

# DRAFT POLICY DIRECTIVE FOR CONSULTATION

**Credentialing and Defining Clinical Privileges for Senior  
Medical and Dental Practitioners in NSW Health**



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# 1 BACKGROUND

## 1.1 About this document

This document details the requirements to be followed in the process of credentialing and defining clinical privileges for senior medical practitioners and dentists employed or appointed by NSW Public Health Organisations. Following the provisions contained in this policy will ensure the alignment of competencies of a medical or dental practitioner with the needs of a health care facility, and ensure that the right clinicians are providing the right services in the right facilities.

## 1.2 Key definitions

**Appointment** – the process of appointing a preferred applicant to a position.

**ACSQHC Standard** - the 2004 publication by the Australian Council for Safety and Quality in Health Care (now Australian Commission on Safety and Quality in HealthCare) – *Standard for Credentialing and Defining the Scope of Clinical Practice: National Standard for credentialing and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals.*

**AHPRA** –the Australian Health Practitioner Regulation Agency responsible for the administration of the National Registration and Accreditation Scheme.

**Clinical Academic** – is a medical practitioner

- (a) holding general or conditional specialist registration who is employed as a member of staff of a NSW university's school of medicine; and
- (b) who accepts an offer of employment under the arrangements set out in the NSW Health policy on clinical academics (PD2010\_036).

**Clinical privileges** – the kind of clinical work (subject to any restrictions) that the PHO determines a practitioner is to be allowed to perform at a given health facility. This definition is synonymous with the way the term “scope of clinical practice” is used in the ACSQHC standard. See paragraph 3.4.1 for more detail regarding the meaning of clinical privileges in NSW.

**Credentialing** – the process of assessing and verifying a practitioner's credentials.

**Credentials** – documented evidence of a person's formal qualifications, training, experience and clinical competence.

**Credentials (Clinical Privileges) Subcommittee** - a subcommittee of the Medical and Dental Appointments Advisory Committee (MDAAC) which is responsible for advising on the delineation of a practitioner's clinical privileges.

**eCredential** – A state-wide, web-based system that allows Local Health Districts and Networks (LHDNs) to support the administrative and managerial aspects of credentialing and clinical privileging and to provide an electronic record to authorised individuals of the clinical privileges of senior medical practitioners and dentists within NSW Health.

**Medical and Dental Appointments Advisory Committee (MDAAC)** - a committee of a PHO Board that provides advice, and where appropriate recommendations, to the Chief

Executive on the appointment of practitioners and the clinical privileges that should be granted to those persons.

**Model By-laws** – means the (Local Health Districts District by-laws [*Model By-laws*]) made under the Health Services Act 1997 and published in the Government Gazette on 1 March 2012, as amended or substituted from time to time.

**Public Health Organisation (PHO)** – under the Health Services Act 1997 (NSW), means a local health district, a statutory health corporation or an affiliated health organisation in respect of its recognised establishments and services.

**Re-credentialing** – the formal process of reviewing and reconfirming a practitioner's qualifications, experience and other professional attributes.

**Recruitment and Selection Policy** – NSW Health Policy Directive 2015 -02 *Recruitment and selection of staff to the NSW Health Service*, or any replacement policy.

**Role delineation** – the level of clinical services that can be provided safely and is appropriately supported within a health facility as determined by the available support services, staffing profile, minimum safety standards and other requirements. Reference should be made to the *NSW Health Guide to the Role Delineation of Clinical Services 2016* to determine the role delineation of health services.

**Scope of clinical practice** – see clinical privileges.

**Senior dental practitioner** - a person appointed or employed by a PHO as a senior dental practitioner who has specialist registration with the Dental Board of Australia.

**Senior medical practitioner** – a person appointed by a PHO as a Staff Specialist, Clinical Academic or Visiting Practitioner.

**Staff Specialist** – a medical practitioner employed at a PHO as a staff specialist under the Staff Specialist (State) Award.

**Verification** – the process of formally validating the authenticity of the credentials submitted by a practitioner.

**Visiting Practitioner** – a medical practitioner or dentist who is appointed under Chapter 8 of the Health Services Act by a PHO (otherwise than as an employee) to practise as a health practitioner in accordance with such conditions of appointment at any of its public hospitals or health services as may be specified in an appointment.

**Visiting Practitioner Appointment Policy** – NSW Health Policy Directive 2016\_052 *Visiting Practitioner Appointments in the NSW Public Health Service* or any replacement policy.

