Accreditation of Health Practitioners Procedure

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1. Introduction

Mater Health, its employees, and accredited health practitioners have a legal and moral obligation to ensure that services are provided in circumstances where patient safety and quality of care has been properly addressed.

This procedure outlines the process for accreditation of a health practitioner providing services at Mater and is to be read in conjunction with the Mater By-Laws for Accredited Health Practitioners (referred to in this procedure as the By-Laws) to ensure all identified health practitioners are appropriately credentialed and have a defined scope of practice (SoP) to provide safe and high-quality health care services.

2. Governance

a. This document is the operational procedure to support the Credentialing and SoP as defined in the Mater By-Laws.

b. Appropriate systems and processes are in place to identify, manage and report concerns of any accredited health practitioners to Executive and senior leadership. *Refer to section 15: Health Practitioner Concern (HPC).*

c. A delegation's register within this procedure provides a summary of who the Chief Executive Officer (CEO) or Mater Group Board delegates to perform action pursuant to the By-Laws. *Refer to section 17: Delegations Register.*

This procedure applies to:

- Visiting medical officers.
- Mater employed senior medical officers.
- Non-specialist medical officers undertaking supervised private practice or surgical assisting (e.g., surgical fellows, registrars, and junior doctors).
- Visiting allied health practitioners, endorsed midwives, and registered nurses (including nurse practitioners, practice nurses and perioperative nurse surgical assistants).
- Visiting dental practitioners.
- Visiting surgical assistants (dental assistants).
- Clinical visitors (supervised clinical practice or observer).

This procedure excludes:

- Employed doctors in training (junior medical officers, registrars, fellows) other than explicitly included, where they are working under supervision and working within their Mater employed SoP.
- Employed allied health practitioners, registered nurses, and midwives where they are working within their Mater employed SoP. Note – advanced SoP processes may be included within this procedure.
- Health practitioners undertaking research if the research involves no patient contact or indirect care or responsibilities.
- Student placements. Note - any allied health, nursing or medical students seeking clinical (or extra-curriculum) placement at Mater is undertaken by the Student Placement Office (via Mater Education).

2.1 Governing policy

- Mater Health By-Laws for Accredited Practitioners (2024).

3. Initial accreditation

a. The relevant General Manager (or their delegate) will facilitate a meeting with the applicant to discuss goals, plans and intentions, clinical capability, facility operations, organisational need, and capability. The General Manager or delegate will ensure verbal reference checks have been completed, including speaking to a lead accredited health practitioner within the same specialty. If acceptable, the General Manager will notify the Credentialing Officer to invite the applicant to apply for credentialing.

b. Initial accreditation is granted for a maximum period of up to five (5) years from approval date.

3.1 Verification of credentials

The following evidence will be reviewed to verify an applicant's credentials:

a. Evidence of AHPRA registration or other professional association for those self-regulated health practitioners.

b. Evidence of recognised undergraduate and postgraduate awards, fellowships and certificates that demonstrate successful completion of training from a relevant college, association, or training Institution.

c. Health practitioners applying for an advanced SoP are to provide evidence of additional training (e.g., higher degrees or diplomas and certificates) from accredited training programs in specific clinical skills and/or advanced practices.

d. Ensure health practitioners provide acceptable documentation to meet the 100-point identification check.

e. Ensure a google search is completed for all initial, amendment to scope and renewal applications.

f. Evidence of relevant clinical activity, practice, and experience in similar settings in which the SoP is being sought (e.g., curriculum vitae, logbooks, reports).

g. Evidence of any specialty specific credentialing requirements relevant to the requested SoP, if applicable.

3.2 References and referee checks

a. Initial and amendment to scope applications - a minimum of two (2) current written references must be obtained; at least one (1) referee from the same speciality/discipline and at least one (1) who is currently credentialed at Mater.

b. Renewal and mutual recognition applications - a minimum of one (1) written reference is required, usually from a referee from the same specialty/discipline who is currently credentialed at Mater. Ideally if the Practitioner is being engaged by a private practice to obtain a reference outside of this group.

c. Surgical assisting applications - a minimum of one (1) written reference is required, usually from a specialist Surgeon who is currently credentialed at Mater and can attest to their recency of practice as a surgical assistant.

d. Clinical visitor and urgent temporary accreditation applications - no references are required for any clinical visitors, as the applicant is seeking short-term accreditation only and will be supervised by a senior accredited health practitioner who will be responsible for them whilst on-site. Where time allows, a reference should be obtained for a health practitioner requiring temporary accreditation.

e. References must be obtained from referees who have observed and can attest to the applicant's recent clinical practice within the last 12 months.

f. All written references must be signed and dated by the referee within the preceding 12 months from when the application was submitted.

g. Any Queensland Health / locum agency references may be acceptable if they provide the same information as Mater Health's approved template.

h. In cases of recently qualified specialists: it is recommended that one (1) referee be within the same specialty/discipline, and at a minimum one (1) referee will be from either the head of the speciality, direct line manager (or equivalent) at the healthcare facility where the applicant most recently practiced, or the supervisor of training or director of a program where the applicant completed their final year of training for a new graduate.

i. Non-acceptable referees (unless special circumstances exist):

- Financially related to the applicant.
- Are a spouse or related to the applicant.
- Last clinical contact was over 12 months ago.
- Within the same private practice engaging the applicant's services.

3.3 Continuing education and professional development

a. Applicants are required to provide evidence of ongoing professional development (e.g., current CPD statement or certificate, or a screen shot of the Practitioner's CPD dashboard ensuring their name is visible) at initial and renewal accreditation, and at any time requested by Mater.

b. Evidence of Mater Health required learning (e.g., fire safety, resuscitation, hand hygiene certificate), including any evidence to support the relevant SoP being applied (e.g., laser safety, robotic training), if required.

3.4 Professional indemnity insurance

a. Accredited health practitioners are required to provide evidence annually of their professional indemnity insurance, or at times of any change to insurance or amendment to SoP.

b. Evidence of current and adequate professional indemnity insurance that is sufficient for the approved SoP and level of activity, where the liability limit is acceptable by Mater to cover all potential liability (including legal costs).

c. For surgical assistants (medical, dental and nursing) – if the assistant only holds indemnity insurance under the surgeon's insurance policy (whom they will be assisting), a copy of the surgeon's insurance policy will be acceptable and must be obtained within the application. Scope conditions will be applied to reflect the applicant is only able to assist the nominated surgeon.

3.5 Pre-commencing checks and other documentation

a. A minimum requirement for initial and re-accreditation is evidence of current registration by the relevant national board (e.g., AHPRA) or other professional association for those self-regulated health practitioners.

b. The following documentation forms part of the credentialing process:

- Current curriculum vitae.
- Evidence of identity: 100-point identification check.
- Passport and copies of relevant visas for overseas trained health practitioners.
- Internet/social media google searches of the applicant.
- Any submitted specialty specific credentialing requirements relevant to SoP being applied (e.g., colonoscopy recertification, ALS/PLS, robotic certification), if required.
- Declaration covering existing or previous restrictions or conditions to the applicant's registration with the relevant national board or other professional association, criminal history, professional misconduct, unsatisfactory misconduct, or outstanding complaints.
- Applicant acknowledgement they have read, understood, and agree to abide by the By-Laws and other Mater Health policies.

