

Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline

Department of Health Guideline
QH-GDL-390-1-1:2017

Introduction

This guideline has been developed as a best practice risk management strategy for the Department of Health (the department). It assists employees in understanding requirements surrounding credentialing and approving a scope of clinical practice (SoCP) for an identified medical practitioner or dentist.

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

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

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 and natural justice at all times. The principles of procedural fairness, transparency and accountability underpin the process of assessment of credentials and delineation of SoCP.

Implementation of this guideline essentially aims to protect the safety of:

- 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

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 changeable environment. Therefore all information should be validated to ensure currency.

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Part 1: Overview

1. Purpose

A safe working environment is valued by every member of the Queensland Health workforce.

This guideline is a key risk management strategy to assist in the management of credentialing processes that underpin the maintenance of clinical governance within the department.

This guideline is supported by the following documents:

- *Credentialing and defining the scope of clinical practice* policy (QH-POL-309:2015)
- *Credentialing and defining scope of clinical practice for medical practitioners and dentists* standard (QH-IMP-390-1:2017).

2. Scope

This guideline applies to medical practitioners and dentists (collectively referred to as 'practitioners') that are registered with the Australian Health Practitioner Regulation Agency (AHPRA), and are employed by the department. This includes Health Support Queensland (HSQ) and the Queensland Ambulance Service (QAS).

This guideline does not apply to the following departmental staff:

- dental students
- medical administration trainees
- medical registrars undertaking project work
- practitioners undertaking research and teaching which does not involve patient contact or responsibility
- practitioners who are in the role of undertaking a clinical review or a health service investigation under the *Hospital and Health Boards Act 2011* (Qld).

3. Delegations

Delegations pertaining to credentialing and SoCP functions are found in the Department of Health HR Delegations Manual: HRM functions of the Director-General.

<http://qheps.health.qld.gov.au/hr/delegations/docs/hr-delegations.pdf>

It is necessary to check and refer to the HR Delegations Manuals and the *Credentialing and defining the scope of clinical practice* policy (Schedule A) regularly, as content may change over time.

3.1 Decision makers

It is important to note that:

- the decision maker with delegation to approve SoCP must not participate in the credentialing committee process or its deliberations ([with the exception at times of a temporary SoCP refer to Part 3](#))
- the Director-General (DG) maintains delegation for the full suite of credentialing/SoCP functions/activities. However, in practice, the DG's role as decision maker should ideally be preserved for credentialing appeals
- the DG is the decision maker for credentialing decisions with respect to the Chief Health Officer and Deputy Director-General, Prevention Division

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- the Chief Executive, Health Services Queensland, is the decision maker for credentialing decisions with respect to the Executive Director Medical Services and the Executive Director, Pathology Queensland.

The Department of Health HR Delegations Manual¹ includes the delegations and functions described below, for which processes are outlined in this guideline.

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.

3.1.1 Approve the appointment of the chair to credentialing and scope of clinical practice committee.

- Chief Health Officer and Deputy Director-General, Prevention Division (CHO and DDGPD)
- Chief Executive, Health Support Queensland (CE HSQ)

3.1.2 Approve the SoCP for individual practitioners (refer to Part 2)

- CHO and DDGPD
- Chief Operating Officer, (COO) HSQ
- Executive Director Medical Services, (EDMS) Health Support Queensland (HSQ)
- Executive Director, Pathology Queensland, (ED PQ) HSQ

3.1.3 Approve the temporary SoCP for individual practitioners (refer to Part 3)

- CHO and DDGPD
- COO HSQ
- EDMS HSQ
- ED PQ HSQ

3.1.4 Approve termination, suspension or reduction of SoCP (refer to Part 4)

- CHO and DDGPD
- CE HSQ

3.1.5 Approve a statewide/multi-HHS SoCP to individual practitioners (refer to Part 2)

(This only applies to persons as referenced in services in Schedule A of the *Credentialing and defining the scope of clinical practice policy*)

- CHO and DDGPD
- COO HSQ
- EDMS HSQ
- ED PQ HSQ

¹ Department of Health Human Resource Delegations Manual, HRM Functions of the Director-General, July 2017.

3.1.6 Initiate a practitioner's 'right to appeal' process to the appeal committee (refer to Part 5)

- CHO and DDGPD
- CE HSQ

3.1.7 Approve the SoCP of a practitioner at the conclusion of the appeal process² (refer to Part 5)

- Director-General (DG)
- CE HSQ

4. Judicial review —recommendations and decisions under the *Judicial Review Act 1991* (Qld)

Any decision made, or a failure to make a decision, about a practitioner regarding credentialing/SoCP may be reviewable by the Queensland Supreme Court under the *Judicial Review Act 1991* (Qld), including the original decision, any interim decision, or any decision made after consideration by the appeal committee.

The *Judicial Review Act 1991* provides for judicial review in relation to actions and conduct leading up to the making of the decision. Accordingly, any recommendations made by a committee to a decision maker, including by an appeal committee, may be considered by the Supreme Court as part of their deliberations over a judicial review matter.

Applications for judicial review under the *Judicial Review Act 1991* of a credentialing/SOCP decision are able to be made by the practitioner generally within 28 days of the decision that has impacted them being made (section 26 of the *Judicial Review Act 1991*). Applicants may also request the reasons for a decision that has adversely affected them.

Certain practices can minimise the likelihood of, or assist in responding to, requests for a Statement of Reasons or an application to the Supreme Court for judicial review. All decision makers and committee members should ensure that:

- delegations are current
- procedural fairness and natural justice practices are followed at all steps of the process
- each step in a decision or recommendation is carefully documented, and that file notes taken in the decision making process do not contain irrelevant considerations
- outgoing correspondence contains the name of the decision maker
- correspondence produced about a decision, after a decision is made, does not vary or contradict the decision.

5. Obligations to notify the Queensland Office of the Health Ombudsman and other entities

This guideline is not intended to provide a process or procedure for notifications to the Queensland Health Ombudsman regarding practitioners. Formal processes for making a notification should be followed by department employees, where these processes exist.

² An appeal committee is not a statutory body, and does not have decision-making authority. The committee is able to make recommendations to the appropriate delegated credentialing and SoCP decision-maker

However, in some circumstances, notifications must be made (mandatory notifications), or may be made (voluntary notifications), to the Queensland Health Ombudsman under the *Health Practitioner Regulation National Law Act 2009* (Qld) (National Law). In addition, any person, including any employee of Queensland Health, may make a health service complaint against a practitioner, pursuant to sections 13 and 32 of the *Health Ombudsman Act 2013* (Qld).

Further, there are circumstances when information, including credentialing and SoCP information, about a practitioner is obtained under the *Private Health Facilities Act 1999* (Qld) which may be disclosed to the Queensland Health Ombudsman or to other health facilities. However, this can only occur in very specific circumstances detailed under Part 11 of the *Private Health Facilities Act 1999*.

It is important to ensure that the relevant thresholds for notification under the legislation are met prior to making a notification. Notifications to entities external, to the department or a HHS can impact significantly on a practitioner, and this should be taken into consideration.

6. Dissemination of information regarding a practitioner's scope of clinical practice

Dissemination of information regarding a practitioner's SoCP must be in compliance with privacy legislation, including the *Information Privacy Act 2009* (Qld). Obtaining consent from practitioners permits the dissemination of information regarding the approval/amendment/refusal of their SoCP.

Where authorised, the department should ensure that information regarding a practitioner's SoCP is accessible at all times to relevant staff.³

Information should include:

- practitioner's name
- AHPRA registration number
- dates the SoCP is valid
- details of the approved SoCP, including location/facility/department where the SoCP is valid
- details of any supervision and/or condition requirements
- name of the decision maker who determined the SoCP
- name of the relevant credentialing committee that made recommendations regarding SoCP to the decision maker.

The Application for SoCP form includes the following consent provision under the authorisation section:

'I consent to information regarding my credentialing and SoCP being disclosed by the Department of Health and the HHSs in the following circumstances:

- for my credentialing and SoCP details to be published in a register on the Queensland Health Electronic Publishing Service (QHEPS)
- for my credentialing and SoCP information to be disclosed between HHSs and the Department of Health for a purpose associated with the approval, amendment or refusal of my credentials and SoCP, including, for example, as part of the mutual recognition process of my credentials and SoCP.'

³ National Standard for *Credentialing and Defining the Scope of Clinical Practice* 2004, Standard 6.7, Disseminating information about the scope of clinical practice.

The organisation should—

(a) establish procedures to ensure that information about each medical practitioner's authorised scope of clinical practice, including any changes, is promptly disseminated within and external to the organisation, according to the organisation's policy; and
(b) in particular, ensure that the information is accessible at all times to staff in all relevant patient care areas.

7. Document responsibility – *Right to Information Act 2009 (Qld)*

It is important to understand that documents obtained or created by a committee may be accessible under the *Right to Information Act 2009* (Qld) (subject to the exemptions specified in that Act) and other court processes, for example subpoenas.

For further information relating to Right to Information (RTI) processes and responsibilities, refer to the following website <http://qheps.health.qld.gov.au/governance/privacy-rti/rti.htm>

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 implementation of the *Credentialing and defining the scope of clinical practice* policy. It identifies and recommends individual position accountabilities and responsibilities in relation to managing the standard process.

2. Supporting documents

Appendix 4	Credentialing committee—sample terms of reference
Appendix 5	Position responsibilities — applicants, decision makers and the credentialing committee members
Appendix 6	Practitioner —guide to preparing a written submission
Appendix 7	Sample—Application for scope of clinical practice form
Appendix 8	Sample —General referee report template

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 that any perceived or real conflicts of interest are appropriately managed ([refer to Part 4, section 3](#)).

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 must not consider an incomplete application, or make a recommendation about a practitioner's SoCP pending submission of further information.

For international medical and dental graduates who have limited experience in the Australian health system, additional evidence may be required by the credentialing committee to ensure there is an understanding of the differences in the Australian healthcare setting and the possible impact of this on clinical practice and patient care.

Specific review of SoCP will be required when an individual practitioner seeks to practice outside the specialty area usually associated with their professional group. This is increasingly common in health services where specialties usually recognised as non-procedural specialties become more interventional.

The committee makes a recommendation on the practitioner's SoCP to the decision maker ([refer to Part 1, sections 3.1.2 to 3.1.7](#)). The committee's recommendation/s must align with any reprimands, conditions, notations or undertakings imposed by the registration board on the applicant's registration.

Each approved SoCP must be in accordance with the Clinical Services Capability Framework (CSCF) for each service. Current frameworks can be located at:

<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/hospitals/public/default.asp>

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3.1 Applying the standard process

3.1.1 Practitioners only working in a Department of Health division

Where a practitioner works within a division of the department, 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/ Department of Health divisions

Where a practitioner works across a number of HHSs/department divisions, the practitioner may undergo the standard credentialing process in their home HHS/department division and may then undergo the mutual recognition process in the other HHSs/department divisions as set out [Part 2, section 6](#).

3.1.3 Practitioners working across the state

Practitioners providing services statewide or across multiple HHSs may be granted a statewide/multi-HHS SoCP. **NB:** This process only applies to services listed in Schedule A in the *Credentialing and defining the scope of clinical practice policy*.

The practitioner must provide clinical services consistent with the CSCF level/s of the public health facility/ies where the practitioner is working at the time.

Refer to [Part 2, section 7](#)—statewide/multi-HHS credentialing process.

NB: Details of all practitioners with current statewide/multi-HHS SoCP are to be accessible to the department and all HHSs via QHEPS (refer to Part 2, section 7).

4. Standard application for scope of clinical practice

The practitioner's application for SoCP, accompanied by a complete set of documentation (credentials), is provided to the committee for consideration.

The committee checks and assesses the documentation and makes a recommendation to the decision maker ([refer to Part 1, section 3.1.2](#)) regarding a practitioner's SoCP, including the duration of that SoCP. In assessing the application the committee should give consideration to the factors outlined below in [Part 2, sections 4.1 – 4.5](#).

Wherever possible, credentialing processes should be completed prior to commencement of the practitioner's employment or engagement. However, in the event that the standard credentialing process cannot be completed prior to commencement, a decision may be made regarding an interim SoCP (for a maximum period of three calendar months) in accordance with [Part 3, section 4](#).

The decision maker ([refer to Part 1, section 3.1.2](#)) must then communicate the decision in writing to the practitioner and relevant employing staff within 10 business days of the committee's recommendation.

4.1 Relevant considerations — standard credentialing process

The committee should, as a minimum, examine the following:

- a) A completed and signed application form⁴ for credentialing and SoCP. The application form must meet National Standard⁵ requirements.

⁴ **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.

- 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 any 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 recommendation on credentials and SoCP.
- c) Verification of the practitioner's registration status in the appropriate category with AHPRA. Any recommendation regarding a practitioner's SoCP must take into account any conditions, reprimands, 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 must reflect the exclusion of the procedure from their SoCP.
- NB: It is the obligation of the practitioner to advise the committee of any conditions, reprimands, notations, undertakings, or other restrictions on their registration.
- d) The applicant's current curriculum vitae [the preferred format is the AHPRA standard format for curriculum vitae <http://www.ahpra.gov.au/registration/registration-process/standard-format-for-curriculum-vitae.aspx>].
- 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 applicant's professional college or college representative, 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, online learning and a summary of clinical activities undertaken over the past 12 months). 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 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, with no conflict of interest, and who can attest to the

⁵ National Standard for Credentialing and Defining the Scope of Clinical Practice 2004
<http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/credentl.pdf>

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).

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 given to resources and the needs of the public health facility, 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 or provisional 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 or provisional registration in an area of need, or for renewal of limited or provisional registration, must comply with all registration requirements, including supervision, conditions, notations and undertakings.

4.2.2 Dentists 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 should 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 that is reasonably relevant to safe practice, including items not noted on the application form, for example:

- reports from the Office of the Health Ombudsman, AHPRA and/or Medicare Australia
- patient and staff complaints and compliments
- medical indemnity history and status, including audits of litigation matters
- clinical performance review and audit information
- clinical activity log books including objective data on the outcomes of that clinical activity
- 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 must 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 ([also refer to Part 2, section 4](#)).

4.4 Duration of scope of clinical practice

If recommending SoCP, the committee must recommend a SoCP for a specified period with a defined end date. In all circumstances, this period must not exceed five years⁶.

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

- a defined period of employment
- uncertainty about clinical expertise in the practitioner's requested SoCP (the committee would make a recommendation to the decision maker regarding arrangements to assess practitioner expertise, and subsequent review)
- medical or personal circumstances which may impact the practitioner's capacity to provide patient care for a period of time.