### 1.3 Legislative and policy framework

#### Legislation

- *Health Services Act 1997 (NSW)*
- Health Services Regulation 2013 (NSW)
- Health Services Model By-laws (2012).

#### Related documents

- PD2016\_052: Visiting Practitioner Appointments in the NSW Public Health Service
- PD2015\_026: Recruitment and Selection of Staff to the NSW Health Service
- PD2011\_010: Visiting Medical Officer (VMO) Performance Review Arrangements
- Australian Commission on Safety and Quality in Health Care: Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners.
- Australian Commission on Safety and Quality in Health Care - National Safety and Quality Health Service (NSQHS) Standards (in review)
- Australian Council for Safety and Quality in Health Care (July 2004): Standard for Credentialing and Defining the Scope of Clinical Practice.

## **1.4 General Principles**

Credentialing and defining clinical privileges for senior medical and dental practitioners employed or appointed by a PHO underpin the overarching objective of ensuring the delivery of high quality health care services to the community and patient safety.

PHOs have a governance responsibility to undertake credentialing and define clinical privileges to ensure all appointed senior medical and dental practitioners demonstrate an acceptable level of professional performance. This process ensures that practitioners' practice within the scope of their education, training and competence in the context of the facility's specific organisational capability, capacity and service need.

Credentialing and defining clinical privileges are complemented by registration requirements under the Health Practitioner Regulation National Law and strong partnerships with professional colleges, bodies and associations.

## **1.5 Practitioners subject to this policy**

All clinical staff undergo a credentialing process as part of their recruitment. The Recruitment and Selection policy sets out how documents presented by applicants at recruitment are verified. Position descriptions set out the role of employed staff.

The process of credentialing senior medical and dental practitioners is subject to additional statutory requirements as set out in the Health Services Act and Model By-laws. That process involves the role of the Medical and Dental Appointments Advisory Committee and Credentials (Clinical Privileges) Subcommittee. The following staff are

required to undergo the process set out in this policy: senior medical practitioners (staff specialists, visiting practitioners, clinical academics), senior dental practitioners (those employed as senior dental practitioners with specialist registration with the Dental Board of Australia).

## **2 ROLES AND RESPONSIBILITIES**

### **2.1 Boards or Governing bodies**

As part of its governance responsibilities, the board or governing body of a PHO is responsible for ensuring effective clinical governance frameworks are in place, including appropriate processes for credentialing and defining clinical privileges for senior medical and dental practitioners.

The board or governing body of a PHO is to establish a Medical and Dental Appointments Advisory Committee (MDAAC) and a Credentialing (Clinical Privileges) Subcommittee. The role and composition of the MDAAC and Subcommittee must be in accordance with the by-laws of the PHO.

Under the Health Services Act 1997, a PHO may not make a by-law unless it is the same, in substance, as a Model By-laws published by the Health Secretary (except in certain circumstances set out in the Act). The provisions of the Model By-laws are set out below.

### **2.2 Medical and Dental Appointments Advisory Committee (MDAAC)**

#### **2.2.1 Role and composition**

The Model By-laws require the Board to establish an MDAAC to provide advice, and where appropriate, make recommendations with reasons to the Chief Executive, on matters related to the appointment, or proposed appointment and clinical privileges for senior medical and dental practitioners.

The MDAAC shall be comprised of:

- two members appointed by the Board (at least one of whom is not a medical practitioner), one of whom is to be nominated as the chairperson of the committee;
- two members nominated by the medical staff executive council (or where there is no medical staff executive council the medical staff council);
- the Chief Executive or his/her nominee;
- the medical administrator (however designated) of the PHO or his/her nominee;
- such of the following persons (being medical practitioners or dentists) appointed by the Chief Executive as are necessary, in the Chief Executive's view following consultation with the two representatives of the medical staff executive council (or medical staff council), for the proper consideration of matters referred to the committee:
  - one representative of the PHO relevant to the matter under consideration;
  - one representative with qualifications in the speciality or sub-speciality relevant to the matter under consideration and who is not a member of the Medical Staff Executive Council or (or where there is no medical staff executive council the medical staff council);
  - one representative of a university affiliated with the local health district for the purposes of the training of health practitioners;

- where a matter or class of matters referred to the Committee concerns an appointment of a person as a visiting practitioner, staff specialist or dentist to a hospital or hospitals under the control of a local health district, a representative of the medical staff council, if any, for each hospital to which the appointment relates; and
- where a matter or class of matters referred to the committee concerns the clinical privileges of a visiting practitioner who is a medical practitioner or of a staff specialist, a representative of the medical staff council, if any, for each hospital to which the appointment relates.

