



Clinical Governance, Safety and Quality Policy Framework

Credentialing and Defining the Scope of Clinical Practice MP 0084/18

Credentialing and Defining Scope of Clinical Practice for Medical Practitioners Standard

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1. Background

This Standard recognises the establishment of the Medical Board of Australia (MBA) and the Australian Health Practitioner Regulation Agency (AHPRA) in 2010. This Standard also takes into account the new devolved governance model in the WA health system, the result of the *Health Services Act 2016* (WA) introduced on 1 July 2016.

This Standard has been developed in consultation with the Australian Medical Association. It replaces the Policy for Credentialing and Scope of Clinical Practice for Medical Practitioners (2nd Edition) OD 0177/09 and those elements of the Memorandum of Understanding which deal with credentialing of medical practitioners and which are superseded by this Standard.

It mandates the continuing use of the CredWA credentialing system in the WA health system and further defines the credentialing and scope of clinical practice requirements and processes for specialists and other senior medical practitioners engaged by Health Service Providers. This revision builds on consultation from clinical stakeholders across the WA health system and further strengthens and clarifies the roles, responsibilities and functions within the credentialing system.

Recruitment, selection and appointment processes sit outside the scope of this Standard and are to be referred to in the *Employment Policy Framework*.

This Standard does not replace Health Service Provider policies and procedures (however titled) which deal with credentialing of medical practitioners but to the extent of any inconsistency this Standard prevails.

2. Definitions

Applicant - a medical practitioner who has submitted an application for credentialing or re-credentialing using CredWA.

Appointing Officer - a senior officer (however titled) of a Health Service Provider who has delegated authority or is otherwise authorised to offer employment or other engagement to a medical practitioner at a Health Care Facility or group of Health Care Facilities. Appointing officers are commonly but not exclusively Principal Administrators.

Australian Health Practitioner Regulation Agency or AHPRA - the organisation responsible for the administration of the National Registration and Accreditation Scheme across Australia.

Chief Executive - the Chief Executive of a Health Service Provider.

Chief Pathologist - the Principal Medical Administrator of PathWest Laboratory Medicine WA.

Clinical Academic - a medical practitioner whose contract of employment is regulated by the *WA Health System - Medical Practitioners (Clinical Academics) AMA Industrial Agreement 2016* (or its replacement) or a medical practitioner who is otherwise employed, as a salaried medical practitioner, by a Health Service Provider who is concurrently employed by a University in Western Australia as a clinical academic (however titled).

Clinical Practice - the professional activity undertaken by medical practitioners for the purposes of investigating patient symptoms and preventing and/or managing illness, together with associated professional activities related to patient care.

Competency - the demonstrated ability to undertake clinical practice at an expected level of safety and quality.

Comprehensive documentation - the documentation or information that all Credentialing Committees should retain as a part of their formal records. Retained documentation includes supporting evidence that was reviewed and decisions made about credentialing and determining the scope of clinical practice for each medical practitioner within their organisation.

Contracted Medical Practitioner or CMP - a medical practitioner engaged by a Health Service Provider under a Medical Services Agreement to provide medical and other services in a Health Care Facility.

Credentialing and Scope of Practice Committee or CASOP or Credentialing Committee - the formally constituted committee of practitioners and managers who collectively analyse and verify the information submitted by an applicant, conduct referee checks and make a determination on the scope of clinical practice for a medical practitioner.

Credentialing Committee Approval Date - the date of the Credentialing Committee's final determination of credentialing and scope of clinical practice.

Credentials - the formal qualifications, training and experience of the medical practitioner.

CredWA - the web portal used to administer the credentialing process.

Defining the Scope of Clinical Practice - the process of delineating and articulating the extent of an individual medical practitioner's clinical practice within a particular Health Care Facility based on the individual's credentials, competence, performance and professional suitability, together with the needs and capabilities of the Health Care Facility.

Doctor in Training - has the meaning set out in the Industrial Agreement.

Head of Specialty - a specialist who is the administrative and clinical head of a specialty area of practice in a Health Care Facility.

Health Care Facility or Health Care Facilities - a place or places (however titled) in which a medical practitioner undertakes clinical practice including, but not limited to, a hospital, a mental health facility or community health service under the control of a Health Service Provider.

Health Service Provider or HSP – a body corporate established under the Health Services Act to provide health services and provide teaching, training and research which supports the provision of health services.

Health Service Provider Board or Board – a governing body of a Health Service Provider established under Health Services Act.

Health Services Act or HSA - the *Health Services Act 2016* (WA).

Industrial Agreement - the *WA Health System - Medical Practitioners - AMA Industrial Agreement 2016* (or any replacement).

Junior Medical Officer - a Junior Doctor or Doctor in Training.

Limited Registration - a type of registration that applies to medical practitioners who do not qualify for general or specialist registration (see also Provisional Registration).

Medical Board or **Medical Board of Australia** or **MBA** - National Health Practitioner Board for medical practitioners established under section 31 of the *Health Practitioner Regulation National Law (WA) Act 2010 (WA)*.

Medical Services Agreement or **MSA** - a contract for services under which medical services are provided to public patients in a Health Care Facility.

Memorandum of Understanding or **MOU** - Memorandum of Understanding between the Minister for Health, and the Director General of Health and Boards of Management and the Australian Medical Association (Western Australia) Incorporated in respect of Clinical Privileges, Conduct and Governance in Western Australian Government Hospitals and Health Services 2015

Non-Salaried Medical Practitioner - a Contracted Medical Practitioner.

PathWest or **PathWest Laboratory Medicine WA** - the administrative division of the North Metropolitan Health Service which is under the direction and control of the Chief Pathologist.

Peer Review - the evaluation by a practitioner of creative work or performance by other practitioners in the same field in order to assure, maintain and/or enhance the quality of work or performance. Peer review may be conducted as part of a routine clinical practice, as a professional activity or as part of a specifically coordinated review activity.

Principal Administrator - the senior officer (however titled) with responsibility for the general management of a Health Care Facility or group of Health Care Facilities. Principal Administrators are commonly but not exclusively titled Executive Director or Regional Director.

Principal Medical Administrator or **PMA** - the medical practitioner (however titled) with delegated responsibility for clinical governance and oversight of credentialing matters for a Health Care Facility or group of Health Care Facilities. Any salaried medical practitioner may be designated by the Chief Executive as Principal Medical Administrator for the purposes of this Standard. Principal Medical Administrators are commonly but not exclusively titled Executive Director of Medical Service or Executive Director of Clinical Services.

Provisional Registration - a type of registration that applies to medical practitioners who do not qualify for general or specialist registration (see also Limited Registration).

Region - one of the administrative divisions of the WA Country Health Service (**WACHS**) which are Great Southern, South West, Wheatbelt, Goldfields, Mid West, Pilbara and Kimberley.

Salaried Medical Practitioner - a medical practitioner engaged by a Health Service Provider under a contract of employment to provide medical and other

services in a Health Care Facility or Health Care Facilities whose contract of employment is regulated by the Industrial Agreement.

Senior Medical Practitioner – a specialist or a medical practitioner who is not registered as a specialist but is engaged by a Health Service Provider to practice without clinical supervision exclusively in a specialist field and/or clinically supervises other medical practitioners.

Senior Registrar and/or Fellow - registered medical practitioners appointed as a Senior Registrar or Fellow which may include those medical practitioners registered with MBA under Level 3 or Level 4 supervision (Guidelines - Supervised practice for international medical graduates MBA 4 January 2016).

Subcontracted Medical Practitioner - a medical practitioner engaged by a Contracted Medical Practitioner to provide any part of the medical services the Contracted Medical Practitioner is contracted to provide.

Specialist - a medical practitioner who is registered as a specialist by the Medical Board of Australia and who is engaged by a Health Service Provider to practice in that field of speciality.

Unsupervised Overseas Trained Doctor - an unsupervised international medical graduate or unsupervised overseas trained specialist.

Verification - the act of citing, reviewing, inspecting and authenticating documents supplied by a medical practitioner to establish that the medical practitioner's registration documents, undergraduate and postgraduate qualifications and references meet national and WA regulatory, standard or specification requirements.

3. Purpose

The purpose of this Standard is to ensure there is a clear framework for credentialing and defining the scope of clinical practice for medical practitioners practicing in the WA health system.

This Standard provides guidance to medical practitioners, executives and administrative staff on the credentialing and defining scope of clinical practice process, and the rights and responsibilities of the participants in regard to credentialing and defining the scope of clinical practice for medical practitioners.

This Standard is not a mechanism for dealing with discipline matters.

The key principles which underpin credentialing and defining scope of clinical practice processes include:

- *Patient safety* – by ensuring medical practitioners practice within their capability of education and training and within the capacity of the Health Care Facility in which they are working;
- *Consistency* – by ensuring alignment with recognised National Safety and Quality Standards; and
- *Natural justice and procedural fairness* – by ensuring credentialing and scope of clinical practice processes are underpinned by natural justice and procedural fairness.

This Standard does not seek to:

- limit appropriate professional initiatives designed to improve standards of practice;
- restrict reasonable innovation in introducing new clinical procedures or interventions;
- restrict actions that need to be taken in an emergency situation;
- control the clinical decisions of a medical practitioner with respect to admissions, treatment, transfer or discharge of a patient;
- permit medical practitioners to work in isolation without appropriate supervision and support systems; or
- impose the delivery of health care on a medical practitioner where the facilities, supervision and support are either inadequate or unavailable.

