Foreword

The New Zealand Health Strategy published by the Minister of Health in December 2000 identifies seven principles that are to be reflected across the health sector. These include the requirement for a ‘high performing system in which people have confidence’ and ‘active involvement by consumers and communities at all levels’.

These principles identify two important developments in the New Zealand health sector. The first is the need for District Health Boards to be accountable for the quality of services they fund and/or provide. The second is the need to improve public confidence in the service provided through better information, and in some cases, direct involvement in the monitoring of service quality.

The publication of a framework for credentialling that identifies ‘organisational’ scope of practice is timely. It helps to address the requirements of the New Zealand Health Strategy and it complements the developing Health Professionals Competency Assurance Bill, which will enable professional bodies to describe a ‘professional’ scope of practice for a practitioner on registration.

A national credentialling framework for senior medical officers is an important milestone on our journey toward clinical excellence for all health professionals and has international significance. Developing partnerships between clinicians and managers for local solutions to implement this framework will be key to our success. This will require the support of other stakeholders groups identified in this document, such as professional groups, the public and central agencies, to ensure we achieve the main purpose of credentialling – to improve health outcomes for patients.

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Director – General of Health
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Section 1: Credentialling of Senior Medical Officers in New Zealand

Credentialling is a relatively new concept to the New Zealand health sector, and its development to date has focused on senior medical officers in public hospitals. The purpose of credentialling is to protect patients by carefully defining the clinical responsibilities of practitioners. In doing so it also protects the hospital and the District Health Board (DHB), which are required to ensure that appropriate systems are in place to manage service quality.

The Medical Credentialling Project commenced in 1999 with a Health Funding Authority (HFA) study to describe the development of the credentialling process in Hospital and Health Services (HFA 1999). At that time only three of the 22 Hospital and Health Services had a process in place. In response to the recommendations made in that report, the Medical Credentialling Working Party was established, jointly sponsored by the HFA and the Ministry of Health. The Working Party’s task was to assist clinical leaders to develop a common approach to the credentialling of senior medical officers, focusing on framework development and implementation issues, and collecting the available ‘best practice’ information. Appendix A outlines the role of the Working Party in more detail.

One of the notable features of this project has been the readiness with which organisations and individual practitioners in the sector have engaged in the debate about credentialling. The task is complex and there are no models available internationally that can be readily applied to New Zealand. In addition, the timeframe from planning through to implementing the process is lengthy – somewhere around two to three years. The support of organisations that had commenced a credentialling process prior to the development of the credentialling framework has been particularly helpful. Not only have they shared their experience and expertise, but they have also been prepared to address the issues raised by the Working Party in their own process development.

At the time of publication Counties Manukau DHB remains the only organisation to have credentialled all senior medical staff. A further seven DHBs have completed initial credentialling of at least one specialty group. Of the remainder, 12 are in the process of developing policy and one DHB is yet to start planning. While there is a lot of work still to do, senior medical officers are becoming increasingly aware of the need to develop credentialling processes.

The Ministry of Health is committed to the development of credentialling in New Zealand. This document will be supplemented by further Ministry-funded resources described in subsequent sections to assist DHB implementation of the credentialling framework for senior medical officers in public hospitals.

Credentialling has relevance for all health professionals. The principles are generic, although the process may differ between professions. Currently the Nursing Council of New Zealand is developing a competency assurance framework that includes credentialling, and other professional groups are expected to develop credentialling models over time.
1.1 Definition and purpose of credentialling

‘Credentialling’ in the New Zealand context is defined as:

- a process used to assign specific clinical responsibilities (scope of practice) to health professionals on the basis of their training, qualifications, experience and current practice, within an organisational context. This context includes the facilities and support services available and the service the organisation is funded to provide. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient.

- It is an employer responsibility with a professional focus that commences on appointment and continues throughout the period of employment.

The use of the term ‘credentialling’ in the health sector in New Zealand should be confined to that described in this document. While hospitals may delegate the development of this process in other professional groups (such as the process described in the model being developed by nursing), the responsibility to ensure that practitioners are competent to work in a particular setting ultimately lies with the employer. It should be noted that where practitioners are self-employed and publicly funded the ‘employer’ is considered to be the funding agency. In the case of private health facilities, credentialling would form part of the access agreement made with practitioners.

Putting in place a credentialling process will not eliminate the occasional medical error. It will help to manage this risk by identifying both systems errors and individual practitioners who are developing a pattern of poor performance. Similarly, credentialling will not eliminate those very few practitioners who deliberately attempt to defraud the system. The credentialling process relies largely on the ability of practitioners to engage actively in self and peer assessment. It takes a quality improvement rather than disciplinary approach, where practitioners actively participate in the process as part of professional accountability.

1.2 Credentialling implementation by evolution, not revolution

While the need to develop systems to manage clinical quality has been influenced by patient complaint, success in developing credentialling systems both nationally and internationally has typically depended on practitioners who champion the process in their organisation. Credentialling cannot be imposed on practitioners without consultation. Implementation of credentialling for senior medical officers within publicly funded provider organisations has been identified as a priority to improve patient safety and public confidence in the health system. The December 2000 Planning Signal sent to Hospital and Health Services by the Ministry of Health through the Hospital and Health Service National Service Framework Project requires DHBs to have a credentialling process in place for public hospitals by June 2002.

1.3 Role of the public

The main aim of credentialling is to improve outcomes for patients. However, practitioners are sometimes uncertain about the purpose of involving patients or members of the public in clinical quality improvement activities. Public confidence in the health and disability system has been undermined by cases such as the recent Ministerial Inquiry into the Under-Reporting of Cervical Smear Abnormalities in Gisborne. Internationally, the same concerns are evident, with a recent British

The ease with which public input is incorporated into the credentialling process will depend on a number of factors, some related to practitioner acceptance and some outside the control of the practitioners who manage the process. However, it is imperative that New Zealand has systems in place to reassure consumers about the quality of health care they can expect from the public health system.

1.4 Role of the Medical Council of New Zealand, medical colleges and specialist societies

The Medical Council of New Zealand will continue to refine its system to manage the initial verification of qualifications and experience of practitioners applying for registration in New Zealand, and will increase random auditing to monitor the quality of this system. In addition, the council will need to determine the longer-term requirements of a national database, including storage of credentialling outcome data and levels of access to information. It is expected that the Ministry of Health will fund some of this work as part of its ongoing support of this project.

The role of medical colleges and specialist societies and their relationship with the Medical Council is developing. The professional focus of credentialling implies a strong link with the appropriate professional group and the service being credentialled.

1.5 Implications for other health professions and provider organisations

Private health service providers

A form of credentialling has been used by a number of private hospitals in New Zealand for some time. However, until recently the focus of this process has been primarily on practitioner access to facilities rather than identifying organisational scope of practice as described in this document. A major difference between public and private health providers in New Zealand is that practitioners working at private hospitals are not usually employees. The private sector will be expected to conform to the Health and Disability Sector Standard for credentialling of senior medical officers where they provide publicly funded services.

Third party accreditation

Quality Health New Zealand, which provides health service accreditation, requires organisations to have a credentialling process in place. Other quality certification programmes do not have specific requirements for credentialling. A national standard for credentialling of senior medical officers is yet to be developed and no decision has been made as to which agency should audit this standard. The priority now is to assist hospitals that are in the process of implementing a credentialling system to develop local processes using a common framework.
Other professional groups

Credentialling has relevance to all professional groups in health care, but it is not the purpose of this document to describe a generic system. The focus of the Working Party and this document is the medical profession; specifically, senior medical officers in public hospitals. For most groups outside the medical profession the more immediate concern is for development in two areas: the ability to require evidence of practitioner competence as a prerequisite for the issue of practicing certificates and the development and formalisation of professional sub-specialisation. Some aspects of these developments will require empowerment through the Health Practitioners Competency Assurance Bill.

1.6 Terminology

A glossary of terms is included at the back of this document. Where possible, definitions have been aligned with those being used or developed by the Medical Council of New Zealand and other professional groups.

1.7 Resources to assist in developing and implementing credentialling

Development and initial implementation of credentialling processes are time consuming and resource-intensive. However, much of the ongoing work required for credentialling is also required for organisational quality management, recognised as part of the accountability expected of any hospital providing publicly funded services. For this reason resources have been focused on specific areas of credentialling development. The Working Party identified a number of potential barriers to credentialling development in New Zealand and it has been recommended that the Ministry of Health provide some ongoing support in these areas. These barriers and the resources that are proposed to assist organisations to overcome them are discussed in Section 10.
Section 2: Credentialling - Key Concepts

An important finding of the 1999 HFA study was the need to develop a common system to credential health professionals to meet the particular needs of the New Zealand public health system. A shared approach will:

- assist in the development of a national approach to clinical quality improvement for practitioners
- allow some information about credentialled status to be transported from one organisation to another, thereby simplifying initial credentialling of practitioners on subsequent appointment
- assist in developing a process that can be audited nationally - an expectation of Health and Disability Sector Standard implementation.

The Working Party consulted widely to develop consensus around the basic concepts that form the foundation for such a framework for senior medical officers. This section identifies these key concepts.

2.1 Credentialling protects patients by defining the scope of practice for senior medical officers within an organisation

The central purpose of any quality initiative in health care must be to improve health outcomes for patients. Credentialling does this by clearly defining and monitoring practitioner competence within a given scope of practice. In doing so it also protects the practitioner and the employer. The organisation demonstrates a proactive approach to its responsibility to be accountable for the actions of practitioners in its employ, and practitioners are supported to work within and develop their level of competence in a particular setting or service environment.

2.2 Credentialling as part of a wider organisational quality and risk management system

Credentialling of health professionals is just one of the tools an organisation can use to improve the quality of patient care, and it needs to be viewed within this context. As such, it supports the ‘clinical governance’ approach promoted by the British National Health Service and increasingly being discussed in New Zealand, where:

Organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish (NHS 1999:6)

This is illustrated in Figure 1, which has been adapted from a British National Health Service model (NHS 1998b). While financial systems have historically taken precedence in public sector risk management, the current focus is on developing clinical quality systems to improve clinical outcomes for patients. Credentialling requires a focus on the quality improvement rather than the risk management end of the governance continuum (see Figure 1). This distinction is important in clarifying the difference between credentialling and performance appraisal, discussed in detail in Section 4.
Credentialling is the responsibility of the Chief Executive as a requirement of clinical governance. The tasks of credentialling are delegated to senior medical staff on the basis that judgements of practitioner competence require professional peer review. The confidence of practitioners and their willing participation in the process are essential: effective credentialling processes require a partnership between clinicians and employers based on trust and mutual respect. This point should not be underestimated: of the eight organisational factors identified as influencing credentialling development in New Zealand in the 1999 HFA report, five related to organisational culture.