Terms of appointment to the MDAAC are at the discretion of the Board or nominating organisation (if the member is a nominee). Where a representative has been appointed to consider a particular matter, he or she is a member until such time as the matter under consideration is finalised.

### **2.2.2 The MDAAC's role in relation to temporary appointments**

Under the Model By-laws, where the Chief Executive has delegated such a function to that position, the medical administrator of the PHO (however designated) may appoint a visiting practitioner or staff specialist to an available position for a period not exceeding three (3) months. Such appointment may be extended for one further single three (3) month period. However, any exercise of this delegation shall be subject to the advice of the MDAAC, if the advice or recommendation of the MDAAC is required for that position.

## **2.3 Credentials (Clinical Privileges) Subcommittee**

Under the Model By-laws, the Credentials (Clinical Privileges) Subcommittee is to be established by the MDAAC to provide advice to the MDAAC on all matters concerning the clinical privileges of visiting practitioners, staff specialists or dentists, including the following:

- the clinical privileges to be allowed to an applicant or person proposed for appointment as a visiting practitioner;
- the clinical privileges to be allowed to a staff specialist or dentist on appointment;
- the review of the clinical privileges of a visiting practitioner, staff specialist or dentist at the request of the visiting practitioner, staff specialist or dentist; and
- the review of the clinical privileges of a visiting practitioner, staff specialist or dentist at the request of the Chief Executive.

There are no restrictions on the number of Credentials (Clinical Privileges) Subcommittees. According to circumstances, it may be appropriate to have a subcommittee for an entire PHO, for each health facility within the organisation or for particular specialities or classes of appointment.

There is no bar under the Model By-laws to the Credentials (Clinical Privileges) Subcommittee being constituted concurrently with an interview subcommittee provided that when exercising powers relating to the determination of clinical privileges, the Credentials (Clinical Privileges) Subcommittee is constituted according to the provisions required by the by-Laws.

### 2.3.1 Composition

Under the Model By-laws, a Credentials (Clinical Privileges) Subcommittee is to consist of:

- at least two members of the committee (MDAAC) who are either medical practitioners or dentists, nominated by the committee; and
- any other medical practitioners or dentists appointed by the committee (MDAAC) who the committee considers are necessary to consider the matter or matters referred to the subcommittee for advice.

The committee (MDAAC) is to nominate one of the persons under the first point above as chairperson of the subcommittee.

*Consultation question 1: Should this policy directive set out any additional requirements regarding membership of the Credentials (Clinical Privileges) Subcommittee or is this a matter for local decision making?*

Clause 59(3) of the Model By-laws states that there should be compliance with any further provisions regarding the subcommittee's membership that are set out in NSW Health policy.

Terms of appointment to the Subcommittee are at the discretion of the MDAAC. Where a representative has been appointed to consider a particular matter, he or she is a member until such time as the matter under consideration is complete.

## 2.4 Conduct and procedure of the MDAAC and the Credentials (Clinical Privileges) Subcommittee

A quorum is constituted by a majority of members, and decisions are made by majority.

Members of the MDAAC and Credentials (Clinical Privileges) Subcommittee should be properly appointed and each committee should have Terms of Reference approved by the Board. Members are to comply with the provisions of the NSW Health Code of Conduct, including provisions on conflicts of interest. Members are not to participate in any discussions or deliberations regarding their own appointment.

PHOs should make provisions regarding the confidentiality of proceedings of the committees which also allow for appropriate transparency and accountability (see Section 5.3).

PHOs should undertake regular review of the operation of the committees, including terms of reference; membership; and compliance with the ACSQHC Standard.

Both the MDAAC and the Credentials (Clinical Privileges) Subcommittee must be supplied with all relevant documentation regarding the practitioner as set out in the NSW Recruitment and Selection Policy, including all documentation relevant to verification of Credentials and proposed Clinical Privileges.

