



The
**Credentialling
Framework** for
New Zealand Health Professionals

2010

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Foreword

The Ministry of Health published the original framework for credentialling of senior medical practitioners in New Zealand nine years ago. Practitioners' experience with the credentialling process has been a learning experience ever since, and, although feedback has mostly been positive, there are still improvements to be made. This updated document takes into account information gathered from the past nine years, and acknowledges changes in health service provision, new legislation (the Health Practitioners Competence Assurance Act 2003) and recommendations arising from recent Health and Disability Commissioner reviews, including an extension of the credentialling framework to include other health professions and practice situations.

The format for this document is new. The first three sections form a generic credentialling framework, focusing on quality improvements driven by sound clinical leadership, applicable to all health professions and all practice situations. This framework provides the foundation for the 'specifics' of medical credentialling, which are outlined in Section 4.

Unlike the previous edition, this framework recommends the credentialling of all medical practitioners (including locums but excluding those under direct supervision, such as house officers and those in training schemes), in all practice situations.

Practitioners are inclined to feel burdened by the obligation to meet all the requirements of their employers and of professional bodies in terms of demonstrating competence and quality. However, this is a matter of public trust: the New Zealand public needs to be assured that health professionals are competent to undertake specific clinical responsibilities in particular practice settings. Credentialling is currently the only organisational process in the health system addressing competence in a specific practice situation.

The **principles** that form the core of this document are critical; the **process** may vary between professional groups and practice situations. In this respect, attention to all four sections of this document is essential. Although it may initially prove challenging, the successful implementation of this framework will pave the way for future development of outcome measures to validate the process.

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Section 1: Credentialling in New Zealand Health and Disability Services

The Ministry of Health published the first national credentialling document, *Toward Clinical Excellence: A framework for the credentialling of senior medical officers in New Zealand*, in 2001. Its focus was on the credentialling of senior medical practitioners in secondary and tertiary services within a single service or facility.

This updated framework has a wider application. The credentialling process it details applies not only to medical practitioners but to all health professionals in all New Zealand health and disability services, both public and private.

However, the credentialling process outlined here will not necessarily apply to all health practitioners in a particular profession. Rather, it is tailored for those working at a senior level (or for nurses within an expanded or extended scope of practice) where there are particular risks of serious harm or a lack of direct clinical oversight. This credentialling process applies to all medical practitioners except those working under supervision at house officer level.

Sections 1–3 of this document are generic, summarising principles and responsibilities common to all health professions and practice situations. This document is not a standard. While a standardised approach is desirable, at this stage of development, and given the changes proposed, this document can provide guidance only. For medical practitioners already using a credentialling system, it recommends the development of outcome measures based on the principles outlined here, rather than on a specific process.

1.1 Definition and purpose of credentialling

Credentialling is a process used by health and disability service providers to assign specific clinical responsibilities to health practitioners on the basis of their education and training, qualifications, experience and fitness to practice within a defined context. This context includes the particular service provided, and the facilities and support available within the organisation.

The prime focus of credentialling is patient safety. It is also beneficial in terms of practitioner protection, provider accountability and consumer confidence in the health system.

Credentialling is a responsibility delegated to professional peer groups in co-operation with professional bodies. It is a proactive process that commences on an individual's appointment and continues for the period of their employment.

The use of the term 'credentialling' in the health sector in New Zealand should be confined to the processes described in this document. While it makes sense for professional groups to manage credentialling, ultimate responsibility for practitioner competence lies with organisational governing bodies. Where practitioners are self-employed, service contract agreements may require evidence of credentialling. In the case of private health facilities, credentialling should form part of access agreements made with practitioners.

Credentialling will not eliminate the occasional practitioner error; nor will it eliminate those very few practitioners who deliberately attempt to defraud the system. Credentialling manages risk by identifying system errors and individual practitioners with a pattern of poor performance. Its success relies on practitioners who engage actively in self- and peer assessment. The process focuses on quality improvement rather than discipline: practitioners actively participate in the process as a means of measuring their professional accountability.

1.2 Credentiailling implementation by evolution, not revolution

Clinical leaders who champion the credentialling process within their own organisations are critical to the development of effective credentialling systems. Credentialling cannot be imposed on practitioners without consultation.

1.3 Role of the public

Although the main aim of credentialling is to improve outcomes for patients, some practitioners involved in the process in recent times remain unconvinced of the benefits of involving members of the public in their clinical quality improvement programmes. This, among other factors, has affected the extent to which consumer input has been incorporated into the credentialling process. It is imperative that New Zealand has authoritative systems in place to reassure consumers about the level of quality they can expect from their public health system.

1.4 Role of regulatory authorities

The Health Practitioners Competence Assurance Act (HPCA) 2003 prescribes clear responsibilities for regulatory authorities, including defining scopes of practice for registration. Regulatory authorities set competence standards, but employers define the specific clinical responsibilities of a practitioner in a particular practice situation. Such responsibilities may form all or part of the scope of practice for registration, depending on the particular service and its available facilities and supporting resources.

1.5 Role of professional colleges and specialist societies

The professional focus of credentialling means that professional colleges or specialist societies have a large part to play in the process. Such organisations may specify the standards required for membership, or define levels of competence required for clinical practice. Additionally, colleges and societies may nominate peers as external reviewers for credentialling committees, particularly in reviewing medical practitioners.

1.6 Key terms

The following terms are defined for the purposes of this document. The HPCA 2003 has redefined some terms used in the previous framework, published in 2001. Terms used in this document reflect those changes.

Scope of practice refers to that determined by the regulatory authority for a particular profession, specifically:

‘any health service that forms part of a health profession and that is for the time being described under section 11; and in relation to a health practitioner of that profession, ... one or more of such health services that the practitioner is, under an authorisation granted under section 21, permitted to perform, subject to any conditions for the time being imposed by the responsible authority’ (HPCA 2003).

Note: The term ‘specific clinical responsibilities’ replaces the term ‘scope of practice’ as used in the previous framework. Where ‘scope of practice’ is used in this document, it refers to the HPCA definition.

Expanded scope ‘a professional strategy with increased range of autonomy, accountability and responsibility. Usually occurs within a specialist nursing practice and involves additional skills such as diagnosis and prescribing. There is a formal pathway to role expansion that entails further education and may include regulation’ (New Zealand Nurses Organisation (NZNO) 2009).

Extended scope ‘the addition of a particular skill or area of nursing practice responsibility usually in response to increased demand or consumer need’ (NZNO 2009).

Professional peer ‘in relation to a health practitioner ... a person who is registered with the same authority with which the health practitioner is registered’ (HPCA 2003).

Required standard of competence ‘the standard of competence reasonably to be expected of a health practitioner practising within that scope of practice’ (HPCA 2003).

Competence to Credentiailling is the process used to assess this. It is peer-driven; requires a relevant, current practising certificate and acknowledges any limitations to practice imposed by the regulator.