4.4.1 Duration for locum practitioners

The duration of a standard SoCP for a locum practitioner must be for no more than five years⁷, 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 reasonably determined by the department division:

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

4.5 Credentialing committee — recommendations

When the committee has considered all aspects of the practitioner's application, the committee will make a recommendation in writing to the decision maker ([refer to Part 1, section 3.1.2](#)) regarding the SoCP. This recommendation may be to approve a SoCP with or without limitations, or not to approve any SoCP.

If applicable, the recommendation may include for example:

- supervision or condition requirements
- limitations on the period of SoCP.

⁶ National Standard for *Credentialing and Defining the Scope of Clinical Practice* 2004, page 32 www.safetyandquality.gov.au/wp-content/uploads/2012/01/credenti.pdf

⁷ This duration of locum SoCP may be determined at the discretion of the credentialing committee.

Committee recommendations must reflect any conditions, reprimands, notations and undertakings imposed on the practitioner's registration.

The committee must clearly document any reason/s why the practitioner's SoCP has a limitation or why SoCP is not recommended ([refer to Part 2, section 4.4](#)).

4.6 Decision of the decision maker

The decision maker ([refer to Part 1, section 3.1.2](#)) has delegated authority to make the final decision on credentialing and SoCP, giving consideration to the recommendation/s of the committee.

4.6.1 The decision maker makes a decision consistent with the committee recommendations

Where the decision maker ([refer to Part 1, section 3.1.2](#)) agrees with the committee's recommendation the following applies:

- The decision maker approves SoCP for the practitioner as per the committee's recommendation
- The approved SoCP must be communicated to the practitioner by the decision maker within 10 business days of the committee meeting when the committee's recommendation was made
- In situations where SoCP is approved which is different to the SoCP requested, correspondence from the decision maker must include the reason/s for that variation, and the process for the practitioner to make a submission requesting a review of the decision ([refer to Part 2, section 5](#)).

4.6.2 The decision maker makes a decision that is inconsistent with the committee recommendations

Where the decision maker ([refer to Part 1, section 3.1.2](#)) 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 may request a further review of the application
- The decision maker will advise the practitioner, in writing, of the decision within 10 business days of the committee meeting when the committee's recommendation was made and additionally outline a process for a review of the SoCP application
- If the committee is requested by the decision maker to review their recommendation/s, the committee must 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 may make a new recommendation or 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 the committee's recommendation.

5. Process —review of the decision

A practitioner may apply for a review of SoCP at the department divisional level. (NB: resolution of credentialing and SoCP matters should be exhausted at this level before progressing to the appeals process). This application should include a submission from the practitioner that supports the application for review.

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Effective date: 23 October 2017.

The steps a practitioner must take in seeking a review of a SoCP decision are:

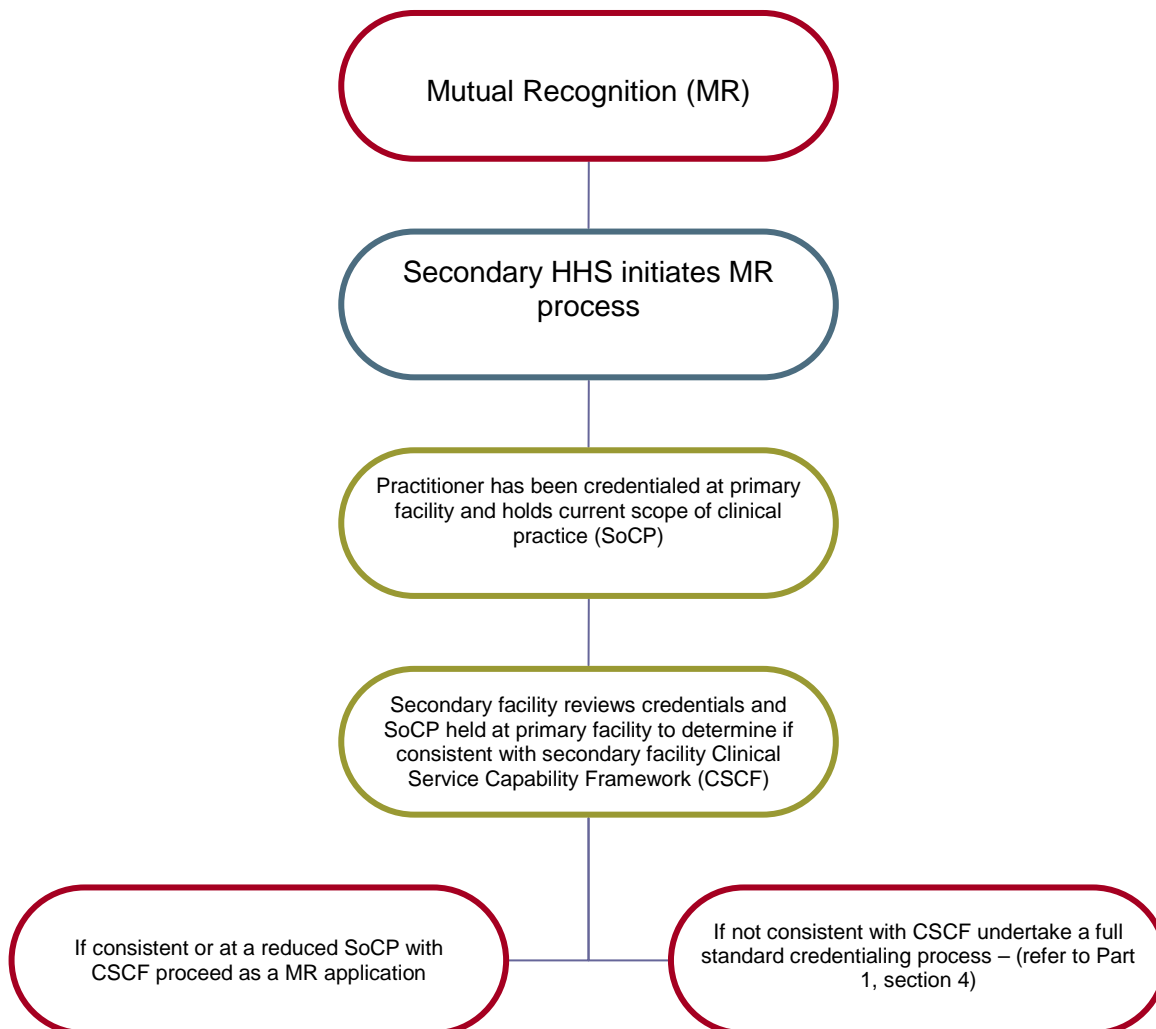
- a) Within 20 business days of receiving the decision, the practitioner must request a local review of the credentialing and SoCP decision, in writing.
- b) The practitioner should include a submission with their request that includes specific grounds and reasons for requesting a review ([refer to Appendix 6](#)).
- c) The practitioner's submission is to be presented to the decision maker
- d) The decision maker ([refer to Part 1, section 3.1.2](#)) must consider the practitioner's request for review and submission, and may seek advice from the committee, where appropriate.
- e) Within 20 business days of the receipt of the submission from the practitioner, the decision maker must communicate their decision on the review of the practitioner's SoCP, including the reason/s for that decision, in writing, to the practitioner. The letter must also outline the process for the practitioner to lodge a formal appeal ([refer to Part 5, section 4](#)).

[Appendix 6](#) provides an outline of what information to include in a written submission for a review of SoCP. The written submission provides the practitioner with the opportunity to provide further supporting information to the credentialing committee and the decision maker.

NB: If appropriate, the practitioner's current approved 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

The following mutual recognition process may be used when a currently credentialed practitioner seeks to provide clinical services at other HHSs/department divisions, and the SoCP approved at the employing/engaging HHS/department division covers the SoCP required at the secondary HHS/department division.



The Mutual Recognition process is not appropriate for:

- When the SoCP requested varies from the primary facility *or*
- Private facility to Public facility credentialing, *or*
- Interim credentialing processes

The mutual recognition process involves the recognition of credentials approved by the primary SoCP decision maker and is not an automatic transposition of SoCP.

A separate and distinct SoCP determination must be made by the secondary HHS/department division. This determination may be to not proceed with the mutual recognition SoCP process. In these cases, a standard credentialing and SoCP application by the practitioner is then required ([refer to Part 2, section 4](#)).

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Where the practitioner's SoCP requested at the secondary HHS/department division is not covered by the credentialing and approved SoCP at the first HHS/department division, the mutual recognition process must not be used. In these cases, a complete standard credentialing process must be undertaken ([refer to Part 2, section 4](#)).

There is no provision in this guideline for mutually recognising the credentials and SoCP of a private practitioner from a private facility. The practitioner must submit a new application to the credentialing committee for full consideration.

The mutual recognition SoCP process does not apply to an interim SoCP.

Where the mutual recognition credentialing process is undertaken:

The first or primary HHS/department division credentialing committee should:

- ensure the practitioner has appropriate SoCP for the service they are providing in their HHS/department division
- make available requested relevant documents to secondary HHS/department divisions for the purposes of processing a mutual recognition SoCP, subject to privacy and confidentiality obligations (refer to the declaration section of the Application for SoCP Form v4 01/2017)
- maintain a record of HHSs which have mutually recognised the primary SoCP
- notify other credentialing committees in HHSs which have mutually recognised the primary SoCP of any changes to the primary SoCP, or other circumstances which may affect ongoing SoCP (this may include a patient safety or a clinical competence concern).

The secondary HHS/department division credentialing committee should:

- be satisfied that the credentialing process in place at the primary HHS/department division meets the local policy requirements of the secondary HHS/department division
- continue to exercise due diligence with credentialing processes and the monitoring of a practitioner's SoCP
- immediately notify the HHS/department division credentialing committee who granted the primary SoCP of any circumstances that may arise which may affect ongoing SoCP (this may include a patient safety or a clinical competence concern).
- make available relevant documents to the first or primary HHS/department division for the purpose of notifying any patient or clinical concerns that may arise, subject to privacy and confidentiality obligations,

NB: SoCP may only be mutually recognised against the primary HHS/department division, in other words it must not be secondary to another mutual recognition decision.

The management of performance concerns regarding a practitioner (separate and distinct to credentialing processes) is the responsibility of the respective HHS/department division where the concerns have been raised. Management of the process should involve consultation with all entities where the practitioner has an approved mutual recognition SoCP.

6.1 Process — mutual recognition

There are various steps and levels of accountability with the mutual recognition SoCP process. These steps may include:

6.1.1 Accessing documentation

The primary credentialing committee must provide documents requested by the secondary HHS/department division to facilitate the mutual recognition process.

The secondary HHS/ department division must obtain a copy of the practitioner's approved SoCP, committee recommendation from the primary credentialing committee (which may be an extract from committee minutes), and verify the practitioner's registration status in the appropriate category with AHPRA.

Any recommendations regarding a practitioner's SoCP must take into account any current conditions, reprimands, notations or undertakings on their AHPRA registration.

The secondary HHS/ department division may also obtain:

- a reference from an appropriate clinical line manager from the employer HHS/ department division who is able to attest to the applicant's current clinical performance in the primary HHS/ department division
- a copy of the application reviewed by the primary HHS/ department division committee
- a copy of the practitioner's current curriculum vitae.

6.1.2 Request process

There are various methods by which mutual recognition can occur. These are dependent on locally approved processes.

This guideline outlines the following two options:

- the credentialing committee at the secondary HHS/department division reviews the documentation provided by the primary HHS and makes a recommendation to the local decision maker for a mutual recognition SoCP in line with, or less than, the SoCP approved by the decision maker at the primary HHS/department division.
OR
- the senior medical/dental administrator (for example EDMS or executive director) at the secondary HHS/department division reviews the documentation provided by the primary HHS and makes a recommendation to the local decision maker for a mutual recognition SoCP in line with, or less than, the SoCP approved by the decision maker at the primary HHS/department division.

This process usually occurs outside the credentialing committee's process.

If the senior medical/dental administrator does not support the decision of the primary HHS/department division decision maker the mutual recognition process does not proceed, and a full application is to be progressed through the local committee ([refer to Part 2, section 4](#))

6.1.3 The decision maker's role

The decision maker considers the recommendation of the senior medical/dental administrator (for example EDMS or executive director) or credentialing committee, and then communicates their decision regarding SoCP in writing to the practitioner within 10 business days of the date of the recommendation.

In making a decision, the decision maker should consider the following:

- the SoCP to be approved by the secondary HHS/ department division must be consistent with the CSCF service level/s of the public health facility/ies in which the practitioner will provide clinical services, and may be a reduced SoCP/range of services than the SoCP approved by the primary HHS/ department division.

For the approval of a lesser SoCP than the primary SoCP, correspondence to the practitioner must include reasons for the decision.

- the SoCP to be approved by the secondary HHS/ department division must not be a greater SoCP/range of services than the SoCP approved by the primary HHS/ DoH division, regardless of CSCF service level/s.
- the expiry date of the mutually recognised SoCP must be no later than the expiry date of the SoCP approved at the primary HHS/ DoH division.

6.1.4 The role of the secondary credentialing committee

To formalise the process, the secondary HHS/department division credentialing must:

- note the decision maker's decision at the next credentialing committee meeting, and
- notify the primary HHS/department division that the practitioner has been granted a SoCP under mutual recognition

6.2 Renewal —mutual recognition

Provided the primary HHS/department division undertakes a completed renewal of the practitioner's SoCP, the second and subsequent HHS/department divisions may again use mutual recognition to grant the practitioner a SoCP in their respective HHS/department division. As the mutual recognition process is occurring at the same time as the renewal, at the discretion of the second HHS/department division, referee reports may not be required for mutual recognition renewals.

7. Statewide/multi Hospital and Health Services scope of clinical practice

Statewide/multi-HHS SoCP describes the scenario where services are managed, coordinated and monitored by a single HHS, or the department, and these services are then provided by practitioners in multiple other public health facilities across the State.

The *Credentialing and defining the scope of clinical practice* policy Schedule A (Schedule A), lists designated statewide/multi-HHS services and the corresponding department credentialing committee responsible for assessing SoCP applications for those services. Only the designated credentialing committees may make recommendation/s regarding a statewide/multi-HHS SoCP to the relevant decision maker ([refer to Part 1 section 3.1.5](#)).

The decision maker at the secondary HHS (recipient of the designated statewide/multi-HHS service) is responsible for deciding whether to accept the statewide/multi-HHS SoCP awarded by the primary HHS, and determining a practitioner's local SoCP to deliver the designated service.

