Health
State Scope of
Clinical Practice Unit

Model Scope of Clinical Practice Project
For Senior Medical Practitioners and Dentists

Phase 2 Consultation:

REPORT AND RECOMMENDATIONS

NSW State Scope of Clinical Practice Unit - September 2015

Contents

List of Acronyms

ACSQHC - Australian Commission on Safety and Quality in Health Care

AHPRA – Australian Health Practitioners Regulation Agency

CPD – Continuing Professional Development

LHD/SN – Local Health Districts and Specialty Networks

MDAAC – Medical and Dental Appointments Advisory Committee

PDR – Performance Development and Review

PHO – Public Health Organisation

SMPD – Senior Medical Practitioners and Dentists

SoCP – Scope of Clinical Practice

SSoCPU – State Scope of Clinical Practice Unit

Thank You

The project team would like to sincerely thank those who have participated in consultation, including those who attended meetings with the project team, those who provided written responses, and those who assisted to organise site visits.

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1. Introduction

1.1 Purpose of This Report

This Report is intended to inform and seek comment from those who have a role with the NSW Health project to develop model Scopes of Clinical Practice (SoCP) for each medical specialty and dentists, including Project Sponsors, Local Health District and Specialty Network (LHD/SN) Chief Executives, members of the State Scope of Clinical Practice Unit (SSoCPU or the Unit) Governing Council, other SSoCPU committees and forums, and those who have participated in the consultation processes to date.

The history of the project has been discussed during the consultation processes and examination of initial issues and expected benefits of the project are available in the SSoCPU Discussion Paper available at www.schn.health.nsw.gov.au/ssocpu. The history of the project, findings from the literature review and initial issues pertaining to the SoCP project will **not be reiterated** in this report. This Report is not intended to be read in isolation.

This report aims to reflect the themes and ideas that arose, most of them repeatedly, during discussions and in written feedback, and which have been used to formulate recommendations. The project team has received a wealth of insightful and useful comments from individuals and organisations which may continue to inform the project as it moves forward; however brevity dictates that not all of these comments can be included, especially where the comments were isolated.

Developing model scopes of clinical practice is inextricably intertwined with credentialing policy and practice generally. This, in turn, raises matters of clinical governance and, to a certain extent, the appointment of senior medical practitioners and dentists (SMPDs). Many valuable insights were gained from the consultation process in relation to these matters which do not pertain directly to developing model scopes of practice. These issues are brought to the attention of readers in section 3 of this Report: Associated Issues Arising from the Consultation.

1.2. Role of the State Scope of Clinical Practice Unit

The SSoCPU has been established to assist NSW Health organisations by creating model SoCPs for each medical specialty and dentists, and provide advice regarding credentialing policy in NSW as it relates to SoCP. The model SoCPs will be used by LHD/SNs when defining the SoCP of SMPDs as part of their credentialing and re-credentialing processes. As defining an individual's SoCP includes consideration of the service capability or role delineation of a facility, there are effectively three levels of SoCP:

- An overarching model for a medical or dental specialty
- A facility or service-specific SoCP
- An individual's delineated SoCP

This project will deliver the over-arching model SoCPs for specialties and sub-specialties for which NSW Health employs SMPDs based on those listed by the Medical Board of Australia and Dental Board of Australia, accessible via the Australian Health Practitioners Regulation Agency (AHPRA). SoCPs appropriate for other categories of medical practitioners (Career

Medical Officers, Junior Medical Officers) or other types of clinicians are out of scope of the current project.

1.3 Project Approach

The project is broadly following three phases:

Phase One is complete and involved consultation with Directors of Medical Services (or those in similar roles) from all LHD/SNs across NSW. The information gathered during these discussions was combined with a literature review to develop a Discussion Paper which formed the basis of Phase 2. The Discussion Paper is available at www.schn.health.nsw.gov.au/ssocpu.

Phase Two is complete and involved written and face to face consultation. An overview of people and organisations involved in this consultation is in **Appendix 1**.

This consultation was aimed at developing the best approach towards a model scope of clinical practice. The themes that arose during this phase of consultation are presented in this Report, along with a set of recommendations which include a proposed template to use for developing the model SoCPs. The draft template is in **Appendix 2**.

Phase Three will commence when the recommendations in this Report and the proposed SoCP template have been agreed to by the combined Chief Executives of the LHD/SNs following a brief period of consultation. Phase Three will then proceed with a pilot of the proposed SoCP template with five different medical or dental specialties to ensure the template is practical and captures the right information. The template will be then be reviewed and the project team will work with the medical specialist and dentist groups to develop the clinical content to populate the model scope of clinical practice for each specialty.