Most members of the MDAAC and Credentials (Clinical Privileges) Subcommittee will be NSW Health employees or visiting practitioners. Such persons will, so long as they carry

out their functions as members of the MDAAC or Subcommittee in good faith and in accordance with the applicable terms of reference, this policy directive and the relevant by-laws, generally be protected from any personal liability that may arise from the carrying out of those functions.<sup>1</sup> From time to time it may be necessary to appoint a person external to NSW Health as a member of an MDAAC or Credentials (Clinical Privileges) Subcommittee – for example, a university representative, or to ensure there is a representative on the committee with qualifications in the specialty or sub-specialty relevant to the matter under consideration. In these circumstances, the PHO may, if requested, provide a contractual indemnity to the member.<sup>2</sup>

## **2.5 Senior medical and dental practitioners**

Senior medical and dental practitioners, in the process of credentialing and defining scopes of clinical practice, are responsible for:

- Providing all relevant information and documentation required and requested by a PHO to undertake credentialing and delineation of clinical privileges
- Providing services within their clinical privileges
- Providing notification and advice to a PHO on any changes to circumstances which may require a change to their clinical privileges.

Under NSW Health appointment and employment policies, applicants must provide written consent to the PHO to obtain information about past performance and confirmation of credentials. This information is to be provided as relevant to the MDAAC and the Credentialing (Clinical Privileges) Subcommittee.

## **2.6 Documentation and record keeping**

Comprehensive records should be kept of deliberations, recommendations, decisions and information considered by relevant parties throughout the course of undertaking credentialing and delineating clinical privileges processes.

The MDAAC is required to prepare a written report to the Chief Executive, setting out its advice and recommendations for appointment and the clinical privileges to be allowed. To enable proper evaluation, the Chief Executive must have access to all relevant material considered by the MDAAC. This includes advice and recommendations from the interview subcommittee and the Credentials (Clinical Privileges) Subcommittee. If the advice and recommendations of the MDAAC to the Chief Executive are not in accordance with the advice and recommendations of any subcommittees, this must be documented with a clear explanation of the decision-making process in a form that allows the decision to be reviewed or defended if it is challenged.

eCredential provides a platform for the management for credentialing and privileging documentation and audit.

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<sup>1</sup> Under section 133B of the Health Services Act 1997, persons acting under the direction of a public health organisation are exempt from personal liability in respect of actions or omissions done for the purposes of executing the Health Services Act.

<sup>2</sup> Any queries regarding the provision of indemnity may be referred to MOH Finance Branch for assistance.

### **3 CREDENTIALING AND DELINEATING CLINICAL PRIVILEGES AT APPOINTMENT**

#### **3.1 The appointment/employment process**

The employment of staff specialists and clinical academics is governed by the NSW Health Recruitment and Selection Policy. The appointment of visiting practitioners is governed by the NSW Health Visiting Practitioner Appointments Policy. Under these policies, credentialing and determining clinical privileges are an essential part of the recruitment and appointment of these practitioners. This policy must be read in conjunction with the Recruitment and Selection Policy or the Visiting Practitioner Appointment Policy (whichever is relevant). These policies set out the general framework for the entire recruitment and appointment process, of which credentialing and defining clinical privileges is one part.

#### **3.2 Steps in the credentialing and clinical privileging process**

The process of credentialing and delineating clinical privileges is a two-step process:

1. *Credentialing/verification*

This entails the objective assessment of a practitioner's competence through an initial review and verification of a practitioner's credentials.

2. *Delineating clinical privileges*

Following initial credentialing/verification, a practitioner's clinical privileges are defined for a specific health facility.

#### **3.3 Step 1 – Credentialing**

##### **3.3.1 Credentials**

Credentials are documents that constitute evidence of a person's formal qualifications, training, experience and clinical competence. Credentialing refers to the formal process of reviewing and verifying credentials and other relevant professional attributes of a practitioner for the purpose of forming a view about their competence and suitability to provide safe health care services at a given hospital or health facility.

##### **3.3.2 Information required for initial credentialing**

PHOs should consider at a minimum, the information detailed under Appendix A to undertake initial credentialing processes.

*Consultation question 2: Is the information contained in Appendix A appropriate?*

In addition, PHOs may choose to consider information provided by specialty colleges who can provide advice on<sup>3</sup>:

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<sup>3</sup> When developed, the model scopes of clinical practice will provide additional guidance on information required to undertake credentialing to determine core, specific and/or extended scopes of practice. See section 3.5 – Model scopes of clinical practice

- Qualifications and recent experience required to provide a specific medical or dental service
- Infrastructure required to support a practitioner within a specialist area
- Relevant postgraduate training qualifications

### **3.3.3 Verification of Credentials**

All credentials presented at application (or upon review of clinical privileges) must be verified. Original documents must be sighted and the authenticity of the documents checked with the relevant issuing authority.