Initial credentiailling and **credentiailling on appointment**. These terms tend to be used interchangeably; however, there may be a considerable time period between appointment and commencement, particularly among overseas practitioners. In this case, it is preferable that the initial credentiailling meeting with a delegated clinician occurs when the practitioner begins work (see Section 2).

Performance review. A generic human resource process which assesses an individual's ability to meet the requirements of their employment contract. Credentiailling is not the same as performance review. However, an annual confirmation of clinical competence, as part of the credentiailling process, contributes to the performance review process.

Recertification. The process whereby a practitioner's competency is assessed by a professional regulatory body in order for that practitioner to maintain a current practising certificate.

Section 2: Principles of Credentialling

The following principles apply to all health professions in New Zealand. They replace the ‘key concepts’ of the previous framework, and reflect a consensus reached by the working party following wider health sector consultation. The purpose of these principles is to promote a nationally consistent credentialling system that will:

- protect health service consumers
- promote professional practice development among health practitioners
- improve risk management in provider organisations
- support clinical improvement activity
- allow some credentialling information to be accessible between organisations
- be able to be audited nationally
- improve public confidence in the health system.

Principle 1: Credentialling is a process used by all health and disability service providers to promote the provision of quality health care.

The **responsibility** for credentialling lies with the governing body of a particular organisation – the chief executive and the board, or, in the case of a smaller private facility, the proprietor. The governing body must ensure that agreed credentialling policies and procedures are documented and adhered to, that due process is followed and that there is a robust appeal system.

The governing body delegates responsibility for credentialling to a professional peer group, nominating a senior practitioner for each profession to co-ordinate the process (for example, the chief medical advisor, director of nursing or director of allied health services).

In primary care settings, it may be appropriate for a primary health care organisation (PHO) to co-ordinate the process on behalf of individual practices.

The confidence of practitioners in the process and their willing participation are essential: effective credentialling requires an **ownership** of the process by practitioners and a **partnership** between practitioners and employers based on trust and mutual respect.

All publicly funded services should have a credentialling system in place. In private health facilities, credentialling should form part of all formal agreements made with practitioners.

Credentialling aims to achieve continuous improvement. It is a proactive and non-punitive process, which includes the legislative protection of information in some circumstances. As with all quality and risk management systems, credentialling processes must be open to audit.

Principle 2: The focus of credentialling is on the competence of health practitioners to perform specific clinical responsibilities within a designated service environment.

The focus of credentialling is the individual. However, no practitioner works alone, and the wider context of the clinical team and the service as a whole is always part of any credentialling discussion. Typically, one credentialling committee applies the credentialling process to a group of practitioners within a particular service at one time, and reviews the department or service itself as part of that process.

Most health professions already have systems in place to monitor and support safe practice. Governing bodies, in consultation with professional organisations, determine which practitioners should be credentialled. As a guideline, the Ministry of Health recommends that practitioners whose practice is in some way specialised and not subject to routine supervision be credentialled.

This would include the following:

medicine: senior medical officers, general practitioners, medical officers and locums

nursing and midwifery: practitioners in specific areas of practice covered by the general scope but considered to be expanded or extended

allied health professions: practitioners covered by the general scope in specific areas of practice and/or procedural extensions of practice.

Principle 3: Professional bodies, employers and individual health practitioners have essential roles in credentialling that are distinct and complementary.

The HPCA 2003 prescribes the responsibilities of regulatory authorities for each professional group. These responsibilities include defining the scope of practice; ensuring practitioners are competent and fit to practice; and managing recertification, as a mechanism for ensuring ongoing competence.

Professional colleges and societies focus on particular areas of specialist practice, and professional unions focus on broader employment issues. Both groups play a part in credentialling; the former through documenting external evidence of practitioner competence and through specialist input into the credentialling process, and the latter through working with service providers and practitioners to ensure facilities and supporting resources meet requirements for safe practice.

The precise nature of the relationship between professional bodies and service providers in relation to credentialling is likely to be profession-specific, but should always be clarified on both sides in order to ensure that requirements are met without unnecessary duplication of assessment and administrative processes.

Principle 4: Consumer input is a requirement of the credentialling process.

The primary purpose of credentialling is to improve health outcomes for patients, who therefore should play a critical role in the process. Among other responsibilities, credentialling must respond to the particular needs of Māori, and acknowledge the Government's responsibility under the Treaty of Waitangi to work in partnership to improve health outcomes for Māori.

Consumers need to be involved in the credentialling process at a local level. For this to be effective, however, practitioner and organisational 'readiness' is critical. Experience in New Zealand has shown that when practitioners are actively involved in the credentialling process, consumer involvement gains greater acceptance. Further, the degree to which consumers participate in other areas of the organisation has an effect on their readiness to contribute to the credentialling system. The Ministry of Health expects that all organisations will recognise the principle of consumer involvement in their credentialling programmes. *Toward Clinical Excellence: A toolkit to develop consumer participation in credentialling*, published in 2003 by the Ministry of Health, provides a comprehensive resource for health service providers in this respect.

The primary consumer role in the credentialling process will be as a representative member of the credentialling committee, with a major role to play in the review process. Consultation with a consumer representative (along with cultural consultation) is also often a part of practitioner appointment processes, in which case there is no requirement for consumer input into credentialling on appointment.

Consumers on credentialling committees must be appropriately appointed and supported, and be subject to the same protection and obligations with regard to credentialling information as health practitioners are.

Credentialling policy must identify how and what information is made available to consumers/patients. The outcome of credentialling – the

credentialled status of a practitioner – should be in the public domain. Where a practitioner’s specific clinical responsibilities are less than their regulatory authority’s scope of practice specifies, the reasons for this must be made explicit in the public record. Depending on circumstances, however, the information generated during the credentialling process may be confidential under the HPCA.

Principle 5: Credentialling is a regular, ongoing, responsive process that commences on appointment and continues for the period of employment.

Compared to the previously published credentialling framework, this document places greater emphasis on the concept of credentialling as a systematic process that commences on a practitioner’s appointment and continues for the period of their employment. To emphasise that credentialling is a continuous process, the term ‘recredentialling’ has been replaced by the term ‘credentialling review’.

Routine credentialling processes should include:

- credentialling on appointment or immediately before taking up the appointment
- annual confirmation of credentialled status as part of performance review
- periodic formal review of credentials.

In addition, further credentialling processes should be in place to respond to ‘non-routine’ situations practitioners face from time to time, such as the introduction of new technology.

Processes may differ between professional groups and between specialist areas within a single profession, but every professional group should adhere to the principle of ongoing credentialling.

Principle 6: Credentialling processes must be fair, transparent and robust.

Organisational commitment to quality patient care and objective professional standards provides the foundation for an unbiased credentialling system.

Two other concepts are equally important in the development of credentialling policies: due process and equal protection. ‘Due process’ entails two aspects: **substantive** due process refers to the duties, rights and responsibilities of practitioners and managers (in other words, agreed policy) and **procedural** due process refers to the processes by which the policy is maintained (for example, procedures required to be carried out and records required to be kept). ‘Equal protection’ refers to freedom from discrimination on the grounds of race, creed or gender, or on any other basis considered to be discriminatory.