The Unit will then assist LHD/SNs to implement the model scopes of clinical practice, via guidelines, commencing with matching the model scope of clinical practice with hospital role delineation and then integrating with the SMPD credentialing processes. LHD/SNs will be required to adapt the model SoCPs according to the role delineation or service capability of each facility and if a practitioner holds appointments at several facilities within one LHD/SN that have different service capabilities they will require a contract that has multiple SoCPs attached.

2. Themes and Recommendations

The project has overall received positive feedback and support, notwithstanding that many people have expressed concerns on various aspects of the project, and a minority have expressed their specific non-support. Comments of support include:

- This is an important project
- State-wide consistency and uniformity would be good
- Enhancing the ability to share information between LHDs is welcomed
- Defining SoCP not a bad way to manage some risk
- This could be a positive step for better managing locum appointments
- It would be good to have a system where SoCP changes don't have to be redefined by each LHD/SN when clinical developments occur within a specialty, and there is less re-inventing of the wheel

There were a range of areas where it was seen that a more clearly defined SoCP could assist, for example:

- Ultrasound – especially clinician performed ultrasound, FAST
- Laser
- Laparoscopic surgery
- Application to paediatric patients
- Application to morbidly obese patients
- Interventional radiologists/neuroradiologists having admitting rights
- Sedation for dentists
- Endoscopy and endoscopic retrograde cholangiopancreatography
- Radical head and neck surgery
- Interventional cardiology
- High dependency units
- GPs undertaking work in mental health, anaesthesia, surgery and obstetrics
- When a radiation license is required
- Use of Botox
- Telemedicine
- BreastScreen NSW

Whilst there was a lot of support for the project, a few people provided some negative feedback or raised concerns, including:

- It is not clear what the problem is that needs to be solved and there is in fact no problem that needs solving.
- As there is no formal research to validate any particular method of defining SoCP, no changes should be made until such research is undertaken.
- SoCP could restrict doctors from acting in an emergency situation if the required practice/procedure is outside their SoCP. The same was expressed about working on call, where a sub-specialist practitioner may be the only person available to perform a procedure they have minimal skill or recent experience with because there is no one else available.

- While SoCP might not be a bad way to manage some risk, communication and attitudes are often a bigger challenge.
- Professional autonomy should be maintained and responsibility and accountability for acting within individual SoCP should remain with the individual practitioner. Some acknowledged the tension between the need for professional autonomy and the need for others to know that the person is competent.
- The Specialist Medical Colleges' role in the employer's credentialing responsibilities and delineation of individual SoCP was not clear, and some were of the view that only Colleges should determine SoCP. There were concerns that fundamental credentials such as College fellowship would be overlooked as part of the process of delineating SoCP.
- Concerns were raised that this is a metropolitan-dominated exercise and will only fit the needs of metropolitan hospitals. Rural practice is more general, and more generalists are required. A minority of practitioners from metropolitan hospitals commented that the Discussion Paper was 'ruralist'.
- Several people believed that this project is part of establishing UK-style revalidation processes, however the project team clarified that this is not the case, but acknowledged that if the current Medical Board of Australia considerations lead to altered registration requirements including revalidation or recertification that would have an impact on credentialing requirements.
- Many people assumed that there would be a state-wide credentialing unit running credentialing processes on behalf of LHDs, however the project team clarified during discussions that there is no intention at this time to establish such a unit. The role of SSoCPU is to create model SoCPs, but the responsibility and accountability for credentialing and defining SoCP for employed and contracted senior medical practitioners and dentists will remain with LHD/SNs.

2.1 Principles for Credentialing and Defining SoCP

Whilst there was overall agreement that the existing principles for delineation of clinical privileges as described in NSW Health policy are good, there were many specific suggestions for additions, including but not limited to:

- The goals of patient safety and good outcomes and public confidence in the system should be more prominent.
- Expand on the principles of natural justice, e.g. SoCP should not be used to unfairly restrict someone's income or to assert a right to practice, and there should be an appeals process.
- Adoption of the principles contained within either the QLD Department of Health's *Guide to Credentialing and Defining the Scope of Clinical Practice for Medical Practitioners and Dentists in Queensland* or the WA Department of Health *Policy for Credentialling [sic] and Defining the Scope of Clinical Practice for Medical Practitioners (2nd Edition)*.

Recommendation 1: That the principles for delineation of SoCP are considered in the current review of NSW Health policy.