4. Scope

4.1 Application

This Standard applies to the credentialing of the following types of medical practitioners engaged by Health Service Providers:

- Salaried Medical Practitioners;
- Clinical Academics;
- Contracted Medical Practitioners;
- Subcontracted Medical Practitioners;
- Junior Medical Officers at King Edward Memorial Hospital who are to be credentialed and provided with a defined scope of clinical practice in Obstetrics & Gynaecology (Douglas Inquiry 2001¹);
- Junior Medical Officers rotating from King Edward Memorial Hospital to WACHS and outer metropolitan sites who are to be credentialed and provided with a defined scope of clinical practice in Obstetrics & Gynaecology (Douglas Inquiry 2001); and

¹ The **Douglas Inquiry** (2001) was “to inquire into the provision of obstetric and gynaecological services at King Edward Memorial hospital’ over the period 1990 to 2000. Recommendations from the Inquiry relating to credentialing were included in the scope of the Standard to ensure they were not overlooked. Key findings of the Douglas Inquiry relating to junior medical officers include: *the Hospital gave inadequate support to its staff, particularly junior doctors; lack of supervision of junior medical staff; junior doctors were often left to manage difficult cases without help and without necessary skills to do the job safely.* The Douglas Inquiry recommendations state:

- *Recommendation 9.4.1 The role of the Medical Credentialing and Clinical Privileging Advisory Committee (the “Credentialing Committee”) is to be expanded to oversee the credentialing of junior medical staff.*
- *Recommendation 9.4.3. The Credentialing Committee is to approve a list of the clinical privileges granted to each medical staff member in respect of particular procedures, together with the conditions applying to the privileges granted (the “credentialing list”).*

- Unremunerated medical practitioners from WA, interstate or overseas who attend a Health Care Facility in a limited clinical capacity including for the purpose of demonstrating new modes of clinical practice, techniques or equipment.

This Standard recognises that a number of Senior Registrars, Fellows and Resident Medical Officers employed by Health Service Providers may be partly independent or unsupervised by a Specialist or Senior Medical Practitioner. In such circumstances, it is a requirement that Health Service Providers ensure that the transition of these Senior Registrars, Fellows and Resident Medical Officers from supervised training programs to independent practice is appropriately managed in accordance with this Standard.

4.2 Exclusions

This Standard does not apply to the credentialing of:

- Doctors in Training other than those explicitly included;
- Registered medical practitioners enrolled in:
 - a recognised training program; or
 - working under supervision in a WA public hospital;
- Senior Registrars and/or Fellows – registered under Level 1 or Level 2 supervision (Guidelines - Supervised practice for international medical graduates MBA 4 January 2016); and
- Medical practitioners undertaking research – if the research involves no patient contact or indirect care or responsibilities.

5. Medical Practitioner Obligations

Medical practitioners are responsible for:

- providing the necessary information to a Credentialing Committee to enable the credentialing committee to make an informed decision about the appropriateness of the medical practitioners credentials and the requested scope of clinical practice;
- complying with their approved scope of clinical practice;
- notifying their employer/s if there are any restrictions and/or conditions placed on their registration by the MBA;
- participating in clinical governance activities, which may include assisting in the credentialing and defining the scope of clinical practice of other medical practitioners; and
- participating in performance review programs.

6. Health Service Provider Obligations

Health Service Providers have a responsibility to ensure that all health care provided to patients is safe, appropriate and within the capability and role of the service.

Credentialing and defining the scope of clinical practice for medical practitioners is a core responsibility of Health Service Providers to ensure that the medical workforce is appropriately skilled and competent to undertake their clinical workload.

All Health Care Facilities are required to be covered by a Credentialing and Scope of Practice Committee (hereafter known as a Credentialing Committee) that operates under this Standard.

Credentialing Committees may be created at any level of a Health Service Provider (for example: region, site or department). However a Health Service Provider wide Credentialing Committee has the benefit of supporting the management of medical practitioners who work across multiple Health Care Facilities.

Health Service Providers will:

- maintain a Credentialing Committee covering each Health Care Facility or Credentialing Committees covering any combination of Health Care Facilities or a single Credentialing Committees covering all Health Care Facilities; and
- designate a Principal Medical Administrator for each Health Care Facility or group of Health Care Facilities, as the case requires.

Health Service Providers that operate multi-purpose sites, aged care facilities or residential care facilities must ensure that credentialing of medical practitioners who provide services in these facilities is carried out to at least the minimum standard required for facility accreditation to the National Safety and Quality Health Service Standards. The scope of clinical practice should be consistent with the normal primary care role provided by the medical practitioner.

7. Credentialing Committee Obligations

Credentialing Committees ensure that a rigorous peer review process is undertaken for credentialing and defining scope of clinical practice for medical practitioners.

It is the responsibility of a Credentialing Committee to verify a medical practitioner's credentials and determine a clinical scope of clinical practice in accordance with the *WA Health Clinical Services Framework 2014-2024* or its replacement.

The determinations made by a Credentialing Committee are to specify the scope of clinical practice, any conditions attached and the reasons for any limitations on the duration of credentialing approval or the scope of clinical practice.

A determination by a Credentialing Committee cannot of itself give rise to employment or other engagement of a medical practitioner.

Medical practitioners must be credentialed and have a prescribed scope of clinical practice before commencing clinical practice in any capacity.

Credentialing Committee determinations inform an Appointing Officer of the terms of employment or engagement, as they relate to the scope of clinical practice which may be offered to a medical practitioner.

Terms of Reference and guidance for the Credentialing Committees are included in:

- Appendix 1** Template Terms of Reference for the Credentialing Committee
- Appendix 2** Additional Guidance for the Credentialing Committee

8. Credentialing and Defining the Scope of Clinical Practice Process

Credentialing is the formal process used to verify the qualifications, experience and professional standing of medical practitioners for the purpose of ascertaining their competence, performance and professional suitability to provide safe, high quality health care services within a particular Health Care Facility.

Defining the scope of clinical practice is the process of delineating and articulating the extent of an individual medical practitioner's clinical practice in a particular Health Care Facility based on the individual's credentials, competence, performance and professional suitability, and in consideration of the needs and capabilities of the Health Care Facility. It defines the clinical practice that a medical practitioner is permitted to conduct at a particular Health Care Facility. A scope of clinical practice is sometimes referred to as "clinical privileges".

The credentialing and defining the scope of clinical practice process consists of three distinct stages:

1. **initial credentialing** which involves a review and verification of a medical practitioner's qualifications, skills, experience and competencies (refer section 8.1);
2. **defining the scope of clinical practice** for a medical practitioner within a specific Health Care Facility (refer section 8.2); and
3. **renewal** (otherwise known as re-credentialing) of credentials and the scope of clinical practice to confirm that a medical practitioner has maintained or improved their qualifications, skills and competencies and that the Health Care Facility still requires, and is able to support, the defined scope of clinical practice (refer section 10).

Initial credentialing and defining the scope of clinical practice is to be included as part of the initial employment or engagement process, however it is an independent process under the governance of the Credentialing Committee.

8.1 Initial Credentialing

8.1.1 Invitation to submit a credentialing application

On application for employment or engagement by a Health Service Provider, medical practitioners must concurrently submit their clinical profile as an application to the CredWA system to enable the credentialing process to

commence. The employment or engagement process and the credentialing processes may occur simultaneously, however they are separate processes.

8.1.2 Committee review/consideration of application

On completion of a profile within CredWA and submission of all relevant documentation to support a medical practitioner's application for credentialing, the application is to be considered at the next scheduled Credentialing Committee meeting.

The Credentialing Committee shall make a determination:

- prior to the medical practitioner's first day of clinical practice at the Health Care Facility; and
- on an on-going basis at least every five years.

Where exceptional circumstances require a medical practitioner to commence clinical practice prior to a formal determination, the Principal Medical Administrator must have approved a Temporary (Interim) Credentialing and Scope of Clinical Practice prior to the commencement of clinical practice.

The following documents are provided to assist in effective management of the credentialing and defining scope of clinical practice process:

Appendix 3 Credentialing and Scope of Clinical Practice Procedural Checklist

Appendix 4 Credentialing, Renewal of Credentialing and Defining Scope of Clinical Practice Checklist

Appendix 5 Documentation the Credentialing Committee is required to retain as part of its records

8.2 Defining Scope of Clinical Practice

Specific criteria for defining the scope of clinical practice must be developed by the Credentialing Committee to ensure consistency and equity in decision making.

The *National Standard for Credentialing and Defining the Scope of Clinical Practice* suggests the following approaches for defining the scope of clinical practice:

- checklist: an exhaustive list of possible clinical services, procedures or other interventions that may be requested;
- categorisation: well-defined categories or levels of scope of clinical practice that can be used by each applicant;
- descriptive: the applicant describes the requested scope of clinical practice, in narrative format; or
- a combination of the above.

Defining the scope of clinical practice involves:

- reviewing the scope of clinical practice required by the particular Health Care Facility and requested by the applicant, using one of the above approaches;

- identifying the issues to be considered in making a determination (see Appendix 3 for a list of potential issues to be considered); and
- determining the scope of clinical practice for the applicant.

