



Clinical Credentialling Policy

Policy Number

CHC-PC-0019

Version Nos:

21

1. Purpose

This Policy outlines the processes with regard to the credentialling of Senior Medical Officers (SMOs), Medical Officers of Special Scale (MOSS), General Practitioners and Midwives providing clinical services to Coast Health Care (CHC) and the West Coast DHB (WCDHB).

2. Application

This Policy is to be followed by all CHC clinicians.

3. Definitions

For the purposes of this Policy

Credentialling is taken to mean a process used to assign specific clinical scopes of practice to clinicians on the basis of their training, qualifications, experience and current practice, within an organisational context. The process includes a review of the facilities and support services available and the service the organisation is funded to provide.

Credentials are taken to mean the formal qualifications, training, experience and clinical competence and ongoing audit of the clinician providing the professional health service. They are evidenced by documentation such as university degrees, fellowship of professional colleges or associations, registration by medical boards, certificates of service, certificates of completion of special courses, periods of verifiable formal instruction, supervised training, information contained in confidential professional referees reports, audit reports and medical indemnity history and status.

Clinicians are taken to mean all Senior Medical Officers (SMOs), Medical Officers of Special Scale (Moss's), General Practitioners (GPs), Midwives, Joint Clinical Appointments, Locum clinicians (for a minimum of six weeks), Visiting Specialists, Contractors, clinicians subject to Access Agreements and Honorary Appointments who provide clinical services to the West Coast District Health Board (WCDHB) and Coast Health Care (CHC).

Clinical Audit is taken to mean a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are implemented at an individual, team or service level and further monitoring is used to confirm improvement in healthcare delivery.

4. Responsibilities

For the purposes of this Procedure:

The **Chief Executive Officer (CEO)** is responsible for:

- the credentialling process;
- all matters relating to the appointment, re-appointment, suspension or removal from office of clinicians;
- facilitating the credentialling appeals process.

The **Clinical Credentialling Committee (CCC)** is responsible for making all credentialling decisions and is also responsible for ensuring that the credentialling procedure is efficient and effective.



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The *Credentialling Subcommittees (CSC)* is responsible for assessing and making recommendations to the CCC on credentialling of clinicians while at post and any other matter delegated to it by the CCC.

The *External Advisor* is required to provide guidance, support and credibility to the CCC during the establishment phase of credentialling.

The *General Manager - Operations* is required to: act on the advice of the CCC and address any agreed “facility review” requirements.

Project Manager is responsible for facilitating the process of credentialling clinicians. The Project Manager is also responsible for meeting clinicians to discuss the range of available audit tools.

The *Clinical Appeals Tribunal (CAT)* is responsible for assessing and determining appeals arising from credentialling decisions.

Individual Clinical Audit. The purpose of individual clinical audit in the credentialling process is to enhance the individual clinician’s practice and in doing so also improving the organisation’s quality of care. The credentialling process is both a top down and bottom up approach.

5. Resources Required

This Policy requires no specific resources.

6. Process

1.00 Introduction

- 1.01 Credentialling is part of the wider WCDHB/CHC quality and risk management system, and is a requirement of good clinical governance.
- 1.02 WCDHB/CHC requires that:
 - i) all clinicians (as defined below) are credentialled before commencing clinical duties and are credentialled while at post at regular intervals;
 - ii) clinicians may only practice within their credentialled scope;
 - iii) credentialling requirements form part of all clinicians’ employment conditions with the WCDHB.
- 1.03 This Policy sets the framework for establishing and maintaining a successful credentialling programme at WCDHB/CHC.
- 1.04 The primary objective of credentialling is to protect patients by assigning at an organisational level specific clinical responsibilities to clinicians that match their training, qualifications, experience and current practice.
- 1.05 Although the focus is on individual clinicians, there is a relationship between the individual clinician and the service in which they work. In that context credentialling includes a review of the facilities and resources available for the services that WCDHB/CHC is funded to provide.