A set of draft principles is in **Appendix 3**.

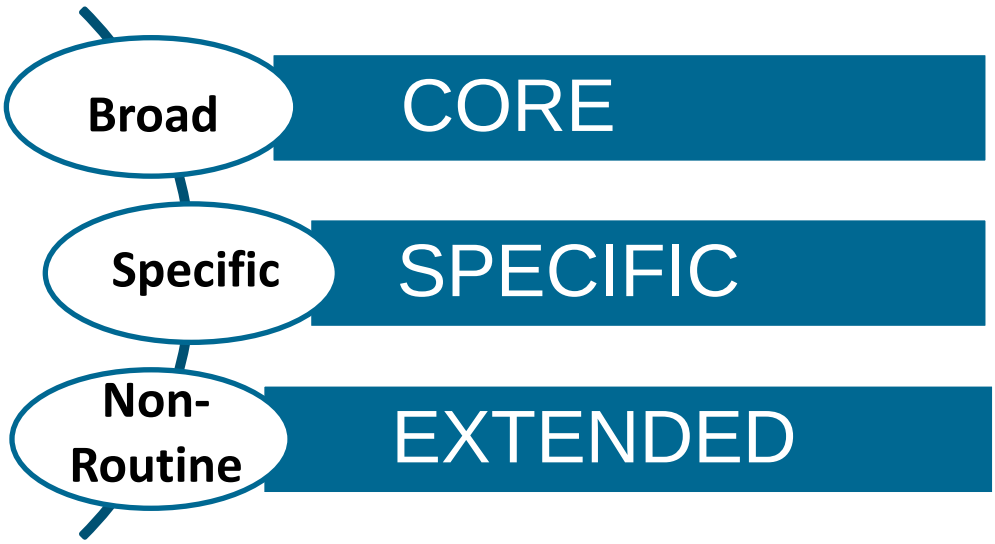
2.2 Overarching Approach to SoCP Template – Core and Specific

The most frequently raised issue during consultation was the challenge of creating a SoCP methodology that is able to accommodate the needs of different locations (such as rural and regional hospitals) and different shift types (such as on call). The most frequent concern raised is about SoCP being too limiting, for example if sub-specialist physicians or surgeons are provided with a SoCP that restricts them to their subspecialty and does not include general physician/surgery duties. The fear is that the end result could be:

- Inability to utilise sub-specialist physicians and surgeons for on call rosters which require general surgery/medicine
- Inability for rural/regional facilities to keep services running
- Specialists opting out of treating patients in emergency/on call situations, or opting out of being on call altogether, with the claim that they cannot perform the required duties due to limitations on their SoCP
- Inability to service paediatric patients
- Sub-specialists having to retrain in order to be able to step back into a more generalist role, creating a disincentive to sub-specialise.

Whilst these concerns were expressed during the consultation, it should be noted that many senior medical and dental practitioners are working with well-defined SoCPs in NSW and other parts of Australia, and the project team was not made aware of any instance where such fears have come to fruition. Examples of clinical incidents that were given to the project team were the result of SoCP being too broadly defined and lacking specificity, rather than being too restricting.

During Phase 2 consultation, the Australian Commission on Safety and Quality in Health Care (ACSQHC) circulated a draft of their document *Guide for Managers and Clinicians: Credentialing Health Practitioners and Defining and Managing Practitioners' Scope of Clinical Practice* (not publicly available). The document recommends a SoCP approach of describing a 'core' SoCP (those tasks that can reasonably be expected to be undertaken by all practitioners holding a particular qualification, having undergone the requisite training) and 'specialised' SoCP (procedures or practices that may require specific credentialing for safe and effective performance).



Current and Proposed NSW Categories for SoCP

Whilst NSW Health may use different terminology, such an approach can be readily accommodated in the NSW Health SoCP template and is consistent with the feedback received during consultation.

There was overarching support during consultation for the concept of having a base line for core competencies based on expectations of competencies to be gained by the completion of their Fellowship training program, as outlined in the college curricula, then having more detailed criteria for additional specific or non-routine elements above and beyond the core SoCP of that particular qualification. The responses from written consultation indicate overall support for inclusion of sections describing the usual practice within a specialty and elements of practice within a specialty that may require additional training, qualifications, experience or address other specific factors.