2.3 Credentialling: an employer responsibility with a professional focus

Credentialling is an employer responsibility with a professional focus, which commences on appointment and continues throughout the period of employment. This professional focus transcends purely organisational boundaries, making the contribution of medical colleges, specialist societies and the Medical Council an integral part of the process. Credentialling complements the Health Professionals Competency Assurance Bill, which focuses on the scope of practice defined by the professional body responsible for the registration and licensing of senior medical officers, the Medical Council of New Zealand.

The scope of practice defined by an organisation is likely to be more specific than that defined by the professional registering body, and may exclude some areas in which the practitioner is considered competent but are not required by the organisation. It may therefore be useful to differentiate between ‘registration’ and ‘organisational’ scope of practice. The former covers that described by the professional body on registration, while the latter covers a potentially more limited ‘organisational’ scope of practice, which may be constrained by the facilities and support available in the organisation or the service it is funded to provide.
The term ‘credentialling’ should therefore be used only in the context of a health service provider organisation. While credentialled status in one organisation may assist credentialling in another, the decision is organisation-specific and not necessarily transportable.

### 2.4 Credentialling as a ‘Four-step’ process

Credentialling commences on appointment (initial credentialling) and continues for the term of employment (ongoing credentialling or recredentialling). These two stages of the process each have two steps (see Figure 2). While Step 1 is a responsibility that should be undertaken by the Medical Council of New Zealand, the other three steps are specific to the organisation. Of these, Step 3 provides the bulk of the work of credentialling in the form of ongoing clinical quality monitoring and improvement.

**Figure 2: The ‘Four-step’ credentialling process**

![Diagram of the ‘Four-step’ credentialling process]

The management of Steps 2 to 4 may vary within organisations, depending on local circumstances. However, the process should:

- be documented in each organisation, agreed with practitioners, consistent with national credentialling standards and open to audit
- assure practitioners, the public and management that the process is fair and transparent (this should include the use of an external assessor on credentials committees, and an appeals process that emphasises due process and equal protection).
2.5 Due process and equal protection

An organisational philosophy that puts emphasis on the quality of patient care and objective professional standards provides the foundation for an unbiased credentialling system that is fair to practitioners and management. Two other concepts should also be considered when developing credentialling policies: due process and equal protection.

‘Due process’ has two requirements:

- *substantive* due process sets the duties, rights and responsibilities of practitioners and managers (policy)
- *procedural* due process describes the process by which these are carried out (procedures).

‘Equal protection’ refers to freedom from discrimination on the grounds of race, creed or gender, and should include any other factors that are considered discriminatory, such as economic credentialling practices.

2.6 Transportability of credentialled status

Credentialling is more specific than vocational registration in terms of both the skills and scope of practice, which are organisation-specific and relate to a particular timeframe (the period between reviews). While information about the credentialled status of a practitioner in one organisation could be made available to another as part of an appointment process, it is an organisation-specific finding. Each organisation must make its own decision about the credentialled status of practitioners in their employ.

2.7 Purpose and limitations of credentialling

Credentialling protects the public by carefully defining the responsibilities of medical practitioners with the explicit purpose of improving clinical outcomes for patients. It has a *quality improvement* focus, and has a different purpose to performance appraisal. Both processes have been recently introduced for senior medical officers in New Zealand, so it is not surprising that there is a lack of clarity about the relationship between credentialling and performance appraisal. This distinction is discussed in more detail in Section 4.

Credentialling should *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 adequate professional linkages, peer review, audit and continuing medical education facilities are established for that practitioner
- discriminate against practitioners on economic grounds.
2.8 Public input into the credentialling process

Public input must be demonstrable and show progressive development toward inclusion of independent public appointments to credentials committees, within a specified timeframe.

The role of the public as consumers of health care is evolving. For some this development is too fast; for others it is too slow. If we accept that the primary purpose of credentialling is to improve health outcomes for patients, the role of a patient as a consumer of medical care must be identified and strengthened. This includes – but is not restricted to – responding to the particular needs of Māori and our responsibility under the Treaty of Waitangi to develop effective partnerships to improve the health outcomes for Māori.

Two of the seven principles underlying the New Zealand Health Strategy (King 2000) support a developing role for the public in the credentialling process. These are the requirement for a ‘high performing system in which the people have confidence’ and ‘active involvement by consumers and communities at all levels’.

The need to involve the public in the credentialling process at a local level is an integral part of the credentialling framework. However, practitioner and organisational ‘readiness’ will be critical to meaningful public involvement. Experience in New Zealand has shown that once practitioners become actively involved in the credentialling process the concept of direct public involvement gains greater acceptance. Also, the degree to which the public participates in other areas of the organisation will influence readiness to include them in credentialling. Therefore, it is expected that the implementation of direct public involvement as described in the framework will vary between organisations, but that all will be able to demonstrate progressive development toward this goal within the given timeframe.

2.9 Credentialling information management

The outcome of the credentialling process – the credentialled status of a practitioner, should be in the public domain. The information generated by the organisational credentialling process must be legally protected.

The task of verifying the qualifications and experience of a practitioner (Step 1) should be managed by the Medical Council of New Zealand to a standard acceptable by the employing organisation. This information, together with the credentialled status of the practitioner, should be in the public domain. Where the practitioner’s scope of practice in an organisation is less than the total scope of competence, the reasons for this must be made explicit in the public record. Public members of credentials committees should be subject to the same protection and obligations with regard to credentialling information as health professionals.

2.10 Timeframe for credentialling implementation

A credentialling system for senior medical officers in public hospitals consistent with the framework described in this document will be a requirement for publicly funded service provision by June 2002. It is expected that organisations will actively engage in developing a local credentialling process within the framework described in this document. The development of standards has been delayed so that hospitals yet to introduce credentialling can participate in standards development once they have experienced credentialling at a local level. It is expected that standards will be developed towards the latter part of 2001/02, and that audit will commence in 2002/03.
Section 3: The Role of Stakeholders

The evolutionary nature of credentialling development in New Zealand is likely to be reflected in changes in stakeholder relationships over time. These will include clarification of the role of medical colleges, specialist societies and the Medical Council of New Zealand, and increasing public participation. Figure 3 illustrates the current information flow between the major stakeholders using the credentialling framework.

Figure 3: The credentialling process – information flow between stakeholders

The roles of the key stakeholders in this process are outlined in Table 1 to clarify their interrelationship under headings that describe the way they are protected, and their responsibilities in terms of process and communication.
### Table 1: The credentialling process - role of stakeholders

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<tr>
<th>Stakeholder</th>
<th>Role in the credentialling process</th>
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<td><strong>Practitioners</strong></td>
<td>- partnership with employer, proactively managing clinical quality and risk to protect patients, practitioners and the organisation</td>
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<td>- understanding organisational credentialling requirements on appointment, including the potential impact ongoing credentialling may have on the employment contract</td>
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<td></td>
<td>- knowing how credentialling information is stored and in what circumstances the information will be made available, to whom, and for what purpose.</td>
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<td>- making credentialled status available as part of effective patient communication</td>
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<td>- explaining credentialled status where this is appropriate</td>
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<td></td>
<td>- proactively reporting concerns about self or peer competence.</td>
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<td></td>
<td>- working within an agreed scope of practice</td>
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<td></td>
<td>- complying with agreed organisational credentialling processes</td>
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<td></td>
<td>- participating constructively in self, peer and service review to improve quality of clinical practice</td>
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<td>- abiding by credentialling decisions made, and using the formal appeal process where necessary.</td>
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<td><strong>Communication</strong></td>
<td>- participation in local credentialling systems development and review mechanisms</td>
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<td>- use of appropriate public information and patient satisfaction systems.</td>
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<td><strong>Process responsibilities:</strong></td>
<td>- requiring compliance with Health and Disability Sector Standard</td>
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<td></td>
<td>- providing protection for individuals engaging in clinical quality assurance activities.</td>
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<tr>
<td><strong>Empowerment to:</strong></td>
<td>- ask for clarification where information given by a practitioner is unclear or non-existent</td>
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<td>- use the complaint process where issues are not resolved.</td>
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<td><strong>Public participants</strong></td>
<td>- public input in developing credentialling processes</td>
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<td></td>
<td>- assisting in development of public education about the credentialling process, including how to access the credentialling status of practitioners.</td>
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<tr>
<td><strong>Ministry of Health</strong></td>
<td>- requesting information to:</td>
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<td></td>
<td>- respond to specific situations for which the Minister is ultimately accountable</td>
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<td>- facilitate benchmarking.</td>
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<td>- initiating changes to legislation to facilitate credentialling</td>
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<td></td>
<td>- providing support to facilitate development and sharing of credentialling information and expertise.</td>
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**Protection through:**
- requiring compliance with Health and Disability Sector Standard
- providing protection for individuals engaging in clinical quality assurance activities.

**Communication responsibilities:**
- requesting information to:
  - respond to specific situations for which the Minister is ultimately accountable
  - facilitate benchmarking.

**Process responsibilities:**
- initiating changes to legislation to facilitate credentialling
- providing support to facilitate development and sharing of credentialling information and expertise.
| Public hospitals | • resourcing clinical quality as an organisational priority  
• developing a system that is fair and transparent to all parties  
• creating an environment that encourages proactive clinical quality improvement through partnership with practitioners. |
| Communication responsibilities: | • providing clear, written communication about the process for:  
  – employee practitioners and potential employees  
  – patients and public  
  – other stakeholders  
• responding appropriately to central agencies, patients and practitioners on issues arising from the credentialling process  
• receiving constructive feedback from stakeholders and making improvements. |
| Process responsibilities: | • ensuring a credentialling process is developed to meet local requirements within the framework provided  
• resourcing a credentialling system that:  
  – encourages practitioner participation  
  – is acceptable to practitioners and patients. |
| Medical colleges and specialist societies | • involvement in standard setting in vocational registration, continuing medical education, maintenance of professional standards and practice definition  
• advisory role to individual practitioners, the Medical Council of New Zealand, and DHBs. |
| Communication responsibilities: | • providing timely advice and expertise to hospitals on request to:  
  – recommend external assessors  
  – specific advice on competence issues. |
| Process responsibilities: | • collaborating with hospitals to:  
  – develop innovative ways to achieve credentialling requirements in small/highly specialised services  
  – improve practitioner competence. |
| Medical Council of New Zealand | • verification of training and qualifications of practitioners on registration  
• taking appropriate action on information provided about practitioner competence. |
| Communication responsibilities: | • communicating effectively to facilitate the work of other stakeholders in the credentialling process  
• database management  
• co-ordinating with colleges and specialist societies to facilitate vocational registration. |
| Process responsibilities: | • providing verified data for credentialling in a timely manner  
• involving stakeholders in development that impacts on credentialling  
• ongoing quality assurance activities for data management processes. |
Section 4: Credentialling and Performance Appraisal

A number of questions have been raised about the relationship between credentialling and performance appraisal. As neither process is as yet used universally with senior medical officers in New Zealand, and given that there is some potential overlap in the two processes, this response was not unexpected. The purpose of this section is to clarify the roles of these two processes.

