SESLHD PROCEDURE COVER SHEET

NAME OF DOCUMENT	Credentialing & Re-credentialing of Senior Medical & Dental Practitioners - Process
TYPE OF DOCUMENT	Procedure
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KEY TERMS	
SUMMARY	To ensure compliance with granting and review of Scope of Clinical Practice (SoCP). National Quality & Safety Standards mandate that all clinicians should have their credentials reassessed every five years.

Credentialing & Re-credentialing of Senior Medical Officers - Process

SESLHDPR/624

1. POLICY STATEMENT

To ensure compliance with granting and review of Scope of Clinical Practice (SoCP). National Quality & Safety Standards mandate that all clinicians should have their credentials reassessed every five years.

2. BACKGROUND

All Senior Medical and Dental Staff must undertake Re-credentialing every five years under the National Quality and Safety Accreditation Standards. Those Standards also require a process to ensure that all clinicians are practicing within their approved Scope of Clinical Practice.

All Senior Medical Officers and Dental Staff undertake Credentialing for the purposes of defining Scope of Clinical Practice at the time of initial appointment in accordance with SESLHDPR/625 Procedure for Recruitment and Appointment of Senior Medical and Dental officers.

3. RESPONSIBILITIES

3.1 Senior Medical and Dental Officers will:

- Undertake Performance Review annually.
- Request any changes to Scope of Clinical Practice in accordance with this policy.

3.2 Line Managers will:

- Ensure Senior Medical Officers have Performance Review annually.
- Identify the need to amend Scope of Clinical Practice.

3.3 Facility DCS will:

- Ensure compliance with the annual Performance Review process and undertake regular auditing of Scope of Clinical Practice.

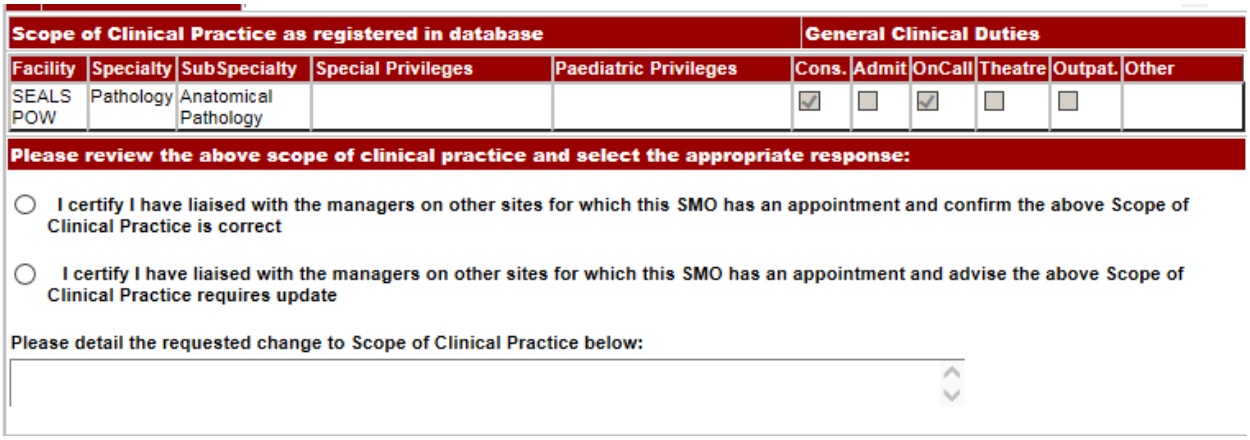
3.4 SMO Services and MDAAC:

- Will administer and oversee the process.
- The Credentials Subcommittee of the MDAAC will make recommendation to the MDAAC, and via the MDAAC to the Chief Executive regarding the Credentials and Scope of Clinical Practice of all Visiting Practitioners, Staff Specialists and Clinical Academics.

4. PROCEDURE FOR STAFF SPECIALISTS AND CLINICAL ACADEMICS

4.1 Performance Reviews are the mechanism for reviewing Scope of Clinical Practice for Staff Specialists and Clinical Academics. Performance Reviews for Staff Specialists and Clinical Academics are done electronically using the Performance Management System which is aligned to the SMO Database. Senior Medical Officer Services will send an email to the Staff Specialist or Clinical Academic advising them that their performance review is due. Staff Specialists and Clinical Academics are to complete their Performance Review online and indicate whether the Scope of Clinical Practice is correct.