It is not necessary to verify qualifications that have been used to gain registration if these are shown on the relevant National Board's register of medical or dental practitioners as maintained by AHPRA<sup>4</sup>. Where an applicant is not yet registered or holds additional qualifications to those shown on the AHPRA register, or the AHPRA register is not clear about qualifications held, verification must take place.

Where original documents are not available, the Recruitment and Selection Policy specifies when certified copies may be used, although authentication must still take place.

Where a third party, for example, a recruitment agency, is used to source applicants and undertakes part of the verification process, the PHO should still verify documentation submitted by or on behalf of a practitioner.

Credentials that are noted as verified in the eCredential system need not be re-verified. See paragraph 6.3.

All reference checks are to be undertaken in line with the Recruitment and Selection Policy and the Visiting Practitioner Appointment Policy.

All verified documents, including completed reference checks should be made available to the MDAAC and Credentials (Clinical Privileges) Subcommittee to ensure all documentation is available and accessible as part of the decision making process.

## **3.4 Step 2 - Delineating clinical privileges**

### **3.4.1 Use of the term clinical privileges in NSW**

In NSW, the term "clinical privileges" is defined in s 105 of the Health Services Act 1997 as "the kind of clinical work (subject to any restrictions) that the PHO determines a practitioner is to be allowed to perform at any of its hospitals". Certain statutory rights of visiting practitioners to appeal decisions regarding "clinical privileges" are dependent upon the definition.

While the term "scope of clinical practice" is used by the ACSQHC, and in several other jurisdictions, the use of the term "clinical privileges" remains in NSW due to this statutory basis. The ACSQHC Standard describes the delineation of "scope of clinical practice" as the process that follows on from credentialing and involves delineating the extent of an individual medical practitioner's clinical practice within a particular organisation based on

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<sup>4</sup> eCredential will interface with the AHPRA database to provide up to date information regarding a practitioner's registration status. See section 6 – Electronic credentialing systems

the individuals' credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the medical practitioner's scope of clinical practice. Accordingly, the use of the term "scope of clinical practice" by the ACSQHC is the same as the way the term "clinical privileges" is used in this policy.

### 3.4.2 The process of delineating clinical privileges

Delineation of clinical privileges is the process of determining the extent of an individual practitioner's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to provide particular services. The delineation of clinical privileges accorded to an individual practitioner at an individual facility therefore involves consideration of two factors by the MDAAC, the Subcommittee and the PHO:

- the credentials and experience of the practitioner
- the role delineation of the facility, the infrastructure and support available at the facility, and the services the PHO determines are appropriate for provision at the facility.

The individual's clinical privileges will be those that meet the PHO's requirements in respect of both those factors.

At recruitment, the PHO is responsible for determining the clinical privileges advertised in relation to a position. These may or may not be recommended for modification by the MDAAC and Subcommittee and PHO when the credentials and experience of the individual applicant are considered.

There is no obligation upon a PHO to provide support or infrastructure for any given clinical service or intervention at a facility simply because the practitioner has the credentials, skills and abilities to perform that service or intervention, or performs it at another public or private health facility. Rather, credentialing is a process designed to support the service provision of the PHO in each individual facility.

Based on this, a practitioner's clinical privileges will be facility specific and should be documented for each facility in which a practitioner practices.

### 3.5 Model scopes of clinical practice

Model scopes of clinical practice are currently being developed by NSW Health for medical and dental specialties to provide clarity and consistency in the way practitioner clinical privileges are defined, whilst still allowing for local decision making in line with the facility's needs and role delineation. Model scopes of clinical practice will provide guidance in the process of credentialing and defining clinical privileges, and where available, should be used as part of the credentialing process to assist in defining individual clinical privileges.

It is anticipated that the model scopes of clinical practice will allow practitioners to be granted clinical privileges in three categories:

**Core:** The type of work that can reasonably be expected to be undertaken by all practitioners holding a particular qualification, having undergone requisite training.

**Specific:** Procedures or treatments within the practice of a given specialty that require specific credentialing for safe and effective performance.

**Extended:** Practices or procedures undertaken by a practitioner that fall outside the usual practice of their specialty, for which they have been trained and which the health service will support.

