinical disciplines.²¹ These practitioners must possess the necessary knowledge, skills and experience to provide independent, high quality advice²²
- the director of nursing or their nominee or an appropriately qualified allied health professional
- for dentist applicants, a suitably qualified dentist.

At least one committee member is to be familiar with the requirements of the Queensland Health recruitment and selection process in accordance with the provisions of Human Resource Policy B1. Alternatively, have ready access at each meeting to a senior human resources professional with the relevant skills and experience.

The chair of the committee prior to each meeting will request in writing or in person the input/opinion from the applicant’s nominee or supervisor²³ if a relevant representative who practices in the field and speciality to the applicant is not a member of the committee.

The committee has the power to co-opt additional medical practitioners with specific clinical skills and experience relevant to the scope of clinical practice being requested.

2. Access to expert advice

The committee must access medical practitioners and dentist(s)²⁴ with the specific clinical skills and experience relevant to the SoCP being requested, including (but not limited to as appropriate):

- a nominee of a relevant professional college or association, accredited by the Australian Medical Council (AMC)

²¹ Participation may be either in person or by videoconference or teleconferencing.

²² All medical practitioners and dentists who are members of the core committee must have general or specialist medical/dental registration, with no disciplinary conditions or undertakings.

²³ Participation may be either in person or by videoconference or teleconferencing.

²⁴ The medical practitioner/dentist has the discretion to provide their opinion either in writing, via electronic mail, teleconference/videoconference or in person to the committee.

- a nominee from a non-AMC accredited body if that is the relevant peer
- a relevant supervisor, for example the director of the applicant's clinical department/unit
- if a nominee and/or supervisor is not able to attend the meeting, the chair will request their input/opinion in writing or in person prior to the meeting²⁵
- the EDMS from the practitioner's 'home' public health facility must provide input²⁶ into the deliberation
- the committee is empowered to access senior human resource advice, as appropriate.

3. Chair of the committee

The HSCE/DoH division CE or delegate will appoint the chair of the committee. The chair will generally be the EDMS or director of clinical governance.

The chair of the committee appoints credentialing committee members.

When the credentials of the chair are being reviewed, the chair will exempt himself/herself from the meeting and the HSCE/DoH division CE or delegate will appoint an acting chair. In other circumstances, the chair has the discretion to appoint an acting chair.

4. Quorum

A quorum includes a minimum of:

- two medical practitioners (one of whom must be the chair or his/her nominee),
- one senior dentist (for dentist applicants);
- the director of nursing or his/her nominee; plus
- one other member.

A quorum of not less than four members should be present for all deliberations of the committee, to provide continuity of process and decision making by the committee.

5. Length of appointments to the committee

Membership of the committee will be for a term of three years with no limit on subsequent appointments to the committee.

6. Frequency of meetings

This may be determined locally based on requirements and the volume of work of the committee, however meetings should occur on at least a monthly basis. The chair may convene an extraordinary meeting if a matter cannot reasonably wait for the next committee meeting.

7. Role and function of the committee

The committee must at all times conduct itself in accordance with relevant legislation, including, but not limited to legislation relating to privacy, equal opportunity, and defamation.

²⁵ Teleconferencing/videoconferencing can be used as a substitute for attendance in person

²⁶ Teleconferencing/videoconferencing can be used as a substitute for attendance in person

Each committee must obtain a written undertaking from each member of the committee that they will abide by the committee's terms of reference and procedures.

The committee will:

- follow the established terms of reference, written protocols and procedures for evaluation of credentials and defining the SoCP, as stipulated in the local credentialing and defining SoCP policy
- observe confidentiality throughout its processes
- assist each public health facility to ensure that clinical services are provided by competent medical practitioners and dentists in a clinical setting that supports the provision of safe, high-quality healthcare services
- ensure all members understand the role they bring to the committee which is expertise and experience and that they are not to act in a way that represents their personal interests
- produce a timetable for the periodic formal review and verification of the credentials and SoCP of all practitioners with existing appointments
- undertake the process of assessing credentials and recommending appropriate SoCP for new applicants
- determine specific criteria with reference to the health service capability framework, the resources and public health facilities available, and the recommendations of clinical colleges, where appropriate. These criteria will be used for determining a recommended SoCP for each application
- review scopes of clinical practice as soon as practicable on request, of existing employed practitioners who provide health services or clinical supervision within a public health facility, to ensure there is no administrative cause for a lapse in currency of a practitioner's SoCP.
- not recommend a SoCP on an incomplete application
- make recommendations to the HSCE/DoH division CE or delegate in respect of all medical practitioners and dentists whose SoCP have been considered
- ensure comprehensive records of all deliberations and recommendations of the committee are maintained for 70 years as per the provisions of the 'General Retention and Disposal Schedule for Administrative Records'. The accountable officer is the chair of the committee
- ensure that the credentialing and defining the SoCP process is conducted in a fair, transparent, timely and legally robust manner.