7.1 Process —awarding a statewide/multi Hospital and Health Service scope of clinical practice

Schedule A describes specific accountabilities for HHSs/department divisions which employ/engage practitioners with an approved statewide/multi HSS SoCP.

Where the statewide/multi-HHS credentialing and SoCP process is undertaken the following steps apply:

- a) The practitioner's clinical service is confirmed as a designated statewide/multi-HHS service (refer to Schedule A of the policy).
- b) The practitioner applies for SoCP, or renewal of SoCP, through the designated department credentialing committee as per the standard application processes in [Part 2, sections 4 and 11](#).

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- c) Where the decision maker ([refer to Part 1, section 3.1.5](#)) approves an initial or renewed statewide/multi-HHS SoCP, regardless of any limitations or alterations to the requested SoCP, this decision must be notified in writing to the practitioner and all other relevant HHSs/department divisions (recipients of the statewide/multi-HHS service) within 10 business days of approval of SoCP.
- d) Where the decision maker does not approve the initial or renewal of statewide/multi-HHS SoCP, this decision must be notified in writing to all other relevant HHSs/department division credentialing committees within 10 business days of the decision.
- e) The management of performance concerns regarding a practitioner (separate and distinct to the credentialing processes) is the responsibility of the HHS/department division which employs the practitioner. Management of the process should involve consultation with all entities where the practitioner has an approved statewide/multi-HHS SoCP.

7.2 Process —accepting a statewide/multi Hospital and Health Service scope of clinical practice

7.2.1 Accepting a practitioner's statewide/multi Hospital and Health Service scope of clinical practice without conditions

Where the decision maker in the recipient HHS/department division makes a decision to accept a practitioner's statewide/multi-HHS SoCP without conditions:

- a) The secondary HHS /department division decision maker should notify the primary HHS/department division credentialing committee of their acceptance of the practitioner's statewide/multi-HHS SoCP
- b) The secondary HHS committee must document the details of the practitioner's approved statewide/multi-HHS SoCP at the next committee meeting. This includes the practitioner's name, the committee that facilitated the approval of the original SoCP, details of SoCP including any conditions, and the expiry date of the SoCP
- c) The practitioner's approved SoCP must be communicated by the secondary HHS /department division decision maker to the practitioner and relevant clinical departments/units where the practitioner will be working
- d) Any concerns regarding the performance of a practitioner must be notified to the decision maker who first approved the practitioner's SoCP ([refer to Part 4, section 7 and 8](#)).

7.2.2 Accepting a practitioners statewide/multi Hospital and Health Service scope of clinical practice with conditions

If a HHS is not satisfied with the credentialing process and awarding of a SoCP to a practitioner from the employing/engaging HHS/ department division, the HHS may choose to:

- a) accept the credentialing process from the employing/engaging HHS/department division, but issue a new SoCP recognising that at times the recipient HHS CSCF may be at a different level than the CSCF as part of the granted SoCP

OR

- b) acknowledge the employing/engaging HHS/department division's credentialing and SoCP decision, and conduct an additional risk management process to affirm the employing/engaging HHS/department divisions' decision.

All the process steps detailed in [Part 2, section 7.2.1 a\) to d\)](#) apply.

The recipient HHS/department division may request additional information from the employing/engaging HHS/department division regarding a practitioner's SoCP (for example, in conducting an additional risk management process). Resource implications of this are to be managed between respective entities.

The recipient HHS/department division may also request information directly from the practitioner as per a new SoCP application.

7.3 Process – Renewing a practitioner's statewide/multi Hospital and Health Service scope of clinical practice

Renewal of a practitioner's statewide/multi-HHS SoCP is managed by the employing/engaging HHS/department division credentialing committee in accordance with [Part 2, section 11](#).

HHS/department divisions that are recipients of a statewide/multi-HHS service must confirm that the employing/engaging HHS/department division credentialing committee has undertaken a renewal of a practitioner's SoCP. If the practitioner's statewide/multi-HHS SoCP is not being renewed by the primary department committee, and the practitioner still provides services to other HHS/department divisions, a new SoCP application must be submitted by the applicant to the relevant HHS/department division credentialing committee.

8. Radiology Services

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

It is important to note that teleradiology is not a SoCP, it is simply a means/medium for providing radiology services.

The process for credentialing and approving SoCP for radiologists is the same process as for other practitioners detailed in this guideline.

For externally contracted services, it is incumbent on the department division to be fully satisfied that the practitioner providing the contracted service is appropriately credentialed through either:

- a) ensuring that the provisions of the contract includes appropriate credentialing processes for the practitioner in alignment with the *Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline* and the *National Standards for Credentialing and defining the scope of clinical practice*

OR

- b) ensuring that the externally contracted practitioner undergoes the same credentialing and approval of SoCP processes that would be undertaken within the department division for a departmental practitioner.

Importantly, whatever option is selected by the department division, it must be clearly articulated in the contract with the external service provider.

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9. Telehealth

Telehealth, in the context of the Australian healthcare setting, can be defined as the use of videoconferencing technologies to conduct a medical consultation where audio and visual information is exchanged in real time. While telehealth is not designed to replace face-to-face consultations, it can be used to enhance and simplify ongoing specialist services to patients whose access might otherwise be limited⁸.

It is important to note that telehealth is not a SoCP, it is simply a means/medium for providing clinical services.

Ad hoc and spontaneous phone/video/teleconferencing communication between practitioners for the purpose of obtaining an opinion/advice does not require a defined SoCP.

All practitioners providing telehealth services must have SoCP from the HHS/department division where they are located when providing telehealth services. It is the responsibility of the HHS/department division where the patient is located to verify the SoCP in the practitioner's home HHS/department division and be satisfied that the practitioner has appropriate and current SoCP for the service provided to that patient in that HHS/department division.

The HHS/department division may choose to accept the SoCP by obtaining evidence that the telehealth practitioner has existing SoCP in the practitioner's HHS/department division, or may choose the mutual recognition SoCP process ([refer to Part 2, section 6](#)). The decision as to which process option to follow rests with the decision maker ([refer to Part 1 section 3.1.2](#)).

10. 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 a primary focus on patient safety.

10.1 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. Before the credentialing committee considers making any recommendation regarding expanding the practitioner's SoCP, the facility must confirm that it has the capability and the need for the practitioner to expand their SoCP.

The practitioner should submit to the credentialing committee:

- an Application for scope of clinical practice form
- 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 requested SoCP.

Refer to the standard application process and considerations at [Part 2, section 4.1](#).

⁸ The Royal Australasian College of Physicians, Telehealth, Guidelines and Practical Tips page 1.

10.2 Practitioner who has conditions, suspensions, notations or undertakings removed by AHPRA

A practitioner may request a review of their SoCP when conditions, suspensions, notations or undertakings on their AHPRA registration, which affects the practitioner's SoCP, are removed or reduced.

The practitioner should submit to the credentialing committee:

- an Application for scope of clinical practice form
- evidence and details of the changes to conditions, suspensions, notations or undertakings on their AHPRA registration
- 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 current clinical performance in the additional requested SoCP.

The committee may request further information or details regarding the background and nature of the changes to AHPRA registration, or other additional material which they may consider is reasonably relevant to safe practice ([refer Part 2, section 4.2](#)).

Refer to the standard application process and considerations at [Part 2, section 4.1](#).

10.3 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.

The practitioner is to request in writing the reduction of SoCP to the decision maker ([refer to Part 1, section 3.1.2](#)). The decision maker will confirm the reduction of SoCP in writing to the practitioner within 10 days of receipt of the request from the practitioner. The decision maker will notify the relevant credentialing committee of the voluntary reduction in SoCP, which will be noted and minuted at the next scheduled credentialing committee meeting.

10.4 Review of conditions

Practitioners with any conditions imposed on their SoCP may have those conditions reviewed on submission of evidence that the conditions have been met.

Evidence will be presented at the next scheduled credentialing committee meeting for the purpose of review and recommendation to the decision maker. The practitioner is to be notified of the decision in writing by the decision maker ([refer to Part 1 section 3.1.2](#)) within 10 business days from the date of the committee's recommendations to the decision maker.

10.5 Review of supervision

Practitioners with any supervision imposed on SoCP may have their supervision requirement reviewed on submission of evidence to support changes in their circumstances.

Evidence will be presented at the next scheduled credentialing committee meeting for the purpose of review and recommendation to the decision maker. The practitioner is to be notified of the decision in writing by the decision maker ([refer to Part 1 section 3.1.2](#)) within 10 business days from the date of the committee's recommendations to the decision maker.

10.6 Introduction of new clinical services, procedures, technology or interventions

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

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

When new services are introduced, practitioners wishing to incorporate these 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.

The practitioner is required to submit to the credentialing committee:

- an Application for scope of clinical practice form
- 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.

Refer to the standard application process and considerations at [Part 2, section 4.1](#).

10.7 Significant alteration to a clinical service, procedure, technology or intervention

A practitioner may request a review of a SoCP where there is a significant alteration to a clinical service, procedure, technology or intervention in a facility.

Evidence will be presented at the next scheduled credentialing committee meeting for the purpose of review and recommendation regarding SoCP to the decision maker. The practitioner is to be notified of the decision on the SoCP in writing by the decision maker ([refer to Part 1 section 3.1.2](#)).

11. Renewal —credentialing and scope of clinical practice process

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

Renewal of SoCP must not exceed a period of five (5) year intervals (refer to *Credentialing and defining the scope of clinical practice policy*). A renewal application should be obtained within a time frame that allows sufficient time for processing prior to the existing SoCP lapsing. There is no obligation on the department to maintain a previously approved SoCP.

Refer to [Part 2, section 4.1](#) for committee considerations regarding the renewal of a SoCP. All committee considerations within section 4.1 apply with the **exception** of points d), e) and j). With reference to point g) only one (1) peer referee is required for a renewal application. All considerations are at the discretion of the credentialing committee.

11.1 Other factors to be considered by the credentialing committee

The factors to be considered by the credentialing committee are the same as the standard application process for credentialing and SoCP.

Refer to:

- Medical practitioners with limited or provisional registration ([Part 2, section 4.2.1](#)).
- Dentists with limited registration under the public sector dental workforce scheme ([Part 2, section 4.2.2](#)).
- Other information relevant to safe practice ([Part 2, section 4.2.3](#)).

11.2 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 ([Part 2, section 4.3](#)).
- Duration of scope of clinical practice ([Part 2, section 4.4](#)).
- Credentialing committee - recommendations ([Part 2, section 4.5](#)).
- Decision of decision maker ([Part 2, section 4.6](#)).

11.3 Position responsibilities — applicants, decision makers and credentialing committee members.

Refer to [Appendix 5](#) for position responsibilities that apply to applicants, decision makers and the credentialing committee members.

Part 3: Temporary credentialing and scope of clinical practice

1. Purpose

This Part of the guideline outlines best practice for temporary credentialing and SoCP. There are three situations where this process will apply - interim, disaster and emergency/urgent SoCP.

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

2. Supporting documents

Appendix 4	Credentialing committee—sample terms of reference
Appendix 5	Position responsibilities — applicants, decision makers and the credentialing committee members
Appendix 7	Sample —Application for scope of clinical practice form
Appendix 8	Sample—General referee report

3. General requirements

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

Temporary SoCP may be approved in circumstances when the services of a practitioner without SoCP are required at very short notice or where it is not possible to complete the standard process set out in Part 2, prior to the practitioner commencing.

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

4. Interim scope of clinical practice

Where a practitioner is required to commence work prior to completing the standard process outlined in Part 2 an interim SoCP may be approved. Interim SoCP may be approved by the decision maker outside the credentialing committee process. An interim SoCP is intended to cover the period up to when the credentialing committee considers the full application, and a decision is subsequently made by the decision maker ([refer to Part 1, section 3.1.3](#)). Once an application has been considered by the committee and a SoCP approved by the decision maker, the interim SoCP becomes invalid.

In line with the National Standard⁹, the following conditions apply to the approval of an interim SoCP:

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

4.1 Delegation

Refer to [Part 1 section 3.1.3](#) for the delegated decision maker to approve an interim SoCP.

4.2 Relevant considerations

As a minimum, the decision maker should consider the following prior to approving an interim SoCP:

- Verification of the identity of the practitioner through inspection of photographic identification (e.g. current Australian passport or current drivers licence).
- Verification of the practitioner's registration status in the appropriate category with APHRA. Any decision regarding a practitioner's SoCP must take into account any conditions, reprimands, notations 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 APHRA that they will refrain from performing a particular procedure, then their SoCP in every public health facility at which they work must reflect the exclusion of the procedure from their SoCP.
- Verification that the practitioner holds the mandatory qualifications and has the training required for the SoCP.
- At least one professional reference of the practitioner's competence and good standing

A formal application process as detailed in Part 2 must still proceed for consideration by the appropriate credentialing committee, and decision of the decision maker ([refer to Part 2 section 3.1.3](#)), to determine the practitioner's ongoing SoCP.

4.3 Decision of the decision maker

The decision maker ([refer to Part 1, section 3.1.3](#)) makes the decision to approve/refuse 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:

- a) Communicate the decision regarding interim SoCP to the practitioner, in writing, within 10 business days of the decision.
- b) Communicate the practitioner's approved interim SoCP in writing to the public health facility Director of Medical Services (or equivalent) and the director/s of the relevant clinical departments/units where the practitioner will be working.
- c) Communicate the decision to the credentialing committee in writing to ensure the decision can be minuted at the next scheduled credentialing meeting.

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

5. Disaster/major emergency/'short-term' community event

In some situations, practitioners may be required to provide limited short term services in times of disaster, major emergencies or major community events.¹⁰

Temporary SoCP awarded under this section shall be at the discretion of the decision maker ([refer to Part 1, section 3.1.3](#)) and the approved SoCP should not exceed 14 days. This SoCP may be approved by the decision maker outside the credentialing committee process.

In every case, the SoCP determination for each practitioner must be made in writing and communicated to the practitioner. In addition, the decision must be communicated, in writing to the credentialing committee for minuting at the next scheduled credentialing committee meeting.

If time permits, the decision maker may approve formal SoCP through mutual recognition process ([refer to Part 2, section 6](#)) or approve an interim SoCP ([refer to Part 3, section 4](#)). Consideration should be made to the expiry date of the SoCP, which, in the case of disaster, major emergencies or major community events, must be a maximum of 14 days.