3.6 Application verification and compliance

a. When organisational need has been confirmed by the GM or delegate, the Credentialing Officer will review the application ensuring all supporting documentation has been received and is current (i.e., CV, CPD, indemnity insurance, registration, mandatory training and any additional requirements relevant to SoP).

b. A specialty peer reviewer (within the same specialty at the facility or, if unavailable, at another facility) will then review the application to confirm the applicant holds appropriate qualifications, training, and experience for the SoP being applied and provide their recommendation to the committee (i.e., endorsed tenure and comments). For escalation to the General Manager, if there is a conflict of interest declared.

NOTE: If a peer reviewer selects a lesser tenure period from the recommended five (5) years accreditation, they are required to provide reason/s (i.e., applicant providing interim locum cover, on a temporary VISA, existing AHPRA conditions, concerns around applicant's current fitness or clinical capability, ongoing medical condition).

4. Credentialing Governance Committee and/or Medical Advisory Committee

a. Credentialing Governance Committee and/or Medical Advisory Committee will follow the terms of reference.

b. The Medical Advisory Committee will review all applications taking into consideration the applicant's credentials, requested SoP, and the Mater Health facility's organisational capability and need. Where there are concerns that cannot be resolved at the MAC, these are to be escalated to the Credentialing Governance Committee.

c. The Medical Advisory Committee will provide a recommendation of the health practitioner's application to the General Manager who will advise the Credentialing Officer of the decision, or if further documentation/information is required from the health practitioner. Applications where additional information is required will be held over until the next committee meeting.

d. The Credentialing Officer will forward all applications approved or not approved, including the Committee's recommendations to the General Manager for their review and sign-off.

4.1 Successful applications

a. The Credentialing Officer will initiate and send a letter within the credentialing system to advise the applicant of their successful application. The approval letter will include the approved SoP, practice rights, any SoP restrictions/conditions outlined and accreditation tenure period (i.e., of up to five (5) years). The approval letter will outline their accreditation is subject to the agreement that they:

   i. Abide by Mater's By-Laws, policies and procedures.

   ii. Notify the Credentialing Officer of any changes to their indemnity insurance.

   iii. Notify of any changes to their registration with AHPRA or other registration board, including current or new undertakings, conditions, endorsements, suspensions, reprimands, or notations imposed on their registration.

   iv. Upon their understanding, they may undergo formal or informal review of their performance (as defined in the By-Laws) routinely on or around their 12-month anniversary from their initial accreditation tenure date.

b. The Credentialing Officer will:

   i. Electronically store a copy of essential supporting documentation relating to each health practitioner within the credentialing system.

   ii. Enter the health practitioner's approved credentials into the credentialing system and other relevant systems.

   iii. Complete the final office action process within the credentialing system to move each approved application into the finalised application stage, including inputting any scope conditions or recommendations made by the committee, the credentials expiry date and sending a notification letter.

4.2 Unsuccessful applications

a. Peer reviewers of applications will provide their recommendations/comments to the Credentialing Officer for not recommending an application for consideration by the Medical Advisory Committee for their endorsement.

b. The Credentialing Officer may seek additional information required to be disclosed by the applicant for further consideration of their application by the Medical Advisory Committee, if required.

c. Where an application is not to be progressed, the Credentialing Officer will prepare a letter to send to the applicant advising of the Medical Advisory Committee's decision. All unsuccessful letters must be signed by the General Manager of the relevant Mater Health facility, where the application has been declined.

d. It is recommended that the General Manager has a conversation with the applicant prior to any unsuccessful letter being sent, providing them with the reason(s) for this decision. To also provide them with an opportunity to withdraw their application as they are required to disclose this information on any future accreditation applications.

e. If the applicant is also accredited at another Mater Facility(s) the General Manager where the application has been declined will contact the General Manager at the other Facility(s) if there is a matter of concern.

f. Any unsuccessful applications will be documented within the credentialing system's electronic committee meeting minutes.

5. Temporary accreditation

a. Applications for temporary accreditation at Mater will be considered in exceptional circumstances, in accordance with the By-Laws and after consideration by the General Manager or their delegate.

b. The Credentialing Governance Committee and/or Medical Advisory Committee will be responsible for making their recommendations to the relevant General Manager following review of the applications. The relevant General Manager can refuse an application if concerns are raised.

c. Temporary accreditation may be approved by the General Manager or their delegate on an exception basis only, and for a one-off period of three (3) months. Any further requests for an extension of temporary accreditation must be made to the relevant Executive Director outlying the reason/s for request.

d. Temporary accreditation should not be considered as a routine process used to credential health practitioner and the application process for most health practitioners should be undertaken through the standard application processes. Auditing of approved temporary accreditation applications at each facility will be monitored and reported monthly to the Medical Advisory Committee through the credentialing list agenda.

5.1 During business hours

The Credentialing Officer will:

a. Receive notification from the relevant Facility's clinical area where the practitioner is wanting to provide patient care. Ensure approval obtained from the General Manager or their delegate for urgent temporary accreditation.

b. Undertake a 100-point identification check.

c. Check the practitioner holds current AHPRA registration or are registered with other regulation body. Specialist registration will need to match the SoP for which the health practitioner will be providing patient care at Mater.

d. Confirm the health practitioner holds current and adequate indemnity insurance. Refer to section 3.4: Professional Indemnity Insurance.

e. Contact the relevant General Manager or their delegate for approval of temporary accreditation.

f. Update the credentialing system and other relevant systems with the temporary accreditation.

g. Send approval accreditation letter to the health practitioner.

5.2 Outside of business hours

The on-call Executive will:

a. Be notified by the relevant clinical area if a health practitioner presenting to provide patient care who is not Mater accredited for their approval.

b. Undertake a 100-point identification check.

c. Check practitioner holds current AHPRA registration or are registered with other regulation body. Specialist registration will need to match the SoP for which the practitioner will be providing relevant patient care at Mater.

d. Check practitioner holds and adequate indemnity insurance. Refer to section 3.4: Professional Indemnity Insurance.

e. Approve or decline the request for urgent temporary accreditation.

f. Inform the Credentialing Officer (via email) of the urgent temporary accreditation, including the following details:

- Name of practitioner.
- Name of patient.
- Reason for admission, including specialty services to be provided.
- Mater Health facility; and
- Name of relevant on-call Executive who approved the urgent temporary accreditation.

g. The Credentialing Officer will update the credentialing system with temporary accreditation and send the Practitioner an invitation to complete and submit an initial application.

6. Amendment to scope of practice (SoP)

a. The health practitioner will be required to complete an amendment to scope application and provide relevant supporting documentation (i.e., evidence of additional qualifications and/or training to support application).

b. Amendment to scope may arise when there is a request for the introduction of a new clinical service, procedure or other intervention.

c. All amendment to scope applications must follow the process outlined within the initial accreditation process.