8. Requirement to comply with principles of natural justice and procedural fairness

The committee's determinations and deliberations must at all times be carried out in accordance with the principles of natural justice and procedural fairness. Any deliberations and determinations are reviewable under the *Judicial Review Act 1991*. Practitioners are entitled to a hearing free of prejudice before any decision is made or implemented which affects the way in which they practice or are employed. This principle should be particularly observed in relation to cases where potential termination/suspension or limitation of their SoCP is being considered.

The committee must, as a minimum, adhere to the following principles of natural justice and procedural fairness:

- To act fairly, in good faith and without bias or perception of bias.
- To ensure all relevant documents which are being considered by the committee are disclosed in a timely manner to the parties concerned.
- To ensure practitioners know what allegations/claims are made against them.
- To allow practitioners sufficient time to prepare their responses to the issues or claims against them.
- To ensure practitioners are given the opportunity to adequately state their case and correct or contradict any statement prejudicial to their case.

All members of the committee, on commencement, must declare any conflicts of interest and manage those in consultation with the chairperson.

Appropriate management may range from merely declaring the conflict, through to resignation from the committee.

- Examples of potential conflicts of interest in credentialing and defining the SoCP include:
 - situations where a committee member owns and/or manages a private practice/facility in which the applicant has a clinical practice
 - situations where the decision maker is in competition with the practitioner under review and stands to benefit from any negative outcome for the practitioner under review
 - situations where the decision maker is related to a person in competition with the practitioner under review and that related person stands to benefit from any negative outcome for the practitioner under review
 - situations where the decision maker stands to benefit from a positive outcome from the practitioner under review, either because he or she hopes to obtain a similar positive outcome if his or her practice was under review, or because he or she will gain some benefit from the work of the practitioner under review
 - situations where the decision maker is related to, is in a relationship with or has a close personal friendship with, the person under review
 - situations where a member of the committee is in dispute with the practitioner.
- When a member is recused he/she must physically leave the meeting, and must not take any action to influence the committee's deliberations.
- When a member is recused, the reason for that recusal should be documented in the minutes of the committee meeting.
- It is essential that any decision maker who is in competition or stands to benefit from any outcome of the proceedings declare that conflict, and manage it in a transparent and appropriate manner.

9. Documentation/written procedures

The committee, in consultation with the relevant HSCE/DoH division CE, must ensure that written procedures for dealing with the process of assessment of credentials and delineation of SoCP for medical practitioners and dentists are developed. These will be informed by local policy and procedure.

Any documents obtained or created by the committee will be accessible under the *Right to Information Act 2009* (subject to the exemptions specified in that Act) and other court processes, for example subpoena.

The outcome of the credentialing processes, including deliberations and minutes and the credentialed status of the practitioner, will be stored and maintained and must be accessible for at least 70 years as per the provisions of the 'General Retention and Disposal Schedule for Administrative Records'.

10. Education and training

On appointment, core committee members must be provided with an education and training package by the chair to assist them in their role on the committee. Members must be informed that their obligation is to bring experience and expertise, rather than to act as a representative of any nominating organisation.

11. Credentialing of committee members

Where the credentials and SoCP of any member of the committee are being considered, that member shall excuse themselves from participation in those deliberations.

12. Indemnity of committee members

Members of the committee are indemnified, in accordance with Queensland Health indemnity arrangements²⁷.

²⁷ Indemnity for Queensland Health employees, HHS employees and other persons covered under Queensland Health or HHS Indemnity policies will be covered by the terms of those policies. Where this member is a non-Queensland Health employee, an application for indemnity would be considered on a case-by-case basis, subject to the same eligibility considerations that apply to a Queensland Health employee.

Appendix 9: Practitioners guide to preparing a written submission

A guide for practitioners to prepare written submissions

As you move through the stages of the credentialing process, the review process or an appeal process there may be times when the relevant committee invites you to make a written submission. The written submission provides you with an opportunity to provide further supporting information.

Why does the committee ask for submissions?