Determinations regarding scope of clinical practice shall involve consultation by the Credentialing Committee with the relevant Head of Specialty (except when the Head of Specialty is the applicant, in which case a relevant peer should be consulted).

The Credentialing Committee's determination date is the commencement date of the medical practitioner's credentialing and scope of clinical practice. The only exception to this is where applications are noted only, for example: locums who have been credentialed under a Temporary (Interim) Credentialing and Scope of Clinical Practice Process (refer to section 9).

Refer to **Appendix 6** Determining the Scope of Clinical Practice Checklist

8.3 Duration of Scope of Clinical Practice

Decisions regarding the duration of a medical practitioner's credentialing and scope of clinical practice are at the discretion of the Credentialing Committee, up to a maximum of five years.

Where a medical practitioner has been granted temporary credentialing status, but a final determination regarding an appropriate credentialing term cannot be determined at the next Credentialing Committee meeting based on factors outside the Credentialing Committee's remit, the Credentialing Committee has discretionary authority to determine an appropriate duration of the temporary (interim) scope of clinical practice, factoring in the principles of procedural fairness, natural justice and patient safety. An example of this is limiting a medical practitioner's scope of clinical practice until the Credentialing Committee is provided with relevant information to support a final determination by the Credentialing Committee.

8.4 Inconclusive Committee Determinations

If the Credentialing Committee has any uncertainty about the credentials or scope of clinical practice of a medical practitioner, it is to raise the matter with the medical practitioner concerned and provide the medical practitioner an opportunity to respond in writing.

The Credentialing Committee will request a written submission from the medical practitioner when it:

- is unclear about an aspect of the application;
- requires further information on the scope of clinical practice that has been requested; or
- is unclear or seeking further information about the review of the scope of clinical practice.

While there is no obligation for an applicant to provide a response to issues raised by the Credentialing Committee, conclusions about the medical practitioner's clinical practice and the subsequent determination of the Credentialing Committee are based on available information. If a written

response is not provided, the Credentialing Committee will still be required to make a determination on the information that has been made available to the Credentialing Committee.

If the Credentialing Committee remains in doubt after the additional information has been provided, it is to determine an appropriately varied scope of clinical practice and refer the matter to the Principal Medical Administrator for immediate action. This may involve a requirement for additional training or further experience under supervision.

If the medical practitioner does not accept the Credentialing Committee's final determination, the medical practitioner is to be informed of the Credentialing appeal process (refer to section 13 Credentialing Appeal Process).

Refer to **Appendix 7** Inconclusive Credentialing Committee Determination Flowchart

8.5 Portability of a Defined Scope of Clinical Practice

The scope of clinical practice granted to a medical practitioner is Health Care Facility specific. Information concerning a medical practitioner's scope of clinical practice can be shared with other Health Service Providers with the prior approval of the medical practitioner.

8.6 New Clinical Service, Procedure or Intervention

A medical practitioner may request additional scope of clinical practice where there is an introduction of new clinical services, procedures and technology or interventions. Examples include:

- a new technology or procedure is introduced outside of the medical practitioner's existing approved scope of clinical practice;
- the medical practitioner is introducing an established technique or clinical intervention into the particular Health Care Facility for the first time;
- the medical practitioner acquires enhanced skills or competencies that they wish to integrate into their work practice; and
- the medical practitioner is introducing a new technique or clinical intervention into the particular Health Care Facility for the first time as part of a human trial and/or research.

Health Service Providers are required to ensure that for each Health Care Facility there are policies and processes that define the requirements for introducing new clinical services, procedures or other interventions.

8.7 Medical Practitioner Request for Review

Once a determination has been made in relation to a medical practitioner's application, the medical practitioner can request a review of the Credentialing Committee's determination.

On receipt of a request to review a determination, the Credentialing Committee will invite the medical practitioner to make a submission to the Credentialing Committee in order to understand the basis for the review request before a final determination is made. The medical practitioner may

consider whether they wish to speak with their private professional indemnity provider or engage legal counsel as part of this process.

When preparing a submission, the medical practitioner is to be encouraged to address each concern or matter outlined by the Credentialing Committee and provide additional information which will assist the Credentialing Committee to better understand the medical practitioner's perspective.

The submission the medical practitioner makes may be oral, written or both, although the medical practitioner should be encouraged to provide a written submission in the first instance. The medical practitioner must then be provided with the option to support their written submission with an oral presentation to the Credentialing Committee. If the oral presentation is recorded, the medical practitioner must provide consent and be provided with a copy of the recording.

The Credentialing Committee has an obligation to ensure that the process is fair to the medical practitioner and all other parties. All evidence considered by the Credentialing Committee as part of the determination and review processes must be made available to the medical practitioner. Anonymous or undocumented complaints are not to be considered as appropriate evidence.

If the medical practitioner does not accept the Credentialing Committee's final determination, the medical practitioner is to be informed of the Credentialing appeal process (refer to section 13 Credentialing Appeal Process).

There is no obligation for a medical practitioner to respond to any queries the Credentialing Committee has regarding the review request, nor to review submissions, however conclusions about the medical practitioner's clinical practice and the subsequent determination of the Credentialing Committee are based on available information. The Credentialing Committee can only make a determination based on the information that has been provided.

Refer to **Appendix 8** Credentialing Committee Review Flowchart

9. Temporary (Interim) Credentialing and Scope of Clinical Practice Process

Temporary credentialing and scope of clinical practice is known as 'interim' credentialing within the CredWA system.

The Principal Medical Administrator can approve a temporary scope of clinical practice for up to a maximum of 90 days in the following circumstances:

1. short-term appointments where the period of employment or engagement will cease prior to convening of the next Credentialing Committee meeting (e.g. short term locum appointments). These approvals are to be tabled at the next Credentialing Committee meeting for purposes of governance and notification to the committee membership; or
2. where an application is pending ratification at a meeting of the full Credentialing Committee, the next Credentialing Committee meeting must occur before interim credentialing period expires.

As a minimum, before approving a temporary scope of clinical practice the Principal Medical Administrator must ensure the following requirements are satisfied:

- the medical practitioner has current registration in the appropriate category with the MBA;
- the scope of clinical practice is consistent with any conditions or undertakings on that registration;
- the medical practitioner provides an up-to-date curriculum vitae with no unexplained gaps in employment;
- the medical practitioner holds the qualifications mandatory to the appointment (for example: specialist fellowship). Registration can be accepted as providing evidence; and
- a reference check from the candidate's most recent place of employment (or, in the case of locums, the most recent locum posting) is undertaken. This may be obtained as a verbal reference, but must be documented by the officer who receives the reference.

Where temporary credentialing is approved it is the responsibility of the Principal Medical Administrator to ensure that they are satisfied that the medical practitioner does not present a risk to the safety and well-being of patients and/or staff.

9.1. Extending Temporary Credentialing and Scope of Clinical Practice Status

Temporary credentialing and scope of clinical practice may be extended past the initial 90 days for an additional maximum of 90 days in the following circumstances only:

- the medical practitioner is under review by the MBA and the Credentialing Committee's decision is pending the outcome of an MBA decision;
- the medical practitioner is under review by the Credentialing Committee pending the outcome of an internal investigation or a Health Care Facility clinical supervised performance review process; or
- the medical practitioner's application is pending the submission of additional documentation required by the Credentialing Committee.

9.2 Temporary Credentialing and Scope of Clinical Practice: Further Opinion by Private Psychiatrist

Under section 182 of the *Mental Health Act 2014 (WA)* a patient has the right to request an independent further opinion.

Private psychiatrists providing further opinion (including via teleconference) are required to be credentialed. Where a private psychiatrist is not credentialed and is required to provide a further opinion on a case by case basis, the temporary (interim) credentialing process is to be followed.

9.3 Urgent Credentialing and Scope of Clinical Practice

The Principal Medical Administrator can give verbal approval for temporary credentialing and scope of clinical practice of **up to 24 hours** in an urgent situation. This applies only to a Medical Practitioner who is credentialed and has a corresponding scope of clinical practice at another Health Care Facility,

and the Principal Medical Administrator of that Health Care Facility can confirm and provide evidence of that scope.

A determination in the above circumstances **must not exceed 24 hours and may not be extended**. Urgent credentialing and scope of clinical practice determination can be made verbally and must in every case, be subsequently confirmed in writing and documented in the minutes at the next Credentialing Committee meeting.

9.4 Disaster and Emergency Scope of Clinical Practice

9.4.1 Disaster situations

Medical practitioners engaged or deployed in response to disasters or other disruptive events may be granted Temporary Credentialing and Scope of Clinical Practice at the discretion of the Director General or their Delegates as per section 28 of the *Health Services Act*.

Health Service Providers must ensure after event record keeping.

9.4.2 Emergency situations

In an emergency situation where no other credentialed medical practitioner is available, a medical practitioner can be authorised by the Principal Medical Administrator to provide whatever clinical care is deemed necessary to preserve the health and life of a patient.

Health Service Provider policies and processes must include provision for credentialed medical practitioners to administer necessary treatment outside their authorised scope of clinical practice in emergency situations.

The particulars of the service provided which was outside the medical practitioners scope of clinical practice must be provided as soon as reasonably practicable to the Principal Medical Administrator.