7. Mutual recognition

7.1 Internally recognised health practitioners (Mater Health accredited practitioners)

a. A process of mutual recognition for accreditation is applied when an accredited health practitioner holds existing accreditation at another Mater Health facility and requires mutual credentialing for the purposes of providing services.

b. The health practitioner will have the same SoP recognised as credentialed at the other Mater Health facility. If an advanced SoP is required at the requested facility, an amendment of scope application process is required. *Refer to section 6: Amendment to scope of practice.*

c. The SoP must align with the clinical capability and licensing of the Mater Health facility where credentials are being sought.

d. The accredited health practitioner will not be required to complete an application. Instead, the Credentialing Officer of the existing facility will create a credentialing file for an additional location for the new facility where credentials are being sought.

e. The Credentialing Officer will process and submit the additional location application to the relevant General Manager or delegate to confirm organisational capability and need, prior to submitting to the Medical Advisory Committee for their recommendation.

f. The committee will consider the application based on mutual recognition of the credentialing processes undertaken at the facility where the health practitioner is primarily practicing or has existing credentials.

g. The relevant committee will make a recommendation for accreditation, including SoP to the General Manager for approval.

h. The accreditation granted will match the health practitioner's primary statewide facility's credentials expiry date, ensuring the same date is applied across state. Unless there is a specific reason for the committee recommending an alternate expiry date, where the 2nd expiry date will be applied.

i. The Credentialing Officer will update the credentialing system, other relevant systems and send a notification letter to the accredited health practitioners confirming their approved SoP.

7.2 Externally recognised health practitioners (Queensland Health employees)

a. Where a health practitioner is employed at a Queensland Health facility and not employed at Mater Health or undertaking any private practice, a process of mutual recognition for Accreditation is utilised. This acknowledges the credentialing processes at these facilities are aligned with those of Mater Health.

b. The health practitioner may only apply for the same SoP recognised as credentialed at the Queensland Health facility, which is being utilised for mutual recognition.

c. The SoP must align with the clinical capability and licensing of the Mater facility to which accreditation is being sought.

d. The maximum period of accreditation will be determined by the accreditation date of the health practitioner at the Queensland Health facility. The health practitioner must complete and submit a mutual recognition application for Mater Health accreditation, and provide authorisation for the Credentialing Officer to obtain:

   i. a copy of the Queensland Health accreditation application form, including all supporting documentation (i.e., CV, photo identification, references).

   ii. a copy of the Queensland Health facility accreditation letter, outlining the health practitioner's SoP and credential's expiry date.

8. Re-accreditation

a. Applications for re-accreditation at Mater Health are granted for a period up to a maximum of five (5) years, as determined by the General Manager or their delegate.

b. The renewal application will automatically be dispatched from the practitioner's primary statewide location six (6) months prior to their credential's expiry date. The health practitioner is required to provide all relevant supporting documentation as prompted by the credentialing system and determined by the selected SoP (i.e., providing any specialty specific credentialing documentation, CPD/CME) and submit the application.

c. The Credentialing Officer will prepare information with respect to credentials, referee reports, performance, and activity volumes (including identified low-volume high-risk procedures) for consideration by the Medical Advisory Committee.

d. The Credentialing Officer of the primary location will process the submitted application, ensuring all supporting documentation is attached, including reference(s).

e. If the health practitioner is seeking additional accreditation at other Mater Health locations, the primary Credentialing Officer will confirm with the Credentialing Officer to determine an organisational need. If yes, the primary location will create a credentialing file for each additional location.

f. All renewal applications must follow the process outlined within the initial accreditation process.

g. Any renewal applications requiring an extension of up to three (3) months to allow sufficient time for review by the Medical Advisory Committee will require General Manager approval. Any requiring an extension beyond three (3) months must be made to the relevant Executive Director outlying the reason/s for request.

9. Clinical visitors (observers or supervised clinical practice), medical proctors, scribes, clinical researchers

a. All health practitioners attending Mater Health who will have patient care involvement or interaction for any of the below listed purposes will be required to complete the clinical visitor application.

- For their own education or professional development;
- For providing education or professional development for Mater Health employees; or
- For providing mentoring, guidance and / or to evaluate the clinical competence of an accredited Practitioner.

b. All clinical visitors (observers or supervised clinical practice) or medical proctors will be granted up to a maximum of three (3) calendar months (unless for exceptional circumstances) and are not considered for the purpose of providing direct patient care.

c. All clinical visitors or medical proctors will be considered for approval by the General Manager or delegate.

d. All clinical visitors will always be directly supervised by an approved senior Mater Health Practitioner.

e. Clinical observers will not participate directly in the care of a patient at Mater Health, either through interviewing, physical or psychological examination or procedures.

f. Scribes do not require accreditation under the By-Laws. The accredited health practitioner who employs them must ensure the following, as in accordance with the By-Laws:

    i. All patient records contain complete and adequate information relating to care and treatment.

    ii. Full, accurate, legible, and contemporaneous records are always maintained, ensuring entries are dated, time stamped and signed and are sufficient to allow any person involved in care, at any point in time, to understand the instructions, orders, and treatment plan.

g. Clinical visitors participating in supervised clinical practice must be registered with AHPRA (excluding overseas visitors) or other professional body and hold appropriate professional indemnity insurance.

h. The Mater Health nominated supervisor(s) will ensure the patient consent processes is undertaken for all clinical visitors and medical proctors. When the approval letter is emailed to the visitor, a copy is also sent to their supervisor(s).

i. All clinical visitors will obtain a Mater visitor identification badge from the Security Office, which is required to be returned at the completion of their visit.

j. The relevant clinical areas will be notified of the clinical visitor or medical proctor's presence, and their role in that area.

k. Clinical researchers (who are not employees or accredited practitioners) attending Mater facilities must undergo the Research Governance processes, where authorisation and approval is required from the Mater Health Human Research Ethics Committee (HREC) to enable research study.

l. If the clinical researcher requires access to Mater Health patient information/data, the Research Governance Office will ensure approval is obtained from the Privacy Office.

m. Consideration of privacy, confidentiality and consent of patients involved in care of any of the roles in this category must be considered by the General Manager or delegate in their decision whether to grant approval and duration or conditions of approval.

10. Surgical assistants

a. Surgical assistants are required to complete a short application as they will practice under the direct supervision of a specialist consultant. The application requires a current CV, 100-point identification check, adequate professional indemnity insurance, current registration with AHPRA and one reference obtained by the Credentialing Officer.

b. If the applicant is undertaking an AHPRA supervised practice plan, documentation is required to confirm their approved supervisor(s), level of supervision and approved site(s). This documentation can be the supervised practice plan or the AHPRA registration annexure. If the Mater Health facility, or supervisor (for supervision levels 1 & 2) they will be assisting is not listed on their supervised practice plan, the surgical assistant will need to contact AHPRA directly to complete a change in circumstances form.

c. Dental assistants without AHPRA registration will be considered on a case-by-case basis. Applicants, however, must demonstrate evidence they hold a base qualification of at least a Certificate III.

d. Surgical Nurse assistants are required to provide their perioperative nurse surgical assistant (PNSA) certificate or university letter confirming they are PNSA qualified. If a surgical nurse assistant is applying for a clinical placement as a surgical assistant (supervised practice), they are required to provide a letter of support from the university to confirm their enrolment in a PNSA course and the Mater Health clinical placement is supported.

e. Interns requesting surgical assisting credentials must meet Mater Health's Intern Coordinator (if Mater Health employed), or Queensland Health intern coordinator (if Queensland Health employed) requirements.

f. The General Manager may require some applicants to undertake the full accreditation application process where they are assessed as requiring a higher skill / experience level (e.g., a fellow undertaking periods of unsupervised practice in complex procedures such as cardio-thoracic surgery or other complex surgical procedures).

g. Surgical Assistants will only require endorsement by the relevant General Manager or delegate.

h. The endorsed application will be forwarded to the Medical Advisory Committee for noting.

i. The Credentialing Officer will update the credentialing system, other relevant systems and send a notification letter to the accredited health practitioners confirming their approved SoP.

j. All approved surgical assisting applications will receive accreditation for a period of up to five (5) years.