NOTE: If requiring an update, Staff Specialists, Clinical Academics and their Managers must make the relevant selection and add a descriptive comment.



Scope of Clinical Practice as registered in database					General Clinical Duties					
Facility	Specialty	SubSpecialty	Special Privileges	Paediatric Privileges	Cons.	Admit	OnCall	Theatre	Outpat.	Other
SEALS POW	Pathology	Anatomical Pathology			☑	☐	☑	☐	☐	

Please review the above scope of clinical practice and select the appropriate response:

○ I certify I have liaised with the managers on other sites for which this SMO has an appointment and confirm the above Scope of Clinical Practice is correct

○ I certify I have liaised with the managers on other sites for which this SMO has an appointment and advise the above Scope of Clinical Practice requires update

Please detail the requested change to Scope of Clinical Practice below:

4.2 When **Scope of Clinical Practice requires update** has been selected, and a descriptive comment provided, an automated email is generated and sent to the Site Medical Administration Officer with instruction to request a change to the Scope of Clinical Practice.

4.3 SMO Services will generate a report from the Performance Management System once per month for submission to the District MDAAC. This report will indicate Senior Medical Staff whose Performance Reviews have been conducted in the previous month and their outcome.
Where no changes are indicated, a 'Nil Change' outcome report is advised to the District MDAAC.
Where a change to Scope of Clinical Practice is indicated/requested, a notation of this change is advised to the facility via SESLHD MDAAC Minutes with request to submit request for change of Scope of Clinical Practice.

NOTE: The Site should already be aware of change under (4.2) above i.e. automated email generated from online Performance Management System to the Site Medical Administration Officer with instruction to request the change.

4.4 Recommendations from sites are sent to the SESLHD MDAAC via Form 1 for consideration and will be applied once the District MDAAC Minutes have been approved by Chief Executive Officer.

4.5 If a submission in response to a requested change is not received at the next District MDAAC, the item should remain open, and marked "IN PROGRESS" for the next SESLHD MDAAC until finalised.

4.6 If a Site has not submitted a recommendation to change the Scope of Clinical Practice via Form 1 within three months of its first appearance in the Minutes of SESLHD MDAAC, the Senior Medical Officer will be sent an email **(with a copy to Head of Department and Site DCS)** reminding them that the requested change of Scope of Clinical Practice has not occurred and therefore **is not** available to the Senior Medical Officer until such time it is recommended by the MDAAC.

5. PROCEDURE FOR VMOS & VDOS

5.1 The mechanism for performance review is the Quinquennium reappointment process. All VMOs undertake either a Level 2 Performance Review, or re-application and interview as part of their reappointment process. Scope of Clinical Practice for VMOs is considered at this time.

5.2 In accordance with NSW Health PD2011_010 Visiting Medical Officer (VMO) Performance Review Arrangements, public health organisations are required to ensure that a Level 1 performance review is conducted annually for each specialist VMO engaged by that organisation, and that a Level 2 performance review is conducted in the penultimate year of an appointment involving a term of three years or longer of each specialist VMO.

5.3 All VMOs and VDOs are recredentialled during the quinquennial reappointment process, but may undertake recredentialing during the quinquennium as part of the Level 1 performance review if required.

6. NON COMPLIANT PERFORMANCE REVIEW DOCTORS - PERFORMANCE REVIEW HAS NOT BEEN DONE WITHIN A FIVE YEAR PERIOD

Under the National Standard, all Practitioners must have their Scope of Clinical Practice reviewed every 5 years.

SMO Services will produce a report for sites and District services identifying Senior Medical Officers who are non-compliant in undertaking a Performance Review within a five year period.

7. REQUESTS FOR CHANGES TO SCOPE OF CLINICAL PRACTICE OUTSIDE THE PERFORMANCE REVIEW PROCESS

Individual clinicians may be required to request changes to Scope of Clinical Practice outside the Performance Review process. This may be as a result of Scope of Clinical Practice audits, approval of new procedures or services, or through the acquiring of new skills.

Changes to Scope of Clinical Practice outside the performance review process are actioned via the Form 1 process.

Temporary changes to Scope of Clinical Practice may be requested urgently, and will be approved by the District Director Medical Services who is the delegate for temporary changes.

8. DOCUMENTATION

Form 1 is used for all requests for changes to Scope of Clinical Practice.