Credentialling must not be used to:

- limit responsible professional initiatives designed to improve standards of practice
- restrict the use of exceptional measures taken in emergency situations
- condone practice in isolation without reassurance that the lone practitioner has established adequate professional linkages, along with workable peer review, audit and continuing professional education policies.

Credentialling policy must document an appeals process, including specifications on:

- grounds for appeal
- the person or body to whom an appeal should be addressed
- timeframes for lodging an appeal and the completion of the appeal process
- the rights of the appellant
- the process to dispute the outcome of an appeal.

Principle 7: Credentialling processes accommodate a variety of practice settings and practitioner working arrangements.

This principle incorporates a number of separate aspects.

1. Developing common credentialling processes between public and private service providers

The Ministry of Health recommends that, for the sake of consumer confidence, public and private organisations across all sectors, including primary health care, use a common credentialling framework.

There is a need for more common processes both between public and private providers (although currently there is some accommodation in this respect in the credentialling of practitioners with dual appointments) and between District Health Boards (DHBs).

Providers need to acknowledge different ‘drivers’ for credentialling in public and private services. A particular issue is that practitioners working in private facilities are not employees, and effectively receive private access to separately owned operating theatres and other facilities. Facilities where credentialling is not required may be more attractive to these practitioners, and although provision of such facilities may seem a better economic choice for private providers, ultimately consumers may suffer. All services purchased by DHBs from private providers should provide evidence of an acceptable credentialling process, thereby creating a ‘level playing field’ among private service providers.

2. Credentialling of teams

In highly specialised services in which individuals’ clinical responsibilities are closely interwoven with those of others, in a multidisciplinary team, it will often be appropriate to credentialling an individual practitioner within in the team context. Credentialling the team as a whole will ensure that collectively it provides a safe service in which consumers and practitioners alike are protected. Team credentialling may be particularly relevant where practitioners practice within an extended scope.

3. Regional credentialling

A regional credentialling system provides a mechanism to ensure the safe delivery of services in which components are provided across a number of organisations: for example, services dealing with a low volume of consumers; services requiring a high level of expertise; recovery and rehabilitation services providing prolonged care; or small services relying on larger organisations for emergency back-up.

Integrated regional services ensure that as far as possible a patient's journey through diagnosis, treatment and recovery or palliation is safe and coordinated, and that services are provided as close to home as possible, while making the best use of limited specialised facilities and human resources.

Regional credentialling is a way of ensuring that health practitioners working across a number of health facilities to provide a regional service are practicing at a consistent standard of safety and efficiency. Practitioners who practice outside recognised DHB boundaries are candidates for regional credentialling, as are those who work as part of a team providing advice and support through telephone and video conferencing, for example.

Credentialling of regional services is a new concept in New Zealand. Its implementation within particular services may include:

- designing an efficient means of credentialling practitioners or teams working in more than one organisation and across different levels of service (primary, secondary and tertiary)
- designing an efficient means of credentialling a number of organisations that contribute to a single regional service
- ensuring that organisations have the ability to contribute to the credentialling processes of another where the two organisations share clinical responsibility (for example, one provides emergency back-up support for the other).

4. Primary health care

To date, no definitive conclusions have been reached as to how the process of credentialling might operate among primary health care practitioners. Where general practitioners (GPs) are employed to undertake procedures which technically fall within other specialist medical scopes, the credentialling process is clearer than it is for GPs who are either self-employed or employed in small businesses.

The Cornerstone accreditation programme provides a measure of the quality of facilities and support within general practices. However, it does not currently address the competence of individual practitioners, and participation is voluntary.

GPs working in public hospitals in certain areas, such as the emergency room, may be credentialled by that hospital's DHB. In reality, the chief medical advisor, under delegated authority from the DHB, is responsible for ensuring that all practitioners employed and contracted to practice in the DHB engage in the credentialling process.

The Ministry of Health expects that nursing and allied health credentialling processes for practitioners working in an extended or expanded scope of practice can be applied to such practitioners who work in primary care.

Section 3: The Credentialling Process

Credentialling guidelines to date in New Zealand have focused on senior medical officers working within DHBs. This document recommends a much broader framework, under which credentialling will potentially apply to all health professions in any practice situation. Successful implementation of this recommendation depends on the following on the part of stakeholders:

- agreement on the principles outlined in Section 2 and the responsibilities of parties involved as outlined in this section
- acceptance that while the **principles** of credentialling should be universal, the **process** may differ between professional groups and practice settings
- acknowledgement that the confidence of practitioners in the process and their willing participation are essential: there must be a partnership between practitioners and employers based on trust and mutual respect
- a shared effort to standardise credentialling processes for each professional group in New Zealand. This would allow for a degree of transportability and ultimately the development of a set of national outcome measures.

The purpose of this section is to clarify the roles and responsibilities of key stakeholders – organisations, regulatory authorities, professional bodies, practitioners and consumer representatives – by the use of a common framework. Section 4 provides guidance specific to medical practitioners, building on the generic responsibilities outlined here.

3.1 Organisational governance responsibilities

A health service provider must take all reasonable steps to ensure its health professionals are capable of safely undertaking the clinical responsibilities specified in their contracts. Credentialling is one means of fulfilling this duty of care. It is a governance responsibility to:

- include credentialling in organisational policy resource, monitor and maintain the clinical competence of all health practitioners working in the organisation, whether employees or independent contractors.

Experience shows that the credentialling process is more effective when:

- there is strong governance support for it
- practitioners proactively support it
- the parties concerned effectively communicate with each other, including maintaining a ‘no surprises’ approach to information sharing
- a defined process is followed in appointing a credentialling committee.

In implementing a credentialling system an organisation should take the following five steps.

Step 1: Determine who should be credentialled

General guidance as to which practitioners in a professional group should be credentialled is given in Section 2. It is expected that for each type of professional they employ or contract with, organisations will determine the specific clinical responsibilities requiring credentialling.

Step 2: Agree on and document the credentialling process

Each organisation is likely to have general policy requirements for credentialling, and specific policy requirements for the credentialling of different professional groups.

It is recommended that documented *policy* include:

- a statement that an effective credentialling system is a governance responsibility, and a statement delegating this responsibility to an appropriate professional peer group
- a list of practitioners requiring credentialling within the organisation
- an indication as to the circumstances in which a credentialling committee is required
- clarification of the relationship between credentialling and practitioner performance reviews

- a statement of reporting requirements, including how such requirements relate to the organisation's quality and risk management system
- a clear policy on information management, including specifications as to which information is to be publicly accessible
- an outline of the appeals process, noting the right of a practitioner to appeal a decision made by a senior clinician on initial credentialling or an annual review of credentialled status
- a clear policy on audit requirements to ensure the organisation complies with the agreed policy and procedure.