The committee invites you to write a submission as it wants to fully understand all the circumstances regarding your SoCP before a decision is made. The committee also has an obligation to ensure that the process is fair to you and all other parties.

The committee may make a request for a written submission when the committee:

- is unclear about an aspect of your application
- seeks further information on SoCP which you have requested (e.g. a new technology is introduced)
- the committee is unclear or seeking further information about the review of your SoCP
- wants to fully understand all the circumstances around your request for appeal

Do you have to write a submission?

No. You are not required to provide a submission.

The submission you make may be oral or written, or both. Should you choose to provide a submission to the committee you are encouraged to provide a written submission in the first instance. You then have the option to support your written submission by an oral presentation to the committee. If the oral presentation is recorded you will be provided with a copy of the recording.

What happens if you don't write a submission?

While there is no obligation for practitioners to provide a response to issues raised by the committee, conclusions about your clinical practice and the subsequent decision of the committee are made from all the available information. If a written response is not provided, the committee will still be required to make a recommendation on the information that has been made available to the committee.

Preparing your submission

- Address each concern or matter raised—look at each concern or matter of the committee and consider if you can provide any additional information which will assist the committee to better understand your perspective.
- Include relevant information—only include information relevant to the issues identified by the committee. If you are unsure, include the information and explain why you think it is relevant.
- Provide evidence not anecdotes—provide objective evidence to support your statements. If you write, 'I have excellent clinical outcomes', try to provide additional information (e.g. your clinical management approach has led to fewer unplanned re-

admissions or lower infection rates for your patients). The information provided to the committee may assist you to demonstrate your point. Should you require additional clinical material you may approach the executive director of medical services or equivalent to request assistance with access to patient records for the purposes of preparing your submission.

- Consider the value of testimonials—if you include testimonials they should be relevant and specific to the issues before the committee and supported by evidence. Testimonials from colleagues are valuable if they address the matters before the committee and are not merely providing an endorsement of you as a person. Patient testimonials may be of limited value as credentialing and SoCP is a peer review process.
- Keep it succinct—your submission will be more effective if the most relevant points are explained clearly and succinctly. If your submission is lengthy it would be helpful to provide a summary of key points at the beginning.
- Make a suggestion to solve the problem—if you agree that the relevant committee’s concerns have a basis, and you have a suggestion that would remove the cause of their concerns, then it is helpful if you put this forward.

Remember, the committee really does want to consider in full your side of the story and this information sheet aims to help you provide them with useful information. You should consider whether you wish to speak with your medical protection insurer or engage legal counsel. Engaging legal counsel is not covered by Queensland Health’s Human Resource Policy I2 or I3 (for indemnity).

For more information on a written submission for the review or appeal process contact:

The chair of the committee requesting the submission

Appendix 10: Rural public health facilities for general practitioner locum credentialing and scope of clinical practice

Public health facilities	
A	
Alpha Hospital	Augathella Hospital
Aramac Hospital	Aurukun Primary Health Care Centre
Atherton Hospital	Ayr Hospital
Atherton Primary Health Care Centre	
B	
Babinda Hospital	Birdsville Clinic
Badu Island Primary Health Care Centre	Blackall Hospital
Bamaga Hospital	Blackwater Multipurpose Health Service
Banana District Community Health Service	Boigu Island Primary Health Care Centre
Baralaba Multipurpose Health Service	Bollon Bush Nursing Service
Barcaldine Hospital	Boonah Health Service
Beaudesert Hospital	Boulia Primary Health Care Centre
Bedourie Clinic	Bowen Hospital
Biggenden Health Service	Burketown Health Centre
Biloela Hospital	
C	
Camooweal Health Centre	Clermont Multi-Purpose Health Service
Capella Outpatient Clinic	Cloncurry Hospital
Capricorn Coast Hospital and Health Service	Coconut (Poruma) Island Primary Health Care Centre
Cardwell Community Health Centre	Coen Primary Health Care Centre
Charleville Hospital	Collinsville Multipurpose Health Service
Charters Towers Health Centre	Cooktown Multipurpose Health Service
Charters Towers Rehabilitation Centre	Cow Bay Outpatient Clinic
Cherbourg Health Service	Cracow Primary Health Care Centre
Childers Hospital	Croydon Primary Health Care Clinic
Chillagoe Hospital	Cunnamulla Hospital
Chinchilla Health Service	
D	
Dajarra Primary Health Care Centre	Dingo Outpatient Clinic
Dalby Health Service	Dirranbandi Hospital
Darnley (Erub) Island Primary Health Care Centre	Doomadgee Hospital