11. Third party providers

a. The Board has endorsed a modified credentialing process be adopted for selected third party providers (external stakeholders) based on their specific contractual arrangements. These entities may include the following:

   i. Radiology providers (Those Radiologists seeking any of the following advanced SoP: Interventional Radiology Tier B, CTCA, MRCA and Cardiology Diagnostic procedures will require to undergo the full accreditation process).

   ii. External pharmacy providers.

   iii. Physiotherapy and other allied health providers.

   iv. Pathology providers.

b. This endorsement does not require health practitioners employed by each entity to complete a full application for all types of accreditations at a Mater Health facility, nor require internal peer review and endorsement.

c. A signed certification document for each practitioner outlining details of the new staff member (or staff member who is applying for re-accreditation), their medical indemnity cover and AHPRA registration will be provided by the third-party employer.

d. The Credentialing Officer will issue a full or renewal letter to the health practitioner confirming accreditation pursuant to the agreement in place.

e. The health practitioner's credentials will be entered into the credentialing system and other relevant systems.

f. Where an applicant is not to be progressed, the General Manager will prepare a signed letter to be forwarded to the applicant. Details will be entered within the credentialing system declining the lodged application.

g. If a third-party provider's contract is terminated, the accreditation of the health practitioner or other category of health practitioner delivering services on behalf of the third-party provider will also immediately terminate. There will be no appeal permitted pursuant to the By-Laws from this decision.

12. Credentialing of allied health, nursing, midwifery and pharmacy professionals

a. Allied health, nursing, midwifery and pharmacy professionals do not need to apply for accreditation if they are:

   i. employed by MH and have therefore been assessed as possessing the clinical skills to undertake their role and have ongoing supervisions.

   ii. undertaking non-clinical roles.

   iii. students under formal supervision arrangements in accordance with training deeds of agreement; or

   iv. providing services independently of Mater Health whereby the patient is not a Mater Health patient (e.g., private outpatient services).

b. All private allied health, nursing, midwifery, and pharmacy professionals, unless covered by a third-party agreement, will be required to apply for accreditation.

c. Applications will be considered and endorsed by the professional leads for Nursing, Midwifery and Allied Health, prior to tabling at the Medical Advisory Committee.

d. The Credentialing Officer will update the credentialing system, other relevant systems (if applicable) and send a notification letter to the health practitioner confirming their approved, or if declined credentials.

e. Successful applications at Mater Health will receive up to five (5) years accreditation.

13. Telehealth (Virtual Care)

a. Virtual care is defined as the use of telephone, video-conferencing, secure-messaging and remote monitoring technologies, as an alternative to face-to-face health care delivery.

b. Where a health practitioner is accredited at the primary Mater facility and will be providing telehealth services at another facility, they are not required to be credentialed at the facility where the telehealth service is required.

c. The use of virtual care for outpatient consulting in private rooms, or at a Mater facility, generally falls within an Accredited Practitioner's approved Consulting scope of practice.

d. Practitioners providing virtual care should undertake training relevant to the clinical use-case, including technical aspects of virtual care delivery, escalation, downtime, documentation, and handover.

e. Accredited Practitioners will thereafter review the patient within clinically appropriate timeframes, which at a minimum will ordinarily be in person 24 hourly, or through their on-call or locum cover, or via video-conference where the consultation is observed and documented by a Mater Health clinician present at the bedside. If accredited Practitioners are unable to personally provide this level of care, the accredited Practitioner will secure the agreement of another accredited Practitioner to provide the care and will notify the Facility in writing of this arrangement.

14. Key documents

a. The credentialing system has a built in 'Key Documents application', which is designed to manage and maintain current credentialing requirements and/or licences for all accredited health practitioners.

b. The system will automatically send an invitation to the Practitioner to update their key document one month prior to the health practitioner's key document expiring. As well, a second reminder from the credentialing office email and a final 'SMS' reminder over a four (4) week period.

c. Failure to provide appropriate documentation will result in interim suspension, or if there is no organisational need as deemed by the GM or delegate, the health practitioner's accreditation will be terminated.

d. Once this key document is received and verified by the Credentialing Officer the key document file will move back to 'current' status.

e. If the Credentialing Officer receives no response from the Practitioner. The key document file flags to 'expired' and requires action by the Credentialing Officer.

15. Health practitioner concerns

a. Concerns about the behaviour or performance of an accredited health practitioner can arise from a situation, behaviour, event, incident, complaint, or can be found through established clinical governance processes that aim to identify contributory factors to variation in processes, outcomes, or systems.

b. Under the By-laws, an accredited health practitioner can only practice at the facility with the ongoing agreement of the General Manager, as delegate to the CEO. The General Manager is responsible for managing practitioner concerns professionally and promptly when they arise. Additional support and advice are available through Mater's Group Office, the Chief Medical Officer and the Clinical Governance Team, with such matters being managed in line with the By-Laws.

c. The principle of Natural Justice (or our duty to act fairly) for the health practitioner is important in considering the concern raised, evidence available and actions to be undertaken. A General Manager may need to seek further information and/or expertise in order to consider the issue and determine if there is a risk for patients, staff and/or the organisation. Under the Health Practitioner Regulation National Law, protection of public safety is the primary foundation on all decisions.

d. Mater Health has systems and processes in place to proactively identify these types of concerns, however it is recognised that variation in performance (particularly variation considered to be outside that of peer clinical skill and competence) and the ability to recognise clear underperformance can often be difficult to identify.

e. Staff may be asked to provide a statement or be interviewed by the Mater Senior Lawyer, the General Manager or their delegate to provide further relevant information to assist in understanding the concern.

f. A review of accreditation may result in an internal and/or an external review of practice.

g. A show cause process may be initiated via the Office of the CMO/CEO following an internal/external review, or if there is evidence of a breach of terms and conditions of the By-laws by an accredited health practitioner resulting in possible suspension, scope conditions, amendment of scope of practice, terms and conditions or termination.

h. Accredited health practitioners have some rights of appeal for processes and decisions made in relation to their scope of practice and term and conditions.

15.1 Documenting concerns and management of accredited health practitioners

a. Concerns about an accredited health practitioner are documented within the health practitioner concerns (HPC) application as a single source of truth to record, monitor and action all relevant matters of management, in particular medical practitioners. The General Manager needs to be satisfied that if there is a concern, they need to take action to protect patients, staff and/or the organisation. This also provides visibility and transparency of issues and the actions undertaken for the Clinical Governance Team, Mater Health and Group Executive.

b. The Mater Graded Response Framework (document link included within the HPC app) outlines how matters of concern are managed, responded to, escalated, and documented.

c. When a concern is to be formally recorded, the General Manager is responsible for entering the concern details relating to the accredited health practitioner within the Health Practitioner Concern (HPC) app, including documenting the Grade of the response, and attaching all supporting documentation.

d. Regular reviews will be undertaken by the Credentialing Officer using the credentialing system to identify the list of accredited health practitioners with active concerns and the progress with actions to ensure ongoing management and follow-up occurs.