The primary purpose of an annual performance appraisal is to review a practitioner’s ability to meet the terms and conditions of their employment contract. Part of this assessment is the ability to work within the scope of practice identified in the credentialling process. In some situations scope of practice may become a performance issue; for example, incompetence, practitioner request, or changing organisation requirements such as skill mix in the team, facilities available and the work the organisation is funded to do.

4.1 Relationship between performance appraisal and credentialling

Basically, performance appraisal monitors a practitioner’s performance against their employment contract, and credentialling identifies the scope of professional practice in this organisation and monitors ongoing competence. The key differences are summarised in Table 2.

It is evident from this summary that credentialling may impact on performance appraisal where:

- the employment contract is frustrated by a change in scope of practice resulting from a credentialling review
- the practitioner refuses to engage in the credentialling process where this is a condition of employment.

In the normal course of events credentialling and performance appraisal are quite separate activities. However, where the competence of a practitioner is a concern to patient safety, and when ongoing education and supervision do not result in improved practice, the situation becomes abnormal. It is then no longer a matter of credentialling, which has a quality improvement focus, but becomes a performance management issue.

A shared understanding of the difference between performance appraisal and credentialling is important and will develop as both processes are implemented for senior medical officers. The priority at this stage, however, is to ensure that the use of credentialling information is regulated to protect the parties involved. This will, in turn, encourage practitioners to focus on quality improvement activities to assure patients and employers that senior medical officers are clinically competent.
Table 2: Differences between performance appraisal and credentialling

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<th>Key difference</th>
<th>Employment contract</th>
<th>Credentialling</th>
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| **Documentation:** | - Defines conditions of employment  
- Identifies scope of practice on employment and indicates that this may change as a result of recredentialling  
- Includes mandatory credentialling requirement as a condition of employment  
- Requires annual performance appraisal. | - Describes policies and procedures for the four steps of the medical credentialling process, including terms of reference for credentials committees, data management and the appeals process  
- Clarifies remedies to be used in the event of a mismatch between the credentialled status of the practitioner and the needs of the organisation with ongoing credentialling. |
| **Review timeframe:** | - Annual appraisal of performance against employment contract (includes position description). | - Following initial credentialling on appointment, requires ongoing monitoring of clinical practice with at least five-yearly formal review within the context of a wider service review. |
| **Locus of control:** | - Organisation-wide human resource process facilitated by the appropriate service and clinical management. | - Specific professional practice process facilitated by credentials committee. |
| **Focus of review:** | - Focus on employee performance to contract  
- Relates to specifics of contract such as hours of attendance, volumes, additional responsibilities and requirements for teaching and research, general interpersonal skill issues  
- Includes organisational requirements for communication skill and cultural competence  
- Refers to ongoing credentialling in terms of:  
  - compliance with required collection of information for recredentialling  
  - any outstanding credentialling issues, such as a requirement for interim review  
- Considers ongoing vocational education requirements in terms of scheduling, funding, relevance to the organisation. | - Focus on professional competence within identified scope of practice  
- Update of credentials (qualifications, training and fitness to practice) since last review; includes ongoing vocational education requirements from a professional development perspective  
- Reviews specific technical and interpersonal skill related to current scope of professional practice to maintain continuity of clinical care and communicate effectively with patients, family and/or whānau  
- Reviews quality of organisational facilities and skills of other health professionals supporting this scope of practice  
- Recognises and plans for practitioner’s professional development aspirations and the future needs of the organisation. |
| **Implications of review outcome:** | Employer required to:  
- have appropriate practitioner numbers, skill mix and facilities for funded services  
- take all reasonable steps to upskill or retrain practitioners where current skill level inadequate or redundant. | Where credentialled status alters, the employment contract is renegotiated  
- Change in scope of practice may require supervision, education, or retraining. |
Section Five: The ‘Four-Step’ Credentialling Process

The use of credentialling in public hospitals in New Zealand so far has been mostly confined to practitioners who are currently employed by an organisation, with less emphasis on credentialling on appointment. A basic principle of the credentialling framework is that credentialling commences at appointment and continues throughout the term of employment. The process has four steps; two relate to initial appointment, and two to the ongoing review of credentials. Although the majority of the work done by credentialling committees concerns ongoing credentialling, the four steps are considered equally important in clinical quality management.

The scope of practice agreed between a practitioner and the hospital credentials committee is developed within the context of the service in which the practitioner is employed. It is specific to the facilities and support available at a specified period, and to the service the organisation is funded to provide. Because a review of the service is clearly an integral part of the process, where the scope of practice of a practitioner is limited due to organisational constraints, these limitations should be documented. Similarly, credentialling to provide a service should not be forced on a practitioner by an employer where facilities and support are inadequate.

In summary, practitioners have both the right and the obligation to work within their level of competence in a particular setting or service environment.

Organisational climate is a key determinant of implementing successful credentialling. A partnership relationship between practitioners and managers and the support of key senior medical staff to ‘champion’ the process were key elements identified in the 1999 HFA review of credentialling (HFA 1999).

Practitioner confidence in the credentialling process is heightened by:

- personal commitment to clinical quality improvement
- participation in credentialling process development
- the acceptability of the practitioners who will be responsible for the credentialling review
- practitioner perception that the process is just and equitably applied
- clear understanding of what happens to the information generated by the process, to whom it is accessible and for what purpose
- a non-punitive environment of support and remediation
- a documented appeal process.

Figure 4 summarises the ‘four-step’ credentialling process. The remainder of this section provides a detailed description of these four steps.
5.1 Step 1: Verification of training, qualifications, experience and registration

The initial credentialling of practitioners already on staff is an issue for organisations introducing formalised credentialling. While the process is essentially the same for new appointments, the level of detail will vary as these practitioners already have a work history in this organisation.

The following description of initial credentialling attempts to clarify the difference in this level of detail, although much will depend on the individual practitioner.

Initial credentialling of a new appointment

Step 1 of the credentialling process commences once agreement has been reached on the preferred applicant for a position and prior to an offer of employment. It is the responsibility of an employer to ensure that the documentation provided by an applicant is complete and accurate. For practitioners not currently registered in New Zealand, this includes fitness for registration. The Medical Practitioners Act 1995 sets out requirements for registration by the Medical Council of New Zealand.

Figure 4: Summary of the ‘Four-step’ credentialling process
These are:

- reasonable ability to communicate effectively in English
- no conviction by any court in New Zealand or elsewhere of any offence punishable by a term of three months or longer, as long as the offence does not reflect adversely on fitness to practice
- no physical or mental condition that affects fitness to practice
- not subject to professional disciplinary hearing in New Zealand or any other country, and the nature of the proceedings or investigation does not reflect adversely on fitness to practice
- not subject to an order of the Medical Practitioners Disciplinary Tribunal or the Medical Council of New Zealand, or of any other medical organisation or similar tribunal in another country, and the order does not reflect adversely on fitness to practise medicine
- adequacy of skills and knowledge to practice medicine
- Medical Council satisfaction of fitness to practice medicine.

In addition, a Certificate of Good Standing, issued within the last three months by the practitioner’s most recent registration authority which confirms their registration for the last two years must be provided before starting work (abridged from Medical Practitioners Act 1995: Section 13).

The position description developed by the organisation for each appointment should identify the qualifications and experience required. While the development of the position description is the responsibility of service management, verification of documentation supplied by the applicant (apart from reference checking) has largely been a human resource function. This is not a difficult task for New Zealand-qualified practitioners, but can be more complex for organisations employing overseas-trained practitioners. Currently, verification of documentation by public hospitals is not standardised and is sometimes superficial, particularly in areas outside training and qualification requirements. The Medical Council is improving processes and audit of initial verification of qualifications and experience so that local verification by hospitals of this information should not be necessary.

Most organisations ask practitioners to sign a declaration on the understanding that providing false information invalidates their employment contract. Three additional requirements are considered reasonable for all health professionals on employment.

1. **Health status**

A clause could be added to the employment contract giving the employer the right to require a health check:

- at any time, should there be cause for concern
- as part of the recredentialling process.

2. **Cultural competence**

This requirement needs to consider:

- the requirement that practitioners employed understand their responsibilities as health care providers for Māori under the Treaty of Waitangi, the cultural expectations of Māori consumers, and an ability to provide culturally safe and culturally effective health services for Māori
• a more general understanding about New Zealand society, particularly for practitioners trained overseas which in addition requires:
  – the ability to communicate effectively in English
  – an understanding of gender expectations of health-care delivery systems in New Zealand, such as the rights of women to make independent decisions about their health and welfare
  – the general perspective of New Zealanders with regard to the sanctity of life.

These cultural requirements can create problems for practitioners trained overseas. A more realistic approach may be to assess competence in these areas and require specific organisational orientation based on this assessment. Subsequent acceptable cultural behavior may be considered a condition of ongoing employment, with a review timeframe agreed on appointment. It is expected that DHBs will include public participation when developing local hospital orientation programmes.

3. Professional disciplinary and criminal record

The improvements currently being implemented in the verification processes by the Medical Council of New Zealand for overseas-trained practitioners should provide sufficient confidence for this process to be accepted by hospitals without further checking. For those with a practice history in New Zealand, the Medical Council of New Zealand Register will indicate if a practitioner has any conditions on their annual practising certificate or on their registration. The employer should also check with the applicant whether they have had any disciplinary action taken against them or have outstanding complaints about their practice or competence, including proceedings managed by the Health and Disability Commissioner.

Matters such as a complaint under investigation may not be a reason to decline employment, but should be checked. With regard to criminal record, all health workers with responsibility for patient care should be checked to ensure they have no work-related record, particularly in areas where patients are especially vulnerable, such as the elderly, children and those with mental illness. However, the employer cannot access such records as of right and must provide the practitioner with justification for requesting a criminal record check and obtain their consent.

Initial credentialling of existing employees

When introducing credentialling in an organisation it is usual to credential the entire service; that is, the work the service is contracted to perform, facilities and staff supporting the service, and the individual practitioners employed.

For practitioners already employed, this review should include:

• review (or development) of a written job description
• verification of registration status and any oversight requirements
• review of clinical quality data available such as that outlined in section 5.3
• health status review
• notification of any outstanding disciplinary action or unresolved complaints.