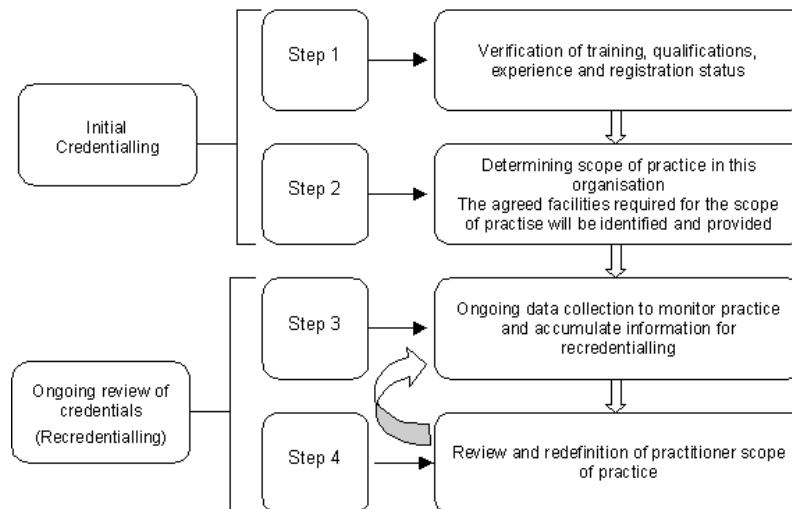
- 1.06 Credentialling is designed to be a flexible tool. It is not intended to be a threatening process, and does not have a disciplinary function. However, credentialling may impact on performance appraisal where:
- i) the employment contract is frustrated by a change in scope of practice resulting from a credentialling review;
 - ii) the clinician refuses to engage in the credentialling process where this is a condition of employment.
- 1.07 Credentialling should not be used to:
- i) limit responsible professional initiatives designed to improve standards of practice;
 - ii) restrict the use of measures taken in emergency situations;
 - iii) condone practice in isolation without reassurance that adequate professional linkages, peer review, audit and continuing medical education facilities are established for clinicians;
 - iv) discriminate against clinicians on economic grounds.
- 1.08 Credentialed status will be granted for a specific period of time determined by the CCC, usually between three to five years, at which time further credentialling will take place. The CCC may also impose any limitation or condition of credentialling as it considers to be appropriate, including a probationary period.
- 1.09 Credentialling of a clinician upon appointment will normally be assessed and decided by the CCC without convening a CSC, as it is not feasible to convene a CSC for every new appointment. All new appointments and locum appointments (employed for greater than six weeks will be subject to the Process for Initial Credentialling of New Appointments and Locums. (See Appendix V)

2.00 When Credentialling Is To Take Place

- 2.01 It is intended that all Clinicians will undergo credentialling under this Policy by December 2004, with the exception of GPs, who are to be credentialed in 2005.
- 2.02 Thereafter, credentialling must be carried out:
- i) on appointment of any clinician;
 - ii) at regular intervals while at post (as determined by the CCC);
 - iii) at the end of any probationary period;
 - iv) at any time at the request of the Chief Executive Officer, General Manager Operations or Chief Medical Advisor;
 - v) at the request of a clinician applying for variation of his or her credentialed status;
 - vi) at the request of a clinician intending performing a significantly new procedure or technique or using new technology for which credentialling has not already been granted.



3.00 Credentialling Process



- 3.01 The CCC may convene a CSC in accordance with the Membership and Terms of Reference of CSC to assess and make recommendations to the CCC on the credentialling of one or more clinicians.
- 3.02 As soon as the membership of the CSC has been finalised the Chair will inform the clinician/s of the timeframe in which credentialling will be undertaken, which shall in every case be reasonable.
- 3.03 The process is intended to be flexible and take into account the range of clinical services. The CSC determines the most appropriate process to be adopted in every case, based on this policy and on a credentialling framework that is customised for the specialty in which the clinician/s practices, to be prepared by the Chair of the CSC. The Chair of the CSC must consult with the clinician/s on the proposed framework before it is finalised.
- 3.04 For the purpose of determining the customised framework the Chair of the CSC will obtain a short factual report on the particular service from the nominated specialist/s within that service, which will contain a concise overview of the service, including basic statistics to indicate the nature and volume of the clinical work that is undertaken by that service, including, but not limited to:
- Clinical role within the West Coast DHB – listing core and subspecialties;
 - Catchment population;
 - Linkages with and support from other West Coast DHB services;
 - Links with other health providers e.g. tertiary providers;
 - Contracted services and volumes (if relevant) and relation to these to clinical need;
 - Teaching, training and research roles;
 - Staff establishments within the service (number of individuals and total FTEs);
 - Any special responsibilities.