16. Auditing and compliance

a. Each Facility will regularly undertake auditing of a random sample of accredited health practitioners to identify the following:

   i. Practising within approved SoP.

   ii. Procedures performed align with Mater's private licensing arrangements / Clinical Services Capability Framework (CSCF).

   iii. Performance compared to peers.

   iv. Numbers of procedures being performed align with Mater Health thresholds.

b. The program of auditing will comply with the credentialing requirements outlined within the By-Laws, to ensure that the key requirements of accredited health practitioners are continuously met and align with the requirements for accreditation, jurisdictional standards, and legislation. There are two components to the auditing process for credentialing, firstly the administrative credentialing component audited against credentialing application processes and secondly, the clinical practice component audited against terms and conditions of the By-Laws with clinical outcomes for accredited health practitioners on a risk-based sampling process or around the 12-month anniversary of an accredited health practitioner's initial accreditation.

c. The credentialing system provides a dashboard of key metrics required for the administrative credentialing component of the audits and will be extracted on business day three (3) of each month by the Credentialing Officers for each facility quality or executive team to provide exception commentary on defined KPI's and reported to Executive Director, Mater Health and key governance committees on business day seven (7) of each month.

d. An annual audit schedule and audit tool will be created by the Credentialing Officers, and Quality and Safety Managers, assigning auditors to ensure independence of the audited activity, and to undertake specific tasks appropriate to the auditor's knowledge and skills.

e. The audit schedule will be made available for all facility and Mater Health leaders involved in credentialing processes.

f. Audit scope will include a percentage of health practitioners each month across Mater Health, with facilities rotated for auditing across the year but at least quarterly for each facility.

g. For the administrative audit component, a sub-set of files from each stage of the credentialing process in the credentialing system will be sampled.

h. The auditor will provide audit results to the General Manager to discuss any concerns, provide responses to questions/clarification.

i. The General Manager will be accountable for reviewing the audit results, documenting evidence of any corrective actions taken within the e-credentialing system and maintaining status updates. They will advise the Clinical Governance Team if there are ongoing audit requirements to monitor concerns or outcomes and agree on processes going forward.

j. A de-identified high-level summary of audit process, scope and results will be provided by the Clinical Governance Team to Executive Director for discussion at the Medical Advisory Committee.

17. Delegations Register

Unless stated otherwise in the specific condition of the 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, Mater policies, procedures and By-Laws.

The delegations register reflects the roles and responsibilities conferred by the By-Laws for accreditation, pursuant to By-Law 3.2 Delegation and Delegations Register.

By-Law		In this By-Law, the "CEO or Delegate" means:
5.5 Standard of conduct, behaviour and performance	(e) An accredited health practitioner is expected to promptly report to the CEO or delegate a breach or potential breach by another accredited health practitioner of any of the matters set out in (a) or (b).	General Manager
5.6 Notifications	(a) Accredited health practitioners must immediately advise the CEO or delegate and follow up with written confirmation within 2 days…	General Manager
5.7 Obligations to disclose	(a) The accredited health practitioner must keep the CEO or delegate continuously informed of every fact and circumstances which has, or will likely have, a material bearing upon…	General Manager
5.8 Representations and media	(a) Unless an accredited health practitioner has the prior consent of the CEO or delegate or is authorised by virtue of their employment, an accredited health practitioner may not use the facility's name…letterhead or in any way suggested that the accredited health practitioner represents these entities.	General Manager
	(b) The accredited health practitioner must obtain the CEO or delegate's prior written consent before interaction with the media regarding any matter involving or relating to Mater Health or the facility. A Patient of the accredited health practitioner admitted to or previously admitted to the facility, or any matter involving or related to Mater Health or the facility.	General Manager
	(d) If there is any instance of non-compliance with any of the matters set out above, in addition to this constituting a breach of the By-Laws, the accredited health practitioner is required to follow the directions of the CEO or delegate in managing the consequence of non-compliance, including a retraction or agreed public statement.	General Manager
5.9 Confidentiality	(g) If a breach of any of the confidentiality obligations set out above occurs, including through inadvertence or a third-party cyber security breach, then the accredited health practitioner must immediately notify the CEO or delegate and actively assist to resolve the breach.	General Manager
5.11 Voluntary Assisted Dying (VAD)	(a) As a Catholic healthcare service, Mater Health adheres to the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia and as such does not promote or facilitate treatments where the primary purpose is to terminate life.	General Manager

By-Law		In this By-Law, the "CEO or Delegate" means:
	(b) Accredited Practitioners will not facilitate or assist in voluntary assisted dying review and assessments of a Mater Health patient, in accordance with Mater Health's Statewide Policy – Requests for Voluntary Assisted Dying, even if the accredited practitioners are appropriately credentialed by State's administering authority to undertake this role.	CEO
6.1 Clinical practice and continuous improvement	(i) Failure to comply with a reasonable request to participate in patient care and service review processes, as set out in this By-Law, will at the discretion of the CEO or delegate constitute a breach of the terms and conditions of Accreditation.	General Manager
6.4 New procedures	(a) Accredited Practitioners proposing to introduce, provide or use a New Clinical Service, Procedure, Therapeutic Medicine, Therapeutic Good, Medical Device, Technology or other Intervention will provide the CEO or delegate with supportive evidence to the satisfaction of the CEO or delegate in keeping with the agreed governing policy and procedures of Mater Health and the Facility, in accordance with the timeframe set out in the policy and procedure.	General Manager (with inclusion of the Chief Medical Officer/ Executive Director Health) Recommendation to Credentialing Governance Committee
	(f) Following consideration of the reported outcomes and benefits referred to in (e), the CEO or delegate may withdraw approval for the continuation of the new procedure, or may impose restrictions, with there being no right of appeal from this decision.	General Manager escalate to Chief Medical Officer for decision and notification to Executive Director Health and CEO
6.5 Admission, availability, resources, communication and discharge	(a) Accredited health practitioners will admit or consult patients at the facility on a regular basis within any twelve-month period or as reasonably determined by the CEO or delegate in relation to a specific clinical specialty.	General Manager
	(r) Accredited health practitioners will ensure that any changes to contact details are notified promptly to the CEO or delegate and ensure that this is recorded in any other document prescribed by the facility for documenting and communicating such changes.	General Manager
6.10 Research	(a) The facility approves, in principle, the conduct of research (including a clinical trial) in the facility. However, no research will be undertaken without the prior approval of the CEO or delegate and the HREC (where required), following submitted application by the accredited health practitioner in the required form and with all required information.	General Manager
6.11 Utilisation of accreditation	(a) Accredited health practitioners will be advised upon accreditation or re-accreditation, or at any other times as determined by the CEO or delegate, of the expectations in relation to exercising accreditation and utilisation of the facility.	General Manager
7.1 Eligibility for accreditation as a medical practitioner	(a) Accreditation as a Medical Practitioner will only be granted if the Applicant demonstrates to the satisfaction of the CEO or delegate adequate credentials, meets requirements of organisational capability and organisational need, otherwise satisfies the requirements of the By-Laws, agrees to comply with and accept all	General Manager