As a minimum, the decision maker should consider:

- Verification of the identity of the practitioner through inspection of photographic identification (e.g. current passport or current drivers licence).
- Verification of the practitioner's registration status in the appropriate category with APHRA. Any decision regarding a practitioner's SoCP must take into account any conditions, reprimands, notations 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 APHRA that they will refrain from performing a particular procedure, then their SoCP in every public health facility at which they work must reflect the exclusion of the procedure from their SoCP.
- Verification that the practitioner holds the mandatory qualifications and has the training required for the SoCP.
- At least one professional reference of the practitioner's competence and good standing.

6. Clinical emergency/urgent clinical situations

For the purpose of this guideline, clinical emergencies and urgent clinical situations are managed in the same manner.

In the case of a clinical emergency and where it is not possible to obtain patient consent, 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 time and clinical circumstances permit, the available practitioner should contact the EDMS/senior clinical practitioner or delegate to consider, and if appropriate, approve the emergency SoCP (this can be done verbally).

A temporary SoCP determination in this circumstance must not exceed 24 hours and may not be extended. The EDMS/senior clinical practitioner or delegate will inform the decision maker ([refer to Part 1, section 3.1.3](#)) and the credentialing committee of the temporary SoCP approval. The temporary SoCP must be minuted at the next credentialing committee meeting. This SoCP may be approved outside the credentialing committee's processes.

¹⁰ A major community event is defined as a short term event resulting in a transient, high volume influx of people which results in a significant increase in the population which may compromise the local health care services. Examples may include a music festival, cultural festival or racing event.

7. Position responsibilities — applicants, decision makers and credentialing committee members.

Refer to [Appendix 5](#) for position responsibilities of applicants, decision makers and the credentialing committee members.

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

1. Purpose

This Part identifies where a departmental decision maker ([refer to Part 1, section 3.1.4](#)) may terminate, suspend or reduce a practitioner's SoCP, and describes 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 4	Credentialing committee—sample terms of reference
Appendix 5	Position responsibilities — applicants, decision makers and the credentialing committee members
Appendix 6	Practitioners —guide to preparing a written submission

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 serious detriment to the practitioner's clinical practice and/or reputation.

Should a practitioner's SoCP be terminated, suspended or reduced, the relevant decision maker has a responsibility to immediately notify recipient HHS/department division credentialing committees which have determined SoCP for that practitioner (by either Mutual Recognition or Statewide /multi-HHS processes). Consideration must be given to privacy and confidentiality obligations when notifying other HHSs/department divisions of the reasons underlying the change of SoCP.

At times, human resource (HR) matters may intersect with the credentialing and SoCP process. Importantly, prior to proceeding to a review of a practitioner's SoCP, the committee needs to be clear that the matter to be considered specifically relates to credentialing and SoCP and is not a HR matter. Consultation with HR staff may assist in clarifying and resolving the matter prior to considering or proceeding to a credentialing and SoCP review.

When considering any concerns about the practitioner's standard of care there is a paramount duty to ensure patient safety while at the same time adhering to principles of natural justice and procedural fairness.

Natural justice and procedural fairness require all persons involved in making a decision 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 all issues, allegations or claims made against them
- 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 conflict of interest. Where there is a conflict of interest, the person should withdraw from deliberations regarding the relevant application.

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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.

3.1 Judicial review of recommendations and decisions under the Judicial Review Act 1991 (Qld)

It is important to be aware of the right of a practitioner to seek judicial review of SoCP decisions under the *Judicial Act 1991* ([refer to Part 1, section 4 for this overview](#)).

3.2 Obligations to notify the Queensland Office of the Health Ombudsman and other entities

It is important to note that in some circumstances notifications must be made (mandatory notifications), or may be made (voluntary notifications), to the Queensland Health Ombudsman under the National Law ([refer to Part 1, section 5 for further details](#)).

4. Immediate termination or suspension of scope of clinical practice

A practitioner's SoCP may be immediately terminated by the decision maker ([refer to Part 1, section 3.1.4](#)) when:

- a practitioner's AHPRA registration is cancelled or modified in a way that precludes them from practising within their approved SoCP
- a practitioner's employment/contract is terminated which may include by way of, for example, resignation or the contract comes to an end.

A practitioner's SoCP may be immediately suspended by the decision maker ([refer to Part 1, section 3.1.4](#)) when:

- a practitioner's registration is suspended by AHPRA
- a practitioner's employment is suspended, and in the case of a contracted practitioner, their contract is varied accordingly.

Within 48 hours of becoming aware of the above circumstances, the decision maker must advise the practitioner in writing of the termination or suspension of SoCP and the reasons for the change of SoCP, and notify the relevant credentialing committee to table the matter at the next committee meeting.

An affected practitioner may make a renewal application for SoCP once the circumstances that precipitated the immediate termination or suspension are no longer in effect. ([Refer to Part 2, section 11](#) — Renewal application for SoCP).

If this practitioner has a mutually recognised SoCP or a state-wide/multi-HHS SoCP, the decision maker has a responsibility to immediately notify other affected HHS/department division credentialing committees of the SoCP decision.

Upon notification of the change of the practitioner's SoCP, the receiving HHS should assess, on a case by case basis, the local service impact of the SoCP notification. (Privacy obligations under the *Information Privacy Act 2009* apply).

5. Triggers for assessment of termination, suspension or reduction of scope of clinical practice

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

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- a practitioner has conditions, reprimands, notations and undertakings imposed on their registration by AHPRA
- 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
- a practitioner has an assessed mental or physical impairment affecting their fitness to practice
- a practitioner is involved in an adverse clinical incident
- a practitioner has been convicted of a serious crime which could affect their 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 approved
- the practitioner's clinical practice indicates 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 personal or health circumstances that may impact upon the practitioner's SoCP.

6. Assessing potential termination, suspension or reduction of scope of clinical practice

All requests for review of a practitioner's SoCP must be referred in the first instance to the senior medical/dental administrator (for example EDMS or executive director) and the requests must be documented by all parties. There is no restriction on who can make a request for SoCP review.

In all cases, the senior medical/dental administrator should immediately obtain information that forms a basis for the request, and document the information received. The purpose of obtaining information is to consider the request and then determine if there is a need to urgently limit the practitioner's SoCP in the interests of patient safety.

Information should 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. Where appropriate, the department's Human Resource Branch and the Legal Services Unit should also be consulted.

Following consultation, if it is the preliminary view of the senior medical/dental administrator 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 senior medical/dental administrator 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 circumstances for triggering an assessment of the SoCP have previously been fully investigated, or been assessed as a vexatious complaint, and no new information is available on this occasion, the senior medical/dental administrator may determine that no further action is required.

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

Following the steps outlined in this section, the senior medical/dental administrator (for example EDMS or executive director) can at short notice and in emergency situations, immediately reduce or suspend a practitioner's SoCP if there is reasonable belief that the practitioner presents a risk to the safety of patients.

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The senior medical/dental administrator must immediately notify the original SoCP decision maker ([refer to Part 1, section 3.1.4](#)) of the temporary reduction or suspension in SoCP. This immediate SoCP action must be justified, and is interim in nature, pending review by the committee and a final decision on SoCP being made by the decision maker.

Any action taken should be the least onerous action (with regard to the practitioner's SoCP) 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.

7.1 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:

- a) An immediate decision is made by the senior medical/dental administrator (for example EDMS or executive director) to reduce or suspend a practitioner's SoCP. The reasons for the decision are to be clearly documented.
- b) The senior medical/dental administrator 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.

If this practitioner has a mutually recognised SoCP or a state-wide/multi-HHS SoCP, the decision maker has a responsibility to immediately notify other affected HHS/ department division credentialing committees of the SoCP decision.

Consideration must be given to privacy and confidentiality obligations when notifying other HHSs/department divisions of the reasons underlying the change of SoCP.

- c) The senior medical/dental administrator will advise the decision maker in writing of their immediate decision ([refer to Part 1, section 3.1.4](#))
- d) 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.
- e) 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. The committee will provide its recommendations to the decision maker.

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

If there is no immediate risk to patient safety, and it is appropriate for the practitioner's SoCP to be reviewed, then the steps described in section 8.1 below apply.

Refer to [Part 4, section 5](#) for a list of circumstances which may trigger the termination, suspension or reduction of SoCP.

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

- a) The senior medical/dental administrator will advise in writing the decision maker ([refer to Part 1, section 3.1.4](#)) of the need to undertake a formal review of SoCP

- b) The decision maker will request the credentialing committee to undertake a formal review ([in accordance with section 9 of this part](#)) of the practitioner's SoCP. Reasons for the review must be clearly stated in the documentation.

9. Process —review of scope of clinical practice

This process follows from a direction by the decision maker ([refer to Part 1, section 3.1.4](#)) to the committee that a practitioner's SoCP requires review.

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

The person raising a concern about the specific practitioner is not to be involved in any deliberations or decision-making regarding the practitioner's SoCP.

9.1 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 are individualised:

- a) Advise the practitioner in writing, within 10 business days of the request for review, that a review has been requested. The following must be included in the written correspondence to the practitioner:
- the subject of the review
 - all reasons for undertaking 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, are to be provided to the practitioner in a timely manner. In some cases this may include part or all of relevant patient/s records. NB: Section 142 of the *Hospital and Health Boards Act 2011* (Qld)¹¹ 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 anticipated timeframes, including the date of the proposed review meeting
 - an invitation for the practitioner to provide a written submission within 20 business days of the date of the letter
 - inform the practitioner of the option to make an oral presentation to the committee to support any written submissions provided. If oral presentations are to be made, this may require a second or subsequent review meeting.
- b) Provide the individual or entity that made the 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.

¹¹ <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 or not a practitioner should be granted SoCP)

- c) Determine membership of the review committee depending on the matters under review or the speciality of the practitioner.
- Where required additional committee members may be considered to ensure appropriate peer review. These additional committee members should have the skills and experience relevant to the SoCP being reviewed and may include the appropriate clinical director, experienced college Fellow (medical/dental) or senior dentist with expertise in the same clinical domain as the practitioner under consideration. 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.
 - Representatives of the department's Human Resource Branch and/or Legal Services Unit may also be included where necessary. However, it is usually more appropriate for these representatives to participate in an advisory capacity rather than as members of the committee.
 - 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.
 - Ensure the person who originally made the request for review, or raised the concern, is not a member of the committee. If this person was the senior clinical practitioner /chair of the committee then the holder of an equivalent position will be the substitute.
 - Ensure all members of the committee are familiar with the role and responsibilities of committee members in a review process.
 - Ensure all members of the committee and the practitioner are provided with all available documentation, including the written submissions, at least five (5) business days prior to the relevant committee meeting.
- d) Convene the committee meeting within 20 business days after the closing date for the receipt of the practitioner's written submission.
- At the first committee meeting, the committee will consider all available documentation, and may request further information if necessary.
- e) If necessary, convene a second or subsequent meeting of the committee to hear oral presentations, or consider additional information submitted by the practitioner.
- f) Ensure all members of the committee and the practitioner are provided with all available information at least five (5) business days prior to the meeting.
- g) Following the consideration of all available relevant material (including any oral presentations) the committee must make a recommendation/s regarding the practitioner's SoCP to the decision maker ([refer to Part 1, section 3.1.4](#)). All reason/s and recommendation/s of the review must be clearly documented.

9.2 Obligations of the committee when undertaking a review of scope of clinical practice

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

- The committee must conduct credentialing proceedings as if it were considering an application for SoCP for the first time, including ensuring that accurate meeting minutes are kept.
- The committee must ensure any recommendation to limit a SoCP is the least onerous action necessary, whilst having as a paramount consideration the protection of patients.

- The committee must gather sufficient information to allow a fully informed recommendation to the decision maker ([refer to Part 1, section 3.1.4](#)).
- The committee must ensure that where further information is required, temporary restrictions on SoCP may be recommended if appropriate, pending receipt and review of the further information.
- The committee must provide an opportunity for the practitioner to make statements and/or present documents. However, this does not include a right for the practitioner to be present for the entirety of the committee's proceedings.
- Should the practitioner choose to attend a committee meeting for the purpose of making an oral statement based on the presented written submission, they may be accompanied by an adviser (who may be a legal practitioner, including Counsel). Legal representatives are present in an advisory capacity only and may not advocate to the committee on behalf of the practitioner.
- 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 also ensure the practitioner has sufficient time to respond to any issues or claims that have been raised.
- The committee must conclude their review and make a recommendation/s to the decision maker in a timely manner.

9.3 Committee recommendations to the decision maker

The committee must make recommendation/s in writing to the decision maker ([refer to Part 1, section 3.1.4](#)) regarding the practitioner's SoCP, including reasons for the recommendation/s.

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

- 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
- imposing conditions on a practitioner's SoCP
- requiring a level of supervision to be applied to the practitioner's SoCP
- requiring the practitioner to undertake additional training or a period of up-skilling
- no change to the practitioner's SoCP is required.

9.4 Decision of the decision maker

On receipt of the committee's recommendation/s, the decision maker ([refer to Part 1, section 3.1.4](#)) must take the following steps:

- Where the SoCP is recommended to be changed in a manner that is likely to be detrimental to the practitioner and the decision maker agrees with the recommendation, the decision maker must give the practitioner an opportunity to make a submission about the proposed decision.
 - The committee's recommendation, including the reasons for the recommendation, must be communicated to the practitioner in writing within 10 business days of that recommendation being made. The communication must also state that the

practitioner's submissions are to be provided within 10 business days after the receipt of the correspondence.

- In the course of considering the submission, the decision maker may request the committee provide further information or explanation regarding its recommendation/s.
- The decision maker must make a final decision on the practitioner's SoCP having considered all available information:
 - 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 individual or entity who requested the review, if relevant
 - the chair of the committee.
- Written advice to the practitioner describing the review decision must:
 - provide details of the practitioner's avenue of appeal through a credentialing and SoCP appeal committee if they are aggrieved by the outcome; and
 - advise that any request for appeal is to be lodged within 20 business days the practitioner receiving the decision maker's advice regarding the review decision; and
 - provide details of whom a request for appeal should be directed.
- If the practitioner does not submit an application for appeal of the final review decision within the set timeframe, the decision maker will issue a new SoCP reflecting the review decision.
- If SoCP has been reduced or revoked on the grounds of patient safety, the decision maker must notify the Health Ombudsman ([refer to Part 4, section 3.2](#)).
- 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.

If the practitioner has a mutually recognised SoCP or a statewide/multi-HHS SoCP, the decision maker has a responsibility to immediately notify other affected HHS/department division credentialing committees of the decision.