- 3.05 The customised framework may include anything that the Chair of the CSC considers to be relevant, but will normally include the following matters to be addressed in respect of each clinician being credentialled:
- i). Current range of clinical practice (actual practice compared with agreed current range of clinical practice);
 - ii). Either management or clinicians wishing to modify range of practice;
 - iii). Engagement in new practices or procedures;
 - iv). Management concerns with regard to certain areas of practice;
 - v). Nature of Peer review assessment;
 - vi). Continuing professional education managed by relevant professional body;
 - vii). Involvement in clinical audit and other quality improvement activities. This would include the participation in ongoing peer review, clinical audit and CPE; the outputs of which will be reviewed at the end of each credentialling period;
 - viii). Maintenance of professional standards;
 - ix). Clinical quality/safety issues in the service;
 - x). Health issues affecting professional performance;
 - xi). Incidents/complaints;
 - xii). Indemnity/medico-legal issues;
 - xiii). Terms of reference and performance of individuals in leadership roles;
 - xiv). Performance within the context of service requirements within the department;
 - xv). Issues developed from the "Facility Review".
- 3.06 After the individualised credentialling framework has been decided, each clinician being credentialled will be given a specified but reasonable timeframe in which to provide the CSC with the documentation it requires, which will generally include, but need not be limited to, the following:
- i) Curriculum Vitae;
 - ii) Medical or Nursing Council Registration Certificate;
 - iii) College Fellowship Certificate;
 - iv) Current CPE (Continuing Professional Education) Certificate from Specialist College or equivalent;
 - v) Proof of Indemnity Insurance;
 - vi) Audit Reports for the service.
- 3.07 Upon appointment of the CSC, the clinician undergoing credentialling will be interviewed by the CSC at a day and time agreed between them to discuss and when necessary, to examine in more depth, the information provided by the clinician and any other information that the CSC considers to be relevant.
- 3.08 The Credentialling process may include review of documentary, audit material and other evidence, including, but not limited to some of the following matters:
- i) review or development of written job description;
 - ii) verification of registration status and any oversight requirements;
 - iii) eligibility for professional registration held and current entitlement to practice;
 - iv) professional "good standing";
 - v) qualifications and training including undergraduate, postgraduate and special training with respect to credentialling requested;
 - vi) clinical experience and competence in the field of expertise in which credentialling is sought evidenced by logbook and/or outcome data from clinical audit;



- vii) current range of clinical practice to be compared with agreed range of clinical practice as per job description;
- viii) peer review assessment (the nature of peer assessment to be negotiated with the clinicians prior to credentialling);
- ix) interpersonal skills;
- x) clinical competence;
- xi) health issues affecting professional performance - physical and mental fitness to practice. The applicant may be required to undergo a medical examination to assess fitness;
- xii) continuing professional education as approved by the appropriate authority;
- xiii) complaints and incidents;
- xiv) indemnity / medico-legal issues;
- xv) patient satisfaction in professional interaction and clinical service provision;
- xvi) other criteria which may affect the performance of professional duties.

Standard questions that all interviewees, clinicians and management are asked are attached in Appendix VI, VII, and VIII.

- 3.09 Sufficient information will be provided to the clinician to enable him/her to respond to any adverse matters arising out of these inquiries, but there is no obligation to reveal any information that could lead to the identity of the source of any information being revealed where the information has been given on condition of anonymity.
- 3.10 As part of the credentialling process for each clinician, a “facility review” will be carried out to identify any resource issues impacting on the ability of the clinician to operate within their scope of practise.
- 3.11 As part of the credentialling process the clinician is required to agree to be subject to at least two forms of individual clinical audit. The Project Manager will meet with the clinician to discuss the range of available audit tools, some of which are described in Appendix IV.
- 3.12 The agreed individual clinical audit process should be those that best suit the clinician and their clinical discipline.
- 3.13 The audit data collections should start when the discipline is confident in the process. These data collections will be interrogated each year and feedback devised.
- 3.14 The CSC will prepare a credentialling report for the CCC, based on the following questions:
 - i). What are the core and special responsibilities that make up the clinical services provided by the clinician?
 - ii). Does the clinician have the appropriate qualifications, training and experience to safely and competently undertake their core responsibilities and any such special responsibilities allocated to them?
 - iii). Are there sufficient audit/QA activities in place to monitor the actual performance of the individual clinician?
 - iv). Are there significant resource issues that impact adversely on the ability of the individual clinician to practise safely and competently?