It is recommended that documented *procedure* include:

- an outline of the process for initial credentialling
- an outline of the process for credentialling review (including interim credentialling reviews as required)
- specification of the credentialling committee's operations:
 - its membership
 - its terms of reference, including functional and reporting relationships
 - the role and responsibilities of its chairperson, a consumer participant, and external and organisational credentialling committee members
 - the remuneration to be made to its external participants.

Step 3: Delegate responsibility for credentialling

Under the previous credentialling framework, responsibility for credentialling was delegated to chief medical advisors. Under this new, broader approach to credentialling, delegation may need to be shared between a number of professional groups. In this case, all professions within an organisation involved in credentialling should contribute to the development of generic policy and procedure.

Step 4: Receive and act on credentialling reports

Policy must include a process for receiving and acting on credentialling reports, specifying in particular the need for documented evidence that an appropriate process was followed and corrective actions were taken.

Step 5: Establish links to the organisational quality and risk management system through audits and evidence of continual improvement

To date there is little documented evidence of the effectiveness of credentialling. Credentialling processes should be included in an organisation's quality and risk management system, which will then provide an internal mechanism to review processes and outcomes.

3.2 Practitioner responsibilities

The Ministry of Health recommends that the following practitioner responsibilities be included in credentialling documentation.

- The practitioner actively engages in all aspects of credentialling as a condition of his or her employment.
- The practitioner proactively collects quality and audit data as 'evidence' of his or her competence. This may include fulfilling the requirements of a professional organisation.
- The practitioner accepts professional responsibility to report their own and others' diminishing competence.
- The practitioner does not use his or her credentialled status to 'opt out' of clinical responsibilities that are a requirement of his or her job description or contract for reasons of convenience rather than competence.
- The practitioner does not use his or her credentialled status to unfairly demand resources or assert competitive advantage over a fellow practitioner.

3.3 Professional organisation responsibilities

The nature of evidence of competence required by regulatory authorities and professional organisations for credentialling purposes will be profession-specific (and is detailed for medical practitioners in the following section). It is important to note, however, that the competence criteria of regulatory authorities do not replace individual organisations' specifications in terms of the clinical responsibilities asked of their practitioners in particular service settings. Colleges and professional bodies can give advice in this regard, but provider organisations have ultimate responsibility for the credentialling of particular services provided by their practitioners.

3.4 Consumer input in credentialling

Consumer input is a principle of credentialling that is not universally supported or well used. There are a number of reasons for this, including a misunderstanding of the consumer's role in the process; the difficulty of finding and supporting an appropriate consumer representative; and an unwillingness to limit the tenure of a 'good' representative once found, which ultimately reduces the effectiveness of the role.

Understanding and valuing the role of the consumer

Consumers supply information that helps providers make the right decision by:

- providing a service user's viewpoint on aspects of clinical care to complement the perspective of a health professional, which is often more focused on the technical aspects of clinical practice
- predicting how other consumers will react, so that decisions made by the credentialling committee will stand up to public scrutiny.

Areas in credentialling where consumer input is recommended

1. Credentialling on appointment

Most health and disability service providers have a consumer on their appointments committee for senior positions, whose role is to provide a consumer perspective on issues such as an applicant's communication abilities, interpersonal skills and cultural appropriateness. In some circumstances the appointments committee also has responsibility for credentialling.

2. Formal credentialling review

A consumer should be included in the membership of the committee for each formal (five-yearly) credentialling review, and in any non-routine review (such as that for a new service) for which a credentialling committee is convened.

Appointment and support for consumers

In this respect the principles outlined in the previously published credentialling framework stand; namely, candidates should:

- have no alliance with a particular interest group, so that they can provide a broad consumer viewpoint
- be familiar with relevant legislation, including the Privacy Act 1993 and the non-disclosure provisions of the HPCA 2003
- be able to network with local consumer groups
- be appointed by a transparent process
- be appointed for a specific term
- receive initial training and ongoing support at a national or regional level
- work to a clear position description and undergo an annual performance review
- receive remuneration for services provided.

Organisations should consider the development of a local or regional consumer group, where none already exists, to provide consumer input to a multitude of organisations in the area. The benefits of this arrangement would include:

- peer support for consumers
- the opportunity for consumers to work within multiple organisations, giving them a broader view of credentialling issues and avoiding organisational ‘capture’ of individuals
- cost-benefits in recruitment, training and support.

3.5 Information management

The HPCA 2003 provides for ‘protected activities’, which may include credentialling. Although practitioners clearly need to be protected to a certain extent, this requirement must always be balanced with what is considered the ‘public good’. The following principles apply to the management of information arising from credentialling processes.

- The *outcome* of credentialling processes should be in the public domain. However, the data generated (such as meeting notes and other personalised information) should be protected.
- Protection from civil liability for all health professionals is necessary to encourage practitioners to engage in certain aspects of the credentialling process.
- It is a professional responsibility for practitioners to report competence issues pertaining to both themselves and their peers.
- Public members of a credentials committee should be given the same rights of protection as practitioners, and tasked with the same responsibility to maintain confidentiality.

- Organisational policies and procedures should be developed to manage credentialling data, including specifications on:
 - which information is kept on file
 - the manner in which information is stored, including the degree of security
 - how long information is retained
 - who has access to the information, and in what circumstances
 - how and what information is made available to the public and patients.
- Accountability for ensuring that information pertaining to health professionals employed or contracted by health service providers remains confidential ultimately rests with the chief executive, reporting to the board. For the sake of this accountability, the credentialling system must be completely transparent.

3.6 Credentialling and performance review

Credentialling is not the same as performance review. Performance review monitors a practitioner's performance against their employment contract; while credentialling identifies the specific clinical responsibility a practitioner has within an organisation and monitors their ongoing competence in that respect.

While performance review is generally an annual process, formal practitioner credentialling reviews are less frequent (interim reviews in certain circumstances aside). On an annual basis the Ministry of Health therefore recommends that a practitioner's credentialled status be confirmed in writing as part of his or her performance review, along with a confirmation of his or her registration status.

Section 4: Credentialling of Medical Practitioners

The framework published in 2001 addressed credentialling of senior medical officers in DHBs as a voluntary process. Since that time the implementation of credentialling across DHBs has varied considerably. Recent comments by the Health and Disability Commissioner have noted the lack of an effective credentialling process in some organisations, and suggested an inconsistency in the robustness of the credentialling process nationally.

The Health and Disability Services (Core) Standards NZS 8134.1:2008 criterion 2.7.2 requires evidence that ‘professional qualifications are validated, including evidence of registration and scope of practice for service providers’.

Standards that are agreed on and able to be audited are an effective means of measuring compliance and outcomes. Anecdotal evidence suggests that credentialling can:

- assist services and practitioners in safely introducing new treatments
- promote the interchange of ideas and information (for example, through chief medical advisors who participate in credentialling activity outside their own organisation)
- demonstrates overt clinical leadership
- ensure appropriate facilities and support are maintained in practice environments
- effectively detect practitioners who are developing competence problems.