10. Scheduled Renewal of Credentials and Scope of Clinical Practice Process

Renewal of credentials and scope of clinical practice must occur at a maximum of five year intervals. There is no obligation on a Credentialing Committee to endorse the same scope of clinical practice as previously granted.

The Credentialing Committee, at a minimum, must follow the same process used for Initial Credentialing and defining scope of clinical practice as set out in section 8 when considering renewals, including the provisions for request for review and appeal.

The Credentialing Committee may consider other material they believe relevant to safe practice including but not limited to:

- reports from the Health and Disability Services Complaints Office, MBA, AHPRA and Medicare Australia;
- medical indemnity history and status, including audits of litigation matters;
- clinical review and audit; and
- information made available from internal investigations.

Refer to **Appendix 4** Credentialing, Renewal of Credentialing and Scope of Clinical Practice checklist.

11. Unscheduled Credentialing and Scope of Clinical Practice Review Process

A review of a medical practitioner's credentials and/or scope of clinical practice shall be undertaken by the Credentialing Committee at the request of the Chief Executive, a Principal Administrator, Principal Medical Administrator or the medical practitioner to whom the credentials and scope of clinical practice applies. Staff members who have concerns about a medical practitioner's scope of clinical practice should refer these to the Principal Medical Administrator.

The medical practitioner to whom the credentials and scope of clinical practice applies may present to the Credentialing Committee any material they believe is relevant to demonstrate their safe practice, including items not noted on the original application form.

An unscheduled review of a medical practitioner's credentials and/or scope of clinical practice may occur in the following situations:

- with or in response to the introduction of new technologies;
- with the attainment of new qualifications, on application by the practitioner as appropriate;
- in response to the outcome of a performance review;
- in response to the outcome of an investigation following a complaint to the Health and Disability Services Complaints Office;
- the MBA indicates a review is appropriate; or
- where the Principal Medical Administrator deems appropriate to do so.

12. Variation, Suspension or Termination of Scope of Clinical Practice

The Principal Medical Administrator may vary, suspend or terminate the scope of clinical practice of a medical practitioner in response to determinations from the Credentialing Committee.

The medical practitioner must be advised in writing of the decision to vary, suspend or terminate their scope of clinical practice, including the evidence on which the determination was based, and of the Credentialing Appeals Process.

The scope of a medical practitioner's clinical practice can be suspended or terminated if the medical practitioner:

- has their MBA registration cancelled or modified in a way that precludes them from practising;
- employment or engagement contract expires or is terminated;
- ceases to have appropriate and adequate medical indemnity cover or insurance;

- presents a risk to the safety and well-being of patients and/or staff;
- otherwise departs from generally accepted standards of medical practice in their conduct;
- is found to have made a false declaration through omission or false information which justifies such action;
- engages in serious, negligent or wilful misconduct;
- is subject to a criminal investigation or has been convicted of a serious offence.

The scope of a medical practitioner's clinical practice can be varied if:

- the Health Care Facility does not have, or elects not to have, the facilities and/or clinical support for the requested procedure
- the scope of services provided by the Health Care Facility are redefined.

The scope of a medical practitioner's clinical practice must be varied, suspended or terminated in line with any variations, suspensions or terminations imposed by the MBA. This does not preclude the Credentialing Committee from imposing additional restrictions that may, or may not, be related to the MBA restrictions.

A Credentialing Committee has the authority to credential any medical practitioner on general, limited or provisional registration on a case by case basis.

In instances where the MBA has not specified Level 3 or Level 4 supervision requirements (for medical practitioners who have provisional or limited registration), a copy of the specialist medical college's outcome letter can be considered by the Credentialing Committee and assist in determining an appropriate scope of clinical practice.

Refer to **Appendix 9** Additional Guidelines for Variation, Suspension or Termination of Scope of Clinical Practice Process

13 Credentialing Appeal Process

A medical practitioner who has had their requested scope of clinical practice denied, suspended, or varied from the original request may appeal the decision to the Chief Executive. An appeal in accordance with this section can be lodged once the review process provided under section 8.7 - Medical Practitioner Request for Review of this Standard - has been concluded and a final determination is made and provided to the medical practitioner.

Appeals must be lodged in writing to the Chief Executive within 7 days of receipt of the Credentialing Committee's final determination.

The Chief Executive is responsible for the formation of a Credentialing Appeal Panel.

The Credentialing Appeal Panel's recommendations are to be made to the Chief Executive for consideration and decision. The Chief Executive's decision is final.

Refer to **Appendix 10** Guidelines for Credentialing Appeal Panel

Refer to **Appendix 11** Credentialing Appeal Process Flowchart

14 Other Considerations

14.1 Consent to the Retention of Information

The Health Service Provider must ensure that medical practitioners consent, in their credentialing applications, to the retention of all information provided for credentialing and scope of clinical practice processes.

The Health Service Provider is responsible for ensuring that information on the credentialing process and use of retention of information provided as part of this process is available to applicants and currently credentialed medical practitioners.

14.2 Performance Appraisal

The *Terms and Conditions for Indemnity of Salaried and Non-salaried Medical Officers* require non-salaried medical practitioners covered by this arrangement to cooperate with and participate in clinical governance requirements and processes (which include performance appraisal).

The Industrial Agreement provides that medical practitioners will be subject to regular performance review directed towards an individual's skills and competencies.

The Health Service Provider is responsible for ensuring that annual performance appraisals are conducted with medical practitioners.

14.3 Continuing Professional Development

The MBA requires that all medical practitioners participate in regular Continuing Professional Development (CPD) relevant to their scope of clinical practice with the purpose to maintain, develop and update their knowledge, skills and performance to ensure they deliver appropriate, safe care. Medical colleges may have additional requirements.

Medical practitioners are required to confirm their participation in CPD on a regular basis. Whilst the MBA does not currently require the submission of evidence of CPD on a regular basis, medical practitioners are required to submit CPD documentation to the credentialing committee at both initial credentialing and re-credentialing stages.

15 References and Relevant Legislation

- Australian Commission on Safety and Quality in Healthcare, National Standards <https://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf>
- Australian Council for Safety and Quality in Healthcare (2004). *Standard for Credentialing and Defining the Scope of Clinical Practice. A National Standard for Credentialing and Defining the Scope of Clinical Practice of Medical practitioners, For Use in Public and Private Hospitals, available at:* <http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/credenti.pdf>
- Australian Council for Safety and Quality in Health Care. (2002). *National Guidelines for Credentials and Clinical Privileges.*
- Department of Health. (2014). *WA Health Clinical Services Framework 2014-2024*, Department of Health, Perth. <http://ww2.health.wa.gov.au/Reports-and-publications/WA-Health-Clinical-Services-Framework-2014-2024>
- Department of Health. (2003). *Credentialing: An Introduction* (Information Series No 3.1), Department of Health, Perth.
- Department of Health (2017). Health Technology, Governance Policy MP 0072/17.
- Department of Health (2016). Standardised Position Titles Policy MP0042/16.
- Department of Health. (2006). Terms and Conditions of the Indemnity for Salaried Medical Officers, Department of Health, Perth. <http://www.health.wa.gov.au/indemnity/salaried/index.cfm>
- Department of Health. (2013). Terms and Conditions of the Indemnity for Non-Salaried Medical Officers, Department of Health, Perth. <http://www.health.wa.gov.au/indemnity/nonsalaried/index.cfm>
- Health Practitioner Regulation National Law (WA) Act 2010 (WA).*
- Health Services Act 2016 (WA)*
- Legislative Council. (1990). Guidelines Relevant to Minister and Officers involved in Legal Proceedings. Tabled 10 July 1990.
- Medical Board of Australia Registration Standards <http://www.medicalboard.gov.au/Registration-Standards.aspx>
- WA Health System - Medical Practitioners – AMA Industrial Agreement 2016
- Guide to credentialing and defining scope of clinical practice for medical practitioners and dentists in Queensland. A best practice guide. June 2014. https://www.health.qld.gov.au/_data/assets/pdf_file/0026/440891/cred-best-practice-guid.pdf

Appendix 1: Template Terms of Reference for the Credentialing Committee

Health Service Providers must adapt this template to the standard format ordinarily used by the Health Service Provider for Committees and adopt formal Terms of Reference, which are consistent with the principles set out in the Standard, for all credentialing committee established.

1. Name

The Credentialing and Scope of Clinical Practice Committee is to be known as the Credentialing Committee of the (*name of Health Service Provider or Health Facility or Health Care Facilities, as the case requires*).

2. Purpose

The purpose of the Credentialing Committee is to support the delivery of high quality health care and ultimately better patient outcomes by providing (*Name*) with a rigorous peer review process for credentialing and defining scope of clinical practice of medical practitioners engaged by the Health Service Provider.

This requires reviewing the credentials, of all specialists, senior medical practitioners and junior medical officers as prescribed in the Credentialing and Defining Scope of Clinical Practice for Medical Practitioners Standard, so as to determine appropriate scope of clinical practice.

3. Accountability

The Credentialing Committee is accountable to and reports to the Chief Executive.

4. Conduct of the Credentialing Committee

The Credentialing Committee will conduct itself at all times in good faith, according to the rules of procedural fairness and natural justice, without conflicts of interest or bias, and in a manner which does not breach relevant legislation.

The principles of equity, merit and probity form the basis of all phases of credentialing and defining scope of clinical practice processes.