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- v). Does the clinician provide a satisfactory service to other WCDHB services/clinicians and where relevant to other DHBs?
 - vi). Are there any specific conditions/restrictions arising from the credentialling process?
- 3.15 The report will contain:
- i). a concise description of the recommended range of duties for which the clinician has been credentialled;
 - ii). any recommended conditions on credentialling, including any probationary period or any other restriction;
 - iii). any resource issues arising out of the credentialling, including any comment on the skill mix and on quality or safety issues, and recommendations arising there from;
 - iv). audit processes agreed with the clinician;
 - v). the recommended duration of the credentialling term.
 - vi). Provisionally Vocationally registered Practitioners will be credentialled as such until the clinician becomes fully New Zealand Vocationally Registered at which time they will undergo further credentialling.
- 3.16 The clinician will have an opportunity to comment on the CSC report prior to it being finalised and sent to the CCC. Each clinician will be requested to sign that they have read their individual credentialling report, and can verify that the description of the process and factual content of the report are correct. This signature does not in any way imply agreement with the opinions of interviewed staff or the recommendations contained in the report.
- 3.17 The clinician will notify the CSC of any factual or procedural inconsistencies contained within the Draft report. The Draft report will be resubmitted to the clinician for his / her signature. This must occur before the Draft report can be considered by CCC.
- 3.18 Every credentialling decision shall be in writing from the CCC to the clinician, setting out:
- i). the scope of practice for which the clinician has been credentialled,
 - ii). any conditions or restrictions on practice,
 - iii). the credentialling term, following which re-credentialling will be required.
- 3.19 After making its decision, the CCC will inform and provide a copy of it to:
- i). the Clinician;
 - ii). the CEO;
 - iii). the General Manager Operations.
- 3.20 Where credentialling has been declined or granted on conditions other than those sought,
- i). the notification shall include:
 - ii). the reasons for the decision,
 - iii). the appeal rights under this policy.
- 3.21 When the individual credentialling report contains conditions or restrictions, the General Manager Operations is responsible for actioning them.
- 3.22 The CCC will notify the WCDHB of any issues arising out of the facility review.
- 3.23 The Chair of the CCC will notify the CEO where any issues of risk to patient or to WCDHB are identified.



3.24 Where a credentialling decision restricts the area of clinical responsibility that the clinician affected had previously exercised, WDHB will make every reasonable effort to provide training or adjustment of duties to ensure ongoing employment for the clinician and engender confidence in the credentialling programme.

3.25 Any review / inquiry / investigation into a clinician's scope of practice should result in the report, or summary of the report, being received by the CCC for their consideration.

4.00 Appeals Procedure

4.01 A clinician whose request for credentialling has been denied, withheld or granted in a different form to that requested has the right to appeal against the decision to the CAT.

4.02 The appeal shall be lodged in writing to the CEO within 28 calendar days of notification of the CCC's decision. The appeal shall include the grounds of the appeal.

4.03 The Membership of the CAT will be:

- i). The Chair of the West Coast DHB's Hospital Advisory Committee as Chair of the CAT;
- ii). A nominee of the appropriate clinical college;
- iii). The CEO, who will have ultimate responsibility for the process and will facilitate the process, but who will not have voting rights;
- iv). A clinician internal or external to the WCDHB who is not a member of the CCC and who is nominated by WCDHB;
- v). A clinician internal or external to the WCDHB nominated by the appellant.

4.04 The quorum for the CAT shall be all members.

4.05 The CAT shall choose its own procedure and timetable for the appeal.

4.06 The CAT shall choose its own procedure and timetable for the appeal.

4.07 The principles of natural justice and procedural fairness shall apply and the clinician shall be given reasonable opportunity to provide any relevant information for the purpose of the appeal.

4.08 The CAT may have a barrister or solicitor advising it.

4.09 Hearings of the Credentials Appeal Tribunal shall be closed.

4.10 For the decision appealed against to be reversed or modified, at least three of the four voting members of the CAT must support the change.

4.11 If the Clinician or the CAT so wishes, the clinician shall appear before the CAT at a time and place to be agreed. Any failure to appear without reasonable explanation will be deemed to be an abandonment of the appeal.

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- 4.13 The CAT may, either on its own initiative, or at the request of any of its members, call for written or verbal comment and information from any person or organisation, including but not limited to clinicians, Associations or Colleges.
- 4.14 The clinician will be given a reasonable opportunity to respond to any adverse comment it receives, but this does not require the CAT to disclose any confidential source.
- 4.15 Decisions shall be given in writing to the appellant. If the appeal is refused, the CAT shall include reasons for its decision. It may in its discretion include recommendations for the clinician to follow to restore credentialled status, including (but not limited to) a period of supervised practice or a period of training.
- 4.16 The CAT will submit its decision to the CEO, who will inform the clinician, the Chairman of the CCC and the General Manager Operations of it.
- 4.17 The CAT's decision shall be final.
- 4.18 The members of the CCC, CSC and the CAT shall be accorded indemnity for their decisions as outlined in the WCDHB's Directors & Officers And Insured Organisation Indemnity Policy.