Dauan Island Primary Health Care Centre	Duaranga Outpatient Clinic
Dimbulah Hospital	Dysart Hospital
E	
Eidsvold Health Service	Emerald Hospital
Emerald Community & Primary Health Service	Esk Hospital
F	
Forsayth Hospital	
G	
Gatton Hospital	Glenden Community Health Centre
Gayndah Health Service	Glenmorgan Outpatients Clinic
Gemfields Outpatient Clinic	Goondiwindi Health Service
Georgetown Hospital	Gordonvale Memorial Hospital
Gin Gin Hospital	Gurriny Yealamucka Health Service (Yarrabah)
Gladstone Community Health Service	Gympie Hospital
Gladstone Hospital	
H	
Herberton Hospital	Horn Island Primary Health Care Centre
Home Hill Hospital	Hughenden Health Centre
Hopevale Primary Health Care Centre	
I	
Ingham Health Service	Innisfail Community Health Centre
Inglewood Health Service	Innisfail Hospital
Injinoo Primary Health Care Centre	Isisford Primary Health Care Centre
Injune Hospital	
J	
Jandowae Multi-Purpose Health Service	Julia Creek Hospital
Jerico Clinic	Jumbun Community Health Care Centre
Joyce Palmer Health Service (Palm Island)	Jundah Primary Health Care Centre
K	
Karumba Health Centre	Kowanyama Primary Health Care Centre
Kilcoy Hospital	Kubin Community (Moa Island) Primary Health Care Centre
Kingaroy Health Service	
L	
Laidley Hospital	Longreach Hospital
Laura Primary Health Care Centre	Lotus Glen Health Service
Lockhart River Primary Health Care Centre	

M

Mabuiag Island Primary Health Care Centre	Moonie Outpatients Clinic
Magnetic Island Health Service Centre	Moranbah Hospital
Malanda Primary Health Clinic	Mornington Is Primary Health Care Centre
Maleny Hospital	Morven Outpatients Clinic
Mapoon Primary Health Care Centre	Mossman Multipurpose Health Service
Mareeba Hospital	Mount Garnet Out Patient Department
Marie Rose Centre (Dunwich)	Mount Isa Hospital
Meandarra Outpatient Clinic	Mount Morgan Multipurpose Health Service
Middlemount Community Health Centre	Mount Perry Health Centre
Miles Health Service	Moura Hospital
Millaa Millaa Health Centre	Mundubbera Health Service
Millmerran Multipurpose Health Service	Mungindi Hospital
Mission Beach Community Health Centre	Murgon Health Service
Mitchell Hospital	Murray (Mer) Island Primary Health Care Centre
Monto Health Service	Muttaburra Primary Health Care Centre

N

Nanango Health Service	New Mapoon Primary Health Care Centre
Napranum (Malakoola) Primary Health Care Community	Normanton Hospital

O, P, Q

Oakey Health Service	Quilpie Hospital
Pormpuraaw Primary Health Care Centre	

R

Ravenshoe Primary Health Care Centre	Roma Hospital
Richmond Health Centre	

S

Sabai (Kaumag) Island Primary Health Care Centre	St Pauls Community (Moa Island) Primary Health Care Centre
Sarina Hospital & Primary Health Care Centre	Stanthorpe Health Service
Seisia Primary Health Care Centre	Stephen (Ugar) Island Primary Health Care Centre
Springsure Multipurpose Health Service	Surat Hospital
St George Hospital	

T

Tambo Primary Health Care Centre	Thursday Island Hospital
Tara Health Service	Thursday Island Primary Health Care Centre
Taroom Health Service	Tieri Community Health Centre

Texas Health Service	Tully Community Health Centre
Thargomindah Hospital	Tully Hospital
Theodore Multipurpose Health Service	
U	
Umagico Primary Health Care Centre	Urandangie Primary Health Care Centre
W	
Wallumbilla Hospital	Windorah Clinic
Wandoan Outpatients Clinic	Winton Hospital
Warraber (Sue) Island Primary Health Care Centre	Wondai Health Service
Warwick Health Service	Woorabinda Multipurpose Health Service
Weipa Hospital	Wujal Wujal Primary Health Centre
Whitsunday (Proserpine) Health Service	
Y	
Yam (Iama) Island Primary Health Care Centre	York (Masig) Island Primary Health Care Centre
Yaraka Clinic	