Until such time as the model scopes of clinical practice are available, PHOs should continue with their local decision making processes in relation to the details contained in a practitioner's clinical privileges.

### **3.6 Periods of supervision or probation for practitioners**

The Credentials (Clinical Privileges) Subcommittee may recommend a specified period of supervision or oversight for practitioners with newly acquired skills, or with special needs for skill development or enhancement.

In recommending supervision or oversight for the practitioner, the committee should determine:

- The purpose of the supervision or oversight
- Any training requirements
- The method of evaluation to be used to ascertain whether the necessary improvement has taken place
- When and under what conditions supervision or oversight can cease.

The practitioner's credentials and clinical privileges must be reviewed at the end of the specified supervisory or oversight period.

### **3.7 Duration**

Clinical privileges may be granted for a period of time as recommended by the Credentials (Clinical Privileges) Subcommittee. The Subcommittee may recommend limits on the duration of clinical privileges if appropriate or request a review at a specified time. See Section 4: Re-credentialing and reviewing clinical privileges.

### **3.8 Arrangements for clinical services crossing multiple PHOs**

Some practitioners provide clinical services at more than one PHO. This can occur throughout a spectrum of activities from providing tele-health services to practitioners or patients of other LHDs, through to the provision of clinical services to patients of other LHDs. There will necessarily be a spectrum of activity, some of which may require credentialing at the "secondary" LHD, and some of which may not.

Policy Directive 2016\_026 sets out provisions for staff specialist employment arrangements across LHDs, including the credentialing of such individuals, noting that clinical privileges must be determined by each facility where the practitioner has an appointment. This may lead to multiple credentialing processes by multiple PHOs, even where the scope of practice of the practitioner remains the same.

*Consultation question 3. Does PD2016\_26 provide appropriate guidance in relation to the credentialing of practitioners that provide services across PHOs? Should any further guidance be included on the credentialing of such practitioners?*

At present, NSW Health policy does not contain any guidance on the process of credentialing and defining clinical privileges where a practitioner provides the same services across PHOs. PD2016\_26 covers the situation of a staff specialist with

appointments at two PHOs, but may not cover the multiplicity of arrangements whereby interactions of a clinical nature take place across PHOs, for example, tele-health services, Breastscreen services etc. As part of this consultation process, submissions would be welcome as to the different kinds of services that currently exist, the current credentialing arrangements, the effectiveness of these, and any suggestions for improved processes. It is noted that separate arrangements regarding NSW Health Pathology are currently being developed and will be consulted upon separately.

## **4 RE-CREDENTIALING AND REVIEWING CLINICAL PRIVILEGES**

### **4.1 Review of clinical privileges**

A review of a practitioner's clinical privileges may occur within an appointment period, or within the period in which the clinical privileges have been approved. The content of a review will depend on the reasons for the review. For example, a review of all clinical privileges may be necessary, or a review of only certain elements may be appropriate.

Examples of when a review of clinical privileges may be recommended are:

- At the request of the practitioner
- As the result of a performance review that raises issues related to clinical privileges
- As the result of an investigation or complaint regarding the practitioner's clinical practice or fitness to practice
- New technology or clinical interventions are introduced
- A practitioner proposes introducing an established technique or clinical intervention for the first time in a facility
- The PHO ceases providing the required support services or facilities to sustain a clinical service or procedure, or no longer requires the clinical service or procedure
- A practitioner acquires or demonstrates enhanced skills through additional training.

There is no continuing obligation on a facility to support clinical privileges granted at appointment or at any other time, or to extend clinical privileges to accommodate a practitioner's request. It is a matter for the PHO to determine whether a particular clinical service is appropriate for provision at their facility.

In addition to the credentialing process, where new technologies or interventions are introduced, the PHO must comply with any applicable national guidelines or organisational policies.

### **4.2 Re-credentialing at regular intervals**

The ACSQHC Standard requires that in all circumstances, credentialing processes should be undertaken at intervals of no more than five years.

*Consultation question 4. What approach should be taken in relation to this requirement?*

Neither legislation nor current NSW Health policy have any requirements for re-credentialing at certain time-based intervals. In many cases, a practitioner's clinical privileges will not change significantly throughout their employment or appointment. As part of this consultation process, submissions would be welcome as to current practices regarding re-credentialing, the resources required, and the approach that is taken in relation to the above ACSQHC requirement.