The following issues pertaining to the credentialling of medical practitioners in New Zealand need to be addressed.

- The credentialling process needs to include medical officers and locums.
- Public and private facilities across all sectors, including primary health care, need to use consistent credentialling systems.

- District Health Boards need to use consistent credentialling systems.
- Practitioners in full-time private practice need to be credentialled in a manner consistent with their publicly employed counterparts.
- More credentialling information needs to be shared between professional bodies and other organisations.

This section provides specific guidance for medical credentialling. It assumes agreement with the principles, definitions and core processes outlined in Sections 1–3. Some process information from the previous framework has been updated and included in this section for completeness.

4.1 Credentialling as an ongoing requirement for medical practitioners

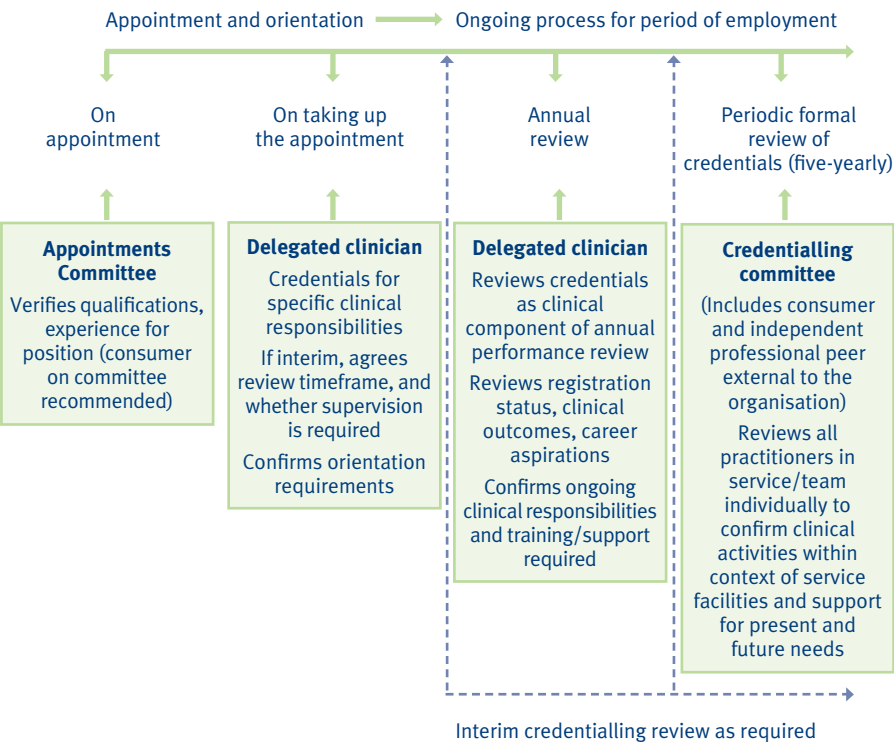
One of the main ways in which this document differs from the previous framework is its focus on credentialling as a systematic and continuous process that commences on a practitioner’s appointment and extends for the length of his or her employment. To emphasise that credentialling is a continuous process, the term ‘recredentialling’, as used in the previous framework, has been replaced with the term ‘credentialling review’.

‘Credentialling review’ covers three activities:

- an annual confirmation of credentialled status, within a performance review
- a five-yearly formal review by credentialling committee
- possible interim reviews for ‘non-routine’ events such as the introduction of a new treatment.

This relationship between these activities is illustrated in Figure 1.

Fig.1. Credentiailling process for medical practitioners



4.2 Credentiailling on appointment

The credentiailling process commences once agreement has been reached on the preferred applicant for a position and prior to an offer of employment. In general, service management is responsible for the development of a position description, and human resources for verification of documentation supplied by the applicant. (Such verification is easier in the case of New Zealand-qualified practitioners than it is in the case of practitioners trained overseas.) Employers are ultimately accountable for the completeness and accuracy of documentation provided by an applicant.

Verification of qualifications, experience and fitness to practice

The following items of documentation are minimum requirements.

1. General information:

- professional registration history
- professional education and training history (certified copies of certificates are required)
- college and professional society memberships
- professional employment history
- references verifiable at source

2. Supporting documentation for the specific clinical responsibilities required of the position applied for:

- qualifications and education specific to the clinical responsibilities of the position
- summary of practice since registration, and activity log
- objective data on clinical audits and outcomes related to that activity
- evidence of teaching, training and research

3. Declarations regarding:

- any previous denial, suspension, termination or withdrawal of the right to practice in another organisation
- any criminal investigations or convictions
- any physical or mental condition, including substance abuse, that could affect ability to practice safely
- consent for the organisation to verify claims made in the documentation provided and to obtain reference checks from all previous employers.

4.3 Determining clinical responsibilities on appointment

Where a credentialling committee separate from the appointments committee conducts initial credentialling of a new appointment, the clinical director of the relevant service should sit on the committee, but an external reviewer is not required. The following criteria must be met.

- The committee must be satisfied that the verified documentation provided by the practitioner meets requirements detailed in the position description.
- The committee must have carried out reference checks and witnessed evidence of the practitioner's competence (for example, a log book or outcome data), and be satisfied of the practitioner's interpersonal skills and 'fit' with the skill mix of the existing team.
- The committee and the practitioner must agree upon and document the specific clinical responsibilities to be undertaken between the time of appointment and the next review date.
- The committee and the practitioner must agree upon and document any conditions, including specific orientation, supervision requirements and interim credentialling reviews.
- The committee and the practitioner must agree upon and document the nature of ongoing credentialling reviews.

4.4 Annual review of credentialled status

The practitioner and the clinical head of department should agree to an annual review of the practitioner's clinical responsibilities, with the oversight of the chief medical advisor. The purpose of this review, which also provides the clinical content of a practitioner's annual performance review, is to confirm ongoing clinical responsibilities and identify training and support required in the coming year. If for some reason ongoing clinical responsibility cannot be confirmed in an annual review, an interim credentialling review may be arranged.

4.5 Formal credentialling review

Credentialling the individual practitioner

A formal credentialling review provides an opportunity for a practitioner to reflect on their clinical practice since the last review and consequently to agree with the credentials committee on their future clinical responsibilities. A formal credentialling review should be seen as a 'stock take' in an organisation's ongoing clinical quality management programme, and should be completed at least five-yearly.

The following aspects should be formally reviewed:

- current clinical responsibilities
- clinical activity since the last review, including volumes and outcomes recommended for maintaining competence
- training and experience gained since the last review, especially as compared to what is required by colleges or specialist societies
- future education or training possibilities and future professional aspirations
- other relevant information, such as complaints, patient satisfaction, accrued leave
- registration status, including any conditions placed on registration status or annual practising certificate
- health status
- any adverse professional or criminal record.