Verification of credentials is the first step in the process of credentialling a practitioner, much of which should be carried out by the Medical Council. However, it is the responsibility of the employer to assess the information provided to ensure the practitioner has the necessary qualifications,
experience, skill, registration status and scope of practice to meet the needs of the organisation. These needs include the service the organisation is funded to provide, the skill mix of the team and the facilities and support available. This process is described in the credentialling framework as Step 2 which will be looked at next.

5.2 Step 2: Determination of scope of practice on appointment

‘Scope of practice’ in the context of credentialling is organisation-specific. It determines what the practitioner will do in the organisation, at the current time, given a specific set of circumstances. Decisions about scope of clinical practice are based on professional judgement. The Chief Executive delegates this task to the credentials committee.

Scope of practice for a new appointment should be reviewed at the end of the first year of employment and thereafter at least every five years.

Determining scope of practice for a new appointment

Determining scope of practice for a new appointment is based on the following criteria:

• acceptance that the verified documentation provided by the practitioner meets requirements detailed in the position description
• further detailed investigation, as required, including reference checks, evidence of competence (such as log book, outcome data), interpersonal skills and ‘fit’ with the skill mix of the existing team
• agreement with the practitioner regarding the scope of practice to be undertaken between the period of appointment and the next review date
• if required, determination of any conditions, including preceptorship requirements, for a probationary period (if a probationary period is agreed, the purpose, length and evaluation of probation should be documented)
• agreement with the practitioner on the terms of appointment in relation to ongoing credentialling (review of scope of practice).

Determining scope of practice for current employees when introducing credentialling

For a practitioner currently employed, definition of scope of practice requires:

• peer and self-review of specific skills related to the area of current practice.
• written agreement as to the ongoing scope of practice.
5.3 Step 3: Ongoing data collection to monitor professional practice and information for recredentialling

In general, the tasks of Step 3 are managed within the service or department using agreed policies and procedures, as part of the service clinical quality improvement programme. The credentials committee may become involved prior to planned recredentialling where:

- a pattern of impaired performance becomes evident and a formal review is required (if the outcome of this review indicates a competence issue, it is no longer credentialling but becomes a disciplinary matter)
- a mismatch develops between the work the service is required to do and the adequacy of the facilities/support provided
- the service or an individual practitioner is considering a new procedure or service where credentialling will be required (this is a separate process from the requirement for regional and local ethics committee approval for a new procedure).

Depending on the specialty, the medical college or specialist society may have very specific criteria for ongoing competence, and the process by which such judgements are made. A good example is The Royal Australasian College of Surgeons’ Credentials Committees, Surgical Appointments and Complaints Procedures (RACS 2000) Therefore, specialty and individual hospital requirements will jointly shape local service policy. Local policy should include the information to be used for recredentialling and the process of access to the credentials committee. This policy should be agreed by practitioners and the organisation, provided in writing, and may include a requirement for:

- peer review
- clinical audit
- record of clinical activity
- patient satisfaction in professional interaction and clinical service provision
- complaints and incident reporting
- feedback from other health professionals
- relevant continuing medical education, postgraduate study, teaching and research.

This information might also be used for initial credentialling of existing employees when credentialling is introduced to an organisation.

5.4 Step 4: Formal credentials review (recredentialling)

The formal credentialling review provides a mechanism for the practitioner to reflect on clinical practice since the last review and, in this light, agree with the credentials committee the future scope of practice in this organisation. It should be viewed as a ‘stock take’ in the ongoing clinical quality management programme. Hospitals should have a formal recredentialling process as part of their organisational credentialling system, managed by a credentials committee. A formal review of credentialled status should be held at least every five years.
Hospitals are responsible for ensuring that quality assurance tools such as clinical indicators and audit are valid and reliable, and are subject to ongoing review. The development, implementation and ongoing review of quality assurance tools are time consuming. Where these tools are not already in place, hospitals may need to prioritise this development.

**Service credentialling**

A review of the service in which the practitioner works provides the context for individual recredentialling. The service should therefore be reviewed concurrently with practitioners, and recommendations made for improvements that would maintain or improve the ability of practitioners to undertake their credentialled role. At the least this should consider:

- the clinical work the unit is funded to provide
- the adequacy of facilities
- the composition and skill level of the clinical team, including other health professionals
- practitioner workload
- service outcome data, including patient satisfaction and performance to contract
- associated clinical activities such as teaching and research
- clinical quality assurance processes.

**Practitioner recredentialling**

The format for individual practitioners should include a review of:

- training and experience gained since the last review, including medical college or specialist society requirements
- registration status, including any conditions of registration status or annual practising certificate
- health status
- any adverse professional or criminal record
- clinical activity, including volumes and outcomes
- other relevant information, such as complaints, patient satisfaction, accrued leave
- current scope of practice and future aspirations.

Hospitals should provide the opportunity for and actively encourage self-review of clinical practice, clinical audit and peer review. Where there are insufficient practitioners to engage in effective audit and peer review locally, it is the responsibility of the employer to ensure that practitioners have alternative opportunities.
Interim review process

A separate process should allow for interim review of a practitioner’s scope of practice. This may be required by the:

- practitioner
- senior medical officer medical director/advisor or clinical leader
- Chief Executive, either independently or in response to a request from a central agency
- agreed process (for example, at the end of the first year of employment).

5.5 Appeals process

A documented appeals process is an essential element of the credentialling framework. This is discussed in detail in Section 8.

5.6 Relationship with external stakeholders

The role of stakeholders in the credentialling process is outlined in Section 3, Table 1, and is further described in the following section dealing with the credentials committee. The relationship between hospital and external stakeholders in initial credentialling (Steps 1 and 2) and the formal review of credentials or recredentialling process (Steps 3 and 4) are outlined in Figures 5 and 6.

Figure 5: Steps 1 and 2 – initial credentialling process on appointment
5.7 Visiting specialists and temporary appointments

**Short-term appointments**

This document does not specifically address the credentialling of locums. However, each hospital’s credentialling system for senior medical officers must describe local policy for the management of senior practitioners where the timeframe of tenure is less than that of the credentialling cycle. The credentialling process for an individual practitioner will depend on the urgency of the appointment and his or her credentialling history in the organisation. The appointment process may need to be fast tracked because of service need. The credentialling outcome in this case may need to include mentoring and initial supervision because of the lack of information on which to base scope-of-practice decisions at the time of the appointment.

**Visiting specialists**

Visiting specialists to the organisation should also be credentialled. Where the visiting specialist is not a public hospital employee, the credentials committee would be expected to undertake the four steps of the credentialling process with the same rigour as for an employee. However, where the specialist is a public hospital employee elsewhere, the two organisations and the practitioner would be expected to confer.
The organisation begins by reviewing the credentialling process employed by the first hospital and, provided it meets the essential components of its own methods, it would be normal to accept the outcome. The focus of discussion would then be on the facilities and support provided by the organisation visited. However, the ultimate responsibility for credentialling rests with the organisation deemed to be responsible for the practitioner.

5.8 Summary

The ‘Four-step’ credentialling process forms the basis of the credentialling framework for senior medical officers in public hospitals. This framework identifies the process for permanent appointees. A process should be documented to accommodate senior medical officers outside this classification, such as locum appointments and visiting medical practitioners. The following key points identify the elements that should be evident in any regional adaptation of this framework.

- The Chief Executive is responsible for ensuring that a robust credentialling system operates in the organisation, including a documented process for appeal.
- The tasks of credentialling are delegated by the Chief Executive to a committee comprised primarily of senior medical officers.
- This process is documented, agreed by practitioners and subject to audit.
- Practitioners engaged in credentialling activities in good faith should be protected, and the data generated by the credentialling process should be kept in confidence.
- The outcome of the credentialling process should be in the public domain, and appropriately annotated where a practitioner’s scope of practice is limited due to organisational circumstances.
- The role of public representation in the design and operation of the credentialling process should be evident and demonstrate progress towards the inclusion of independent public representation on credentials committees.

The following table summarises the four steps of the credentialling process.

Table 3: Summary of the ‘Four-step’ credentialling process for senior medical officers

<table>
<thead>
<tr>
<th>Step</th>
<th>Requirement of credentialling framework</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Verification of qualifications, training, experience and registration status</td>
<td>A clear position description is provided that identifies training, qualifications and experience required for the position offered. The ongoing credentialling process includes a review of training, qualifications and experience.</td>
<td>Verification at source is the ultimate guarantee of authenticity. Medical Council verification quality standard should be acceptable to employers. Once verified, qualification and training details should be held in a central database for subsequent employer access. Reference checking is an employer activity. Training, qualifications and experience and registration status are dynamic criteria. Central database requires regular update.</td>
</tr>
<tr>
<td></td>
<td>Determining the scope of practice on appointment</td>
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<tr>
<td>2</td>
<td>The organisational scope of practice is defined in writing. Preceptorship may be a requirement of appointment during the orientation period, where this is appropriate, while the practitioner establishes a clinical track record in the organisation.</td>
<td>Scope of practice decisions takes into account the competence of the practitioner; the facilities and support available, and the current needs of the organisation. Scope of practice in the context of credentialling is organisation-specific. For a senior medical officer it is most likely to be defined as the area of clinical practice for which the practitioner has the appropriate training, qualifications and experience, identifying any services that cannot be undertaken in this organisation. The scope of practice is reviewed as part of the ongoing credentialling process.</td>
</tr>
<tr>
<td>3</td>
<td>Each service identifies the quality assurance data to be collected and the process of ongoing monitoring of clinical competence. Written policy specifies the role of the credentials committee where: • a trend of declining performance is evident, necessitating a formal review outside planned service recredentialling • a mismatch develops between the work the service is funded to do and the adequacy of the facilities and support provided • the service or an individual practitioner is considering a new procedure/service where credentialling will be required • an interim review is requested Competence monitoring of short-term appointments is specified where tenure will end before formal recredentialling occurs.</td>
<td>The appropriate medical college or specialist society recommendations and the needs of the organisation will influence information requirements. These should include ongoing monitoring and accumulation of information for recredentialling in the following areas: • clinical audit • peer review • record of clinical activity • patient satisfaction • continuing medical education, post graduate study, teaching and research.</td>
</tr>
<tr>
<td>4</td>
<td>A formal review of practitioner credentials (credentialling) within the context of the service in which the practitioner is employed should occur at least every five years. Membership of the credentials committee must include specialty expertise from outside the organisation. A documented appeal process should be managed independently of the credentials committee.</td>
<td>This includes feedback from other health professionals within the service and patients regarding the practitioner’s technical and interpersonal skill related to the scope of practice. This requirement assists in achieving objectivity of assessment, particularly in smaller services, and maintenance of national standards.</td>
</tr>
</tbody>
</table>
Section 6: Credentials Committees

The decisions made by credentials committees require peer practitioner expertise. The Chief Executive delegates this task to committees comprising a majority of peer practitioners and governed by written terms of reference. In this capacity practitioners are using their professional knowledge as an employee of the organisation (or as a contracted consultant; a practitioner external to the organisation with specialty-specific expertise, who is seconded to the committee). The relationship between the credentials committee and other medical and non-medical management groups should be explicit. The structure of the credentials committee will vary between organisations according to need. However, the Chief Executive should remain independent from the deliberations of credentialling committees to ensure that the management of the appeals process is kept separate.