The section for specific credentialing should include (but may not be limited to):

- Identified high risk or complex case management that requires specific additional qualifications or experience, e.g. where specialist medical/dental colleges, specialty societies, the Clinical Excellence Commission, or Cancer Institute NSW have identified and provided guidelines
- Services subject to state planning guidelines such as transplant practices
- Emerging or new technologies that require specific consideration of training, qualifications or experience

Should local circumstances warrant, LHD/SNs may exclude a specific service or procedure from 'core' practice for all practitioners at a facility and add it with criteria to 'specific' credentialing.

Recommendation 2: That NSW Health adopts the approach of a SoCP template that includes 'core' and 'specific' credentialing and which describe the education and training required for these elements.

2.3 Extended Practice

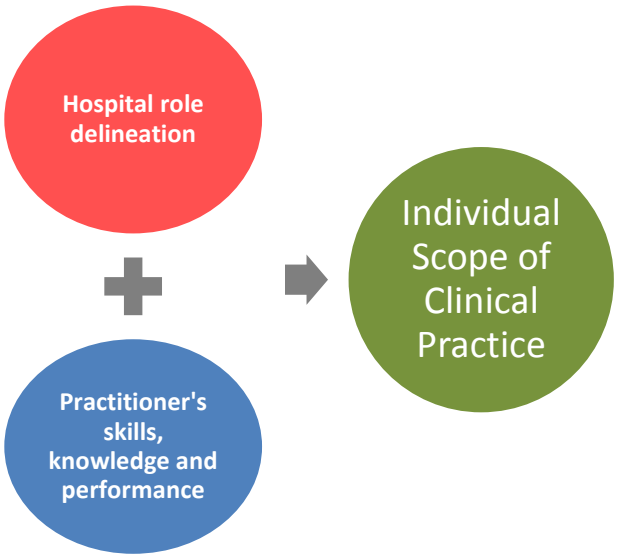
Responses to written consultation indicate support for a section to describe practices or procedures that a practitioner may undertake outside the usual practice of their specialty, for which they have been trained and supported, which the health service can support and for which there is a community need. (In existing NSW Health policy this is referred to as 'non-routine' practice.)

Extended practice is expected to draw on elements of other model SoCPs but it should be noted that inclusion of this section presents a technical issue in terms of electronic system utility and governance. Inclusion of every individual practice/procedure would make the electronic credentialing system overly complex with lengthy checklists; on the other hand allowing free-text fields will lead to a lack of system integrity over time. A system governance solution may be required to manage this element.

Recommendation 3: That the NSW Health SoCP template includes a section for extended practice.

2.4 Service Capability

Whilst there is good support for the idea that SoCP should be better integrated with role delineation or service capability, there is concern and confusion about some aspects of this. Concerns were raised that the SoCP should differentiate between procedures/practices that are excluded from an individual's SoCP due to the unit or department's service capability, versus those that are excluded based on a practitioner's skills, knowledge and performance. Consultation also demonstrated that if individual SoCPs were going to be easily translatable between LHD/SNs, the unit's service capability would need to be readily available and easy to understand within this context.



The NSW Ministry of Health publishes the *Guide to Role Delineation of NSW Health Services*, which is currently being updated and due to be finalised by the end of 2015. The level of service provided in each department at each facility is determined by the LHD/SN, using the descriptors in the Guide. This Guide is designed for service planning purposes and does not necessarily provide the right type of information that may usefully inform an individual SoCP. However, it does exist in a format that can be populated within the eCredential system and may provide some high-level guidance.

Recommendation 4: That the NSW Health SoCP template include the designated role delineation of the unit/service in which the practitioner works.

This may also link to the NSW Health Guide to Role Delineation which provides more information.

Whilst 'service capability' may be a more useful term to describe the type of clinical work undertaken in a unit or department within a facility, this information is currently disparate and the SSoCPU is advised that it does not exist in any collated form that would readily allow for pre-population of the eCredential system. An alternative approach to providing detailed useful information may require populating the system with entire Medicare Benefits Schedule checklists, which would add a significant layer of complexity.

Therefore the best way at this time to reflect unit or department service capability aspects with individual SoCP may be to ensure they apply to the 'specific' areas of practice articulated in SoCP – that is, a facility-level SoCP may indicate that elements in the 'specific' section of the SoCP are not performed within that service.

Recommendation 5: That the 'specific credentialing' section of the SoCP template has a mechanism to indicate when a practice or procedure is not available to be performed within a particular unit or department.