5. Role and Function and Responsibilities of the Credentialing Committee

The Credentialing Committee is to undertake and provide advice on the processes of credentialing and defining the scope of clinical practice:

- prior to start date or reappointment of a medical practitioner;
- at re-credentialing;
- unscheduled review of credentialing and scope of clinical practice;
- upon request for review of determinations; and
- upon introduction of new technologies.

The Credentialing Committee is to:

- determine the type and level of information required for credentialing of existing medical practitioners;
- review and verify training and qualifications to ensure a medical practitioner's experience and skills support the scope of clinical practice required for the position;
- review the clinical services being requested with regard to the role delineation, needs and capability of the health service and the degree of available supervision at the health service where the scope of clinical practice is being requested;
- determine the appropriate scope of clinical practice for a medical practitioner;
- review the scope of clinical practice of all medical practitioners at regular intervals or at the request of the Principal Medical Administrator or Principal Administrator or the medical practitioner to whom the credentials and scope of clinical practice apply;
- determine a scope of clinical practice following the regular review period or requested review;
- notify a medical practitioner of the decision concerning the medical practitioner's scope of clinical practice at the time of the initial appointment and at any future regular reviews;
- undertake an initial review of its own determinations if so requested by the medical practitioner;
- use the state-wide credentialing system known as CredWA as the tool to facilitate credentialing and scope of clinical practice of medical practitioners;
- ensure medical practitioners understand and consent to the retention of information gathered as a part of credentialing and scope of clinical practice processes;
- fully document and keep confidential all Committee proceedings unless directed otherwise by the Chief Executive or by law; and
- conduct itself in good faith, according to the rules of procedural fairness and natural justice, without conflicts of interest or bias, and in a manner that does not breach relevant legislation.

6. Membership of the Committee

Standing membership:

- Principal Medical Administrator as Chair; and
- between three and six medical practitioners, appointed by the Chief Executive, reflecting the mix of clinical services provided at the Health Care Facility.

The Committee will co-opt members from time to time including:

- a university nominee who is a medical practitioner where a clinical academic application is to be considered;

- a nominee of a vocational college of which each of the applicants under consideration are members or eligible to be members;
- at least one medical practitioner from the medical speciality of each of the applicants under consideration;
- a Human Resources Officer from the Health Service Provider; and
- other relevant experts as deemed appropriate.

The Credentialing Committee will not make a determination on credentialing or defining the scope of clinical practice unless at least one of those members present at the meeting, either as a standing member or as a co-opted member, is a Fellow of the relevant vocational college of each of the applicants being considered.

A quorum will comprise two thirds of the Standing membership plus those required to be co-opted for the immediate matters under consideration by the Committee.

7. Appointment

Nominations for membership of the Credentialing Committee are to be called every two to three years by the Chief Executive. The Chief Executive is to appoint standing members for a period of two to three years.

In the absence of the Chair, another of the Standing members shall be elected to act as the Chair. The Deputy Chair is to perform all functions of the Chair when the Chair is unavailable or unable to perform their functions.

The Chair is to be the authorised channel of communication of all decisions of the Credentialing Committee.

8. Proxies

Standing members of the Credentialing Committee may nominate another medical practitioner as a proxy to attend meetings when any of them are unable to attend. The Chair is to be advised of the proxy prior to the meeting.

9. Conflict of Interest

A member of the Credentialing Committee, who has duties or interests in conflict with their duties or interests on the Committee whether direct, indirect, financial, material or otherwise, must withdraw or declare a possible conflict of interest to the Chair. Where a possible conflict of interest is declared it must be dealt with in accordance with the Health Service Provider Conflict of Interest Policy.

10. Confidentiality

The proceedings of the Credentialing Committee are to be confidential unless decided otherwise by the Chief Executive or as required by law.

11. Frequency of Meetings

The Credentialing Committee is to meet according schedule agreed by Credentialing Committee members. The Chair may cancel a meeting if there is insufficient business to warrant holding a meeting or a quorum will not be reached. An additional meeting may be held at the discretion of the Chair.

12. Notice of Meetings

As far as possible, notices of meetings and supporting papers are to be sent five working days in advance of the meeting date.

13. Absences

Any elected member who misses three consecutive meetings of the Credentialing Committee without evidence of a good cause is to be deemed to have resigned.

14. Decisions

Decisions of the Credentialing Committee are to be by the majority. The Chair is to have the casting vote.

15. Secretary

A Secretary is to be appointed by the Chair and is to issue agendas and supporting material at least five working days in advance of each meeting. The Secretary is to prepare minutes of each meeting, to be formally adopted at the subsequent meeting of the Credentialing Committee. The Secretary is to keep separate files of at least the following:

- agendas, minutes and supporting documents;
- correspondence prepared by and on behalf of the Credentialing Committee; and
- other material kept to support the decisions and/or processes of the Credentialing Committee.

The Secretary's files are the property of the Health Service Provider and must be preserved in accordance with the *State Records Act 2000* (WA).

16. Determinations

The Credentialing Committee determinations are to specify the scope of clinical practice, any conditions attached and the reasons for any limitations on the duration or scope of clinical practice.

17. Adoption, Review and Amendment of Terms of Reference

The Terms of Reference are to be reviewed at a minimum every three years.

Terms of Reference may be altered and amended by recommendation to the Chief Executive.

Revision dates:

Date of revision	Revision prepared by	Comments

Appendix 2: Additional Guidance for the Credentialing Committee

Credentialing Committee's review of the Scope of Clinical Practice

If a Credentialing Committee remains in doubt about the competence of a medical practitioner to perform a particular treatment, procedure or intervention, a Committee may:

- request a specific evaluation of the medical practitioner's performance by an external or internal peer;
- require the medical practitioner to keep a log book;
- place restrictions on the time period or scope of clinical practice granted;
- require the medical practitioner to be supervised or to attend further training; or
- introduce a performance review process.

If a Credentialing Committee does not believe there is sufficient information or requires clarification on any aspect of an application prior to making a determination, the application may be held over and a request seeking clarification or further information will be made in writing to the applicant. This information should be tabled at the next scheduled Credentialing Committee meeting. On receipt of the additional information, a Credentialing Committee can reassess the application based on all available information and make a determination.

Credentialing committee's role with new procedures and treatments

Once the hospital has determined that a new procedure will be introduced, the Credentialing Committee will then review a medical practitioner's competence to perform the new technology, procedure or intervention.

Medical practitioners who wish to provide new procedures and treatment modalities will require amendments to their clinical scope of clinical practice. A medical practitioner will be required to initiate a re-credentialing process and present the new technology or procedure (which is currently outside of the medical practitioner's scope of clinical practice) to a Credentialing Committee. The date of the Credentialing Committee's determination shall be documented as the approval date of credentialing for the new procedure. A medical practitioner cannot be approved for modified credentialing by any other means.

Factors that a Credentialing Committee needs to consider in making a determination include:

- that the new clinical service, procedure or intervention is approved according to the particular Health Service Provider or Health Care Facility's policy; and
- the minimum credentials, including evidence of competence, required to enable a Credentialing Committee to make an informed decision are provided.

Probation periods can be prescribed with the introduction of new technologies, procedures and treatments that are currently outside the agreed scope of clinical practice. Before granting the new scope of clinical practice, a Credentialing Committee must define:

- the purpose and timelines of any probationary period;
- any training or supervisory requirements; and

- the method of evaluation to be undertaken.

Credentialing Committee's Determinations

When a Credentialing Committee has considered all aspects of a medical practitioner's application, a Credentialing Committee will minute the Credentialing Committee's final determination. This should include any limitations such as supervision requirements, conditions or undertakings on registration and the period of the scope of clinical practice.

Determinations by a Credentialing Committee to a variation of the role delineation can include the determinations as listed in the above 'Credentialing Committee's review of the Scope of Clinical Practice'.

Dissolution of a Credentialing Committee

Dissolution of a Credentialing Committee can be undertaken following consultation with relevant stakeholders including the Australian Medical Association (AMA). The reasons for dissolution must be clearly documented and retained as a part of a Credentialing Committee's formal records. The Chief Executive may dissolve a Credentialing Committee and replace it with another committee to manage credentialing and scope of clinical practice processes.