By-Law		In this By-Law, the "CEO or Delegate" means:
	terms, conditions and processes set out in the By-Laws (including as amended from time to time) and provides written acknowledgment or electronic confirmation of such agreement.	
7.3 Responsibility and basis for accreditation and granting of scope of practice	(a) The CEO or delegate will determine the outcome of applications for accreditation as Medical Practitioners and the defined scope of practice.	General Manager
7.4 Credentialing and accreditation	(c) Credentialing processes will be governed by the Credentialing Governance Committee and operationalised by the Facility Medical Advisory Committee that will comply with any relevant requirements or standards applicable to the facility.	General Manager, Chief Medical Officer
	(d) The primary role of a Facility's Medical Advisory Committee will be to review the credentialing requirements set out in these By-Laws, along with any associated approved policies and procedures, and make recommendations to the CEO or delegate about the suitability of the applicant to receive accreditation and the sought-after scope of practice.	General Manager
	(f) Nursing, Midwifery and Allied Health professional representative will be members of the Credentialing Governance Committee.	Chief Medical Officer
	(i) Prior to proceeding with an application or at any time during the Credentialing process, the CEO or delegate may request the applicant to attend an interview (along with other representatives of Mater Health or the facility).	General Manager
	(j) As determined by the CEO or delegate, any refusal or failure to fully respond to the requests made in (i) above may result in rejection of the application.	General Manager
7.5 Medical Advisory Committees	(a) The CEO or delegate will establish Medical Advisory Committees to support each facility.	General Manager
	(b) The Terms of Reference of the MAC shall reflect the functions of the Committee......	General Manager
	(c) The MAC members, including the chairperson, will be accredited health Practitioners (or at least a majority of accredited health practitioners) and appointed for periods as determined by the CEO or delegate.	General Manager
8.1 Applications for initial accreditation, re-accreditation and mutual recognition as medical practitioners	(b) Under exceptional circumstances due to urgent patient need, temporary accreditation may be approved by the CEO or delegate pending final consideration of the application.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery, or their delegate), Chief Medical Officer
	(c) The CEO or delegate will consider applications for initial accreditation, re-accreditation and mutual recognition in order to undertake their responsibility of credentialing in accordance with these By-Laws and any associated policy and procedures.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery)

By-Law		In this By-Law, the “CEO or Delegate” means:
	(d) The CEO or delegate will ensure applications are complete and requests for further information complied with, and upon being satisfied will refer applications, together with notes and feedback to the MAC and/or Credentialing Governance Committee for consideration.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery)
	(h) The MAC will make recommendations to the CEO or delegate as to whether the application should be approved and if so, on what terms, including the accreditation category, accreditation type and scope of practice to be granted.	General Manager
	(k) Following receipt of the recommendation from the MAC and/or Credentialing Governance Committee, the CEO or delegate will decide whether the application should be rejected or approved and if the application is approved, the Scope of Practice, period of accreditation and whether any additional terms or conditions will apply.	General Manager
	(l) In considering applications, the CEO or delegate will give due consideration to any recommendations or other information relevant to the application as determined by the CEO or delegate and may make any additional enquiries as the CEO or delegate determines appropriate, with the final decision that of the CEO or delegate.	General Manager
8.2 Consideration of applications for initial accreditation by the CEO or delegate	(a) The CEO or delegate will consider applications for initial accreditation, following receipt of a recommendation from the MAC and/or Credentialing Governance Committee, to decide whether applications should be rejected or approved and if approved the scope of practice, accreditation period and whether any additional terms and conditions will apply.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery)
	(c) The CEO or delegate may defer consideration of an application in order to obtain further information from other stakeholders in executive operational roles, the MAC and /or Credentialing Governance Committee, the applicant or any other person or organisation.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery)
	(d) If the CEO or delegate requires further information from the Medical Practitioner before making a determination then they will notify the Medical Practitioner.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery)
	(e) In the event that the information or documents requested by the CEO or delegate is not supplied in the time set out in the notification, the CEO or delegate may, at their discretion reject the application or proceed to consider the application without such additional information.	General Manager
	(f) The CEO or delegate will forward a notification to the Medical Practitioner advising them whether the application has been approved or rejected.	General Manager
	(g) The CEO or delegate will ensure that information relating to the accreditation category, accreditation type and scope of practice is accessible to those providing/managing clinical services within the facility.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery)

By-Law		In this By-Law, the "CEO or Delegate" means:
8.3 Initial accreditation tenure	(a) Initial Accreditation as a Medical Practitioner at the facility will be for a period of up to a maximum of 5 years, as determined by the CEO or delegate.	General Manager
8.4 Consideration of applications for re-accreditation by the CEO or delegate	(d) If an accredited health practitioner in the 12 months prior to receipt by the facility of the application has not admitted or treated a patient at the facility, the CEO or delegate may elect to notify the Accredited health Practitioner that the application for re-accreditation has not been accepted due to the failure to exercise accreditation sufficiently and any future application will need to be in accordance with the process for initial accreditation, excluding providers of locum cover.	General Manager
	(e) The CEO or delegate, MAC will deal with applications for re-accreditation in the same manner in which they are required to deal with applications for initial accreditation as Medical Practitioners.	General Manager
8.5 Re-accreditation tenure	(a) Re-accreditation as a Medical Practitioner at the facility will be for a period of up to a maximum of five (5) years, as determined by the CEO or delegate.	General Manager
8.6 Mutual recognition	(a) In the complete discretion of the CEO or delegate, a process for mutual recognition may be established involving the local HHS, that allows for the Medical Practitioners from the public sector attending the facility to treat public patients or accreditation to occur between MH facilities where the applicant already holds accreditation at one MH facility.	General Manager, Chief Medical Officer
	(c) If an applicant holds accreditation at one facility and seeks accreditation at another facility, the CEO or delegate will determine whether the application will be treated as an application for initial accreditation, or a more streamlined process established to rely on information supplied by the facility at which the accredited health practitioner holds accreditation.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery, or their delegate) followed by Chief Medical Officer
8.7 Surgical assistants, employed junior medical practitioners or fellowships	(a) In the complete discretion of the CEO or delegate, a more streamlined process may be established for the accreditation category of Surgical Assistant – Dental / Medical / Nurse or with respect to an employed junior Medical Practitioner (non-specialist), as per the Enterprise Agreement.	Director of Surgery, General Manager
8.8 Third party providers	(a) If certain services are delivered by third party providers, such as medical imaging or pathology, the CEO or delegate may require Medical Practitioners or other categories of health practitioner delivering the servicers on behalf of the third-party provider to firstly be granted accreditation pursuant to these By-Laws. Alternatively, the CEO or delegate may require the third-party provider to undertake its own accreditation process and to ensure that the Credentials, professional registration, professional indemnity insurance and vaccinations are strictly verified and then to provide confirmation that this has occurred and/or to provide suitable evidence to the CEO or delegate.	General Manager