Organisations should provide the opportunity for, and actively encourage, self-review of clinical practice, clinical audit and peer review. Where there are insufficient practitioners for effective audits and peer reviews locally, it is the responsibility of the employer to make alternative arrangements, externally if need be.

Reviewing the service in which the practitioner is employed

A review of the service in which a practitioner is employed provides the context for individual credentialling reviews. Services should therefore be reviewed concurrently with practitioners. Recommendations arising from service reviews should aim to improve the ability of practitioners to undertake their specified clinical responsibilities. At the least a service review should consider:

- the clinical services the service is funded to provide
- the adequacy of facilities
- the composition and skill level of all the health professionals within the clinical team
- practitioner workload
- service outcome data, including patient satisfaction and performance to contract
- associated clinical activities based within the service, such as teaching and research
- clinical quality assurance and improvement processes
- succession planning.

4.6 Interim credentialling review

A credentialling review may occur at any time at the request of the practitioner or a person approved to make such requests on behalf of the organisation. Such a review may be requested:

- upon the introduction of new technology or a new procedure that requires specific competence or significant change to facilities or staff support
- upon significant contractual changes affecting practitioner clinical responsibilities.

4.7 Credentialling committees

It is a governance responsibility to resource credentialling committees, which should be primarily comprised of peer practitioners. Committees should be governed by written terms of reference that explicitly state the relationship between the credentials committee and other medical and non-medical management groups within the organisation. In some organisations a credentialling committee may be part of the management structure, in which case a core membership of practitioners across a range of disciplines has responsibility for overseeing the organisation's credentialling system and advising the appointments committee. Such a committee has the ability to co-opt other members from time to time, including external expertise as required. In other organisations monitoring responsibility may be delegated to the medical advisor, who appoints a credentialling committee for each review.

Responsibilities of credentials committees

Three principles underpin the operation of credentials committees:

1. *patient protection* through a process that is comprehensive, quality-based and sufficiently transparent to promote public confidence
2. *practitioner protection* through a process that is focused on practitioner development, considers due process and equal protection and maintains an agreed level of confidentiality
3. *employer protection* through the management and ongoing review of the credentials committee at a level of transparency that provides the board and senior management with assurance that the system is safe and effective.

Credentials committee membership

The structure of credentials committees will vary between organisations according to need. However, the chief executive should always remain independent from the deliberations of credentialling committees, to ensure that the management of the appeals process, for which the chief executive has responsibility, is kept separate.

Credentials committees should be made up of a majority of peer practitioners, and have the power to co-opt members to meet specialty-

specific requirements. The Ministry of Health recommends that the role of medical colleges and specialist societies in the process be standardised to ensure national consistency of processes and criteria within specialist areas of clinical practice.

Where the committee is wholly made up of practitioners, it has a responsibility to ensure that the perspectives of consumers and other health professionals are sought and considered, and that the process is sufficiently transparent to promote public confidence.

Committees delegated to undertake credentialling should include:

- a practitioner nominated from another service within the organisation
- a practitioner with relevant clinical experience co-opted from outside the organisation (the appropriate college or specialist society may be asked to nominate this person).

In addition:

- it is desirable that credentialling committees include consumer representation
- when a credentials committee is reviewing the service of one of its members, the reason for that member's appointment to the committee must be made clear and be accepted by the practitioners under review.

Resourcing the credentialling process

Section 3.2, 'Organisational governance responsibilities', outlines the responsibility of organisational governance to resource the credentialling process. Organisations should note that the need for administrative support is often underestimated, and should be budgeted for.

4.8 Information sharing in credentialling to reduce duplication

Two of the challenges of credentialling are the efficient use of resources and the avoidance of duplicated information. Standardisation and information sharing are the keys to solving these problems.

Credentiailling of locums

Locums are often arranged at short notice, not known to the organisation hiring them and unfamiliar with the facilities and protocols they have to work with. For this reason, locums can pose risks that credentialling can help minimise. The Ministry of Health recommends that all locums be credentialled. At a minimum this should entail a meeting with the clinical director or equivalent before starting work.

There is a need for a mechanism by which employers could access the practice experience of ‘career’ locums. A centrally held database, for example, could provide hiring organisations with immediate access to key information. While there is general agreement that this would be a welcome development, such a database would be a project in itself, and currently remains a recommendation only.

Where a locum is appointed through an agency, the agency should maintain a verified database listing previous employer organisations, employment timeframes, service levels (primary, secondary or tertiary) and clinical responsibilities undertaken for each locum they place.

Overseas locums coming to New Zealand to practice in one facility for longer than three months should be credentialled on appointment and included in ongoing credentialling reviews for their period of appointment. Such locums would not need to be added to the locum database.

Visiting specialists / regional credentialling

Credentials committees should also credential visiting specialists to an organisation with the same rigour as they would an employee.

Where the specialist is an employee of another public hospital employee, the two organisations and the practitioner should confer. The visited organisation should begin by reviewing the credentialling process of the specialist’s original hospital and, should the two processes be essentially similar, accept the outcome. The remaining credentialling focus should then be on the facilities and support provided by the organisation visited. Ultimately, responsibility for credentialling rests with the organisation deemed to be responsible for the practitioner. As with credentialling of

practitioners working regionally in public services, this process will become easier as the credentialling process is standardised over time.

There is also a need for a process to be developed to share verified information, with practitioner permission, between practitioners credentialled for like clinical responsibilities in public and private facilities.

Credentialling review

Currently, colleges and specialist societies play a large part in organisational credentialling decisions, often including recommendation of an appropriate external member of the credentialling committee.

The proposed periodic assessment of performance currently being discussed by the Medical Council of New Zealand (MCNZ) may contribute to, but would not replace, organisational credentialling review.

4.9 Management of information generated by the credentialling process

The outcome of credentialling processes should be in the public domain. However, the data generated (such as meeting notes and other personalised information) should be protected.

Protection from civil liability for all health professionals is necessary to encourage practitioners to engage in certain aspects of the credentialling process. It is a professional responsibility to report competence issues pertaining to both themselves and their peers.

Public members of a credentials committee should be given the same rights of protection as practitioners, and tasked with the same responsibility to maintain confidentiality.

In their credentialling role, senior practitioners deal with detailed and personalised credentialling information. Organisations must develop policies and procedures to manage this data, including how it is stored, who will be allowed to access it and for what purpose, and how long it is to be retained. (See Section 3.5.)

Accountability for medical practitioners' competence to practice in a particular setting ultimately rests with the chief executive, reporting to the governing body. For this reason, the credentialling system must be completely transparent.

4.10 The appeals process

A change to a practitioner's scope of practice resulting from the credentialling process has the potential to influence his or her livelihood, reputation and job satisfaction. Where appropriate, an employing organisation should offer retraining to practitioners whose scope of practice has been reduced. However, when the practitioner and the credentialling committee disagree over such an outcome, a process must be available for the practitioner to challenge the decision. The appeals process must be governed by due process that is clearly specified by the organisation.