Appendix 3: Credentialing and Scope of Clinical Practice Procedural Checklist

- Formally constitute a Credentialing Committee for all medical practitioners**
 - Terms of Reference
 - Delegations manual defines lines of responsibility throughout the Health Care Facility
 - Minutes and determinations of the Credentialing Committee
- Appoint Committee Members**
 - List of Credentialing Committee members
- Confirm the Principal Medical Administrator**
 - Delegations manual defines lines of responsibility throughout the Health Care Facility
- Standard policy and processes are in place and available to Health Service Provider staff for credentialing and defining the scope of clinical practice, including:**
 - Initial credentialing and defining scope of clinical practice
 - Renewal of credentials and scope of clinical practice
 - Temporary credentialing
 - In an emergency situation
 - In a disaster
 - New clinical procedures, technologies and treatments
 - Unplanned review of credentials and/or scope of clinical practice
 - Dissemination of information to medical practitioners and relevant health service staff
 - Policy and procedures manual
 - Pro-forma for seeking referee feedback
 - Letters notifying medical practitioner of outcomes
 - Minutes and determinations of the Credentialing Committee
 - Audit to verify consistency of application of agreed and documented processes
- Policy and procedures for credentialing and defining the scope of clinical practice are readily available to medical practitioners**
 - Policy and procedures manual
 - Information available on staff notice board
 - Information raised in hospitals newsletters, flyers or bulletins
 - Information available on Health Care Facility intranet

- Maintenance of comprehensive documentation**
 - Copies of documentation
 - Procedure for retaining relevant documentation
 - Audit to verify consistency of application of agreed and documented processes
- Education and training mechanism in place to support Credentialing Committee members in meeting their responsibilities**
 - Education and training program developed
 - Attendance at education sessions
 - Information provided to Credentialing Committee members to ensure awareness of responsibilities and issues associated with credentialing and defining the scope of clinical practice
- Standard process for monitoring medical practitioner compliance against scope of clinical practice granted**
 - Performance review mechanism confirms medical practitioner complying with scope of clinical practice granted
- Appeals mechanism in place**
 - Policy and procedures manual detailing the appeals mechanism
 - Evidence of the appeals mechanism being used
 - Audit to verify consistency of application of agreed and documented processes
- Process for regularly monitoring and reviewing the performance of the Credentialing Committee**
 - Review report produced
 - Evidence of implementation of recommendations arising from review
 - Audit to verify consistency of application of agreed and documented processes
- Report on status of credentialing and defining the scope of clinical practice within each Health Care Facility as part of the Health Service's Clinical Governance Framework**
 - Credentialing and defining the scope of clinical practice is an initiative identified in each of the Health Service Providers' Clinical Governance Frameworks
 - Status of credentialing and defining the scope of clinical practice initiatives are reported to the Department as a part of its regular Clinical Governance report
 - Audit to verify consistency of application of agreed and documented processes
- Considered mechanism for providing relevant information to patients and the community**

- Policy and procedures manual
- Credentialing committee meeting records
- Audit reports

Appendix 4: Credentialing, Renewal of Credentialing and Defining Scope of Clinical Practice Checklist

The following information/evidence should be reviewed prior to making a decision on whether or not a medical practitioner will be credentialed (and/or have credentials renewed) and defining a scope of clinical practice:

- Current MBA registration in the appropriate category
 - Applications for medical practitioners on Limited or Provisional Registration must show conditions and the recommended position title, supervision details and area of need dates under 'Notations – Registration Requirements'.
- Position Title
 - The position title of the medical practitioner must be consistent with their MBA Registration and the Standardised Position Titles Policy MP 0042/16.
 - At all time, position titles for medical practitioners who have Limited or Provisional Registration must reflect the position title indicated in the 'Notations – Registration Requirements' section located under the applicant's 'Registration Type', regardless of the 'appointment' position the medical practitioner has been contracted in.
- Current Curriculum Vitae with employment and education history
 - A complete review of an applicant's employment or engagement history, with details of all clinical positions held by the applicant, including location, nature and duration.
 - Education, training and experience gained since the last review, including medical college or specialist society endorsement or accreditation.
 - Summary of clinical activity since last review or at least for the past twelve months, which may include volume and outcomes.
 - Clinical audit or peer review activities.
- Reviews
 - Initial Credentialing – 2 x written references. These are the peer reviews and considered opinions of at least two professional referees of the same discipline, who are able to advise on the applicant's clinical skills, competency and suitability for the scope of clinical practice being sought. The referees' opinions must be obtained directly from the referees, not via the applicant, and should be able to comment on practice within the last 12 months.
 - Renewal of credentials and scope of clinical practice – 1 x Performance Review Report or Continuing Professional Development Report provided by the applicant's Head of Specialty within the last 12 months. The report should review the medical practitioner's competence and performance in the position and scope of clinical practice under consideration, and in particular their ability to provide health care services at the expected level of safety and quality. This review must also include information about the applicant's past performance, including evidence of participation in clinical

- governance activities, undertaking continuing medical education and participation in teaching and research.
- Continued Professional Development (CPD)
 - o Demonstrated participation in a Maintenance of Professional Standards (MoPS) Program or Continuing Medical Education Program (CME) Program.
 - o Summary of clinical activity for at least the past 12 months which may include a logbook, if maintained.
 - Declarations and Undertakings
 - o The medical practitioner needs to declare any prior or current disciplinary actions, professional sanctions, criminal investigations or convictions, or any other matters reportable under the *Health Practitioner Regulation National Law (WA) Act 2010 (WA)*.
 - o Any physical or mental conditions or substance abuse problem that could affect the medical practitioner's ability to perform the scope of clinical practice.
 - Consent - Ensures the medical practitioner understands and consents to the retention of information gathered as a part of the credentialing and scope of clinical practice process.
 - A completed scope of clinical practice – This should be consistent with any conditions, notations or undertakings upon the medical practitioner's registration.

Appendix 5: Documentation the Credentialing Committee is required to retain as part of its records

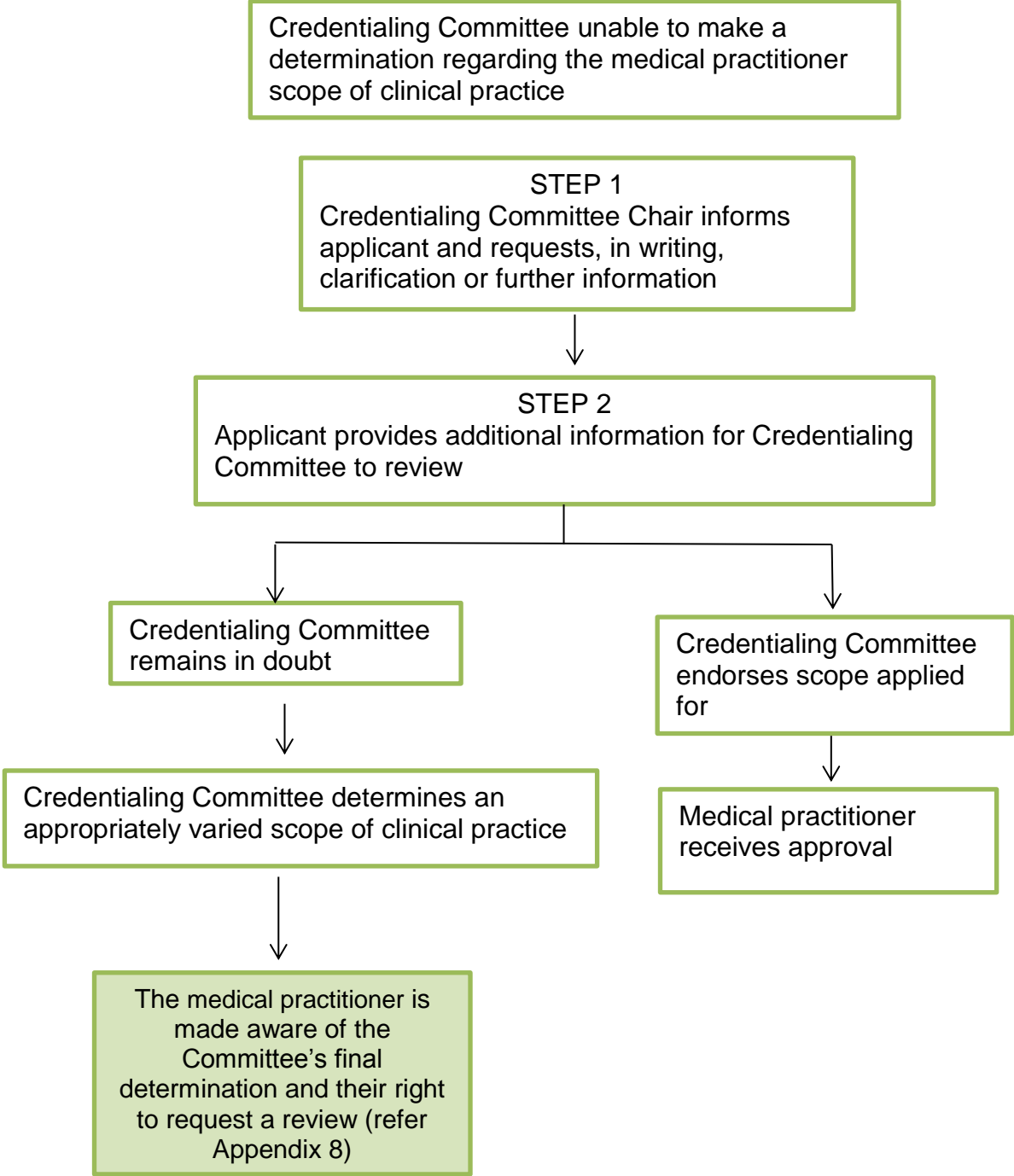
- Names of medical practitioners whose credentials were examined
- Specific registration documents and credentials that were examined, and in what format
- Any concerns about a medical practitioner's competence or performance
- Evidence reviewed regarding a medical practitioner's competence or performance in the position or scope of clinical practice under consideration
- Whether an invitation was extended to and accepted by a medical practitioner to present in person to the Credentialing Committee
- The identity of any support person who assisted a medical practitioner at any presentation
- Additional information that was presented by a medical practitioner
- Conclusions about a medical practitioner's competence and performance in the position or scope of clinical practice under consideration, and in particular their ability to provide health care services at the expected level of safety and quality
- The organisation's ability to provide the necessary facilities and clinical and non-clinical support services
- The Credentialing Committee's determinations regarding a medical practitioner's scope of clinical practice
- Record management and maintenance of applications with a suspended or varied scope of clinical practice, including legal correspondence