6.1 Responsibilities of credentials committees

Three principles underpin the operation of credentials committees:

- **patient protection** through the development of a process that is comprehensive, quality based and sufficiently transparent to promote public confidence.

- **protection of practitioners** by ensuring that the process is focused on practitioner development; considers due process and equal protection; and that the level of confidentiality of information is agreed and assured.

- **employer protection** through the management and ongoing review of the work of the credentials committee, at a level of transparency to provide the Chief Executive with assurance that the system protects patients, practitioners and the wider organisation.

In support of these principles, credentials committees are responsible for:

- verifying an applicant’s training and qualifications and making the necessary enquiries to ensure that their experience and skill support the scope of practice required for the position

- recommending the initial scope of practice on appointment, together with any conditions that should be imposed (these may include a preceptorship requirement and initial review timeframe).

- managing the ongoing review of credentials for all senior medical officers for the duration of their employment (this includes oversight of ongoing service competence monitoring, collection of information for credentialling, and the formal review of credentials at least every five years).

6.2 Credentials committee membership

Credentials committees are made up of a majority of peer practitioners, and have the power to co-opt members to meet specialty-specific requirements. The role of medical colleges and specialist societies must be developed with each organisation to ensure national consistency of processes and criteria within specialist areas of clinical practice. Where the committee is wholly made up of practitioners, there is a responsibility to ensure that information from consumers and other health professionals is sought and considered, and that the process is sufficiently transparent to promote public confidence.
Committees employed 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 medical college may be asked to nominate this person).

In addition:

- organisations should develop strategies for public representation
- where a member of the service under review is included on a credentials committee, the reason for the appointment must be made clear and be accepted by practitioners under review.

### 6.3 Functional relationships

#### Relationship with practitioners

Practitioner confidence in the process is essential. For this reason a credentialling process cannot be imposed without consultation. Each organisation will need to work to accommodate the specific needs and constraints of the organisation within the proposed framework. A *quality improvement* approach that is equally focused on practitioners and the service in which they work, together with a documented data management and appeals process, are considered key elements to promoting active practitioner participation.

#### Relationship with the Chief Executive and service management

This relationship must be specified in the terms of reference and may vary between organisations. The degree of transparency must be sufficient to reassure the Chief Executive, who is ultimately responsible to the DHB for the actions of employees, that clinical quality and risk are being appropriately safeguarded.

#### Relationship with other health providers

In some circumstances collaboration between providers in the form of regional credentialling may be possible. However, it remains the responsibility of the Chief Executive to ensure that practitioners are appropriately credentialled to their organisation. A national database of the credentialled status of practitioners in specific organisations would overcome the current problem of managing situations where a practitioner has their scope of practice reduced in one organisation through incompetence, yet continues to perform these procedures in another organisation. In these cases it would be imperative to annotate areas of practice where the individual is deemed competent, but which are outside the scope of practice in a particular organisation due to organisational constraints (such as lack of appropriate facilities or funding).

#### Relationship with medical colleges and specialist societies

These groups play a pivotal role in recommending to the Medical Council the training, qualifications and conditions required for specialty practice and ongoing competence. In addition, practitioners within public hospitals will call on these organisations for assistance in aspects of credentialling, such as appointment of external reviewers and expert advice in the case of an appeal.
**Relationship with Medical Council of New Zealand**

The Medical Council has statutory responsibility for the registration of practitioners in New Zealand. Possibilities for an expanded role for the Council are discussed in Section 7. These include the management of a national credentialling database.

**Relationship with the public**

Since the purpose of credentialling is to protect patients, providing appropriate information to enable patients to make informed decisions and taking account of feedback from the public must be considered a basic responsibility of the credentials committee. The credentialling process cannot be viewed in isolation from other quality assurance processes. Practitioners and managers will need to determine within their organisation the ways in which the community can be assured that the interests of patients in their service are considered, including their responsibility toward Māori under the Treaty of Waitangi. This will include the way in which patients are informed about the credentialled status of a practitioner, and the linkage between credentialling and other consumer-based quality assurance processes such as patient satisfaction surveys and complaint management. Section 9 of this document discusses in more detail the need for a consumer perspective, and describes some ways in which public representation could be used in the credentialling processes.
There is some lack of clarity over the protection currently available to practitioners engaging in credentialling activities under Part VI of the Medical Practitioners Act 1995. This issue is expected to be resolved with the introduction of the Health Professionals Competency Assurance Bill.

Clearly there is a need to protect practitioners, but there is also a need to balance this requirement with what is considered the ‘public good’. Throughout this document a number of comments are made about information reporting and management that can be summarised in the following principles.

• 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 is necessary to encourage practitioners to engage in aspects of the credentialling process. This protection should be afforded to all health professionals.

• It is a professional responsibility to report competence issues, both personal and peer related.

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

• The task of credentialling in public hospitals is delegated to senior practitioners, who deal with detailed and personalised credentialling information. Policies and procedures must be developed to manage this data, including storage, identifying who will access the information and for what purpose, and how long information is to be retained.

• The accountability for ensuring that senior medical officers employed by a DHB are competent to practise in the setting provided ultimately rests with the Chief Executive, reporting to the board. For this reason, the credentialling system must provide process transparency to assure the Chief Executive that this accountability is being met.

• One of the purposes of a central database is to store and update the credentialled status of senior medical officers employed in public hospitals.

7.1 Management of credentialling information within the organisation

Organisational policy for the management of information derived from the credentialling process should be provided in writing to practitioners. This should include:

• the information that is kept on file
• the manner in which it 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 to be made available to public/patients.

The Chief Executive should receive a quarterly credentialling report. In addition, the organisation should retain a register of credentialled practitioners and keep on file copies of individual service credentialling formats.
7.2 Potential role for central agency

One of the recommendations of the 1999 HFA credentialling report was to clarify the role of a central agency in the credentialling process. This recommendation developed from comments made by medical and non-medical staff in public hospitals indicating that there was a need for:

- improved processes to verify the qualifications of practitioners on appointment
- some standardisation of credentialling processes to provide patients with better information about practitioners and thereby improve public confidence in the health system.

Three tasks could be managed by a central agency:

1. verification of training, qualifications and experience of practitioners (Step 1 of the ‘Four-step’ credentialling process)
2. management of a central practitioner database, including verified credentials, employing organisation/s and current scope of practice in each (tasks would include developing levels of access, including public information; data quality and confidentiality; and the relationship with individual practitioners)
3. oversight of the development of credentialling systems in public hospitals to ensure national standards.

Medical Council of New Zealand as a preferred provider of some central agency services

The majority of those consulted in 1999 saw the Medical Council as their choice of organisation to carry out tasks 1 and 2 (above). The main reason given was that the Council is the body that registers practitioners and has a verification process in place. In developing these tasks, the Medical Council may provide a template for future development in other professions where credentialling is being considered.

The organisation best suited to carry out the third task of a central agency – oversight national credentialling standards – is less clear. Credentialling is just one part of a wider quality and risk management framework required by hospitals to protect patients. Monitoring of credentialling will therefore require specialist medical input within the broader context of Health and Disability Sector Standard monitoring.
Section 8: The Appeals Process

A change to a practitioner’s scope of practice in an organisation has the potential to influence livelihood, reputation and job satisfaction. A practitioner wishing to challenge the decision of the credentials committee must be given access to due process that is clearly specified by the organisation. Usually this will take the form of a hearing, the purpose of which is to ensure that the practitioner is being treated fairly and without prejudice, and has the opportunity to challenge the decision of the credentials committee and present any relevant new evidence.

When scope of practice is reduced due to a competence issue, the employing organisation has the responsibility to offer retraining where appropriate. However, where the credentialling decision is adverse to the wishes of the practitioner, a process must be available to challenge the decision. In reality the appeals procedure should be rarely required if step 3 of the ‘Four-step’ credentialling framework is fully implemented. Ongoing service quality assurance activities should identify and remedy a developing pattern of poor performance so that the formal recredentialling process presents no surprises.

8.1 Grounds for appeal

A practitioner who has had credentialled status denied, withdrawn or limited has the right to appeal. The grounds for appeal in an organisation should be explicit and documented. These may include:

- failure of the credentials committee to comply with the agreed processes
- failure of the credentials committee to consider written or oral evidence submitted
- the opportunity for the appellant to comment on the report and findings against the weight of evidence
- the opportunity for the appellant to submit new evidence
- an avenue for the appellant to contest the scope of practice recommended by the credentials committee on the basis that organisational facilities and support are inadequate to ensure patient safety.

8.2 Documentation of the appeal process

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

- person to whom the appeal should be addressed
- scope of the appeal process
- timeframes for lodging an appeal and the completion of the appeal process
- rights of the appellant
- process if the outcome of the appeal continues to be disputed by the appellant.

8.3 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.
8.4 Process of the appeal

Where alternatives are available to a formal hearing, these should be stated. For example, in some organisations the credentials committee can be asked to reconsider its decision within a given timeframe. Where the outcome of this process continues to be disputed by the practitioner, a formal hearing may be requested.

A formal hearing requires the constitution of an appeals panel made up of practitioners, and governed by written terms of reference. It is generally accepted that one member of the panel will 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.

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

A timely resolution of an appeal is in the interests of both parties. DHB policy must define the timeframe for lodging an appeal, after which the decision of the credentials committee is considered binding. Appeals should be lodged in writing stating the grounds on which the appeal is based. The recommended timeframe is within 30 days from the receipt of notification of the adverse credentialling decision.

Local policy should also provide a timeframe in which the appeal hearing will be held and the timeframe in which the appellant will receive notification of the appeal panel decision. Similarly, under normal circumstances the appeal hearing and communication of the decision of the appeal panel to the appellant should be completed within 30 days.

8.6 Rights of the appellant

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

8.7 Disputing the outcome of the appeal

The sequence of events whereby the practitioner disputes the outcome of the appeal must be clearly documented. This may require an external review by the appropriate medical college or specialist society. 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.

8.8 Summary

A focus on patient care, objective professional standards and attention to the activities of step 3 of the ‘Four-step’ credentialling process provide the basis for a safe credentialling system, where recourse to an appeals process should seldom be required. However, a documented appeals process is an essential component of the credentialling framework.
Section 9: Public Input

The primary purpose of activities to assess and monitor the competence of practitioners, such as employer credentialling, is to promote patient safety and improve public confidence in the health system. Yet, to date, apart from mental health services, the public has not been effectively used in public health services to comment on the elements of practitioner performance that impact on patients’ perception of the care they receive. Historically there have been a number of reasons for this, including:

• medical quality management has been regarded as the ‘business’ of the medical profession with little consideration being given to what the public could offer
• concern that public representatives are at risk of ‘capture’, either by the organisation or by single-issue consumer groups
• lack of cohesion among health consumer groups nationally.