Upon notification of the change to the practitioner's SoCP, the affected HHS/department division should consider the local service impact of the SoCP notification (Privacy obligations under the *Information Privacy Act 2009* apply).

10. Change to Clinical Services Capability Framework/service profile

Following extensive consultation with the relevant practitioner/s and other stakeholder/s, a decision maker may reduce or terminate a practitioner's SoCP due to:

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

When a HHS/department division considers redefining their CSCF or service profile, consideration must be given to the impact on relevant practitioners' SoCP, in consultation with the relevant credentialing committee.

The HHS and departmental decision makers must notify the relevant credentialing committee of the impending reduction of services.

Prior to implementation of a revised CSCF or service delivery, the committee will examine and redefine the SoCP of each practitioner working in the public health facility.

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Within five business days of the change to CSCF or service delivery coming into effect, the decision maker ([refer to Part 1 section 3.1.4](#)) must advise the practitioner/s of their amended SoCP and the reasons for this change to SoCP.

11. Position responsibilities —applicant, decision maker and credentialing committee members

Refer to [Appendix 5](#) for position responsibilities of applicants, decision makers and the credentialing committee members.

Part 5: Appeal process

1. Introduction

The Department of Health (the department), *Credentialing and defining the scope of clinical practice* (SoCP) policy (QH-POL-390:2015) states that the department must have a process in place which affords health professionals the opportunity to have a decision regarding their SoCP reviewed or appealed. This Part describes best practice with regard to the appeal process, and identifies the accountabilities and responsibilities of persons involved in the appeal process.

This Part has been written from the perspective of the Office of the Chief Medical Officer (OCMO) managing the appeal process for the Department of Health.

1.1 Decision makers

Generally speaking, a practitioner's request for an appeal will follow a decision to terminate, suspend or reduce that practitioner's SoCP.

The Department of Health HR Delegations Manual, October 2016, outlines the following delegations with respect to credentialing appeals processes and functions.

1.1.1 Approve the termination, suspension or reduction of the SoCP:

- Chief Health Officer and Deputy Director-General, Prevention Division (CHO and DDGPD)
- Chief Executive, Health Support Queensland (CE HSQ)

1.1.2 Initiate a practitioners 'right to appeal' process to the appeal committee:

- CHO and DDG PD
- CE HSQ

1.1.3 Approve the SoCP of a practitioner at the conclusion of the appeal process:

- Director-General (DG)
- CE HSQ

It is important to note that;

- to maintain the integrity of the appeal process, the decision maker for the outcome of an appeal MUST NOT be the same decision maker who made the original SoCP decision
- the appeal committee is only able to make recommendations, and is not a delegated decision maker.

Whilst the DG has delegation for the full suite of credentialing functions/activities, in practice the DG's role as decision maker should be preserved for credentialing appeals. The practical application of credentialing delegations is shown in the table below

Credentialing Committee	Approves termination, suspension or reduction of SoCP	Initiates appeal at practitioner's request	Makes SoCP decision at conclusion of appeal
Department of Health	CHO and DDGPD	CHO and DDGPD	DG
Health Support Queensland	CE HSQ	CE HSQ	CE HSQ

2. Supporting documents

Attachment A	Appeal Committee —terms of reference
Appendix 6	Practitioners —guide to preparing a written submission

3. General principles

It is imperative that, for an appeal process to be conducted as a true 'appeal', the decision maker for the outcome of the appeal MUST NOT be the same decision maker who made the original SoCP decision regarding a practitioner.

A practitioner whose SoCP has been terminated, suspended, reduced, denied or approved in a different form to that requested, has the right to appeal against that decision through a review by an independent appeal committee.

The appeal process is instigated after all possibilities of resolution have been exhausted at the department division level. This may include conducting a review process, such as holding an extraordinary credentialing committee meeting (at times previously referred to as an 'unscheduled review').

Where a practitioner is still aggrieved by the SoCP decision of the decision maker ([refer to Part 5, section 1.1.1](#)) the practitioner may appeal the decision.

If the decision is under appeal, the practitioner should:

- 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 recommendation on credentials and SoCP
- disclose:
 - professional registration, including any conditions, past or present suspensions, reprimands or undertakings
 - any limitation on SoCP imposed by another entity
 - any other matter that the appeal committee could reasonably expect to be disclosed in order to make an informed recommendation on credentials and SoCP.

It is important to note that a practitioner may also, as a separate process, seek a judicial review of any SoCP decision through the Supreme Court under the *Judicial Review Act 1991* ([refer to Part 5, section 6](#)). This may occur during or after the SoCP appeal process.

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3.1 Applying principles of procedural fairness and natural justice

Practitioners are entitled to a fair hearing before any decision regarding their SoCP is made or implemented. Under the principles of procedural fairness and natural justice, it is the responsibility of the appeal committee to:

- declare any actual or perceived conflicts of interest, and if appropriate withdraw from deliberations regarding the relevant application
- act fairly, in good faith and without bias or perception of bias
- ensure the appellant knows what allegations or claims are made against them
- 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
- give practitioners sufficient time to prepare their response to any issues or claims that have been raised, before a recommendation is made
- ensure practitioners are given the opportunity to adequately state their case, and correct or contradict any statement prejudicial to their case, before a recommendation is made
- ensure that if a practitioner has already responded to some material, but further information comes to the attention of the committee before a recommendation is made, the practitioner must be given an opportunity to respond to that additional information.

3.2 Conflicts of interest

Examples of potential conflicts of interest include, but are not limited to, situations where the committee member is:

- related to, is in a relationship with, or has a close personal friendship with, the appellant
- in dispute with the appellant
- the owner and/or manages a private practice/facility in which the appellant has a clinical practice
- in competition with the appellant and stands to benefit from any negative outcome for the appellant
- related to a person in competition with the appellant, and that related person stands to benefit from any negative outcome for the appellant
- benefiting from a positive outcome for the appellant, either because they hope to obtain a similar positive outcome if their practice was under review, or because they will gain some benefit from the work of the appellant.

4. Appeal process

The steps in the appeal process to be followed include the following:

- a) The appeal is initiated by the practitioner (appellant) making a request in writing to the relevant delegated decision maker ([refer to Part 5, section 1.1.2](#)) within 20 business days from the date of receipt of the decision maker's written advice regarding the practitioner's requested SoCP. The appellant must clearly articulate the grounds for their appeal and submit any associated evidence to support these grounds.
- b) The relevant decision maker ([refer to Part 5, section 1.1.2](#)) must, within 10 business days of receiving the written request, provide written notification to the OCMO that an appeal has been initiated.

- c) The appeal committee must be convened by OCMO within 20 business days of the date the notification is made to the relevant decision maker ([refer to Part 5, section 1.1.3](#)) ([refer to Attachment A for appeal committee terms of reference](#)).
- d) If the appeal committee considers that to assist in making a recommendation 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* (Qld) 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].
- e) The appeal committee may request a person to appear before the committee and provide further information¹², for example, the appellant or the credentialing committee chair, to assist in making a recommendation.

Importantly, 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 process, there is no authority that compels the person to comply with the committee's request
 - to ensure natural justice, any information obtained by the appeal committee through this process must be provided to the appellant, in a timely manner, to allow the appellant an opportunity to respond to that information. All information received, and any further information which may be submitted during the appeal process, whether adverse or not, must be provided to the appellant, as the appellant may wish to rely on positive information that has been provided by persons other than the appellant themselves.
- f) The appeal committee considers all the information presented, and makes a recommendation/s, including the reasons for the recommendation/s.
- g) The appeal committee chair must forward the committee's recommendation/s in writing to the relevant decision maker ([refer to Part 5 section 1.1.3](#)) within 20 business days of the final convening of the appeal committee

The recommendation of the appeal committee will be one of the following:

- agree with the outcome of the original decision regarding SoCP
- disagree with the outcome of the original decision regarding SoCP
- recommend SoCP with conditions that may differ from the original SoCP decision.

If appropriate and relevant, the appeal committee may also make recommendations to assist the practitioner to enhance their clinical competencies, or enhance their prospects for any future application for an increased SoCP, providing the basis for those recommendations.

The appeal committee's recommendations must include comprehensive justifications for the reasons, and these may be reviewable under the *Judicial Review Act 1991*.

- h) Once the relevant decision maker ([refer to Part 5, section 1.1.3](#)) has received the appeal committee's recommendation/s they must make a decision on the practitioner's appeal of their SoCP.

¹² 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 decision maker may

- agree with the appeal committee's recommendations
- disagree with the appeal committee's recommendations
- make a decision that includes conditions being attached to the practitioner's SoCP.

- i) The decision, with comprehensive reasons, must be communicated in writing to the appellant, the chair of the appeal committee and the departmental credentialing committee within 20 business days of the last day that the appeal committee convenes. The appeal is then closed.

Ongoing matters that relate to any conditions that may be imposed as part of the appeal decision, for example, requirements for clinical supervision, must be managed by the relevant delegate in the department.

4.1 Decision maker for the appeal process —Responsibilities

4.1.1 Prior to the appeal process

The responsibilities of the decision maker ([refer to Part 5, section 1.1.2](#)) prior to initiation of the appeal process are to:

- be accountable for receiving notification of the practitioner's request to appeal
- notify the relevant appeal decision maker ([refer to Part 5, section 1.1.3](#)) and OCMO to initiate the establishment of the independent appeal committee to manage the appellant's appeal request.

4.1.2 At the initiation of the appeal process

The responsibility of the appeal decision maker ([refer to Part 5, section 1.1.2](#)) at the initiation of the appeal process is to appoint a chair of the appeal committee.

4.1.3 Close of the appeal process

The responsibilities of the appeal decision maker ([refer to Part 5, section 1.1.3](#)) at the closure of the appeal process

- receipt the appeal committee's recommendations ([refer to Part 5, section 4, f](#))
- accept or reject the appeal committees recommendations, with or without variations
- communicate in writing and within 20 days of the final appeal committee convening, the appeal decision to the;
 - appeal committee chair
 - appellant, and if appropriate, the appellant's legal advisor
 - departmental credentialing committee.

5. Obligations to notify the Queensland Health Ombudsman and other entities

This guideline is not intended to provide a process or procedure for notifications regarding practitioners. Formal processes for making a notification should be followed by department employees, where these processes exist.

However, in some circumstances, notifications must be made (mandatory notifications), or may be made (voluntary notifications), to the Queensland Health Ombudsman under the *Health Practitioner Regulation National Law Act 2009* (Qld) (National Law). In addition, any person, including any

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employee of the department, may make a health service complaint against a practitioner, pursuant to sections 13 and 32 of the *Health Ombudsman Act 2013* (Qld).

Further, there are circumstances when information, including credentialing and SoCP information, about a practitioner is obtained under the *Private Health Facilities Act 1999* (Qld) which may be disclosed to the Queensland Health Ombudsman or to other health facilities. However, this can only occur in very specific circumstances detailed under Part 11 of the *Private Health Facilities Act 1999*.

It is very important to ensure that the relevant thresholds for notification under the legislation are met, prior to making a notification. Notifications to entities external to the department can impact significantly on a practitioner, and this should be taken into consideration prior to any notification being made.

6. Judicial review —recommendations and decisions under the *Judicial Review Act 1991*

Any decision made, or a failure to make a decision, about a practitioner regarding credentialing/ SoCP may be reviewable by the Queensland Supreme Court under the *Judicial Review Act 1991*, including the original decision, any interim decision, or any appeal decision.

The *Judicial Review Act 1991* provides for judicial review in relation to actions and conduct leading up to the making of the decision. Accordingly, any recommendations made by a committee to a decision maker, including by an appeal committee, may be considered by the Supreme Court as part of their deliberations over a judicial review matter.

Applications for judicial review under the *Judicial Review Act 1991* of a credentialing/ SoCP decision are able to be made by the practitioner generally within 28 days of the decision that has impacted them being made (section 26 of the *Judicial Review Act 1991*). Applicants may also request the reasons for a decision that has adversely affected them.

Certain practices can minimise the likelihood of, or assist in responding to, requests for a Statement of Reasons or an application to the Supreme Court for judicial review. All decision makers and appeal committee members must ensure that:

- delegations are current
- procedural fairness and natural justice practices are followed at all steps of the process
- each step in a decision or recommendation is carefully documented by each person who contributes
- file notes taken in the decision making process do not contain irrelevant considerations
- outgoing correspondence contains the name of the decision maker
- correspondence produced about a decision, after a decision is made, does not vary or contradict the decision.

7. Document responsibility – *Right to Information Act 2009* (Qld)

It is important to understand that documents obtained or created by the appeal committee may be accessible under the *Right to Information Act 2009* (Qld) (subject to the exemptions specified in that Act) and other court processes, for example subpoenas.

For further information relating to Right to Information (RTI) processes and responsibilities refer to the following website <http://qheps.health.qld.gov.au/governance/privacy-rti/rti.htm>

8. Position responsibilities —appeal committee members

Position	Responsibilities
Chair of appeal committee	<ul style="list-style-type: none"> • Comply with the Department of Health's <i>Credentialing and defining the scope of clinical practice</i> policy and Part 5 of the <i>Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline</i>. • Abide by the terms of reference of the appeal committee. • 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. • Ensure the appeal committee proceedings are conducted in private, and that members are advised of confidentiality and privacy obligations. Having the committee member's sign a deed of confidentiality and privacy will assist in ensuring this occurs. • Ensure the appeal committee maintains complete records of the credentialing process for each recommendation, and ensure those records are available for audit purposes and maintained in compliance with the provisions of the 'General Retention and Disposal Schedule for Administrative Records' http://www.archives.qld.gov.au/Recordkeeping/GRKDownloads/Documents/GeneralDisposalSchedule.pdf • Ensure appeal committee members understand the Right to Information obligations of record keeping (refer to <i>Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline</i>, Part 5, section 7) • 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. • Meetings of the appeal committee are to be conducted as frequently as necessary to ensure timely progress of the appeal. • If appropriate, engage formal advice from the department's Legal Branch or Human Resources Branch.
Appeal committee members	<ul style="list-style-type: none"> • Comply with the department's <i>Credentialing and defining the scope of clinical practice</i> policy and Part 5 of the <i>Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline</i>. • Abide by the terms of reference of the appeal committee. • Complete training on the credentialing appeal process and understand the role and responsibilities of being a member of the appeal committee. • Apply the principals of procedural fairness and natural justice as per Part 5, section 3.1. • Disclose any conflict of interest as per Part 5, section 3.2. • Disclose any present conditions or limitations with AHPRA. • Recognise that the recommendation/s of the appeal committee are reviewable under the <i>Judicial Review Act 1991</i> (refer to Part 5, section 6), and undertake to maintain comprehensive records relevant to their role in the appeal process. OCMO secretariat

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maintains master records of the appeal process.