7. Precautions And Considerations

- ➔ Credentialling is part of the wider WCDHB/CHC quality and risk management system, and is a requirement of good clinical governance.
- ➔ It is intended that all Clinicians will undergo credentialling under this Policy by December 2004, with the exception of GPs, who are to be credentialled in 2005.
- ➔ Credentialling is not intended to be a threatening process, and does not have a disciplinary function.

8. References

Health Practitioners Competence Assurance Act (2003)

Human Rights Act (1993)

Health and Disability Sector Standards NZS 8134:2001

Toward Clinical Excellence - A Framework for the Credentialling of Senior Medical Officers in New Zealand. Ministry of Health 2001.

Toward Clinical Excellence: A toolkit to develop consumer participation in credentialling (Ministry of Health 2001).

9. Related Documents

WCDHB Terms of Reference for Clinical Credentialling Committee

WCDHB Terms of Reference for Clinical Subcommittee



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CHC Credentialling Audit Tools
CHC Protected Quality Assurance Activities Procedure.
CHC Management of Personal Health Information Procedure
CHC Internal Quality Audit Procedure
WCDHB Quality Policy

Revision History	Version:	21
	Developed By:	Credentialling Working party
	Authorised By:	Chief Executive Officer
	Date Authorised:	October 2004
	Date Last Reviewed:	November 2007
	Date Of Next Review:	November 2009



APPENDIX I CLINICAL CREDENTIALLING COMMITTEE MEMBERSHIP & TERMS OF REFERENCE

MEMBERSHIP

The CCC shall comprise:

- WCDHB's Chief Medical Advisor
- WCDHB's General Manager Operations
- A representative from the MOSSs group elected by the WCDHB's MOSSs
- A representative from the GPs group elected by the WCDHB's GPs
- A representative from the Midwives group elected by the WCDHB's Midwives
- A Community Representative, appointed by the above members of CCC after short listing and interviews (Terms of Reference attached).

The Project Manager (Terms of Reference attached) whose responsibility it is to facilitate the credentialling process may attend meetings to facilitate and to act under direction of the CCC, but shall have no voting rights.

The External Advisor (Terms of Reference attached) may attend CCC meetings to provide guidance and assistance to the process, but shall have no voting rights.

APPOINTMENT

West Coast DHB clinicians (Senior Medical Officers (SMOs), Medical Officers of Special Scale (Moss's), General Practitioners (GPs) and Midwives) shall decide their respective representatives on the CCC as above by electing members who will be appointed by a majority vote. The Project Manager will facilitate this process.

TERM OF APPOINTMENT

Representative members shall be appointed for a term of two years.

CHAIR



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The Chair of the CCC shall be WCDHB's Chief Medical Advisor.

If the Chairman is unavailable at any meeting, members present shall appoint an Acting Chairman for that meeting.

POWER TO CO-OPT

The CCC will have the power to co-opt additional members as required.

OBJECTS

The principal objects of the CCC are to:

- Establish and maintain a procedure at WCDHB for the credentialling of clinicians in accordance with WCDHB's Credentialling Policy;
- Determine the credentialled status of every clinician, either on its own assessment or on recommendation of a CSC;
- Identify resources needed to support the credentialling process;
- Establish a secure system to collect and retain qualifications and audits required by the credentialling process;
- Review the Credentialling Policy at any time for any reason.

DELEGATION

The CCC shall have the power to delegate any aspects of its objects to any of its members and to a CSC.

QUORUM

A quorum shall consist of four members, with the representative of the professional group of the clinician being credentialled being mandatory.

MEETINGS

The CCC shall meet as often as it considers appropriate, which is likely to be fortnightly initially and then monthly.

Meetings may be postponed if there is insufficient business to warrant a meeting and conversely meetings may be scheduled more frequently as required.

Standard meeting procedures and protocols shall apply.

COMMUNICATION



Key points from the CCC Minutes may be communicated to clinical staff as appropriate.

The General Manager, Operations will provide a progress updates of the CCC's activities at Hospital Advisory Committee meetings

APPENDIX II CREDENTIALLING SUB COMMITTEE MEMBERSHIP & TERMS OF REFERENCE

MEMBERSHIP

Each CSC shall comprise to following members:

- A senior clinician employed by the WCDHB in a specialty different from the service concerned, who may or may not be a member of the CCC.
- A second senior clinician employed by WCDHB in a specialty different from the service concerned.
- One or more specialists in the discipline concerned from an external DHB/s.