Organisational readiness and the availability of appropriate consumer input will be a key factors in the successful introduction of public participation in credentialling. Organisational readiness includes not only the degree to which practitioners are committed to clinical quality improvement and have experience in credentialling, but also the degree to which the wider organisation involves public input in quality system development and monitoring.

The New Zealand Health Strategy (King 2000) requires greater involvement of consumers in healthcare planning and quality assurance. However, this cannot be imposed on the organisation. To be meaningful, public input must be recognised by practitioners and managers as a perspective that adds value to the quality improvement process. In developing the credentialling framework the working party spent considerable time and energy debating the concept of public participation. Over this period the group moved from a position of widely divergent views to one of consensus. It is expected that organisations will also need to take this journey. Therefore, the national credentialling framework requires that public hospitals demonstrate both the degree to which the public currently have impact on the credentialling process, and progressive development in public participation over time.

In this section the concept of public participation in the credentialling process is considered in more detail.

9.1 The case for public participation in credentialling

In recent times there have been a number of major enquiries and reports about the medical treatment of patients in New Zealand. These contain the common themes of compromised patient safety, the need for change, blame, mistrust, and punishment of ‘wrongdoers’. Responses to these reports have included legislation, such as the Health and Disability Commissioner Act 1994, and increasing patch protection by both consumers and practitioners. The tendency historically to apportion blame to a practitioner ignores the fact that most medical errors owe more to organisational systems failure than to practitioner incompetence (Reason 1990). These responses have not always been helpful in encouraging practitioner self-review and improvement in clinical competence.
The New Zealand Health Strategy (King 2000) aims to improve public confidence in the New Zealand public health system. The strategy states the need for a ‘high performing system’ in which people have ‘confidence’ and which involves ‘active involvement of consumers and communities at all levels’. These principles introduce a new emphasis on public confidence and public participation in health care provision and have application for employer credentialling.

The Clinical Audit Committee of the British Medical Association suggests that public involvement in health care can occur at three levels (BMA Online 2000):

1. appointed independent ‘professional’ public representation
2. representative of specialised consumer groups, such as those for specific health problems and for gender, age, culture and disability specific groups
3. patients with experience of the service, both individually or through user focus groups and patient satisfaction surveys.

Table 4 at the end of this chapter suggests some ways in which public representation could be usefully applied in wider credentialling issues using the three levels of public involvement outlined above.

The degree of practitioner and organisational concern about public involvement in medical quality management suggests that public involvement may be one of the most difficult aspects of the credentialling framework to achieve. While the Working Party accepts that public involvement may need to be introduced in stages to achieve practitioner acceptance, it is agreed that the medical profession should address the role of public in credentialling for these reasons:

- public participation can enhance the process of medical quality improvement, particularly where such a role is defined and understood by all parties
- public participation provides a mechanism to reassure the community that their interests are being considered in the management of clinical quality.

### 9.2 Defining public participation in credentialling processes

Public participation in credentialling should occur at a number of levels, from consultation in process development to participation in credentialling decisions, through to membership on the credentials committee.

As we have seen, there is a need for organisations to clarify the relationship between employee performance appraisal and credentialling activities (see Table 2). Clarification of the role of public participation in both processes is necessary if public input is to be used in a way that is appropriate and acceptable to all parties.

The public has views about general behaviours related to practitioners, other staff, patients, families, whānau, and the organisation. These views could form part of the annual performance appraisal framework for all hospital staff. Equally, this perspective could provide guidance for the interpersonal component of the appointment process and credentialling. Credentialling generally has a narrower focus: it is specific to clinical competence. However, in this context there are behaviours such as the communication between practitioner, patient and their family or whānau, and issues such as continuity of care, that are specifically related to clinical competence. The credentials committee manages this assessment. The current patient satisfaction survey methodology may provide some information for credentialling, but feedback about an individual practitioner is most likely to come through the patient
complaint system. Independent public representation on credentials committees provides a way to strengthen public input into the credentialling process.

The pace with which direct public participation is implemented will depend on a number of factors, including:

- the stage of development of the senior medical officer credentialling process
- practitioner acceptance of the process
- development of public participation in other areas of the organisation.

9.3 Achieving public representation on credentials committees

The advent of DHBs and the election of Board members by the community provides a clear signal that increased public participation is required. This level of participation may require some changes in the day-to-day operation of public hospitals. At present there is no broad health consumer organisation in New Zealand such as exists in Australia. We have a large number of groups each representing a single health interest and these are not necessarily able to reflect a broader perspective in health care. While such issues may impede public involvement in credentialling, hospitals should consider the inclusion of a member of the public on their credentialling committees as soon as is practicable. The following section provides some guidance for the appointment and management of an independent public representative on a credentials committee.

Independent public representation on credentials committees

Public representatives on credentials committees must be appropriately appointed and supported. The following principles should govern this process. Candidates should:

- have no alliance with a particular interest group (hospital or community based) so that they can provide a ‘global’ consumer perspective
- be familiar with the non-disclosure provisions of the Medical Practitioners Act 1995, Part VI
- have the ability to network with local consumer groups
- be appointed through a transparent process
- have a specific term of appointment
- receive initial training and ongoing support at a national or regional level
- have a clear position description, including reporting structure, and performance appraisal
- receive remuneration for services provided.

Independent public representative: appointment process

The appointment of an independent public representative requires a formal process that is transparent to practitioners and the wider community. The appointment panel for such a position must include practitioners, and organisations should ensure that the selection process is designed to reduce the risk of the person being unduly influenced by the credentialling organisation or by single-issue consumer groups.
**Independent public representative: accountability**

Public representatives of credentials committees should be available to the community and consult with appropriate consumer organisations. In addition, and most importantly, they should share the same accountability and liability as practitioner members of the credentials committee with regard to the disclosure of information.

### 9.4 Summary

The following table summarises some ways in which public participation could be used in credentialling.

#### Table 4: Opportunities for public representation in credentialling

<table>
<thead>
<tr>
<th>Step of credentialling process</th>
<th>Opportunities for public participation</th>
<th>Type of involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial credentialling on appointment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 1:</strong> Verification of credentials</td>
<td></td>
<td></td>
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</tbody>
</table>
|  | **Job description development:** Hospital human resources staff use public input to develop key performance indicators for all health professionals employed related to:  
  - communication skill  
  - cultural competence  
  - quality of information provided to patient/family/whânau. | **Indirect public involvement:**  
  - independent public representative  
  - Māori/specific patient group consultation  
  - patient focus groups. |
|  | **Appointment interview for senior medical officers:** For some practitioners outside New Zealand, this may require teleconferencing or televideo facilities. Consumers have the potential to provide a valid, important and unique perspective on matters related to communication skill and culture. | **Direct public involvement:**  
  - independent public representation  
  - representative of Māori or other specific patient group  
  - existing process within the Medical Council of New Zealand. |
| **STEP 2:** Definition of initial scope of practice |  | |
|  | **Preceptorship requirements:** A role in suggesting ways for an otherwise appropriate practitioner to improve aspects of interpersonal skill. | **Direct public involvement:**  
  - independent public representative  
  - representative of a specific patient group on advice of independent public representative. |
|  | **Information to be made available to patients:** Involvement in generic decision-making process as to how information arising from the initial credentialling process should be made available to patients. | **Indirect public involvement:**  
  - as above. |
<table>
<thead>
<tr>
<th><strong>Ongoing credentialling</strong></th>
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<tbody>
<tr>
<td><strong>STEP 3:</strong> Review of credentials</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Role on credentials committee</strong></th>
<th><strong>Direct public involvement:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The appointed public representative provides a perspective on patient feedback, either involving the service or a named practitioner, and assists in decision-making around recommendations for development in this area.</td>
<td>independent public representative.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Information to be made available to patients:</strong></th>
<th><strong>Indirect public involvement:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>be involved in generic decision-making process as to what information arising from the recredentialling process will be made available to consumers and how.</td>
<td>independent public representative</td>
</tr>
<tr>
<td></td>
<td>representative of a specific patient group on advice of independent public representative</td>
</tr>
<tr>
<td></td>
<td>patient focus groups.</td>
</tr>
</tbody>
</table>
Section 10: Implementing and Resourcing Local Credentialling Policies

The New Zealand Health Strategy directs public health care providers to focus on improving the quality of health care and health outcomes for patients. It also outlines what the public can expect from the health system in terms of consultation and assurance of the quality of services provided. Credentialling will assist in achieving these objectives.

The development of a national framework for credentialling senior medical officers in New Zealand is an initiative that was requested by Hospitals and Health Services in the 1999 HFA credentialling study. This request has been supported and co-ordinated by the central agencies, initially by the HFA and now by the Ministry of Health.

Each public hospital is required to develop and progressively implement a system to credential senior medical officers consistent with this framework, and to develop documented policies and procedures to be implemented by June 2002. While some resources will be made available to assist in this process, the responsibility lies with the DHBs. The credentialling framework provides a structure that allows for adaptation to meet local requirements. This ability to develop local policy was requested by practitioners and managers and supported by the working party. However, policy development can be time- and resource-intensive, often requiring broader debate on organisational philosophy in such areas as the relationship between practitioners and managers, the role of the public and the place of quality improvement in service provision. These issues are much broader than credentialling.

10.1 Each organisation needs a credentialling ‘champion’

Practitioner commitment is a crucial part of developing a credentialling processes. The key to this process is to appoint a senior clinician who is a well-informed advocate of credentialling, and has the support of other senior medical officers, to ‘champion’ the process. In some organisations this person stands out; in others the selection process is more difficult. One of the strategies of the National Learning Programme described later in this section will be to assist organisations where developing a process to date has been thwarted by lack of a credentialling champion.

10.2 Senior medical officer commitment

This equally important second step is usually facilitated through a series of meetings during which senior medical staff learn more about the process and have the opportunity to raise their concerns. Credentialling is a relatively new concept in New Zealand and lack of knowledge and misinformation are counterproductive to developing practitioner support. An understanding of the credentialling framework and the identification of local needs will be key elements of such meetings.
10.3 Partnership with managers

The Chief Executive is responsible for ensuring an effective credentialling system is in place, but the task is delegated to senior medical staff in the organisation. A partnership with managers is evidenced by:

• prioritisation of credentialling development in organisational quality and risk planning
• demonstrable interest and support by managers
• adequate resourcing to facilitate credentialling development.