2.5 'Exclusions' from Practice

Consultation revealed support for 'exclusions' in the SoCP template to indicate when an element of the normal practice of a specialty is excluded from an individual practitioner's SoCP, for example, a procedure for which the practitioner has had adverse outcomes or has not practiced for many years. Whilst some colleges and specialty societies that responded to consultation maintained that initial fellowship training plus participation in CPD programs will ensure that doctors are competent to perform all procedures and practices required within the specialty throughout their working life, and there is no role for public health organisations in determining whether an individual is competent to undertake certain practices, there was acknowledgement during face to face consultation that different circumstances can arise during a practitioner's working life which may lead to de-skilling in some areas, or even never having been trained in particular procedures. This is particularly relevant to paediatric practice if clinicians do not maintain ongoing Continuing Professional Development (CPD) and experience in services to children even if once trained. One example was the introduction of phacoemulsification in ophthalmology, where a very small number of practitioners did not learn the new technology/procedure as it was introduced.

Recommendation 6: That the NSW Health SoCP template include a section for 'exclusions' from practice of an individual practitioner, which might otherwise be undertaken at that facility.

This section would pertain to exclusions based on skills, knowledge and experience of an individual, whereas exclusions based on the service capability would be reflected in 'specific' section.

As with the section on 'extended' SoCP, a section for 'exclusions' presents a technical issue in terms of electronic system utility and governance. Inclusion of every individual practice/procedure would make the electronic credentialing system overly complex with lengthy checklists; on the other hand allowing free-text fields will lead to a lack of system integrity over time. A system governance solution may be required to manage this element.

2.6 Describing SoCP

A key element for the SoCP is guidance for the amount of detail required in each section of a SoCP, and what approach to take. Consultation revealed that a middle ground needs to be found – if it is too detailed it will be administratively burdensome as the pace of change means it will require frequent updating; if it is too general, it will not add value to the process.

A minority of LHDs in NSW, and some hospitals in Victoria, use extensive checklists to describe SoCP. A minority of respondents prefer the checklist style of delineating SoCP because it is very clear, particularly when each item is clearly designated with a yes/no response – a practitioner is either allowed to do something or not. The development of checklists has allowed good discussions within craft groups regarding what is currently core practice.

The majority feel that this would be too administratively burdensome; is too risky in terms of the potential for procedures left off a checklist when they should be included; is more suited to procedural specialties and would not suit non-procedural specialties. Checklists for generalists would be extremely long, and it would be difficult to draw the line between what is core and what is non-core. This approach is not recommended in the national standard.

Those who do not favour the narrative style feel that it is difficult to translate in a practical sense, e.g. theatre managers may have difficulty interpreting whether a particular procedure is included in a surgeon's SoCP. One approach could be to bundle sets of procedures together.

Recommendation 7: That the SoCP template avoid extensive checklists and take a more narrative approach to describing SoCP. Brief checklists may be appropriate for some procedures and sections, such as procedures that require specific credentialing.

2.7 Paediatrics

Paediatrics and services to children need special consideration. There are three levels of practitioner – those solely dedicated to paediatric service which is reflected in their training and specialist qualifications; those who provide adult services but their training includes some paediatrics and they may provide services down to a particular age group; those who provide services to adults but may be required to provide consulting services to paediatricians or children in extenuating situations. SoCP needs to accommodate this and have a mechanism to put parameters/expectations in place.

Recommendation 8: That the SoCP template includes a section to indicate patient age limitations.

Note that the role delineation section of the SoCP template is recommended to indicate age limitations of the unit or service.

2.8 Standards for Competence

Concerns were expressed about the application of standards for attainment or maintenance of competence beyond fellowship or registration requirements for that specialty, which if applied too rigorously could result in the same problems as listed above, i.e. inability to staff on call rosters and inability for rural and regional facilities to maintain services where generalists are required. Standards may include elements such as numbers of procedures undertaken, numbers of cases seen, or quality indicators.

However, if standards for attainment or maintenance of competence are set to the lowest required denominator, this could dilute the robustness of the process. If standards are different for those working in regional areas or on call, this will raise concerns about quality of care.

All specialist medical and dental colleges have a curriculum that stipulates training required for attainment of fellowship and a program for CPD. Many specialist medical colleges and specialty societies who responded to consultation took the view that attainment of fellowship and participation in their CPD programs are the only necessary requirements for assurance of ongoing competence throughout a doctor's or dentist's working lifetime. However, there was feedback from LHDs that CPD doesn't necessarily reflect that the individual is updating what is required for their employment and that participation in CPD programs is not a guarantee of clinical competence. Only a few specialist medical colleges and specialty societies have published standards for maintenance of competence, such as those available from the Cardiac Society of Australia and New Zealand

http://www.csanz.edu.au/resources/#training-competence. The CINSW also has some good evidence around standards for certain types of cancer surgery.