APPOINTMENT

The CCC will nominate the proposed members of the CSC in every case, for consideration by the clinician at least four weeks in advance of the credentialling.

The CCC and the clinician being credentialled shall use their best endeavours to agree on membership of the CSC.

If agreement is not achieved, the Chair of the CSC will make the final decision as to membership.

CHAIR

The Chair of the CSC shall be one of the Senior Clinicians employed by WCDHB in a different specialty, to be decided by the CSC.

TERM OF APPOINTMENT

Members of each CSC are appointed for the duration of the credentialling process.

QUORUM

A quorum shall consist of all members of the CSC.



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POWER TO CO-OPT

The CSC will have the power to co-opt additional members, subject to being supported by the clinician undergoing credentialling and the CCC.

OBJECTS

The principal objects of the CSC will be determined by the CCC in each case, but in general terms includes assessing and making recommendations to the CCC in respect of the credentialled status of clinicians while at post, for example:

- At the end of any credentialling term,
- At the end of any probationary period,
- At the request of the Chief Executive, the General Manager Operations or the Chief Medical Advisor,
- In response to a request of a credentialled clinician applying for a variation to their credentialled status,
- In response to a clinician intending to perform a significantly new procedure or technique or using new technology for which credentialling has not already been granted.

DELEGATION

The CSC may not delegate any of its objects. However, the Project Manager and the External Advisor will provide assistance and administrative support.

PROCESS

The process to be followed is set out in the Credentialling Policy.

Standard meeting procedures and protocols shall apply.



APPENDIX III AUDIT TOOLS

Some of the following audit tools will be required to be put in place for any SMO undergoing recredentialling:

- Output audits where the results of particular areas of clinical management are compared against past performance or agreed external standards.
- System audit of a particular measure of the delivery of a service, or part of it i.e. auditing the system in which the practitioner works.
- Process measure audit is auditing clinical practice against agreed clinical process. Rather than measuring outcome one is measuring the process on the way to the outcome. This has benefits over output audit in some instances.
- Benchmarking is a process where an agreed external standard is identified and measures are put in place to audit the performance against the benchmark. This brings in the concept of external standards.
- Reflective journals may be developed. These document areas of interest, which have been thought about and researched.
- Peer review audit. These are audits where practitioners working in similar fields review each other's clinical practice.
- The above processes involve a variety of data collections, analysis of data, and feedback of the results of the audit cycle data to the practitioner. Longitudinal records will demonstrate the effect of the audit.

The Project Manager will facilitate meetings with the senior medical staff at which the range of available audits will be discussed. Decisions will be made on a small number of audit processes, which seem to best suit the practitioner and the clinical discipline. Processes will be devised and put into place to allow the agreed audits to occur. The data collections should start when the discipline is confident in the process. These data collections will be interrogated each year and feedback devised.

(These are not required to be evidenced for the first round of credentialling, but agreement on which audit tools will need to be identified for the next round of recredentialling).



APPENDIX IV TERMS OF REFERENCES FOR THE COMMUNITY REPRESENTATIVE, CLINICAL CREDENTIALLING COMMITTEE (CCC)

Department:	Medical Administration
Location:	Greymouth
Reporting to:	Chairman, MCEC
Working Relationships:	Members of MCEC

PURPOSE:

The role of the Community Representative, Clinical Credentialling Committee (CCC) is to represent the interests of the broader community on the aspects of clinical care from a service users' perspective.

SIGNIFICANT WORKING RELATIONSHIPS:

- Chairman, CCC
- General Manager, Operations
- Chairman, Senior Medical Staff
- Quality & Risk Manager
- Representative, West Coast GPs/MOSS group
- Representative, West Coast DHB Midwives
- Project Manager, Medical Credentialling
- West Coast Community

The Community Representative will:

- Maintain strict confidentiality of all information received regarding medical credentialing at West Coast DHB.
- Prepare for and attend the CCC meetings regularly, initially on a fortnightly basis.
- Be appointed to carry out medical credentialling for a period of 2 years.
- Have an awareness of bicultural and Treaty of Waitangi obligations, gender issues and some knowledge of relevant NZ legislation related to the rights of consumers.
- Network and consult with community groups.
- Read and comment on papers, policies and plans, and respond to these when needed.
- Contribute to submissions to policies and plans when needed.
- Build up good relationships with community groups.



The Community Representative will be able to:

- Understand an issue and speculate on the effects it may have on a wide range of people within the community.
- Build and maintain good relationships with members of the community.
- Work co-operatively with the CCC to achieve agreed goals.
- Think of creative solutions and options for action on problems.