10.4 Public input

Discussion about public input should start early and may need to be implemented gradually. For some practitioners, discussion about the consumer role in improving the quality of their practice may be a new experience. This will be even more difficult if there is no overt public input in the organisation. The new DHB structure requires greater public input. Managers can assist this process by promoting organization-wide discussion and planning regarding the future role of consumers in their organisation.

10.5 Resources to assist in credentialling process development

The working party identified five areas that may require central agency support:

1. services employing few practitioners, such as small non-metropolitan hospitals and highly specialised units within larger organisations, where the critical mass of practitioners is insufficient to support the activities of credentialling
2. hospitals with no credentialling process planned, or those in the very early stages of development where achieving the Ministry of Health requirement to have a process in place by June 2002 may be difficult to achieve
3. lack of appropriate leadership to champion credentialling development, identified as a key requirement for a successful outcome
4. the need to expand the Medical Council ability, for initial verification of qualifications and experience; and databank capability
5. the requirement for public participation in credentialling, which will require considerable support, particularly the concept of direct involvement through independent public participation on credentials committees.

This section outlines the resources that are to be made available over the next year as part of a National Learning Programme to assist public hospitals to have a credentialling process in operation by June 2002.
10.6 Targeted support

Local issues

These issues include services employing few practitioners, organisations in the early stages of credentialling development, and organisations where lack of credentialling leadership is slowing the development process. A series of regional meetings will be organised during March and April 2001 to identify local issues and promote regional collaboration where this is appropriate. Assistance will be decided on a case-by-case basis.

Developing documentation

The documentation provided by some of the eight DHBs that have credentialled at least one service in New Zealand show greater similarities now than two years ago. This is not unexpected, and reflects a new environment where collaboration between organisations is actively encouraged. It was originally intended to present current DHB documents as appendices. This has not been done, for reasons that include the degree of duplication in forms currently in use and the potential problems that arise when such information is taken out of context. Instead, Appendix C provides a list of contact persons from organisations that have implemented credentialling in at least one service, who are prepared to discuss their experience with credentialling to date and share their documentation.

Medical Council of New Zealand

The Medical Council of New Zealand will continue to refine its system to manage the initial verification of qualifications and experience of practitioners applying for registration in New Zealand, and will increase random audit to monitor the quality of this system. In addition, the Council will need to determine the longer-term requirements of a national database, including storage of credentialling outcome data and levels of access to this information. The Ministry of Health has made a commitment to support this project.

Public participation

Increased public participation in health care planning and provision is a key message of the New Zealand Health Strategy. The will necessitate the development of a closer relationship between DHBs and their local communities. The work has already started. Central resources will be targeted to promote the development of public participation through the use of independent public representation. This is considered necessary for two reasons: it is not currently common practice to involve consumers at this level in public hospitals, and the large number of health consumer groups in New Zealand have no common linking organisation to represent their joint interests.

Sharing progress about credentialling development in DHBs

Over the next few months a series of newsletters will be produced to update the sector on national developments and provide a forum to address questions and comments as they arise. The circulation of this newsletter will include professional, provider and consumer groups outside the public sector.
10.7 Conclusion

The framework for the credentialling of senior medical officers in public hospitals provides a template for credentialling. DHBs will use this framework to develop local policy. A key message to all DHBs is that for credentialling to succeed practitioners must accept and become actively involved in this process. This requires a partnership between practitioners and managers. It also requires organisational prioritisation of clinical quality improvement activities, of which credentialling is a part.

Implementation of credentialling in New Zealand has been described in this document as a ‘journey’. Some aspects of this journey will be more challenging for some organisations than for others. Nonetheless, the development of credentialling systems using this framework is a priority for all public hospitals. During this period resources will be made available to assist, but it is expected that apart from some external expertise, this work will be funded from existing DHB funding.
Glossary

Clinical audit  A systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome for the patient (NHS 1998a).

Clinical competence  The knowledge, skills, attitudes, communication and judgement necessary to perform in accordance with the registration category of the medical practitioner. Competence is what a practitioner is capable of doing, performance is what the practitioner does in day-to-day practice.

Clinical governance  This term is defined by the National Health Service in the UK as:

A framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (NHS 1999:6).

Continuing medical education (CME)  Defined by the Medical Council of New Zealand as including: all types of educational activities, undertaken after initial training, that medical practitioners participate in during the whole of their practising lives for the purpose of maintaining and improving their performance and clinical effectiveness.

Credentialling  A process used to assign specific clinical responsibilities (scope of practice) to health professionals on the basis of their training, qualifications, experience and current practice, within an organisational context. This context includes the facilities and support services available and the service the organisation is funded to provide. Credentialling is part of a wider organisational quality and risk management system designed primarily to protect the patient.

It is an employer responsibility with a professional focus that commences on appointment and continues throughout the period of employment.

Credentialled status  Refers to the current organisational scope of practice agreed in writing by practitioner and employer. For senior medical officers this will most likely be defined as the area of clinical practice for which the practitioner has the appropriate training, qualifications and experience, identifying any services that cannot be undertaken in this organisation. Credentialled status is organisation specific.

Credentialling framework  The following elements described in this document comprise the credentialling framework for senior medical officers:

- definition of credentialling; purpose and limitations (these link to the Health Professionals’ Competency Assurance Bill to provide a connection between professional and organisational scope of practice)
- the ‘Four-step’ credentialling process
- public representation
- information management whereby the outcome of credentialling is in the public domain, but the specific information upon which credentialling decisions are made is protected.
**Credentialling information**

Credentialling information refers to two types of data:

1. **Information collected as part of service quality improvement activities.**
   This information is therefore used for other purposes as well as credentialling and so is at least organisational knowledge.

2. **Information collected specifically to determine credentialled status.**
   This information would include credentialling committee meeting notes where individual practitioners could be identified and should be legally protected. DHBs are responsible for ensuring that policies and procedures are in place to protect this information.

**Credentialling outcome**

The outcome of the credentialling process is a statement defining the practitioner’s credentialled status in an organisation. This information should be in the public domain.

**Credentials**

Include a practitioner’s record of education, training and experience, professional registration and professional college membership. Verification of credentials is not limited to the examination of documents and may include any kind of pertinent information such as referee reports and professional disciplinary record. The objective of the verification of credentials is to ensure that the practitioner has the specialised background they claim to have and that the job description requires.

**Credentials committee**

Appointed by the Chief Executive to manage the credentialling process for the employing organisation. It is made up primarily of practitioners, and governed by written Terms of Reference. The committee has the ability to co-opt members to meet specialty-specific requirements.

**Cultural effectiveness** for Māori is used to indicate a requirement for awareness and responsiveness to Māori aspirations, Māori diversity, Māori participation in service delivery, cultural appropriateness in services, consultation, tribal authority, and Māori health planning (HFA 1995).

**Cultural expectations**

The following extract refers to mental health services, but can be applied to health services generally:

The differing cultural expectations of Māori consumers and Māori health service needs to be understood. The essential components of this are that Māori not only need to have … services provided for them, they need to be able to choose whether they use mainstream services, kaupapa Māori services, or both of these. The services they access must meet their needs and expectations, and strengthen their identity. To work effectively with Māori it is necessary to know and understand the components that contribute to their wellbeing. This includes knowing how Māori cultural identity is defined, and the values, beliefs and behaviours which are part of that identity (MHC 1998).

**Cultural safety**

for Māori means that providers will be sufficiently familiar with Māori beliefs, culture and values to eliminate the risk of inappropriate practices which cause offence or marginalise participation on cultural grounds (Durie 1994).
Economic credentialling

Economic credentialling is the use of economic criteria unrelated to quality of care or professional competency in determining a practitioner’s initial or ongoing scope of practice in a health care facility.

Economic credentialling is not:

- resource utilization, which is considered a desirable approach to encouraging the best use of scarce resources. The development of best practice protocols and clinical pathways based on medical research where the cost of health care is linked to outcome fall into this category
- employing a practitioner on the understanding that they will not use their full range of skills because the organisation is constrained by the type of work it is funded to do or the facilities available.

Economic credentialling is said to occur where:

- credentialled status is withheld based on criteria such as length of time in theatre or above average use of resources without consideration of outcomes
- peers make credentialling judgements that could potentially exclude a practitioner who is considered a competitor.

Fitness for practice

A doctor is not fit to practice medicine if, because of a mental or physical condition he or she:

- is unable to make safe judgements, or
- is unable to demonstrate the level of skill or knowledge required for safe practice, or
- behaves inappropriately, or
- risks infecting patients with whom she or he comes in contact, or
- acts or omits to act in ways that impact adversely on patient safety (Medical Council of New Zealand).

Fitness for registration

Includes:

- reasonable ability to communicate effectively in English, and
- no conviction by any court in New Zealand, or elsewhere of any offence punishable by a term of three months or longer, as long as the offence does not reflect adversely on fitness to practice
- no physical or mental condition that affects fitness to practice
- not subject to professional disciplinary hearing in New Zealand or any other country, and the nature of the proceedings or investigation does not reflect adversely on fitness to practice, and
- not subject to an order of the Medical Practitioners’ Disciplinary Tribunal or the Medical Council of New Zealand, or of any other medical organisation or similar tribunal in another country, and the order does not reflect adversely on fitness to practice medicine.
• adequacy of skills and knowledge to practice medicine
• Medical Council satisfaction of fitness to practice medicine.

In addition, a Certificate of Good Standing, issued within the last three months by the practitioner’s most recent registration authority which confirms their registration for the last two years must be provided before starting work. (Medical Practitioners Act 1995).

**Interpersonal skill**

The Medical Council of New Zealand defines interpersonal skill as:

*The ability to work with a wide range of people in different situations, and to develop and sustain effective relationships.*

**Peer review**

Review by colleagues of audit data for correlation and formulation of action programmes for education, practice modification and development of best practice models and protocols *(RACS Information Manual 2000)*.

**Privileging**

The term ‘privileging’ is used by some organisations to describe the process of deciding the credentialled status of a practitioner. However use of the term ‘privilege’ in New Zealand in this regard is not universally accepted. In this document the terms ‘credentialled status’ and ‘scope of practice’ are used instead.

**Recertification**

Defined by the Medical Council of New Zealand as:

*The mechanism in the Medical Practitioners Act 1995 for setting and recognising recertification programmes to ensure that doctors who hold vocational registration continue to be competent to practise that branch of medicine or special interest of that branch. It is a process by which the postgraduate professional body testifies to the competence of each of its members, a responsibility usually resting with the body that undertook the original training certification.*

**Scope of practice**

The term ‘scope of practice’ used in relation to credentialling refers to organisational scope of practice is defined in this document as:

*The service an individual practitioner can provide in the practice setting (includes location, co-workers, technology, and the service the organisation is funded to provide) and the practice period (the period between formal reviews).*

Organisational scope of practice is therefore likely to be more specific than the scope of practice defined by the professional registration body.