It is noted that practitioners undergo regular performance reviews in which their scope of practice would be a relevant consideration. Submissions would be welcome on how the performance review and re-credentialing processes could be linked to maximise the effectiveness of both processes.

#### **4.3 Notification of a review**

Where a practitioner's clinical privileges are subject to a review (either within the duration of the existing privileges, or as a result of a re-credentialing process), the PHO must provide notice in writing to the practitioner of the review.

#### **4.4 Information to be considered for re-credentialing or review**

PHOs should consider the information detailed under Appendix B, as relevant to undertake re-credentialing or review processes.

*Consultation question 5: Is the information detailed under Appendix B appropriate?*

#### **4.5 Rights of Appeal**

Visiting practitioners have certain rights of appeal under the Health Services Act 1997 where there is a reduction of their clinical privileges, except if the decision to reduce privileges is based on grounds other than the lack of professional competence of the practitioner.

Notification of the decision of the PHO must be given within 14 days, and PHOs should ensure that the processes regarding appeals, as set out in the Health Services Act, are followed.

#### **4.6 Suspension**

Where there is an imminent risk to the health and safety of patients, a decision may be taken by the PHO to immediately vary or suspend a practitioner's clinical privileges in whole or part. This may also be done in conjunction with suspension of a practitioner's employment/appointment. Any decision to suspend a practitioner's employment/appointment should be managed in accordance with the Complaint or Concern about a Clinician Policy Directive (PD2006\_007).

## **5 TEMPORARY CREDENTIALING AND CLINICAL PRIVILEGES**

### **5.1 Disaster medicine**

Urgent appointment or engagement of practitioners may be necessary in exceptional circumstances such as in times of disaster or emergency. These situations should be dealt with in accordance with the Recruitment and Selection Policy, Visiting Practitioner Appointments Policy and the Employment Checks Policy (PD2013\_028).

### **5.2 Emergency situations**

In an emergency and where it is not possible to obtain consent, any health professional, including a registered medical practitioner, may provide any treatment immediately necessary to save the life of a patient, or prevent serious injury to a patient's health, whether or not such treatment is within their approved clinical privileges. Whether to provide treatment outside of approved clinical privileges in an emergency should involve consideration of whether there are any better means of proceeding within the time available.

## **6 CONFIDENTIALITY AND ACCOUNTABILITY**

### **6.1 Confidentiality**

PHOs must maintain the confidentiality of personal information provided to them for the purposes of credentialing and delineating a practitioner's clinical privileges. However certain information regarding a practitioner's clinical privileges, their verified credentials, and their current appointment status should be available to relevant staff within the PHO to ensure that practitioners are acting within the scope of their clinical privileges and to allow for smooth and efficient appointment processes.

Accurate records regarding the appointment, credentialing and privileging process must also be maintained for purposes of accountability and audit. Records must be sufficiently detailed to ensure that all steps taken in the credentialing or delineation of clinical privileges of an individual practitioner can be ascertained.

### **6.2 Accountability: eCredential**

To assist in appropriate record keeping, confidentiality and accountability, a state-wide standalone electronic credentialing system, eCredential, is currently being deployed across NSW Health Local Health Districts and Specialty Networks (LHDNs). The web based platform will allow LHDNs to support administrative aspects of the credentialing processes for senior medical practitioners and dentists. The system provides an interface with AHPRA to obtain up to date registration information, and allows the management of credentialing data including practitioner history and clinical privileges.

Use of eCredential will enhance accountability of LHDNs by ensuring the verification of credentials, and other processes associated with credentialing and delineating clinical privileges, is undertaken and recorded in an auditable form via a secure platform.

The eCredential system will allow individual practitioners to maintain personal records and documentation on their own profile within the system, and grant access to other users at their own discretion. Once access is granted to a practitioner's profile, the degree of visibility of the information contained therein is controlled via varying degrees of user access.

LHDNs should establish rules of permission to ensure access to clinicians' information is limited to those who require it, either for quality and safety purposes, or for the efficient management of appointments for senior medical and dental staff.

This control will result in the ability to define security roles and permissions to ensure that only the appropriate users can access the appropriate levels of data in the system.