HEALTH AND SAFETY

- The Consumer Representative, Clinical Credentialling Committee will be responsible for their own safety and will ensure that no action or inaction on their part will cause harm to any other person.
- The Consumer Representative, Clinical Credentialling Committee will abide by the Organisation's Health and Safety Plan and will participate in plan development and Health and Safety Training as appropriate. The Consumer Representative, Clinical Credentialling Committee will bring health and safety issues to the attention of the Chief Executive in time for consideration during the preparation of plans and budget

PERSON SPECIFICATION

- The preferred appointee should have the following personal qualities:
- Able to maintain confidentiality and use discretion.
- Able to work co-operatively and efficiently as part of a team.
- Have well developed interpersonal skills including the ability to comfortable with people of all social standards, cultures and abilities.
- Culturally sensitive with an understanding of the Principles and Articles of the Treaty of Waitangi.
- Have an interest in health. Some knowledge of the health services provided on the West Coast would be an advantage, but not absolutely necessary, as training will be provided.
- Have no alliance with a particular interest group (hospital or community based) so that they can provide a "global" consumer perspective.
- Have a genuine interest in participating in and supporting the process and the hospital services.
- Be a person of good reputation and some standing within the community.
- Have the ability to network with local consumer groups.

Is not a health professional, Board or advisory committee member, subcontractor to or an employee of the West Coast DHB.



APPENDIX V

PROCESS FOR INITIAL CREDENTIALLING OF NEW APPOINTMENTS AND LOCUMS

When The Applicant Reaches The Point Of Clinical Interview:

Clinical Interview

Conducted by:

- General Manager Operations – as Management representative
- Human Resources Co-ordinator
- Relevant Head of Department
- West Coast DHB's Chief Medical Advisor
- Independent outside clinician – relevant to the specialty
- A representative from the Clinical Credentialling Committee (CCC) if a CCC representative is not already on the interview panel.

This is an in depth interview, conducted by telephone, if it is not possible for the applicant to be present in person. This provides an opportunity for the panel to seriously vet the clinical experience and qualifications of the applicant and to expand on any information contained within the CV.

The applicant is asked to provide:

Documents required	Explanation	Provided
Curriculum Vitae.	A current Curriculum Vitae detailing qualifications and employment history.	
Medical or Nursing Council Registration Certificate. If NZ registration is not available, has the Medical Council provided a pathway to NZ vocational registration?	Copy sufficient	
College Membership / Fellowship Certificate.	Copy sufficient	
Current Continuing Professional Education Certificate from Specialist College or equivalent.	Copy sufficient	
Proof of Professional Indemnity Insurance	Copy sufficient	



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Documents required	Explanation	Provided
<p>Provide information on your current working environment to include:</p> <ul style="list-style-type: none">• Description of the Department / Service in which you work• No. of specialists within the Dept/Service• Clinical role within the Department. Please list core clinical tasks and subspecialty responsibilities E.g. Gynaecology core, Management of Menstrual problems, initial presentations of infertility, genital prolapse, etc.• Population served by your hospital• Teaching, training and research roles• Any special responsibilities (These are clinical activities that require additional qualifications, skills or experience beyond that of core responsibilities)• Any other background information that will assist the WCDHB in understanding the environment in which you currently work.	<p>This information could be included in your logbook submitted to the WCDHB for review.</p>	
<p>Audit Reports.</p> <p>Copies of clinical audit reports, if currently involved in clinical audit.</p>		
<p>Information on whether there are any medico/legal investigations inquiries pending or whether any have been conducted. If there have, what the outcome was and whether there were/are any restrictions placed on the scope of practice of the clinician.</p>		
<p>Reports from referees: minimum of 3 written references and 2 verbal referees from organisations in which the clinician has worked.</p>		



INTERVIEW STRUCTURE

Human Resources Co-ordinator to provide a detailed overview / summary of the first initial interview to the panel. Ideally to include:

- Recreational activities / hobbies of applicant
- Family situation e.g. schooling requirements, sporting and leisure for family
- Reasons for coming to the West Coast and leaving their current place of employ

Questions asked during the interview

- Have you been convicted of any criminal offence during the past 7 years?
- Are there any issues regarding your health that may impact on your work?