By-Law		In this By-Law, the "CEO or Delegate" means:
	(c) In the event a third- party provider undertakes its own Accreditation process, Scope of Practice and access to the facility by a particular Medical Practitioner or other category of health practitioner at all times will be decided by and remains the responsibility of the CEO or delegate.	General Manager
9.1 Temporary accreditation and locum cover	(a) Medical Practitioners may be granted temporary accreditation and Scope of Practice on terms and conditions considered appropriate by the CEO or delegate;	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery, or their delegate), Chief Medical Officer
	(c) Temporary accreditation processes may, at the election of the CEO or delegate, be utilised for a Medical Observer, Medical Proctor and Clinical Visitor. The process will be modified to suit the specific circumstances and will be confined to a particular attendance rather than a period of time.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery, or their delegate), Chief Medical Officer
	(e) Temporary accreditation may be terminated by the CEO or delegate for failure by the Medical Practitioner to comply with the requirements of the By-Laws or failure to comply with Temporary Accreditation requirements.	General Manager (in consultation with the Chief Medical Officer)
	(f) Temporary accreditation will automatically cease upon a determination of the Medical Practitioner's application for accreditation (if an application for Accreditation has been made) or at such other time as the CEO or delegate decides.	General Manager
	(g) The period of temporary accreditation shall be determined by the CEO or delegate. If the period of temporary accreditation is for a specified time rather than an episode of care or specific attendance, this will be for an initial period of no longer than three (3) months and then be limited to one period of extension of three (3) months by approval of the Executive Director Health. If in exceptional circumstances a further period of time may be required beyond that set out in this By-Law, a specific request must be made to the CEO or delegate and the exceptional circumstances set out in order for consideration to be given to the request	Up to three (3) month period General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery, or their delegate), Chief Medical Officer Beyond a three (3) month period Executive Director Health
	(i) In circumstances of an emergency, temporary accreditation may be considered by the CEO and/ or delegate for short notice requests, subject to professional body registration and identity verification, to ensure continuity and safety of care for patients and/or to meet organisational need.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery, or their delegate), Chief Medical Officer
	(j) Verification and information gathering processes set out in this By-Law will be undertaken by the CEO or delegate and will be fully documented.	General Manager
	(k) If Temporary Accreditation was granted based upon an emergency request, it will be approved for a limited period as identified by the CEO or delegate, for the safety of patients involved, and will automatically terminate at	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery, or their delegate),

By-Law		In this By-Law, the "CEO or Delegate" means:
	the expiry of that period or as otherwise determined by the CEO or delegate.	Chief Medical Officer
	(m) The CEO (if undertaken by a delegate), Medical Advisory Committee will be informed of all temporary accreditation granted.	General Manager
9.2 Locum Cover	Locums must be approved for locum cover by the CEO or delegate before they are permitted to arrange the admission of and/or to treat Patients on behalf of Medical Practitioners.	General Manager (inclusion of Director of Clinical Services, Director of Medicine / Surgery, or their delegate), Chief Medical Officer
11.1 Review of accreditation and /or scope of practice	(a) The CEO or delegate may at any time initiate a review of an Accredited Practitioner's Accreditation and/or Scope of Practice where concerns have been identified or allegations made about any of the following in relation to the Medical Practitioner… (b) The Board may request that the CEO or delegate undertake a review pursuant to this By-Law, and if this occurs, then the CEO or delegate must undertake the review. (c) A review may be requested by any other person or organisation, including external to the Facility, however the commencement of a review remains within the sole discretion of the Board or the CEO (other than if the Board has requested that the CEO or delegate undertake a review, then the CEO or delegate must undertake the review).	Chief Medical Officer (followed by report to Executive Director Health and CEO)
	(d) The CEO or delegate will determine whether the process to be adopted is an: (i) Internal Review; or (ii) External Review.	Chief Medical Officer (followed by report to Executive Director Health and CEO)
	(e) Prior to determining whether an Internal Review or External Review will be conducted, the CEO or delegate may in their absolute discretion seek further information from Hospital Executive and /or may in their absolute discretion meet with the accredited health practitioner (the accredited health practitioner may choose to bring along a support person), along with any other persons the CEO or delegate considers appropriate. In advance of or at the meeting the CEO or delegate will advise of the concern or allegation raised and invite a preliminary response from the Medical Practitioner (in writing or orally, as determined by the CEO or delegate). The response may be given at and/or following the meeting. Thereafter, the CEO or delegate will make a determination whether a review will proceed, and if so, the type of review.	General Manager, Chief Medical Officer (followed by report to Executive Director Health)
	(f) The Medical Practitioner who is the subject of a review, whether an Internal Review or External Review: must cooperate fully with the reviewers, including providing information reasonably required to inform the reviewers, failing which the CEO or delegate may make a determination to immediately proceed to suspension or termination of Accreditation.	CEO

By-Law		In this By-Law, the “CEO or Delegate” means:
	(g) Given that the review process, the terms of reference, access to information and reviewers are within the complete discretion and determination of the CEO or delegate, any deviations from the established process will not result in a flawed process and appropriate actions and response to deviations will be as determined by the CEO or delegate.	Chief Medical Officer (followed by report to Executive Director Health and CEO)
	(i) The CEO or delegate may, in their complete discretion, make a determination regarding interim suspension of Accreditation or placing conditions on Accreditation pending the outcome of the review. There is no right of appeal available against a decision to impose an interim suspension or conditions.	CEO
	(j) Circumstances may arise where the CEO or delegate determines that, in addition to undertaking a review, they are mandated by legislation or believe it is in the public's (including patients at other facilities) or patient's interest to notify the Office of Health Ombudsman, AHPRA and/or other accrediting professional organisations of the details of the concerns that have been raised regarding the Medical Practitioner.	CEO
	(k) The CEO or delegate in their absolute discretion, may decide that as an alternative to conducting an Internal Review or External Review the concerns that have been raised regarding the Medical Practitioner should immediately be notified to the Office of Health Ombudsman or AHPRA for those organisations to take the requisite action. Following the outcome of any such action, the CEO may, at their absolute discretion, elect to take any further action they consider appropriate under these By-Laws.	CEO
11.2 Internal Review of Accreditation and / or Scope of Practice	(a) The CEO or delegate will draft the terms of reference of the Internal Review and may seek assistance from the Medical Advisory Committee/s and/or Credentialing Committee or co-opted Medical Practitioners or personnel from within the facility who bring specific expertise to the Internal Review, as determined by the CEO or delegate. (b) The terms of reference, process, access to information and reviewer(s) will be as determined by the CEO or delegate. (c) The CEO or delegate will notify the Medical Practitioner in writing of the review, the terms of reference, process, material to be provided and reviewer(s).	Chief Medical Officer (followed by report to Executive Director Health and CEO)
11.3 External Review of Accreditation and / or Scope of Practice	Entire section	Chief Medical Officer (followed by report to Executive Director Health and CEO)
12.1 Suspension of Accreditation	Entire section	CEO
12.2 Termination of Accreditation	Entire section	CEO