Appendix 6: Determining the Scope of Clinical Practice Checklist

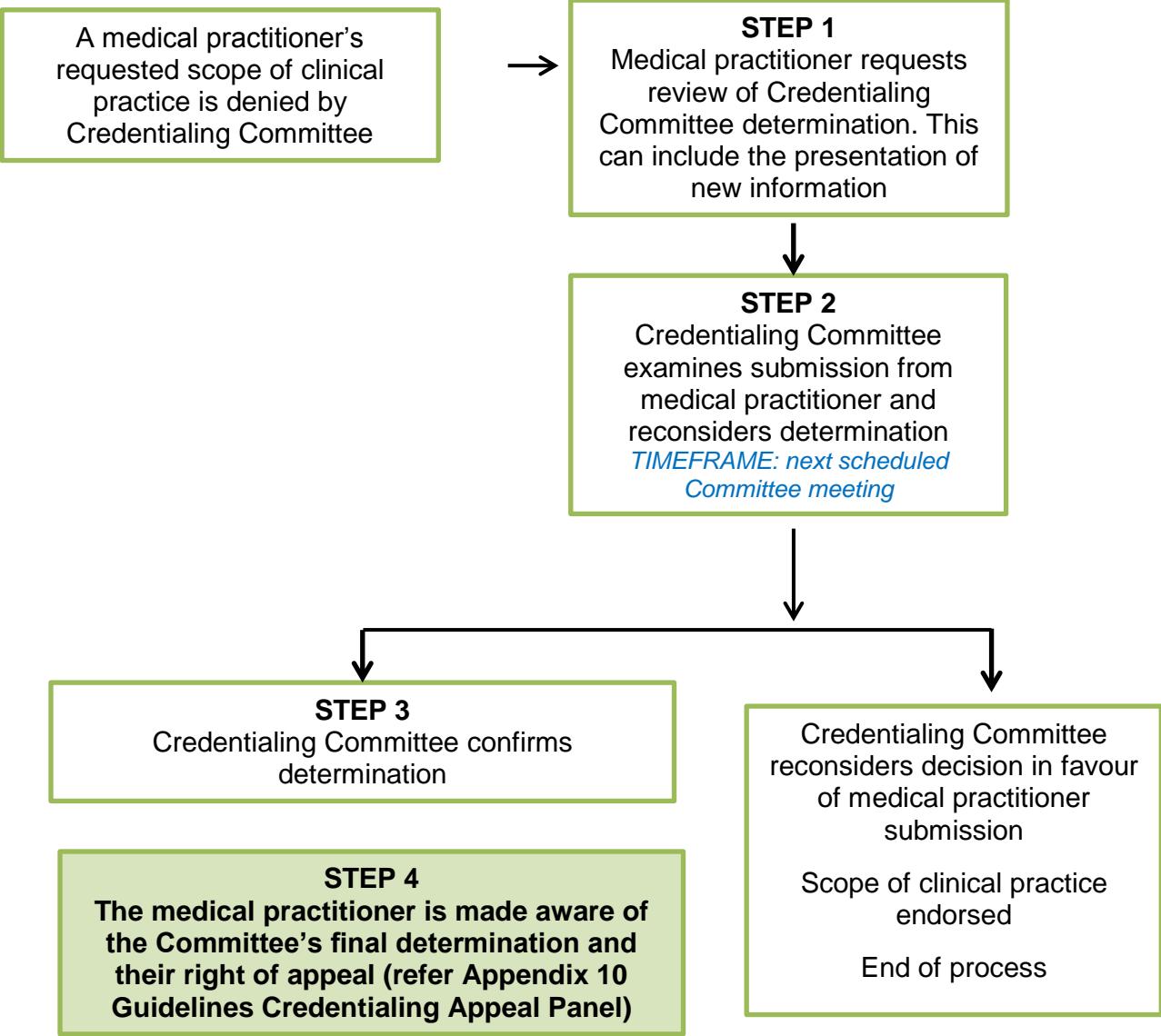
The following information/evidence should be reviewed prior to making a decision on the scope of clinical practice of a medical practitioner:

- Outcomes of the credentialing process, including referee reports and feedback from other/past employers
- Roles and responsibilities of the position
- Standards, guidelines, policies and/or recommendations by the specialty medical college, society or association
- Benefit of the particular treatment, procedure or intervention to patients
- Whether the particular treatment, procedure or intervention is new or new to the Health Care Facility and whether it has been approved by the appropriate authority or committee (e.g. ethics committee and Head of Service or Department)
- Skill mix of the Health Care Facility and the availability of support, facilities and equipment
- The medical practitioner's particular expertise and experience and the recency of that experience
- The volume of clinical activity undertaken by the medical practitioner over the past 12 months
- The Hospital or Health Service's role delineation, as defined by the current *WA Health Clinical Services Framework*
- Evidence-based information in credible publications regarding competence in and performance of the requested scope of clinical practice
- The level of information and evidence to be reviewed will differ based on the seniority of the position

Appendix 7: Inconclusive Credentialing Committee Determination Flowchart



Appendix 8: Credentialing Committee Review Flowchart



Appendix 9: Additional Guidelines for Variation, Suspension or Termination of Scope of Clinical Practice Process

Credentialing Committees are encouraged to develop a process for the reduction, suspension or termination of a medical practitioner's scope of clinical practice. This process should include a Credentialing Committee's:

- outcome or recommendation from the Chair to the medical practitioner
- advice for the medical practitioner to appear before the Credentialing Committee with representation, if so requested by the medical practitioner
- advice to the medical practitioner on their Appeal rights
- final outcome of a Credentialing Committee's decision

Examples where a medical practitioner's scope of clinical practice may be varied, suspended or terminated include if:

- the Health Care facility does not have, or elects not to have, the facilities and/or clinical support for the requested procedure or field of practice;
- the outcome of an investigation following a complaint to the Health and Disability Services Complaints Office or the MBA indicates a review is appropriate;
- a medical practitioner ceases to be registered with the MBA;
- a medical practitioner ceases to have appropriate and adequate medical indemnity cover or insurance;
- a medical practitioner is found to have made a false declaration through omission or false information which justifies such action ;
- a medical practitioner's employment or engagement contract expires or is terminated;
- a medical practitioner engages in serious or wilful misconduct;
- a medical practitioner presents a risk to the safety and well-being of patients and/or staff;
- a medical practitioner otherwise departs from generally accepted standards of medical practice in their conduct;
- a medical practitioner is subject to criminal investigation or has been convicted of a serious offence;
- a medical practitioner has been identified through onsite performance review or peer reference processes as performing substandard to clinical, professional, or ethical standard expectations. Some examples of specific reasons include:
 - making continued poor or incorrect decisions;
 - inability to work unsupervised;
 - failure to collaborate or consult with colleagues and other stakeholders where it is a requirement of the role; and
 - inability to make clinical decisions within the scope of the job requirements, leading to unnecessary referral of decisions to others.

A medical practitioner is to be advised of an immediate review of their credentialing and scope of clinical practice by the Credentialing Committee Chair and their right to the provision of any necessary personal or professional support.

In notifying a medical practitioner of a Credentialing Committee's determination with respect to reducing, suspending or terminating their defined scope of clinical practice, the medical practitioner is to be advised of any modifications, restrictions or request denials and the reasons for these being made. The medical practitioner is to be given a reasonable opportunity to comment with respect to any issues of concern prior to a final determination being made by the Credentialing Committee. At this time the medical practitioner is to also be advised of the appeal process.

If a medical practitioner is applying for scope of clinical practice across multiple sites across a health service, then each Principal Medical Administrator must be informed of the Credentialing Committee outcome any modification, restriction and/or denial.

A Credentialing Committee will, subject to principles of confidentiality and appeal rights, also advise the relevant Heads of Department.

All information and correspondence regarding a Credentialing Committee's decision on modification, restriction and/or denial of scope of clinical practice is to be provided by the Committee Chair in writing. The principles of procedural fairness and natural justice and probity must be observed by a Credentialing Committee. Therefore a Credentialing Committee must be clear in determining if a medical practitioner can continue to practice under the temporary credentialing process or should be suspended or terminated.

If the nature of the matter results in the suspension or termination of a medical practitioner and the Principal Medical Administrator believes in good faith that the safety and quality of health care in another institution is subsequently at risk, the matter is to be referred to the Principal Medical Administrator of that Health Care Facility.