It is recommended the interview cover the following clinical domains:

- Expansion of clinical experience
- Full range of the clinical load defined
- Administrative responsibilities
- Teaching and research responsibilities
- Clinical expectations of the applicant e.g. facilities and resources
- Availability
- Remuneration expectation



APPENDIX VI COMMON QUESTIONS FOR INTERVIEWEES

COMMON QUESTIONS FOR INTERVIEWEES

The Clinical Credentialling Committee has determined that the following common questions will be asked at all credentialling interviews:

1. How does the clinician relate to your area / specialty as a person? Are they approachable?
2. Is the clinician reliable in their attendance and punctual?
3. Is the clinician easily locatable / found?
4. Do you have confidence in this clinician?
5. Are there any areas of concern with respect to this clinician relating to your department / specialty?
6. Do you have any ideas / suggestions for better integration between your department and this clinician?



APPENDIX VII

ISSUES/QUESTIONS TO BE DISCUSSED WITH CLINICIAN

1. Documentation Checklist

The following documentation needs to be checked that it is in order and must be sighted:

- Curriculum Vitae
- Medical or Nursing Council Registration Certificate
- College Fellowship Certificate
- Current CPE (Continuing Professional Education) Certificate from Specialist College or equivalent
- Proof of Indemnity Insurance
- Completed Credentialling Framework
- Completed Factual Report on the service
- Audit Reports (not necessary for first round of credentialling)

THE CREDENTIALLING SUBCOMMITTEE CAN NOT SUBMIT THEIR FINAL REPORT UNTIL THE ABOVE DOCUMENTATION IS SIGHTED

2. Complaints / Incidents Investigations

- Are there any ACC / HDC or complaints pending against you?
- Have any past or current investigations highlighted any issues with regard to competence or made any recommendations / put restrictions on your practice?
- Are there any investigations pending against you?
- Have you had any medical misadventure claims / HDC investigations against you upheld during the past ten years prior to working for the WCDHB?

3. Scope of practise

- Please define your scope of practise.
- Do you have any areas of special interest?
- Are there any procedures / work you don't feel comfortable doing?
- What changes do you want to make to your current scope of practise?

4. Clinical Indicators / Audit

- What measurements of your clinical performance do you have in place? E.g. complaints database, throughput, standard of clinical competence.



- What audit processes do you want to put in place that would benefit you in monitoring your performance?

5. **Continued Medical Education**

- What CME do you attend, how regularly?
- What determines whether or not you attend a CME session / workshop / course / seminar?

6. **Departmental Support**

- Do you feel there are sufficient departmental systems, policies and procedures, facilities and resources in place to support you in your practice?

7. **Links / input with / from other departments**

- Are the inputs and links with / from other departments effective? If not, how do you think these could be improved?

8. **Health Issues**

- Are there any issues regarding your health that impacting on your work?

9. **Interpersonal Relationships**

- How do you relate to other clinicians on staff?
- If personality clashes occur, how do these affect your clinical performance?

10. **Patients admitted under consultants name**

- How comfortable are you in supervising senior medical staff / house surgeons?



APPENDIX VIII

ISSUES/QUESTIONS ABOUT THE CLINICIAN TO BE DISCUSSED WITH MANAGEMENT

1. **Complaints / Incidents Investigations**
 - Are there any ACC / HDC or internal complaints pending against the clinician?
 - Have any past or current investigations highlighted any issues with regard to competence or made any recommendations / put restrictions on their practice?
 - Are there any other investigations pending against the clinician?
 - Have there been any medical misadventure claims / HDC investigations against the clinician upheld during the past ten years prior to working for the WCDHB ?

2. **Clinical Performance Indicators**
 - What measurements of the clinician's clinical performance are in place? E.g. complaints database, throughput, standard of clinical competence.

3. **Continued Medical Education**
 - What CME do they attend, how regularly?
 - Are they provided with sufficient leave to be able to attend appropriate CME?
 - What determines whether or not the clinician attends a CME session / workshop / course / seminar?

4. **Departmental Support**
 - Do you feel there are sufficient departmental systems, policies and procedures, facilities and resources in place to support the clinician in their practice?

5. **Links / input with / from other departments**
 - Are the inputs and links with / from other departments effective? If not, how do you think these could be improved?

6. **Health Issues**
 - Are there any issues you are aware of regarding the health of the clinician that is / could impact on their work?

7. **Interpersonal Relationships**
 - How does the clinician relate to other clinicians on staff?
 - If personality clashes occur, how do these affect the clinical performance of the clinician?

8. **Patients admitted under consultants name**
 - Supervision – does the clinician provide supervision for other clinicians?



Clinical Credentialling Policy

Policy Number

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- How comfortable do you think they are in supervising senior medical staff / house surgeons?

9. **Any other information**

- Is there anything else you would like to mention that relates to the credentialling of this clinician?