Usually the appeals process will take the form of a hearing, the purpose of which is to give the practitioner the opportunity to challenge the credentials committee's decision, and ultimately to ascertain whether the practitioner has been treated fairly and without prejudice.

Grounds for appeal

A practitioner whose credentialled status is denied, withdrawn or limited has the right to appeal. Grounds for appeal should be explicitly documented by individual organisations, and may include:

- failure of the credentials committee to comply with agreed processes
- failure of the credentials committee to consider written or oral evidence submitted.

The appeals process should include:

- the opportunity for the appellant to comment on the credentials committee's report and findings
- the opportunity for the appellant to submit new evidence

- an avenue for the appellant to contest a recommended scope of practice on the basis that organisational facilities and support, rather than the practitioner him or herself, are inadequate.

Documentation of the appeals process

The appeals process must be documented and made available to practitioners as part of the information provided on employment. Documentation should state the purpose of the appeals process and the terms of reference for an appeals panel, and furthermore specify:

- the person to whom an appeal should be addressed
- the scope of the appeals process
- timeframes for lodging an appeal and the completion of the appeal process
- the rights of the appellant
- what happens if the appellant disputes the outcome of the appeal.

Person to whom the appeal should be addressed

In most instances the appeal will be addressed to the chief executive. For this reason the chief executive should not be involved in the day-to-day workings of the credentials committee.

Scope of the appeals process

Appellants should be made aware of any possible alternatives to a formal hearing. For example, in some organisations the policy may allow a credentials committee to be asked to reconsider its decision within a given timeframe, before a formal hearing is requested.

A formal hearing requires the constitution of an appeals panel made up of practitioners and governed by written terms of reference. In general one member of the panel should be external to the organisation, from the same specialist area as the appellant. Members of the credentials committee involved in the original decision must be excluded from the appeals panel.

Timeframes for lodging an appeal and the completion of the appeal process

A timely resolution of an appeal is in the interests of all parties. District Health Board policy must define the timeframe for lodging an appeal, after which a decision of the credentials committee is considered binding (the Ministry of Health recommends 30 days from the receipt of notification of the credentials committee's decision). Appeals should be lodged in writing and clearly state the grounds on which the appeal is based.

Local policy should also state a timeframe within which the appeal hearing will be held and a timeframe within which the appellant will receive notification of the appeal panel's decision. Under normal circumstances both should be completed within 30 days.

Rights of the appellant

The rights of the appellant must be specified in an organisation's appeals policy. These may include the right to nominate a member of the appeals panel, and the right to be accompanied by legal counsel or another person. Accompanying individuals are not permitted to represent the appellant, but may act in an advisory capacity.

Disputing the outcome of the appeal

The sequence of events to be followed when a practitioner disputes the outcome of an appeal must be clearly documented. An external review by the relevant medical college or specialist society may be appropriate. Ultimately, where the appeal decision results in an altered scope of practice that frustrates the practitioner's employment contract, the matter becomes a performance management issue.

4.11 Credentiailling of practitioners in full-time private practice

Credentiailling should be a contractual requirement of any practitioner providing a publicly funded service. Fee-paying consumers require the same level of assurance of competence from private practitioners. Credentiailling of such practitioners may occur voluntarily through a public organisation, or it may occur through a college process such as the periodic assessment of performance currently proposed by MCNZ.

Section 5: Future Directions

5.1 Credentialling of nurses

Nursing has the following scopes of practice: registered nurse, second level nurse and nurse practitioner. New Zealand nurses currently use the International Council of Nurses (ICN) definition of credentialling¹ which has a wider scope than the definition used by New Zealand health service providers. The ICN's definition covers a range of quality initiatives and credentialling of services, individuals, education and products.

The following section outlines how nursing systems, both employer and other, are aligned to the New Zealand credentialling framework.

Current nursing credentialling activities

- i. **On appointment.** The appointments panel verifies qualifications, experience, education, previous employer credentialling, practising certificate status and reference checks.
- ii. **On taking up the appointment.** The nurse completes an organisational induction and comprehensive orientation programme, which may include preceptorship. Organisational certification programmes such as cytotoxic drug administration certification are done.
- iii. **Annual review.** An annual performance review and professional development planning meeting is held between the nurse and line manager or their delegate to review practice against professional standards and the position description requirements, check current status of the annual practising certificate and identify professional development needs.

¹ Credentialling is a term applied to processes used to determine that an individual, programme, institution or product have met established standards set by an agent (governmental or non-governmental) qualified to carry out this task. The standards may be minimal and mandatory or above the minimum and voluntary. Licensure, registration, accreditation, approval, certification, recognition or endorsement may be used to describe different credentialling processes, but this terminology is not applied consistently across different settings and countries. Credentials are marks or 'stamps' of quality and achievement that communicates to employers, payers, and consumers what to expect from a 'credentialled' nurse, specialist, course or programme of study, institution of higher education, hospital or health service, or health care product, technology, or device. Credentials may be periodically renewed as a means of assuring continued quality and they may be withdrawn when standards of competence or behaviour are no longer met (Styles and Affara 1998).

iv. Periodic formal review of credentials. There are systems in place to recognise developing expertise and specific skill sets. These include:

- employer PDRPs
- professional association accreditation programmes, for example, the NZNO NZ Practice Nurse Accreditation programme, which is recognised by GP employers
- huarahi whakatu, a PDRP partnership between Te Rau Matatini and the New Zealand College of Mental Health Nurses
- the non-medical vaccinator authorisation under the Medicines Regulations
- the Ministry of Health's credential for the cervical screening standards.

Nursing Council of New Zealand authorisation process. Currently, Nursing Council authorisation is required for nurses to do the following:

- colposcopy
- emergency contraceptive pill supply
- first surgical assistant
- diagnostic imaging
- nurse practitioner prescribing.

Future credentialling for nurses

The above processes are robust and will continue to develop. Further organisational credentialling for nurses will be restricted to specified registered nurse scope of practice.

In 2009, the Nursing Council and national nursing groups were working together on advancing nursing practice. This includes:

- reviewing the registered nurse and second level nursing scopes of practice
- developing a scope of practice decision-making flow chart

- developing a glossary that includes definitions for expanded and extended practice
- establishing a national consortium of professional representative associations to endorse and advise on specialty standards.

The College of Mental Health Nurses has been reviewing their role as the accreditation and credentialling body for mental health nurses. This work has now commenced incorporating the principles outlined in this document. This is the first piece of substantive work on accreditation and credentialling by a specialist nursing college in New Zealand.

These new processes will continue to be developed as they are tested in the workplace.

5.2 Credentialling of allied health professions

The introduction of the HPCA 2003 effectively disestablished most profession-specific legislation and imposed new, more standardised competence assurance requirements on a number of allied health professions. Currently, however, not all allied health professions are covered by the HPCA Act.