- Understand the Right to Information obligations of record keeping.
- Provide independent advice regarding an application being reviewed by the appeal committee.
- Must at all times act independently of the decision maker (refer to *Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline* [Part 5, sections 1.1.1 and 1.1.2](#)).

Attachment A: Department of Health appeal committee — terms of reference

1. Membership of the appeal committee

The appeal committee will have a minimum of five members selected from any of the following categories. One member must be appointed as Chair:

- Chair – as endorsed by the decision maker (refer to *Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline*, [Part 5, section 1.1.3](#)) (Nomination to have relevance to the matters of the appeal case)
- a practitioner nominated by either the Queensland Branch of the Australian Medical Association or the Queensland Branch of the Australian Dental Association¹³ 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 speciality¹⁴ who practises in the field relevant to the SoCP being reviewed
- an independent medical administrator (e.g. EDMS) from a HHS/department division
- a senior practitioner from a HHS/department division 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) to be satisfied that each member of the appeal committee has the expertise, training and independence required 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 the appeal process in an individual matter.

3. Frequency of meetings

The appeal committee will meet as frequently 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 determinations of the decision maker (refer to *Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline*, [Part 5, section 1.1.1](#)), regarding matters of a practitioner's SoCP.

The committee may consider appeal matters de novo.

¹³ 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.

¹⁴ The chair 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.

A de novo appeal 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 original decision. This may necessitate the committee extending beyond the bounds of the appellant's stated grounds for appeal. However, where this occurs, the appellant **must** be informed of any additional grounds being considered.

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 to submit any documents or information relevant to the appeal, make written submission/s, and provide the option to give an oral presentation to the appeal committee in support of the written submission/s
- 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 (5) business days prior to the meeting. Legal representatives may be 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. Importantly, in following natural justice and procedural fairness, any such comment received must be provided to the appellant to allow an opportunity to respond.

In addition:

- hearings of the appeal committee will be conducted in private and will be closed to persons not directly involved in the appeal process
- final recommendations of the appeal committee will be by majority with the chair having the casting vote, if necessary. However, all recommendations of appeal committee members must be recorded, including where appeal committee members disagree with the final recommendation/s of the appeal committee
- the appeal committee must maintain strict confidentiality and privacy during and after the appeal process
- each committee member, through the chair, must provide an undertaking that they will abide by the committee's terms of reference and procedures
- representations to the appeal committee may be recorded electronically. Where this occurs, the person making representations must be informed that they will be recorded, and they must be provided with a copy of the recording.

5. Recommendations of the appeal committee

It is important to note that the appeal committee is only able to make *recommendations*. Committee members are not delegated decision makers.

A recommendation of the appeal committee will be one of the following:

- agree with the outcome of the original decision regarding SoCP
- disagree with the outcome of the original decision regarding SoCP
- recommend SoCP with conditions that may differ from conditions, if any, of the original decision regarding SoCP.

If appropriate and relevant, the appeal committee may also make recommendations to assist the practitioner enhance their clinical competencies, or enhance their prospects for any future application for an increased SoCP, providing the basis for those recommendations.

In parallel to the process of an appeal committee, registered health practitioners may have regulatory obligations to report matters to the Office of the Health Ombudsman if they are sufficiently concerned

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about the matter ([refer to Part 5, section 5 for guidance on this matter](#)). Information regarding mandatory notifications under the National Law is also provided by APHRA¹⁵.

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

Appeal committee deliberations must be undertaken in accordance with the principles of natural justice and procedural fairness. Any deliberations, determinations, recommendations and reasons are reviewable under the *Judicial Review Act 1991*. 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 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. Refer to *Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline*, [Part 5, section 3.1](#) for the principles of procedural fairness and natural justice and refer to [Part 5, section 3.2](#) for examples of potential conflicts of interest that may affect natural justice.

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 seek legal opinion on the potential conflict of interest.
- When a committee member declares a real or potential conflict of interest after they have 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 committee member becomes aware of a conflict of interest at an appeal committee meeting, they 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 committee 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 person. If an alternate person is required, the chair has the authority to appoint another member.

7. Quorum

The quorum for the appeal committee shall be a minimum of five members.

In matters of clinical judgement, relevant expert clinical members should be present.

8. Documentation/written procedures

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

The outcome of the appeal committee processes, including deliberations and minutes, will be stored and maintained for 80 years¹⁶ and must be accessible as per the provisions of the General Retention and Disposal Schedule for Administrative Records.

¹⁵ <http://www.atsihealthpracticeboard.gov.au/Codes-Guidelines/Guidelines-for-mandatory-notifications.aspx>

9. Indemnity of appeal committee members

Queensland Health and HHS employee members of the appeal committee are indemnified under relevant indemnity policies.

Non-Queensland Health or non-HHS employees, for example a practitioner nominated by the Queensland Branch of the Australian Medical Association, may apply if required for indemnity in accordance with Queensland Health indemnity arrangements.

¹⁶ Reference 1233 – 'Retain for 80 years from date of birth or 7 years from date of separation, whichever is later'
<http://www.archives.qld.gov.au/Recordkeeping/GRKDownloads/Documents/GeneralDisposalSchedule.pdf>

Appendix 1: Definition of terms

Term	Definition/explanation/details
Appellant	A practitioner appealing a decision of the departmental decision maker to the appeals committee
Applicant	An applicant is a medical practitioner or dentist who is: <ul style="list-style-type: none"> • seeking to practice within the department • seeking to renew an existing SoCP • subject to periodic or situation specific review of a pre-existing SoCP
Application	Application for SoCP, whether: <ul style="list-style-type: none"> • new • for renewal • for review • for additional/changed SoCP
Approve	In the Department of Health HR Delegations Manual, 'unless stated otherwise in the delegation function description or 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'.
Audit	A risk management strategy to monitor and verify compliance with the organisation's policies and practices on credentialing and defining SoCP.
Chief Health Officer	The person appointed as Chief Health Officer under section 52 of the <i>Hospitals and Health Board Act 2011</i> .
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. Refer also to 'practice' definition
Clinical Service Capability Framework (CSCF)	The Clinical Service Capability Framework for public and licensed private health facilities provides a standard set of capability requirements for acute public health facility services provided by Queensland Health. 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.
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 practitioner's practice.
Continuing professional development (CPD)	CPD, and continuing medical education (CME) or professional development programs (PDP) are 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.

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	<p>CPD/CME/PDP 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>Colleges relevant to medical practitioners and dentists provide CPD/CME/PDP programs. It is expected, at a minimum, that applicants will meet the requirements established by AHPRA and the relevant college/s. For applicants who have obtained a Fellowship within the past 12 months, the Fellowship certificate will be considered as sufficient evidence of CPD at the time of application only.</p>
Credentials	<p>The qualification, professional training, clinical experience, and training and experience in leadership, research, education, communication and teamwork that contribute to a practitioner's competence, performance and professional suitability to provide safe, high quality healthcare services.</p> <p>A practitioner's history of, and current status with respect to, professional registration, disciplinary actions, indemnity insurance and criminal record are also regarded as relevant to their credentials.</p> <p><i>National Standard for Credentialing and Defining the Scope of Clinical Practice - A National Standard for credentialing and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals – July 2004:</i></p> <p>https://safetyandquality.gov.au/wp-content/uploads/2012/01/credenti.pdf</p>
Credentialing	<p>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.</p>
Credentialing committee	<p>A committee established by the relevant delegate to facilitate the formal process used by the department 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.</p>
Decision maker	<p>The delegated person or position authorised to approve/amend/refuse a practitioner's SoCP within the department.</p> <p>Delegations must always be checked against the Department of Health HR Delegation Manual: HRM Functions of the Director-General</p>
Dentist	<p>A person registered and legally able to practice, within the scope of their registration, as a dentist by the Australian Health Practitioner Regulation Agency:</p> <p>http://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx</p>
Department of Health	<p>Collectively this includes all Divisions, Branches and Units within the administrative area of Queensland Health, described as the 'department' in section 8 of the <i>Hospital and Health Boards Act 2011</i>.</p>
Executive Director of Medical Services	<p>The executive medical officer within the management group who has responsibility for the professional leadership and the clinical governance of medical services.</p> <p>At a local HHS level, the position may be titled as 'medical superintendent', 'director of medical services' or other variant.</p>

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Facility	Refer to 'Public health facility' definition
Governance	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) 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 (HHS)	A Hospital and Health Service as defined within the <i>Hospital and Health Boards Act 2011</i> , which is a separate legal entity under section 18 of the <i>Hospital and Health Boards Act 2011</i> .
Identified medical practitioners and dentists	Means the practitioners that this policy and associated credentialing and SoCP documents applies to, namely medical practitioners and dentists that are registered with the Australian Health Practitioners Agency (AHPRA) and are employed or contracted by the department. This includes Health Support Queensland and the Queensland Ambulance Service.
Locum	An appropriately registered medical practitioner or dentist who is engaged by Queensland Health or a HHS on a temporary basis to meet a specific healthcare need for a specified period of time.
Medical practitioner	A person registered and legally able to practice, within the scope of their registration, as a medical practitioner and/or medical specialist by AHPRA: http://www.ahpra.gov.au/Registration/Registers-of-Practitioners.aspx
National Safety and Quality Health Service Standards	National Safety and Quality Health Service Standards – September 2012: Standard 1.10. Australian Commission on Safety and Quality in Health Care: http://www.safetyandquality.gov.au/ Standard 1.10: https://www.safetyandquality.gov.au/publications/national-safety-and-quality-health-service-standards/
Policy	Unless otherwise specified, refers to the <i>Credentialing and defining the scope of clinical practice</i> policy (QH-POL-390:2015)
Practice	Any role, whether remunerated or not, in which the individual uses their skills and knowledge as a medical or dental practitioner.. Practice need not be restricted to the provision of direct clinical care. It may also include using professional knowledge in a direct, nonclinical relationship with clients, working in management, administration, education, research, advisory, regulatory or policy development roles, and any other roles that impact on safe, effective delivery of services in the profession. Medical Board of Australia– definitions: http://www.medicalboard.gov.au/Registration-Standards.aspx Dental Board of Australia– definitions: http://www.dentalboard.gov.au/Registration.aspx

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Practitioner	A collective term used in this guideline which refers to a medical practitioner and/or dentist.
Public health facility	<p>A public health facility in this guideline refers to a Queensland Health facility which provides health services to public sector patients,, including, but not restricted to the following:</p> <ul style="list-style-type: none"> • hospital • hospice • multipurpose health service • healthcare centre/health service centre/community health centre/primary health care centre • outpatients clinic/care • residential aged care public health facility/public mental health facility • fixed and mobile public health dental clinics.
Queensland Health	Queensland Health is the State department described in the Administrative Arrangements Order made under the <i>Constitution of Queensland 2001</i> that administers legislation relevant to health in Queensland under the Minister for Health and Minister for Ambulance Services, with the Director-General of Queensland Health as the responsible head.
Registration	A practitioner's, professional registration as determined by the Australian Health Practitioner Regulation Agency. The two applicable regulatory authorities are the Medical Board of Australia and the Dental Board of Australia.
Scope of clinical practice (SoCP)	<p>The extent of an individual practitioner's approved clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability and the needs and capability of the organisation to support the practitioner's SoCP.</p> <p>Australian Commission on Safety and Quality in Health Care, <i>Credentialing health practitioners and defining their scop of clinical practice: A guide for managers and practitioners</i>. December 2015:</p> <p>https://www.safetyandquality.gov.au/wp-content/uploads/2016/02/Credentialing-health-practitioners-and-defining-their-scope-of-clinical-practice-A-guide-for-managers-and-practitioners-December-2015.pdf</p>
Statewide/multi-HHS SoCP	Services delivered, or managed and monitored, by a single HHS or the department. These services are then receipted by multiple other HHSs or department divisions, where medical practitioners or dentists (employed or contracted staff) provide health care within public health facilities across the state.
Telehealth	<p>Telehealth, in the context of the Australian healthcare setting, can be defined as the use of videoconferencing technologies to conduct a medical consultation where audio and visual information is exchanged in real time. While telehealth is not designed to replace face-to-face consultations, it can be used to enhance and simplify ingoing specialist services to patients whose access might otherwise be limited.</p> <p>It is important to note that telehealth is not a SoCP it is simply a means/medium for providing clinical services.</p>

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Appendix 2: Abbreviations

AHPRA	Australian Health Practitioner Regulation Agency
CE	Chief executive
CHO and DDGPD	Chief Health Officer and Deputy Director-General, Prevention Division
CME	Continuing medical education
CPD	Continuing professional development
CSCF	Clinical service capability framework
DoH	Department of Health
EDMS	Executive director of medical services
HHS	Hospital and Health Service
HSCE	Health service chief executive
HSQ CE	Health Support Queensland chief executive
OCMO	Office of the Chief Medical Officer
PDP	Professional development program
SoCP	Scope of clinical practice

Appendix 3: Supporting and related documents

3.1 Related or governing legislation

- *Acts Interpretation Act 1954* (Qld)
- *Anti-Discrimination Act 1991* (Qld)
- *Biosecurity Act 2015* (Cth)
- *Criminal Law (Rehabilitation of Offenders) Act 1986* (Qld)
- *Coroners Act 2003* (Qld)
- Coroners Regulation 2015 (Qld)
- *Disaster Management Act 2003* (Qld)
- Disaster Management Regulation 2014 (Qld)
- Disaster Management HSD QH-HSD-003:2015
- *Food Act 2006* (Qld)
- Food Regulation 2016 (Qld)
- *Guardianship and Administration Act 2000* (Qld)
- *Health Act 1937* (Qld)
- Health Regulation 1996 (Qld)
- Health (Drugs and Poisons) Regulation 1996 (Qld)
- *Health Ombudsman Act 2013* (Qld)
- *Health Practitioner Regulation National Law Act 2009* (Qld)
- *Hospital and Health Boards Act 2011* (Qld)
- Hospital and Health Boards Regulation 2012 (Qld)
- *Information Privacy Act 2009* (Qld)
- *Judicial Review Act 1991* (Qld)
- *Major Events Act 2014* (Qld)
- Major Events (Commonwealth Games – Visiting Health Practitioner Exemptions) Regulation 2016 (Qld)
- Major Events (Motor Racing Events) Regulation 2015 (Qld)
- *Mental Health Act 2016* (Qld), s.298
- Patient Safety HSD QH-HSD-032:2014
- *Private Health Facilities Act 1999* (Qld)
- Private Health Facilities Regulation 2016 (Qld)
- Private Health Facilities (Standards) Notice 2016 (Qld)
- *Public Health Act 2005* (Qld)
- Public Health Regulation 2005 (Qld)
- *Public Health (Infection Control for Personal Appearance Services) Act 2003* (Qld)
- Public Health (Infection Control for Personal Appearance Services) Regulation 2016 (Qld)
- Public Health (Infection Control for Personal Appearance Services) (Infection Control Guideline) Notice 2013 (Qld)