All requests for changes to Scope of Clinical Practice must be signed by the Head of Department, or other relevant senior clinician of the same speciality and the site Director Clinical Services or Service Director for District Services. Where the Scope of Clinical Practice includes multiple sites, the site DCS must sign for each site that is requested. Where the Head of Department at the

primary site does not have Scope of Clinical Practice for the site(s) requested, the Head of Department or other relevant senior clinician from that site or sites must sign.

Information in Form 1 should be consistent with the documentation standards set out in Appendix 1.

9. AUDITING OF COMPLIANCE WITH APPROVED SCOPE OF CLINICAL PRACTICE

Sites and District Services are required to audit of Scope of Clinical Practice compliance. The audit should utilise whichever suitable data reporting system/tool (such as iPM) or other specialised database, in order to verify that each Senior Medical Officer within that speciality at that facility, is working within their approved Scope of Clinical Practice and within the approved clinical duties currently awarded.

Audits should be undertaken sufficiently regularly to ensure that all specialties are audited over a minimum five year cycle.

The information collected should be tabled, considered and minuted at the Site MDAAC Sub-Committee and a copy then recommended for review at the SESLHD MDAAC.

10. DEFINITIONS

SESLHD utilises the State Scope of Clinical Practice Unit definitions for Clinical Duties, where defined by SESLHD:

Clinical Duty	Definition
Admitting	May admit patients within the designated specialty under the practitioner's own name. May accept transfer of care to the nominated practitioner. Restricted admitting privileges mean that limited rights can be exercised within specific parameters.
Oncall	Participation in the appropriate specialty on call roster and other on call rosters as required and requested.
Consulting	May be invited for consultation on patients admitted (or being treated) by another practitioner.
Outpatients	May hold an outpatient or privately referred non-inpatient clinic in the practitioner's own name or to participate in a multidisciplinary clinic taking final responsibility for the care of patients attending.

Theatre (called Procedural by the SCoCPU)	May open an operating theatre or a day procedure unit
Teaching	(Granted as a sole clinical duty in SESLHD where a clinician does not otherwise hold clinical privileges) May access SESLHD patients for the purpose of teaching.

11. REFERENCES

SESLHD Credentialing Framework – updated 2018

SESLHD Model By Laws September 2017

NSW Health PD2005_047 Visiting Practitioners and Staff Specialists Delineation of Clinical Privileges

12. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
June 2018	1	Major review to incorporate SESLHDPD/289 and PD 253
July 2018	1	Draft for Comment
August 2018	1	Endorsed by SELSHD Clinical and Quality Council
January 2019	2	Clinical Duties defined
August 2020	3	Updated Executive Sponsor from District Director Medical Services to Director Clinical Governance and Medical Services. Published by Executive Services.

APPENDIX 1: DOCUMENTATION REQUIRED WHEN REQUESTING CHANGE TO SCOPE OF PRACTICE

	SCENARIO			
	INCONSISTENT/OUTDATED TERMINOLOGY OR DATABASE ERROR	**GRANDFATHERING OF EXISTING PRACTICE WHERE NO EXTERNAL STANDARD EXISTS**	**REQUEST FOR EXTENSION OF SOCP WHERE EXTERNAL STANDARD DOES NOT EXIST**	**REQUEST FOR EXTENSION OF SOCP WHERE EXTERNAL STANDARD EXISTS**
INFORMATION TO BE PROVIDED TO MDAAC	Confirmation that clinician already undertakes duties Confirmation that clinician is practicing to a safe standard Request update to terminology/database	Confirmation by DCS that clinician demonstrates ongoing safe practice based on advice from HOD and and available Patient Quality and Safety Reports eg audits / M&M; PACE Reviews / RCAs etc Request update of SoCP and/or clinical duties to reflect current work practices	Demonstrated competency via either evidence of appropriate training, **and/or** evidence of ongoing safe practice if undertaking procedure elsewhere currently	Demonstration of the standard
EVIDENCE TO BE PROVIDED TO MDAAC	Signed Form 1 with requested amendment as per above	Signed Form 1 with requested amendment as per above	Evidence of training via CV and/or references **And/or** Logbook or patient list, plus statement of safe practice from other site (via DCS or equivalent from other site)	Copy of evidence if publically available (such as Conjoint Committee for Endoscopy) Clinician to provide supporting evidence if standard is not publically available