Allied health professional groups generally have a broad scope of practice. In support of this, most have, or are in the process of identifying, advanced practice and competence frameworks. Some professionals, such as pharmacists, are well regulated and subject to audit. However, among a number of other allied health professions the current focus is on formalising and developing educational and competence requirements for advanced scopes of practice. It would be premature to engage in credentialling such professions before these structures are in place.

Discussion with a number of allied health professional groups during the creation of this document elicited a response similar to that given by the nursing profession – credentialling would be most likely to benefit professionals working in extended practice within a general scope.

5.3 Standardisation of medical credentialling in New Zealand

In other countries around the world, credentialling processes for medical practitioners are now standardised. This document recommends outcome measurement only. A major reason for this is that the success of credentialling relies on practitioners proactively taking ownership of the process and voluntarily receiving advice and comment on their practice from peers and external reviewers. Part of ‘taking ownership’ is the ability to adapt the basic principles of credentialling to the needs of an individual organisation; for this reason a move towards standardisation is not unequivocally a positive direction for credentialling to take.

However, approaches to credentialling in New Zealand still vary so widely that a certain level of standardisation is justified. There are also areas in which credentialling is yet to be introduced, which will require guidelines when they are ready to introduce a credentialling framework. Current issues include:

- variation between DHBs; public and private providers; and secondary and tertiary services which may require wider discussion with stakeholders
- credentialling in primary health care
- the degree to which MCNZ’s proposed periodic assessment of performance visits will overlap with credentialling requirements.

The Ministry of Health recommends that rather than developing a standard, outcome measures based on the seven principles of credentialling be established. Using this approach, which allows for process variation between services and professional groups, compliance with credentialling principles may then be compared with patient outcomes, individually and nationwide, to provide an indicator of the efficacy of the principles and ultimately the effectiveness of credentialling itself.

Appendix: Role and Operation of the Credentialling Working Party

This project was sponsored by the Ministry of Health through the Nursing Innovations and Quality Improvement and Innovations teams in the Sector Capability and Innovation Directorate. A working party was assembled in August 2008, and Robyn Woodward was appointed as project manager. The initial brief to the working party was to have no less than three formal meetings between August 2008 and June 2009, at times and locations to be decided by the group, in order to debate issues, receive progress reports and direct the ongoing activities of the project manager. The membership of the working party was as follows:

Dr Robert Logan, Chief Medical Officer, Hutt Valley District Health Board
Andrew Campbell-Stokes, Project Manager, Technical Advisory Services Regional Credentialling Project
Dorothy Gilliland, Allied Health Team Leader, Bay of Plenty District Health Board (Association of Occupational Therapists)
Dr Geoffrey Robinson, Chief Medical Officer, Capital and Coast District Health Board (Royal Australasian College of Physicians)
Dr Johan Morreau, Chief Medical Advisor, Lakes District Health Board
Dr Geoff Fougere, Sociologist, Member National Health Committee
Dr Gloria Johnson, Chief Medical Officer, Northland District Health Board
Joan Crawford, Strategic Programme Manager, Medical Council of New Zealand
Dr Liz Fitzmaurice, GP Liaison, Hutt Valley District Health Board (New Zealand Royal College of General Practitioners)
Nicola Sladden, Chief Legal Advisor, Health and Disability Commissioner
Owain George, Competency Policy Advisor, Pharmacy Council of New Zealand
Susanne Trim, Professional Services Manager, New Zealand Nurses Organisation
Dale Oliff, Chief Operating Officer, Lakes District Health Board

Ex Officio

Gillian Bohm, Principal Advisor Quality Improvement, Ministry of Health
Christine Andrews, Senior Policy Analyst, Nursing, Ministry of Health

Project Co-ordinator

Robyn Woodward, Health Management Consultant

Working Party Terms of Reference:

Review of the Credentialling of Health Professionals in New Zealand

Terms of Reference

Purpose

The working group will provide advice to the Ministry of Health credentialling project team as part of the review of the credentialling of health professionals, with a specific focus on nurse credentialling.

Objectives

The working group's key role is to work with the project team to produce updated guidance for sector consultation on the credentialling of health professionals in New Zealand across a range of practice settings. A review of the sector experience in the implementation and management of credentialling systems since 2001 will be undertaken. The project work will pay particular attention to the development of credentialling within the nursing profession.

Accountability

The group is accountable to the Ministry of Health co-sponsors: Gillian Bohm, Principal Advisor Quality Improvement, Sector Capability and Innovation Directorate and Christine Andrews, Senior Policy Analyst, Nursing, Sector Capability and Innovation Directorate.

Appointment process

The Ministry of Health will appoint the chair of the working group and will take advice from key stakeholder groups as to the organisations to be represented in the working group, including consumer input.

The chair and the Ministry of Health will seek nominations for clinical and other representatives through relevant colleges, professional bodies or non-governmental organisations as appropriate.

Key tasks

The key tasks of the working group are to:

1. determine the role and membership of the reference group
2. make recommendations for national guidance on the implementation, management and maintenance of systems that monitor and support the maintenance of clinical competency by health care professionals in health and disability services.

In doing this the working group shall consider the following:

- the experience of medical practitioner credentialling in District Health Boards since 2001
 - improvements required to the credentialling process for senior medical officers
 - benefits, constraints and mechanisms of team and regional credentialling
 - mechanisms required to link credentialling processes to performance appraisals
 - any adverse financial implications of credentialling systems
 - the potential for application of the guidance to be extended to primary care and the private sector
3. review recent developments in credentialling internationally, particularly the credentialling of nurses and allied health professionals, including:
 - the benefits and potential challenges associated with implementation of credentialling nurses in New Zealand
 - the impact of multidisciplinary credentialling processes on allied health professionals
 - the utility of a national framework and guidance for other health professional groups

4. identify areas requiring update and/or expansion in the previous guidance document: *Toward Clinical Excellence: A framework for the credentialling of senior medical officers in New Zealand*
5. contribute to the development of the revised credentialling guidance for sector consultation.

Working arrangements and frequency of meetings

The working group will meet in Wellington on 19 September, 10 October and 21 November 2008.

All meetings will be convened by the chair or a nominated person. A quorum of seven members, including the chair (or delegated chair), is required at meetings.

Discussion with the project coordinator between and in preparation for meetings will primarily be conducted by email.

Membership

The working group will comprise up to 10 members, excluding the chair and the project group.

Performance measures

The working group will be considered effective when it provides relevant and timely advice to the project team based on reviews of the evidence, consultation with appropriate groups and organisations and, by timely approval, the draft consultation document.

Fees and expenses

There is no payment for meeting preparation or participation in teleconferences. Project participants will be paid the standard Ministry of Health daily attendance rate and travel costs (except district health board employees).

Confidentiality

Queries from, or contacts with, the media regarding the proceedings of the group must be referred to the chair, who will act as spokesperson for the group.

The provisions of the Official Information Act 1982 also apply without exception to the activities of the group. The chair is responsible for ensuring that members of the group are aware of provisions of the Act and the extent to which written material such as the minutes of meetings is potentially discoverable under the Act.



MANATŪ HAUORA