The generic system administrative roles that exist within the eCredential system include:

- 1. Medical Administration** – This role is for users who manage the recruitment of clinicians, and who are responsible for verifying credentials.
- 2. Local Administrator** – Users with this level of access will be able to assign the Medical Administration and General View Access roles within their LHD.
- 3. Credentialing Reviewers/Approvers, MDAAC Panel Members, Chief Executives** – This role is for users who are nominated as a reviewer/approver for the credentialing and privileging process. When assigned to this role, users will only have access to

information that they need to review/approve. Users will be able to view the status report and view clinician profile information.

- 4. General View Access** – This role will allow nominated users to search for a Clinician and view their approved clinical privileges.

### **6.3 Verification of credentials in eCredential**

The eCredential system will allow a practitioner's credentials to be marked as "verified" in the system. These credentials do not have to be re-verified if still current and subsequently relied upon in another credentialing process.

However, care must be taken to distinguish between "verification" of a credential, and the meaning of that credential in terms of the skills and qualifications of the practitioner. A certificate awarded to a practitioner at a given time only means that the practitioner undertook the requirements for the credential as they were at the time the credential was awarded. For example, verification of a certificate in a particular skill that was awarded in 1980 can be relied upon as verification that the practitioner was awarded that certificate on that date. It cannot be relied upon to indicate that the practitioner's skills in that area are still up date at a later time. It is up to the MDAAC / Credentials (Clinical Privileges) Subcommittee to consider the recency of a qualification (along with other matters, such as experience and continuing learning) in determining the skills of the practitioner being credentialed.

## 7 APPENDICES

1. Appendix A - Information to be considered for initial credentialing
2. Appendix B – Information to be considered for re-credentialing or review

## Appendix A: Information to be considered for initial credentialing

- Details of lifetime professional registration history including current evidence from the AHPRA database
- Details of lifetime medical education and training, including undergraduate, postgraduate or specialty training qualifications relevant to the clinical privileges being requested
- Details of accreditation by professional colleges or associations for specific clinical services, procedures or interventions
- Details of all past and continuing health related employment and practice
- Details of involvement in clinical audits, national audits and/or registers, peer review activities
- Details and evidence of involvement in continuing professional development requirements including examples of presentations, supervision, teaching, mentor programs and publications
- Details of experience in teaching, research and quality improvement activities
- Evidence of activity log books, if maintained
- A summary of clinical activity undertaken over the last twelve months, including details on location where services were provided, number, type and location of patients, clinical services or procedures performed, diagnosis treated and consultations rendered relevant to field of expertise in which scope is requested
- Objective data on the outcomes of clinical activity, where available
- Details of clinical privileges requested
- Satisfactory professional referees reports, including peer reports based upon objective assessment
- Details regarding the outcome of any complaints, professional body investigations, indemnity and legal records
- Satisfactory review of performance indicators derived from available data
- A declaration regarding any prior change to clinical privileges, or denial, suspension, termination or withdrawal of the right to practice (other than for organisational need/organisational capability issues) in any other organisation
- A declaration regarding any prior disciplinary action or professional sanctions imposed by any registration board
- A declaration regarding any criminal investigation or conviction
- A declaration regarding the presence of any physical or mental condition or impairment that could affect the practitioner's ability to exercise the requested scope of practice or that would require special assistance to exercise scope of practice safely and competently.

## **Appendix B: Information to be considered for re-credentialing or review**

- Evidence of current registration from the AHPRA database
- Details of education and training, and any accreditation awarded by a professional college or association since the last declaration
- Details of employment or practice, since the last declaration
- Details of involvement in clinical audits, national audits and/or registers, peer review activities since the last declaration
- Evidence of activity log books, if maintained
- A summary of clinical activity undertaken over the last twelve months, including details on location where services were provided, number, type and location of patients, clinical services or procedures performed, diagnosis treated and consultations rendered relevant to current and/or requested clinical privileges
- Objective data on the outcomes of clinical activity, where available
- Satisfactory review of performance indicators derived from available data
- Details of any alterations to clinical privileges requested
- Details regarding the outcome of any complaints, professional body investigations, indemnity and legal records
- Previous performance review outcomes
- Either
  - A declaration there has been no change to the previous information provided regarding any change to the defined scope of practice, or changes to the right to practice in any other organisation; any disciplinary action or sanctions imposed by any registration board; any criminal investigations or convictions; and the presence of any physical or mental condition impairment that could affect the practitioners ability to exercise the requested scope of practice or that would require special assistance to exercise scope of practice safely and competently

Or

  - A declaration describing the specific changes to the information previously provided relating to professional status or performance.
- Evidence of CPD that meets relevant College or MBA requirements