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- *Radiation Safety Act 1999* (Qld)
- *Radiation Safety Regulation 2010* (Qld)
- *Radiation Safety (Radiation Safety Standards) Notice 2010*
- *Right to Information Act 2009* (Qld)
- *Transplantation and Anatomy Act 1979* (Qld)
- *Transplantation and Anatomy Regulation 2004* (Qld)

3.2 Related policy and documents

- Credentialing and defining the scope of clinical practice Department of Health policy (QH-POL-390:2015)
- Credentialing and defining the scope of clinical practice for medical practitioners and dentists Standard (QH-IMP-445:2017)
- Recruitment and Selection Human Resources Policy B1 (QH-POL-212:2014)
- Employees to Notify Supervisor if Charged with or Convicted of an Indictable Offence Human Resources Policy E4 (QH-POL-127:2014)
- Indemnity for Queensland Health Medical Practitioners Human Resources Policy I2 (QH-POL-153:2014). Information regarding indemnity (excluding medical) is available in the Queensland Government Indemnity Guideline
<https://www.qld.gov.au/gov/documents/guideline/queensland-government-indemnity-guideline>
- General Retention and Disposal Schedule for Administrative Records, Queensland Disposal Authority, 1 September 2016,[reference 1233 for employee practitioners]
<http://www.archives.qld.gov.au/Recordkeeping/GRKDownloads/Documents/GeneralDisposalSchedule.pdf> (for administrative records)

3.3 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, (in review) available at:
http://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 – A National Standard for credentialing and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals - July 2004, available at:
<http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/credenti.pdf>
- AHPRA, Recency of Practice Registration Standard relevant to the professions, available at:
<https://www.ahpra.gov.au/>
- AHPRA, Guidelines for Mandatory Notifications relevant to the professions, available at:
<https://www.ahpra.gov.au/>
- Office of the Health Ombudsman Mandatory Notifications, available at:

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<http://www.oho.qld.gov.au/health-service-providers/making-a-complaint-about-another-health-practitioner/>

- Clinical Service Capability Framework for Public and Licensed Private Health Facilities V3.1 2014, available at:
<https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf/default.asp>
- RACMA Guide to Practical Credentialing and Scope of Clinical Practice Processes, available at:
http://www.racma.edu.au/index.php?searchword=credentialing&ordering=newest&searchphrase=all&option=com_search
- Australian Commission on Safety and Quality in Health Care, Credentialing health practitioners and defining their scope of clinical practice: a guide for managers and practitioners, December 2015, available at:
<https://www.safetyandquality.gov.au/wp-content/uploads/2016/02/Credentialing-health-practitioners-and-defining-their-scope-of-clinical-practice-A-guide-for-managers-and-practitioners-December-2015.pdf>

Appendix 4: Credentialing committee— sample terms of reference

1. Membership of the committee

The departmental credentialing committee¹⁷ is responsible for considering a practitioner's credentials and requested scope of clinical practice (SoCP), and recommending to the decision maker (refer to *Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline*, [Part 1, section 3.1.2 – 3.1.6](#)) a SoCP for the applicant. It is recommended that the committee should as a minimum comprise at least five (5) members including:

- for medical applicants: the executive director of medical services (EDMS) or their nominee, or an appropriate medical administrator; AND another suitably qualified medical practitioner
- for dental applicants: the Director of Oral Health or an appropriate dental administrator; AND another suitably qualified dentist
- two other practitioners (dental or medical) with the necessary knowledge, skills and experience to provide independent, high quality advice relevant to the SoCP¹⁸.
- the director of nursing or their equivalent, or an appropriately qualified allied health professional.

At least one committee member should be familiar with the requirements of the Queensland Health recruitment and selection process in accordance with the provisions of *Human Resource Policy B1*. If this is not the case the committee should have ready access at each meeting to a senior human resources professional with the relevant skills and experience.

Prior to consideration of a practitioner's application for SoCP, committee Chair will request in writing or in person, input/opinion from the applicant's nominee or supervisor¹⁹ if a relevant representative who practices in the field and speciality to the applicant is not a committee member.

The committee is able to invite additional practitioners with specific clinical skills and experience to advise on the SoCP being requested.

2. Access to expert advice

The committee must access practitioners²⁰ 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 Specialist College or association as accredited by the Australian Medical Council (AMC)
- 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 meeting²¹
- the committee is able to access senior human resource and legal advice.

¹⁷ NB The Appeal Committee process is a separate and distinct process from that of the Credentialing Committee, for Appeal Committee information refer to Attachment A for Department of Health Appeal Committee – terms of reference

¹⁸ All medical practitioners and dentists who are members of the committee must have general or specialist medical/dental registration, with no disciplinary conditions or undertakings.

¹⁹ Participation may be either in person or by videoconference or teleconferencing.

²⁰ 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.

²¹ Teleconferencing/videoconferencing can be used as a substitute for attendance in person

3. Chair of the committee

The decision maker (refer to *Credentialing and defining the scope of clinical practice for medical practitioners and dentists: a best practice guideline*, [Part 1, section 3.1.1](#)) will appoint the chair of the committee.^{22 23}

The chair of the committee appoints credentialing committee members.

4. Quorum

A quorum of not fewer than three members, including the chair, must be present for all deliberations of the committee, to provide continuity of process by the committee.

The quorum must include at least two practitioner members representing the applicant's profession, for example for medical applicants at least two medical practitioners and for dental applications at least two dental practitioners must be present.

5. Length of appointments to the committee

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

6. Frequency of meetings

The frequency of committee meetings may be determined 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, confidentiality, equal opportunity, and defamation.

The committee will:

- follow the endorsed terms of reference, written protocols and procedures for evaluation of credentials and defining the SoCP, as stipulated in the *Credentialing and defining the scope of clinical practice policy and standard and processes* as recommended within this guideline.
- adhere to confidentiality and privacy obligations 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

²² *RACMA Guide to practical credentialing and SoCP processes* states that 'The Chair of the committee must be an expert in credentialing and defining SoCP processes and be able to use that expertise to challenge committee discussions and decision making if necessary. Wherever possible the committee should be chaired by a FRACMA or AFRACMA or an individual with appropriate training if a suitably qualified person is not available.'

²³ *Department of Health Human Resources (HR) Delegation Manual: HRM Functions of the Director-General*, October 2016 (effective 14 December 2016) section 13, Credentialing /Scope of Clinical Practice functions

- determine specific criteria with reference to the CSCF, 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 SoCP 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 decision maker 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 80 years²⁴ 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 SoCP process is conducted in a fair, transparent, timely and legally robust manner
- conduct compliance audits as per the auditing schedule to the department's Credentialing and defining the scope of clinical practice policy that will assist in ensuring all identified health professionals are credentialed and have a defined SoCP
- report to the relevant decision maker ([refer to Part 1, section 3.1.1](#)) regarding the committee's performance, compliance with the audit, quality assurance reviews and any risk management recommendations for improvement
- regularly, and at a minimum of one yearly intervals, review the Terms of Reference of the credentialing committee.

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

The committee's deliberations must at all times be carried out in accordance with the principles of natural justice and procedural fairness. Any deliberations and determinations may be reviewable under the *Judicial Review Act 1991* ([refer to, Part 1, section 4](#)). Practitioners are entitled to deliberations being made free of prejudice before any decision is made or implemented which affects the way in which they practice or are employed.

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

- 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
- to 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.

²⁴ Reference – 1233 'Retain for 80 years from date of birth or 7 years from date of separation, whichever is later.'
<http://www.archives.qld.gov.au/Recordkeeping/GRKDownloads/Documents/GeneralDisposalSchedule.pdf>

9. Conflicts of interest

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

Appropriate management of conflict of interest may range from merely documenting the conflict with no further action required, through to the member not sitting on the committee.

- Examples of potential conflicts of interest in credentialing and defining the SoCP include, but are not limited to, situations where the committee member is:
 - related to, is in a relationship with or has a close personal relationship with, the applicant under review
 - in dispute with the applicant under review
 - the owner and/or manages a private practice/facility in which the applicant has a clinical practice
 - in competition with the applicant under review and stands to benefit from any negative outcome for the applicant under review
 - related to a person in competition with the applicant under review and that related person stands to benefit from any negative outcome for the applicant under review
 - benefiting from a positive outcome from the applicant under review, either because they hope to obtain a similar positive outcome if their practice was under review, or because they will gain some benefit from the applicant under review.
- When a committee member is recused they must physically leave the meeting, and must not take any action to influence the committee's deliberations.
- When a committee member is recused, the reason for that recusal must be documented in the minutes of the committee meeting.
- It is essential that any committee member 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.

10. Documentation/written procedures

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 80 years as per the provisions of the 'General Retention and Disposal Schedule for Administrative Records' Queensland Disposal Authority, 1 September 2016,[reference 1233 for employee practitioners]

<http://www.archives.qld.gov.au/Recordkeeping/GRKDownloads/Documents/GeneralDisposalSchedule.pdf>

11. Education and training

On appointment, 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.

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Members must have the ability to critically analyse any information about credentials, and have clarity around what support the organisation is able to provide in relation to SoCP of specific clinicians.

12. Credentialing of the Chair and committee members

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

When the credentials of the chair are being reviewed, the Chair will recuse himself/herself from the meeting and the decision maker will appoint an acting Chair.

13. Indemnity of committee members

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

Queensland Health/HHS employees who are members of the committee are indemnified under relevant public service and departmental indemnity policies.

Non-Queensland Health/HHS employees may apply, if required, for indemnity in accordance with Queensland Health/HHS indemnity arrangements.

Appendix 5: Position responsibilities — applicant, decision maker and members of 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 recommendation 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 recommendation on credentials and SoCP.
Decision maker (refer to Guideline Part 1, section 3.1.2 – 3.1.6)	<ul style="list-style-type: none"> • Ensure all practitioners within the department division are credentialed and have an approved SoCP in accordance with the <i>Credentialing and defining the scope of clinical practice</i> policy. • On receipt of the recommendation/s from the committee, the decision maker must take into account all relevant factors prior to making a decision regarding a SoCP. Any factors or information considered by the decision maker that are outside of the information before the committee, must be provided to the practitioner prior to any adverse decision being made about that practitioner. • 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 10 business days of the committee meeting when the committee's recommendation was made. • Ensure that an interim SoCP approval will be for a period of not more than three calendar months and is not renewable. • Ensure SoCP, in all circumstances, is granted for an individual practitioner for a period not greater than five (5) years for each separate application. • Ensure the practitioner is informed of the capability of the services relevant to the practitioner's area of practice. • A SoCP approved by the decision maker is only valid within the department division that the decision is made, with the exception of statewide/multi-HHS services (refer to <i>Credentialing and defining the scope of clinical practice</i> policy, Schedule A) • Immediately notify other affected HHSs/department divisions credentialing committees if a practitioner's statewide/multi-HHS and mutually recognised SoCP has been suspended, terminated or has limiting conditions imposed.
Chair of credentialing committee	<ul style="list-style-type: none"> • Comply with the <i>Credentialing and defining the scope of clinical practice</i> policy. • Abide by the Terms of Reference of the credentialing committee. • Ensure each committee member has completed training on the department division credentialing process and understands their role and obligation as a member of the committee. • Ensure the 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'. http://www.archives.qld.gov.au/Recordkeeping/GRKDownloads/Documents/GeneralDisposalSchedule.pdf • Ensure committee members understand the Right to Information obligations of record keeping • Meetings of the committee should be conducted as frequently as necessary to ensure practitioners are reviewed in a timely manner. • Convene an extraordinary meeting where a matter requires review prior to the next

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	<p>scheduled meeting of the committee.</p> <ul style="list-style-type: none"> • Distribute recommendations to the decision maker in a timely manner. • If appropriate, engage formal advice from the department's Legal Branch or Human Resources Branch.
Credentialing committee members	<ul style="list-style-type: none"> • Comply with the <i>Credentialing and defining the scope of clinical practice</i> policy. • Abide by the Terms of Reference of the committee. • Members will complete training on the department division credentialing process and understand their role and responsibilities as a member prior to sitting on the committee. • Disclose any conflict of interest as per Appendix 4, section 9. • Disclose any current conditions or limitations with their own AHPRA registration. • Have the ability to critically analyse any information about credentials and have clarity around what support the organisation is able to provide in relation to SoCP of specific clinicians. • Be mindful that the recommendation/s of the committee may be reviewable under the <i>Judicial Review Act 1991</i> (refer to Part 1, section 4). • Understand the Right to Information obligations of record keeping. • Recommend an appropriate SoCP based on the information provided.

Appendix 6: Practitioner — 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 regarding the SoCP which you have requested (e.g. a new technology is introduced)
- is unclear or seeking further information regarding the review of your SoCP
- wants to fully understand all the circumstances around your credentialing and SoCP.

Do I 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 electronically, you will be provided with a copy of the recording.

What happens if I don't write a submission?

While there is no obligation for practitioners to provide a response to matters raised relevant to your SoCP, conclusions about your clinical practice and the subsequent recommendation/s of the committee are made based on all the available information. If a written response is not provided, the committee will still be required to make a recommendation on the available information.

Preparing your submission

- Address each concern or matter raised—look at each concern or matter raised, 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 relevant designation, 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

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providing an endorsement of you as a person. Patient testimonials may be of limited value, as credentialing and SoCP is a peer review process. However, if you consider they may be helpful, include them.

- Keep it succinct—your submission may 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 resolve any identified issues or concerns—if you agree that the concerns raised have a basis, and you have a suggestion that would remove the cause for concern, then it is helpful if you put this forward.

Remember, the committee, and ultimately the decision maker, really does want to consider in full your side of the story, and these suggestions are designed to help you provide the committee and decision maker with useful information.