Appendix 10: Guidelines for Credentialing Appeal Panel

1. A medical practitioner whose request for a re-review of a Credentialing Committee's determination has been denied, withheld or granted in a modified form to that requested has the right to appeal the decision. The procedure is:
 - The appellant to inform the Chair of the Credentialing Committee of their intention to proceed to an appeals process within seven days of receiving notification of the result of the re-review from the Credentialing Committee.
 - The appellant to advise the Chief Executive in writing of the intention to undertake the appeal process.
 - The Chief Executive must appoint a Credentialing Appeal Panel whose membership will be entirely independent to that of the Credentialing Committee.
2. The Credentialing Appeal Panel membership is to include:
 - an independent Chair who is a medical practitioner and is not the Principal Medical Administrator nor a member of the Credentialing Committee;
 - a senior medical practitioner from the same clinical discipline as the appellant;
 - a professional nominee of the appellant, who is a medical practitioner;
 - a medical practitioner nominated by the relevant college where the college agrees to make a nominee;
 - where the appellant so requests, the Chief Executive must seek a nominee of the Australian Medical Association, who is a medical practitioner; and
 - other members who the Chief Executive, on the advice of the independent Chair, decides will bring specific expertise to the Credentialing Appeal Panel.
3. Appointments to the Credentialing Appeal Panel will be on an ad-hoc basis to consider particular appeals and will not involve persons previously concerned with the subject of the appeal.
4. The Credentialing Appeal Panel should convene within 28 working days of receipt of a request for a formal hearing. During this time the appellant should not have visiting/admitting rights except within the scope of those visiting rights already granted and not in dispute.
5. At all times the principles of procedural fairness and natural justice are to apply and the appellant given every opportunity to have all available information brought forward for consideration.
6. The Credentialing Appeal Panel will call for written or verbal comment from relevant medical practitioners and Associations or Colleges as to the clinical competence of the appellant in the area of dispute.
7. The appellant is entitled to attend the Credentialing Appeal Panel and to be accompanied by a barrister or solicitor or another person. Such individuals may not represent the appellant but will be in an advisory capacity.

8. Hearings of the Credentialing Appeal Panel are to be closed.
9. Decisions of the Credentialing Appeal Panel are to be by majority of members with the Chair having a casting vote if necessary.
10. The Credentialing Appeal Panel to submit a written recommendation to the Chief Executive within 14 days of the agreed decision.
11. The Chief Executive will consider the Credentialing Appeal Panel recommendation and make a final decision.
12. The Chief Executive will advise the Chair of the Credentialing Committee in writing of the decision.
13. Final outcome of the Credentialing Appeal Panel and the decision of the Chief Executive are to be advised in writing to the appellant within seven days of the final decision which includes reasons for the decision to the appellant.
14. The appellant is eligible to reapply for credentialing or definition of scope of clinical practice if the appeal is refused.

Credentialing Appeals General Principles

15. The appeal process is intended to allow for reconsideration of any adverse decision and for new information to be brought forward if available. In the event that a Credentialing Appeal Panel is required, where possible take the following format:
 - All available information is to be presented to the members. There should be no specific time limit set for the meeting and members should be prepared to debate fully the issues until a solution is achieved.
 - At all times the principles of procedural fairness and natural justice are to apply and the appellant given every opportunity to have all available information brought forward for consideration.
 - Minutes recording the result of the Appeal Panel deliberations are to be kept. Each party is to be given the opportunity to speak seeking clarification and identification of the issues. Every opportunity should be taken to seek options for change and resolution. The aim of the process is to clearly identify the issues and arrive at a solution which, wherever reasonably practicable, is acceptable to all parties.

Credentialing Appeal Panel Roles and Responsibilities

16. The Credentialing Appeal Panel is to:
 - In the absence of exceptional circumstances, hear and determine the appeal on the evidence and matters raised.
 - Not involve persons previously concerned with the subject of the appeal.
 - Not be bound to the rules of evidence but may inform itself on any matter it thinks just and obtain legal advice to assist in its processes and deliberations.
 - Determine the matter according to equity, good conscience, and the substantial merits of the case without being constrained by legal technicalities or legal forms.

- Afford procedural fairness to all persons but may proceed to hear any appeal if documents or information are not provided within time limits specified by the panel.
- Act as rapidly as practicable.
- Prepare a written report setting out:
 - Conclusions arrived at including any dissenting view of a panel member;
 - Reasons for arriving at those conclusions; and
 - Materials:
 - o Referred or provided to the panel; or
 - o Relied upon in arriving at the conclusions.
- Give the appellant adequate opportunity to provide submissions before preparing the report.
- With the consent of the Chief Executive, take legal advice concerning the appeal and may in its discretion keep this advice confidential to itself.
- Otherwise determine the manner in which the appeal is to be conducted.
- Report and provide its recommendations to the Chief Executive and may make such recommendations concerning the appeal as it considers appropriate to best protect the interests of all parties.

Procedural Fairness

17. The Credentialing Appeal Panel must at all times:
- Ensure the principles of procedural fairness are applied throughout the process.
 - Ensure there is no victimisation of complainants, respondents, witnesses or anyone involved in the process.
 - Listen to the appellant's concerns and allegations.
 - Ask questions and gain an understanding of the concerns.
 - Ensure the appellant has the opportunity to present their version of events.
 - Treat all appeals seriously, sensitively and promptly.
 - Ensure that confidentiality is maintained.

Quorum

18. The quorum for the Credentialing Appeal Panel is to be all members. An alternate member is to be provided if an original nominee is not available.

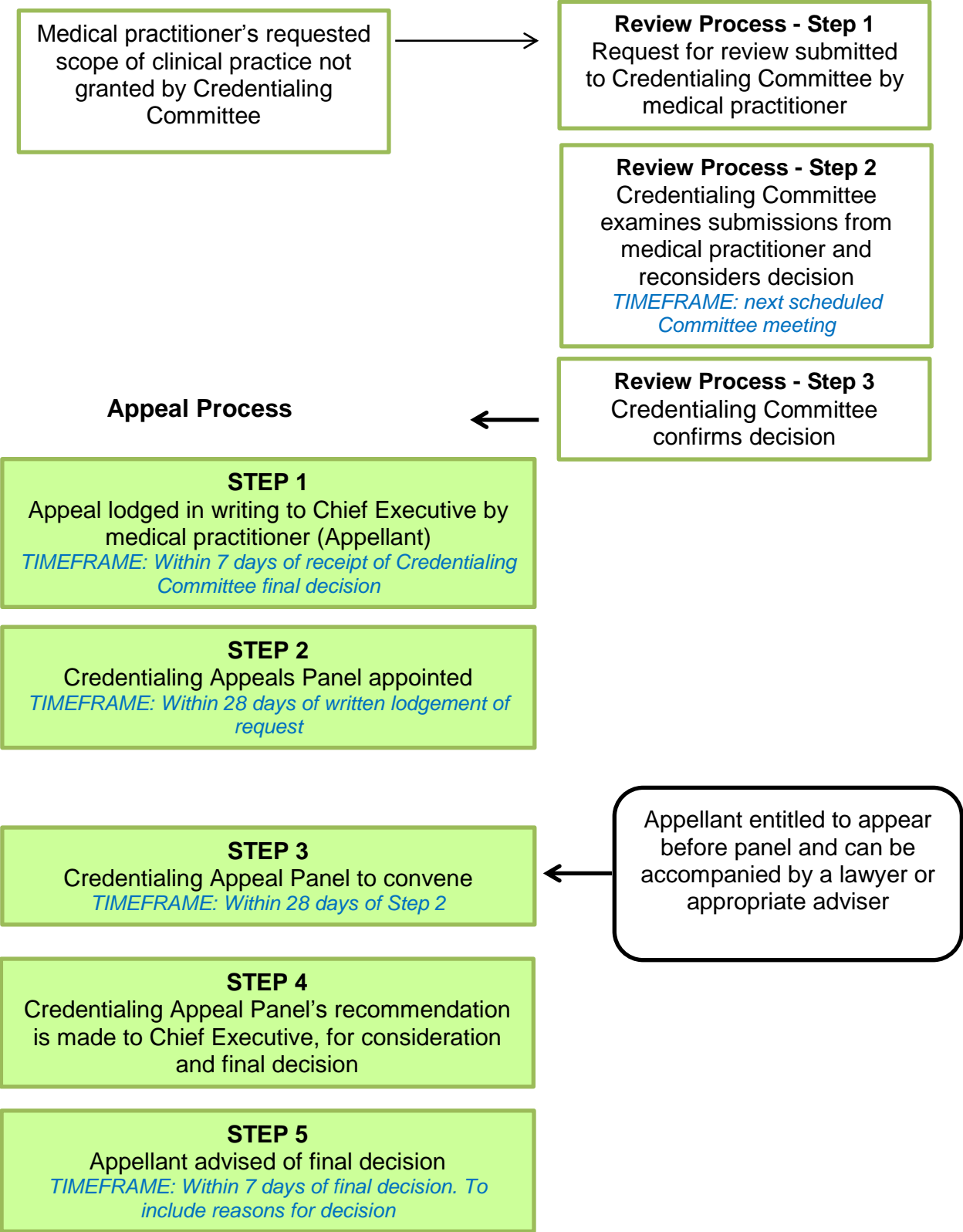
Medical Practitioner Support

19. The appellant is entitled to appear before the panel and can be accompanied by a support person. This person may be a barrister or a solicitor however their role is to advise, not represent, the appellant. Both the appellant and the Credentialing Appeal Panel will be given the opportunity to have all available information brought forward for consideration.

Administrative Costs

20. The administrative costs of the Credentialing Appeal Panel, including any fees for members of the Credentialing Appeal Panel, will ordinarily be borne by the Chief Executive. The legal costs of each party will be borne by the party.

Appendix 11: Credentialing Appeal Panel Process Flowchart



This document can be made available in alternative formats on request for a person with a disability.

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