By-Law		In this By-Law, the "CEO or Delegate" means:
12.3 Imposition of Conditions	Entire section	CEO
12.4 Notification to Other Mater Health Facilities	Entire section	Chief Medical Officer (followed by report to Executive Director Health and CEO)
12.5 Conclusion and Expiry of Accreditation	Entire section	General Manager
13.1 Rights of Appeal Against Decisions Affecting Accreditation	Entire section	CEO
13.2 Appeal Process	(a) A medical practitioner shall have fourteen (14) days from the date of notification of a decision to which there is a right of appeal to lodge an appeal against the decision. (b) An appeal must be in writing, directed to the CEO or delegate and received by the CEO or delegate within the fourteen (14) day appeal period or else the right to appeal is lost. (c) Unless decided otherwise by the CEO or delegate in the circumstances of a particular case, which will only be in exceptional circumstances, lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly. (d) Upon receipt of an appeal notice, the CEO or delegate will immediately forward the appeal request to the Board.	CEO
	(e) The Board will nominate a Board delegate (who will be a member of the Board) to manage the appeal, which will include to provide instructions regarding the appeal, establish an Appeal Committee to hear the appeal and establish terms of reference. The Board will confirm in writing whether the decision of the Board pursuant to the appeal process will be made by the Board or by the Board delegate (who will be a member of the Board).	Board Director
	(f) The CEO or delegate will be responsible for provision of all relevant material to the chairperson of the Appeal Committee.	Chief Medical Officer and Executive Director Health
	(g) The Appeal Committee shall comprise at least three (3) persons and will include: a nominee of the Board, who may be an accredited health practitioner, who must not be involved in making the decision under appeal or involved in matters the subject of the appeal, and who will be the chairperson of the Appeal Committee; a nominee of the CEO or delegate, who may be an accredited health practitioner, and who must not be involved in making the decision under appeal or involved in matters the subject of the appeal; any other member or members who bring specific expertise to the decision under appeal, as determined by the Board, and who must not be involved in making the decision under appeal or involved in matters the subject	Board Chief Medical Officer and Executive Director Health Board

By-Law		In this By-Law, the "CEO or Delegate" means:
	of the appeal, but who may be an accredited health practitioner.	
	(h) Before accepting the appointment, the nominees will confirm that they do not have a known conflict of interest with the appellant and will sign a confidentiality agreement. Once all members of the Appeal Committee have accepted the appointment, the Board delegate will notify the appellant of the members of the Appeal Committee.	Board
	(l) The CEO or delegate (or nominee of the CEO or delegate) may present to the Appeal Committee in order to support the decision under appeal. The nominee may be a lawyer.	Executive Director Health or CEO
	(p) The Appeal Committee will make a written recommendation regarding the appeal to the Board or Board representative, including provision of reasons for the recommendation. The recommendation may be made by a majority of the members of the Appeal Committee and if an even number of Appeal Committee members, then the chairperson of the Appeal Committee has the deciding vote. A copy of the recommendation will be provided to the CEO (or delegate) and appellant.	Board Executive Director Health or CEO
	(q) The Board or Board delegate will consider the recommendation of the Appeal Committee and make a decision about the appeal in its absolute discretion.	Board
	(r) The decision of the Board or Board delegate is final and binding, and there is no further appeal allowed under these By-Laws from this decision.	Board
	(s) The decision of the Board or Board delegate will be notified in writing to the CEO (or delegate) and appellant.	Executive Director Health or CEO
	(t) If a notification has already been given to an external agency or agencies, then the CEO or delegate will notify that external agency or agencies of the appeal decision. If a notification has not already been given, the CEO or delegate, in consultation with the Board or Board delegate, will make a determination whether notification should now occur based upon the relevant considerations for notification to an external agency as set out in these By-Laws relating to the decision under appeal.	Executive Director Health or CEO
14. Accreditation and Scope of Practice of Other Accredited Health Practitioners (not employed by Mater)	(b) This By-Law 14 may also be utilised for other health practitioners (registered and non-registered) who do not fall into the categories outlined above with the process as modified by the CEO or delegate to suit the particular circumstances of the case.	General Manager
	(c) Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the CEO or delegate.	General Manager

By-Law		In this By-Law, the "CEO or Delegate" means:
15. Amendments to, and Instruments Created Pursuant to the By-Laws	(a) Amendments to these By-Laws can only be made by approval of the Board.	Board
	(b) All accredited health practitioners will be bound by amendments to the By-Laws from the date of approval of the amendments by the Board, even if Accreditation was obtained prior to the amendments being made.	Board
	(c) The Board may approve any annexures that accompany these By-Laws, and amendments that may be made from time to time to those annexures. The annexures once approved by the Board are integrated with and form part of the By-Laws. The documents contained in the annexures must be utilised and are intended to create consistency in the application of the processes for Accreditation and granting of Scope of Practice.	Board
	(d) The CEO or delegate may approve forms, terms of reference and policies and procedures that are created pursuant to these By-Laws or to provide greater detail and guidance in relation to implementation of aspects of these By-Laws. These may include but are not limited to Accreditation and Scope of Practice requirements and the further criteria and requirements will be incorporated as criteria and requirements of these By-Laws.	Chief Medical Officer
16. Audit and Compliance	(a) The CEO or delegate will establish a regular audit process, at intervals determined to be appropriate by the CEO or delegate or as may be required by a regulatory authority, to ensure compliance with the processes set out in these By-Laws relating to Credentialing and Accreditation, and any associated policies and procedures.	General Manager
	(b) The audit process will include identification of opportunities for quality improvement in the Credentialing and Accreditation processes that will be reported to the CEO or delegate.	General Manager

18. Related documents and references

Mater documents

- Scope of Practice Framework (contact credentialing@mater.org.au to obtain control version)
- The Mater Graded Response Framework
- Credentialing Governance Committee Terms of Reference
- Medical Advisory Committee Terms of Reference

External documents

1. Credentialing and Scope of Practice for Surgeons (2014). https://www.surgeons.org/about-racs/position-papers/credentialing-and-scope-of-practice-for-surgeons-2014
2. Health Practitioner Regulation National Law Act 2009 https://www.legislation.qld.gov.au/view/pdf/inforce/current/act-2009-045
3. Codes and guidelines for registration standards. Australian Health Practitioner Regulation Agency. (Webpage reviewed 8/08/2018) https://www.ahpra.gov.au/Registration/Registration-Standards/codes-guidelines.aspx
4. Health Ombudsman Act 2013 (current as at September 2017) https://www.legislation.qld.gov.au/view/pdf/inforce/2017-09-13/act-2013-036
5. Australian Commission on Safety and Quality in Health Care. Clinical Governance Standard 2019. https://www.safetyandquality.gov.au/our-work/clinical-governance/clinical-governance-standard
6. Medical Board of Australia. Expert Advisory Group on revalidation Final Report. 2017. Available from: http://Medical-Board---Report---Final-report-of-the-Expert-Advisory-Group-on-revalidation.PDF
7. AHPRA, Medical Board of Australia. Professional Performance Framework. Reviewed 26/04/2018. Available at: https://www.medicalboard.gov.au/Registration/Professional-Performance-Framework.aspx
8. Consultation on the draft Credentialing and Defining Scope of Clinical Practice: A guide for managers and clinicians.

19. Document information

19.1 Revision history

Revision	Published date	Description
1	02 Jun 2020	Release of version 1 on the Mater Document Centre
1.1	01 Jun 2021	Updates with minor amendments; addition of Template 10 and minor addition to 2.12 (last paragraph)
2	02 Jul 2021	Version 2 published on the Mater Policy and Procedure Library – review and update in line with changes to Mater Misericordiae Ltd By-Laws
2.2	25 July 2022	Section 5 robotic surgery updated
3	March 2024	Version 3 published on the Mater Policy and Procedure Library – review and update in line with changes to Mater Misericordiae Ltd By-Laws

19.2 Key Contacts

Author	Credentialing Office
Area	Director of Clinical Governance; Chris Foley
Committee	Credentialing Governance Committee

Affirmation

This governance document is consistent with Mater's Mission.

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