You may wish to consider whether to speak with your medical protection insurer or engage legal counsel. Engaging legal counsel for credentialing and SoCP processes is not specifically covered under *Indemnity for Queensland Health's Medical Practitioners Human Resource Policy I2*, or the *Queensland Government Indemnity Guideline*.

For more information on providing submissions for the credentialing and SoCP review, or appeal processes, contact the chair of the committee requesting the submission.

Version Control

Version	Date	Comments
Version 1	28 June 2017	Previous <i>Guide to credentialing and defining scope of clinical practice for medical practitioners and dentists in Queensland</i> document has been reviewed and converted into a best practice guideline.

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Application for Scope of Clinical Practice

NB: Information included on this application is for Medical Practitioners and Dentists requiring a 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 or Department of Health Division/s where SoCP is requested:

--

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: ☐ Female ☐ Male

Contact Details

Home address:

☐ Preferred address for correspondence

Practice address:

☐ 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 (if applicable)

☐ **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 ▼

Current Clinical Appointment(s)

List appointments and current SoCP that would continue concurrently at other public and private health care facilities, including period of time.

Appointment	Scope of Clinical Practice	HHS / Organisation

☐ Please refer to CV for supporting information

References

Please nominate a **minimum of two** professional peer referees who can attest to your clinical skills and professional performance **within the past 12 months** in the areas for which you have applied for SoCP.

Referee 1 <i>Designation: Current Line Manager / Professional Peer</i>	Name:	
	Current position:	
	Address:	
	Phone (work):	Mobile:
	Email:	

Referee 2	Name:	
	Current position:	
	Address:	
	Phone (work):	Mobile:
	Email:	

Referee 3	Name:	
	Current position:	
	Address:	
	Phone (work):	Mobile:
	Email:	

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.

I understand that, in line with the National Standards, basic details of my SoCP status will be accessible to relevant departmental and Hospital and Health Service staff including those in relevant patient care areas.

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 Directives**
<http://www.health.qld.gov.au/directives/html/c.asp>
- **Department of Health Policies and Regulations**
<http://www.health.qld.gov.au/qhpolicy/html/index-c.asp>
- **Hospital and Health Service Policies**
- **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 a Hospital and Health Service/Department of Health division or cease private practice at a Queensland public 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 Employees to Notify Supervisor if Charged with or Convicted of an Indictable Offence Human Resources Policy E4 (QH-POL-127), employees are to notify supervisor if charged with or convicted of an indictable offense.

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 consent to information regarding my credentialing and SoCP being disclosed by the Department of Health and Hospital and Health Services in the following circumstances:

- for my credentialing and SoCP details to be published in a register on the Queensland Health Electronic Publishing Service (QHEPS)
- for my credentialing and SoCP information to be disclosed between differing Hospital and Health Services and the Department of Health for a purpose associated with the approval, amendment or refusal of my credentials and SoCP, including, for example, as part of the mutual recognition process of my credentials and SoCP.

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:

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

New Application Checklist

- ☐ Yes, photo identification attached
- ☐ Yes, current CV attached (signed & dated as true and correct – gaps in employment explained)
- ☐ Yes, base degree attached
- ☐ Yes, specialist qualification 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)

Renewal Checklist

- ☐ Yes, current CV attached (signed & dated as true and correct – gaps in employment explained) if requested
- ☐ Yes, contacts for referee/s provided
- ☐ Yes, current CME/CPD evidence attached
- ☐ 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**

☐ Endodontics

☐ Public Health Dentistry

☐ Oral Pathology

☐ Dento-Maxillofacial Radiology

☐ Periodontics

☐ Prosthodontics

☐ Oral Medicine

☐ Forensic Odontology

☐ Orthodontics

☐ Oral and Maxillofacial Surgery

☐ Special Needs Dentistry

☐ Oral Surgery

☐ Paediatric Dentistry

Dermatology

☐ **Dermatology**

Emergency Medicine

☐ **Emergency Medicine**

Forensic Medicine

☐ **Forensic Medical Officer**

☐ **Government Medical Officer**

General Practice

☐ General Practice

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.

Specify any exclusions:

General Practice Advanced Specialised Skills

If requesting Scope of Clinical Practice in an Advanced Specialised Skill, please include for the Committee's consideration:

- 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.

OR

- 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.

☐ Obstetrics (DRANZCOG Advanced)

- ☐ Perform normal deliveries, assisted deliveries (excluding Keilland's forceps) and caesarean sections
- ☐ Perform basic elective and emergency gynaecological procedures including laparotomies in emergency gynaecological situations
- ☐ Operative Laparoscopy (Level 1)
- ☐ Colposcopy

☐ Anaesthetics (JCCA)

- ☐ Adults
- ☐ Children – state minimum age or weight:
- ☐ Epidural Anesthesia

☐ Rural Generalist Surgery (24 months advanced skill training with ACRRM)

- ☐ Attached list of specific procedures

☐ Aboriginal and Torres Strait Islander Health (12 months advanced skill training with RACGP or ACRRM)

☐ Adult Internal Medicine (12 months advanced skill training with ACRRM)

☐ Child and Adolescent Health / Paediatrics (12 months advanced skill training with RACGP or ACRRM)

☐ Generalist Emergency Medicine (18 months post FACRRM training)

☐ GP Emergency Medicine (12 months advanced skill training with RACGP or ACRRM)

☐ Mental Health (12 months advanced skill training with RACGP or ACRRM)

☐ Population Health (12 months advanced skill training with ACRRM)

☐ Remote Medicine (12 months advanced skill training with ACRRM)

☐ Gastroscopy (GESA Certification)

☐ Colonoscopy (GESA Certification)

☐ Other (please state):

Intensive Care Medicine

☐ Intensive Care Medicine

- ☐ Echocardiography
- ☐ Gastrointestinal Endoscopy
- ☐ Extracorporeal Membrane Oxygenation (ECMO)
- ☐ Other (please state):

Medical Administration

☐ Medical Administration

☐ Clinical Administration in (please state):

Obstetrics and Gynaecology

☐ Obstetrics and Gynaecology

- ☐ Advanced Operative Laparoscopy Level 4
- ☐ Advanced Operative Laparoscopy Level 5
- ☐ Advanced Operative Laparoscopy Level 6
- ☐ Advanced Endoscopic Surgery
- ☐ Lower Genital Tract Laser Surgery
- ☐ Robotic Surgery

Subspecialties

- ☐ Gynaecological Oncology
- ☐ Maternal-Fetal Medicine
- ☐ Urogynaecology
- ☐ Obstetrics and Gynaecological Ultrasound
- ☐ Reproductive Endocrinology and Infertility

Extra Training

- ☐ Paediatric Gynaecology
- ☐ Video Colposcopy of Children

Occupational and Environmental Medicine

☐ Occupational & Environmental Medicine

Ophthalmology

☐ Ophthalmology

- ☐ Post Fellowship Training (please state):

Paediatrics and Child Health

☐ General Paediatrics and Child Health

☐ Child Protection

- ☐ Level 2 – Medical staff working predominantly with children, young people and parents
- ☐ Level 3 – Designated medical child protection practitioner

☐ Clinical Genetics (Paediatric)

☐ Community Child Health

☐ Neonatology and Perinatal Medicine

- ☐ Echocardiography
- ☐ Ultrasound
- ☐ Other (please state):

☐ Paediatric Cardiology

- ☐ Transthoracic Echocardiography
- ☐ Transoesophageal Echocardiography
- ☐ Fetal Echocardiography
- ☐ Paediatric Cardiac Catheterisation – Level 1 Procedures
- ☐ Paediatric Cardiac Catheterisation – Level 2 Procedures
- ☐ Paediatric Cardiac Catheterisation – Level 3 Procedures
- ☐ Paediatric Cardiac Catheterisation – Level 4 Procedures

☐ Paediatric Clinical Pharmacology

☐ Paediatric Emergency Medicine

☐ Paediatric Endocrinology

☐ Paediatric Endocrinology and Chemical Pathology

☐ Paediatric Gastroenterology and Hepatology

- ☐ Liver Biopsy
- ☐ Endoscopic Retrograde Cholangiopancreatography (ERCP)
- ☐ Gastroscopy
- ☐ Endoscopic Ultrasound (EUS)
- ☐ Colonoscopy
- ☐ Balloon Enteroscopy
- ☐ Capsule endoscopy
- ☐ 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 (Laboratory)
<input type="checkbox"/> Immunology (Laboratory)
<input type="checkbox"/> Microbiology (Laboratory)
<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☐ **General Medicine**

- | | |
|--|---|
| <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): | |

☐ **Cardiology**☐ **Adult Echocardiography**

- ☐ Level 1 – Transthoracic Echocardiography
- ☐ Level 2 – Transoesophageal Echocardiography
- ☐ Level 3 – Stress Echocardiography

☐ **Cardiac Implantable Electronic Devices (CIED) and Electrophysiology**

- ☐ Track 1 – Cardiac Implantable Electronic Devices
- ☐ Track 2 – Cardiac Implantable Electronic Devices
- ☐ Adult Cardiac Electrophysiology

☐ **Coronary Angiography**

- ☐ Diagnostic Cardiac Catheterisation and Coronary Angiography
- ☐ Percutaneous Coronary Intervention (PCI)
- ☐ Level 2 – Stress Echocardiography
- ☐ CT Coronary Angiography (CTCA) Level A Specialist
- ☐ CT Coronary Angiography (CTCA) Level B Specialist
- ☐ Lead Extraction Certification

☐ **Clinical Genetics**☐ **Clinical Pharmacology**☐ **Endocrinology**☐ **Endocrinology and Chemical Pathology**☐ **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): |

☐ **Geriatric Medicine**☐ **Haematology**☐ **Haematology and Pathology**☐ **Clinical Immunology and Allergy**☐ **Clinical Immunology, Allergy and Immunopathology**☐ **Infectious Diseases**☐ **Infectious Diseases and Microbiology**☐ **Medical Oncology**☐ **Nephrology**

- ☐ Renal Biopsy
- ☐ Peritoneal Access Placement
- ☐ Acute Vascular Access

Physician continued☐ **Neurology**☐ **Nuclear Medicine**☐ Positron Emission Tomography (PET)☐ CT Coronary Angiography (CTCA)☐ **Respiratory** ☐ **Sleep Medicine**☐ Flexible Bronchoscopy☐ Endobronchial Stents☐ Endobronchial ultrasound-guided transbronchial needle aspiration (EBUS) TBNA☐ Endobronchial ultrasound-guided transbronchial needle aspiration (EBUS) Guide Sheath☐ Medical Thoracoscopy☐ Endobronchial Electrosurgery☐ Rigid Bronchoscopy☐ Autofluorescence bronchoscopy☐ Laser Bronchoscopy☐ **Rheumatology**☐ Biopsy of relevant tissues and organs☐ Musculoskeletal Ultrasound☐ Arthroscopy☐ Injection techniques under imaging guidance☐ Radioactive or Chemical Synovectomy**Psychiatry**☐ **Psychiatry**☐ Administration of ECT ☐ Advanced certification in (please state):☐ **General Psychiatry associated with Statewide Disaster Response****Public Health Medicine**☐ **Public Health Medicine****Radiation Oncology**☐ **Radiation Oncology****Radiology**☐ **Diagnostic Radiology**☐ MRI☐ Mammography☐ Peripheral Endovascular Therapy☐ **Tier A Procedures**☐ **Tier B Procedures**☐ Thoracic intervention☐ Gastro-intestinal intervention☐ Urological intervention☐ Gynaecological intervention☐ Orthopaedic intervention☐ Neuro-interventional procedures intracranial and extracranial☐ Vascular interventional procedures other than basic diagnostic angiography☐ Venous and arterio-venous graft interventions other than basic diagnostic venography or fistulography☐ Biliary intervention including T.I.P.S.☐ **Nuclear Medicine**☐ **CT Coronary Angiography (CTCA)****Rehabilitation Medicine**☐ **Rehabilitation Medicine**

Retrieval Services	
<input type="checkbox"/>	Medical Coordination
<input type="checkbox"/>	Pre-hospital and Retrieval Medicine
<input type="checkbox"/>	Retrieval Medicine (Paediatric)
<input type="checkbox"/>	Retrieval Medicine (Neonatal)
Sexual Health Medicine	
<input type="checkbox"/>	Sexual Health Medicine
Sports Medicine	
<input type="checkbox"/>	Sports Medicine
Vascular Medicine	
<input type="checkbox"/>	Vascular Medicine
Surgery	
<input type="checkbox"/>	General Surgery
<input type="checkbox"/>	Gastroscopy
<input type="checkbox"/>	Colonoscopy
<input type="checkbox"/>	Other endoscopy (please state):
<input type="checkbox"/>	Post Fellowship Training
<input type="checkbox"/>	Colon and Rectal Surgery
<input type="checkbox"/>	Upper Gastrointestinal (GI)
<input type="checkbox"/>	Hepato-Pancreato-Biliary (HPB)
<input type="checkbox"/>	Bariatric Surgery
<input type="checkbox"/>	Transplant Surgery (please state):
<input type="checkbox"/>	Other (please state):
<input type="checkbox"/>	Cardio-Thoracic Surgery (Adult)
<input type="checkbox"/>	Cardio-Thoracic Surgery (Paediatric)
<input type="checkbox"/>	Neurosurgery
<input type="checkbox"/>	Post Fellowship Training (please state):
<input type="checkbox"/>	Orthopaedic Surgery
<input type="checkbox"/>	Post Fellowship Training (please state):
<input type="checkbox"/>	Otolaryngology – Head and Neck Surgery
<input type="checkbox"/>	Post Fellowship Training (please state):
<input type="checkbox"/>	Oral and Maxillofacial Surgery
<input type="checkbox"/>	Paediatric Surgery
<input type="checkbox"/>	Plastic Surgery
<input type="checkbox"/>	Post Fellowship Training (please state):
<input type="checkbox"/>	Urology
<input type="checkbox"/>	Post Fellowship Training (please state):
<input type="checkbox"/>	Vascular Surgery
<input type="checkbox"/>	Peripheral Endovascular Therapy
<input type="checkbox"/>	Post Fellowship Training (please state):



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 (please rate the applicant's skills, as listed below)

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 ▶ provide details <input type="checkbox"/> No
Would you consider this applicant for another position?	<input type="checkbox"/> Yes <input type="checkbox"/> No ▶ provide details <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 ▶ provide details <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 ▶ provide details <input type="checkbox"/> No
Other comments you may wish to make (optional).	

7. Signature

Name (please print):	Signature:
Position:	
Date:	