**Unit or service credentialling**

Unit credentialling considers the adequacy of facilities; staff and management to provide specific clinical services based on best practice guidelines.

**Vocational branch**

Defined by the Medical Council of New Zealand as:

*A branch of medicine that is recognised by the Medical Council for the purposes of vocational registration. To be recognised, a branch must have a defined body of knowledge and practice, fulfil a recognised health need, have a group of practitioners capable of providing an appropriate professional environment, an acceptable training programme and qualification, an acceptable recertification programme and a national body to report to Council.*
Vocational registration

Defined by the Medical Council of New Zealand as:

A category of registration available to doctors who hold general registration, have satisfied Council requirements for entry to the vocational register and who are competent to practice independently in that branch, subject to recertification. Entry to the vocational register requires successful completion of a training programme recognised by that branch.
Appendix A: Role and Operation of the Medical Credentialling Working Party

This project was sponsored by the Health Funding Authority and the Ministry of Health with oversight by Gillian Bohm, Senior Advisor, Quality Improvement and Audit, Personal Health. A working party was assembled in February 2000, and Robyn Woodward was appointed as project manager. The initial brief to the Working Party was to have no less than three formal meetings to debate issues, receive progress reports, and direct the ongoing activities of the project manager. It was expected that the group would meet between February and July 2000, but the number, timing and location of meetings was to be decided by the group. The membership of the Working Party was as follows:

- Dr Robert Logan, Chairman, Medical Advisors Group (Chair)
- Dr Tony Baird, President, Medical Council of New Zealand
- Gillian Bohm, Quality Improvement and Audit, Health Funding Authority
- Dr Bob Boyd, Chief Advisor, Safety and Regulation, Ministry of Health
- Patsi Davies, Consumer perspective, Hamilton
- Sue De Gilio, Chief Executive Officer, Good Health Wanganui
- Dr Colin Feek, Chief Medical Advisor, Ministry of Health
- Professor Harley Gray, Chief Medical Advisor, South Auckland Health
- Sue Ineson, Chief Executive, Medical Council of New Zealand
- Judy Kilpatrick, Chair, Nursing Council of New Zealand
- Dr Peter Leslie, Chair, Council of Medical Colleges
- Dr Colin McArthur, Medical Advisor Quality, Auckland Healthcare
- Dr Alastair Macdonald, Association of Salaried Medical Specialists
- Liz Mclean, Business Manager, Capital Coast Health
- Robyn Woodward, Consultant, Auckland (Project Manager)
Working Party objectives

The Medical Credentialling Report prepared by Auckland Uniservices Ltd for the Health Funding Authority in December 1999 made recommendations and provided the reference document for the working party objectives.

The purpose of the Medical Credentialling Working Party was described in the terms of reference as:

To promote the development of medical credentialling in New Zealand by implementing the recommendations from the 1999 Health Funding Authority Credentialling Project to:

1. Develop a generic framework for the credentialling of senior medical officers providing publicly funded hospital services. This will include:
   - purpose of a credentialling process
   - recommended steps in process development, including documentation and quality assurance
   - clarification of the roles and responsibilities and the relationships between stakeholders in this process in practical and legislative terms.

2. Describe specific education and support requirements to facilitate the implementation of credentialling in public hospitals.

Principles: The framework developed should be guided by the following principles:

- Assurance of consumer safety and satisfaction is the ultimate goal.
- Maintenance of professional protection and the confidence of medical practitioners are critical to successful implementation.
- While the ultimate quality and risk management responsibility for credentialling lies with health service providers the roles and responsibilities of other stakeholders must be clear and universally recognised.
- ‘Evolution’, rather than ‘revolution’ is necessary in credentialling process development, recognising the need for a staged and flexible approach to accommodate individual hospital needs and circumstances.
- The potential applicability of credentialling to other health professional groups makes a generic approach desirable.

Operation of the Working Party

The working party met formally on 11 February, 7 April, 16 June, 14 July, and 3 November 2000, chaired by Dr Robert Logan. Additional ongoing consultation by the project manager with individual working party members and other stakeholders, and by working party members with other interested parties, was a feature of the operation of this group. Formal stakeholder consultation occurred at three levels – through membership on the Working Party, as part of the ‘stakeholder consultation group’ and by circulation with the consultation document. Over 1500 copies of a formal consultation document ‘Toward Clinical Excellence: a framework for credentialling’ were delivered to health agencies in August 2000. Thirty-three formal submissions on the document were received. A report to the Director-General of Health was delivered November 2000.
Appendix B: Some Frequently Asked Questions About Credentialling

This section addresses some of the more general questions that have been raised during the process of developing a credentialling framework for senior medical officers in New Zealand. As more public hospitals introduce credentialling the questions are likely to become more specific and will form an important part of our national ‘learning’ experience in credentialling as we jointly develop solutions appropriate to the New Zealand context.

Why focus on senior medical officers for credentialling?

Credentialling of senior medical officers has been in development in public hospitals in New Zealand for less than a decade. However, internationally it has a much longer history. ‘The Minimum Standard’ developed by E.A.Codman in 1915 became the basis of the Hospital Standardisation Programme of the American College of Surgeons. Practitioners managed this programme to improve professional standards. It restricted ‘membership’ of staff (physicians and surgeons) to those whose qualifications, competence and character had been scrutinised and found acceptable. Credentialling as an ‘employer activity with a professional focus’ developed in the United States in the late 1960s following a legal judgement, Darling v. Charleston Community Hospital, where a hospital was found legally responsible for ensuring that practitioners employed were competent (Zusman 1999). While over time other groups of medical practitioners and other health professionals have been included in credentialling, the special concern for senior medical staff remains. The reasons for this focus include the:

- historical lack of supervision of this group once vocationally registered
- level of responsibility held by senior medical officers, including the supervision of junior medical staff
- disproportionate representation of senior medical officers in high profile cases where practitioner incompetence resulted in an unacceptable outcome for the patient.

Will credentialling protect practitioners from being held accountable for poor patient outcomes that result from systems failures?

Yes. Credentialling will help to protect practitioners currently held accountable for poor patient outcomes that result from systems failures outside their control.

Organisational credentialling determines scope of practice based on the competence of the practitioner and the service facilities and support available. This provides protection for the practitioner in three ways:

- Initial implementing of credentialling and the subsequent recredentialling process should include a review of the service prior to practitioner credentialling. The ‘service’ includes facilities, competence and number of other staff, and the appropriateness of service integration. The Chief Executive is responsible for ensuring that practitioners are competent to do the work they are employed to do, and that appropriate facilities and support are available for patient safety.
- The second protection comes from ongoing quality assurance activities such as morbidity and mortality review, peer review and audit that form part of ongoing quality monitoring within the
service in Stage 3 of the ‘Four-step’ credentialling process. These activities depend on practitioner participation and should equally focus on systems error and competence issues in terms of best practice. Traditionally system problems have been put in the ‘too hard’ basket in many organisations. Developing solutions to these problems requires partnership between practitioners, managers and funders.

- The practitioner has both the right and the responsibility to ensure that appropriate facilities and services to facilitate the required outcomes for patients match the agreed scope of practice.

**How will credentialling be funded?**

Initial implementation of credentialling is resource intensive, particularly in terms of practitioner time. Resources will be made available to assist hospitals to implement credentialling, focusing on the areas identified by the Working Party. These were discussed in more detail in Section 10.

The requirement to ensure practitioners are competent to do the work they are employed to do and that the appropriate facilities are provided is a wider and pre-existing organisational responsibility. It is likely that credentialling will highlight systems problems in alignment of resources and integration of services. However, this is not a cost of credentialling *per se*, but part of provider accountability as a publicly funded service provider.

**Is public participation an essential part of the credentialling framework?**

Yes. Input from the public as consumers of health care enhances *quality improvement* activities such as credentialling where their role is clearly defined and understood by all parties. However, the implementation of public representation in credentialling must be viewed in context of a particular organisation. The 1999 HFA study of credentialling in Hospital and Health Services showed that organisational climate is a key determinant in successful credentialling implementation. This is evidenced by a focus on patient care, objective professional standards and mutual trust and respect between managers and practitioners. Similarly, organisational climate will influence the approach taken by a particular hospital to the inclusion of consumer input across a range of functions and services. This is likely to be the most important factor in practitioner acceptance of the requirement for public participation.

The stage of development of a credentialling system is a second influencing factor that cannot be underestimated in terms of direct patient input. Experience to date would indicates that readiness in terms of practitioner acceptance of direct public participation on a credentials committee is influenced by practitioner confidence in the local credentialling system and their active engagement in *quality assurance* activities.

Credentialling of senior medical officers in New Zealand is evolving within a national and international context of greater consumer participation in health care. Demonstrable, progressive public input is a requirement of the credentialling framework. However, for this to be effective at a local level, hospital staff may need to engage in a much wider debate to develop and ‘own’ an organisational philosophy around the role of the consumer.
Appendix C: Contacts for New Zealand Credentialling Experience and Documentation

The following DHBs have credentialled some or all of their senior medical officers in their public hospitals and would be prepared to discuss their experience and possibly share some of their documentation with other organisations:

Auckland District Health Board

Contact: Dr Colin McArthur,
Medical Advisor, Quality
Quality of Service, 2nd Floor Building 14
Greenlane Hospital, Greenlane Road
AUCKLAND
Email colinm@ahsl.co.nz

Counties Manukau District Health Board

Contact: Mr Ian Brown
Chief Medical Advisor
Private Bag 93-311
Otahuhu
AUCKLAND
Email ibrown@middlemore.co.nz

Waikato District Health Board

Contact: Dr David Geddis,
Chief Medical Advisor
PO Box 934
HAMILTON
Email geddisd@hw1.co.nz

Taranaki District Health Board

Contact: Dr André Nel,
Chief Medical Advisor
Private Bag 2016
NEW PLYMOUTH
Email andre.nel@thcl.co.nz

MidCentral District Health Board

Contact: Dr Murray Kirk,
Chief Medical Advisor
PO Box 2056
PALMERSTON NORTH
Email murray.kirk@midcentral.co.nz

Nelson Marlborough District Health Board

Contact: Dr Ed Kiddle,
Chief Medical Advisor
Private Bag
NELSON
Email kathryn.sclater@nmhs.govt.nz

South Canterbury District Health Board

Contact: Dr Ian O’Loughlin,
Professional Advisor,
Clinical Services
Private Bag 911
TIMARU
Email ceo@timhosp.co.nz

Whanganui District Health Board

Contact: Dr John Rivers,
Clinical Director
Private Bag 3003
WANGANUI
Email johnr@ghw.co.nz
References