Despite the potential benefits of such standards, it was widely acknowledged that

- There are poor or non-existent methods to record outcome data
- Some outcome data is relatively easier for procedural specialties, but does not apply as readily to physician practice
- It may be difficult for those who work part time to meet such standards
- It will be administratively burdensome for both practitioners and those undertaking credentialing
- The development of standards for attainment or maintenance of competence is the remit of the colleges and specialty societies
- Any application of standards for maintenance of competence should be based on evidence
- Good evidence for standards for maintenance of competence is not always available.
- There are differences of opinion about which is more relevant, volumes or recency of practice, and whether it should be based on individual or unit volumes
- Any available standards should be made known to credentialing committees, however they should be treated as a guideline rather than a hard and fast rule, as it is impossible to apply one standard to all practitioners and facility circumstances

In general, there was some acknowledgement that whilst standards for attainment or maintenance of competence may be useful, they are fraught with difficulties and NSW Health is not at this time ready for widespread development and application of such standards. It may be worth considering evidence of volumes for high risk procedures only. If this is the case, guidance would be needed from Colleges and/or informed by evidence where available.

Where standards for attainment or maintenance of competence are available via an Australian specialist medical college or society, these should be known to those undertaking the credentialing and re-credentialing process. .However such guidelines should act as a guide only, to trigger a conversation – in and of themselves they are not a measure of competence.

Identification of high risk procedures and application of any relevant standards or guidelines will occur during Phase 3 of the project when working with specialty groups.

Recommendation 9: That the NSW Health SoCP template should include a section to reference and link to relevant college, specialty society or NSW Health organisation standards for attainment or maintenance of competence.

Recommendation 10: That the SoCP template should indicate how such standards are to be utilised in the credentialing process, i.e. generally that they should be used as guidelines only.

Recommendation 11: That the SoCP template should allow for application of standards for maintenance of competence for high risk procedures.

2.9 Working Outside SoCP in Emergencies

Feedback included the need to ensure there is a mechanism to support practitioners' individual clinical judgement to work outside their SoCP in an emergency situation, noting that this requirement is included in the national standard. During discussion there appeared to be a lack of consistency regarding what was viewed as an emergency. For example, working on an on call roster is not generally viewed as having to provide care in an emergency situation.

Recommendation 12: That the SoCP template provides clarity regarding support to act outside delineated SoCP in an emergency situation, and provide guidelines as to what constitutes an emergency situation.

2.10 AHPRA Restrictions

It may be convenient to include any conditions, undertakings, reprimands, endorsements and notations on practice applied by AHPRA directly into the SoCP document, therefore it is suggested that the state-wide model include a field to accommodate such information for an individual practitioner's SoCP, which would be drawn directly from AHPRA's public database.

Recommendation 13: That the model SoCP document includes a field to draw individual practitioner's conditions, undertakings, reprimands, endorsements and notations on practice directly from the AHPRA public database.

3. Associated Issues Arising from Consultation

The scope of this project is to develop Model Scopes of Clinical Practice for use by NSW public health organisations when undertaking credentialing processes in line with legislative requirements, NSW Health policies and Australian Guidelines. However, this process is inextricably intertwined with credentialing policy and practice generally. It raises matters of clinical governance, LHD practice and NSW Health policy.

Many valuable insights were gained from the consultation process in relation to these matters which do not bear directly on the content of the model scopes of practice. Nonetheless, they are important matters for consideration.

This section outlines finding of the consultation process on these issues. This report does not make recommendations in relation to these matters. However, it is considered important to bring them to the attention of the relevant bodies for consideration and action where considered appropriate.

3.1 Terminology

There is little consensus on the matter of whether the terms ‘clinical privileges’ and ‘scope of clinical practice’ are synonymous. Many people believed that the term ‘scope of clinical practice’ is sufficient to use to refer to the extent of an individual SMPD’s clinical practice within a particular organisation. Others felt that ‘clinical privileges’ refers to the duties or settings in which the practitioner works, for example, the clinical privilege of opening an operating theatre does not delineate what type of procedures a surgeon may undertake in that theatre.

There was general support for the fact that ‘clinical privileges’, when defined as a set of duties or clinical settings, adds value to defining what a practitioner may or may not do within a particular hospital setting. This is different to delineating the type of clinical work to be undertaken and could be termed ‘clinical duties’. There was feedback received about the terms and definitions used for clinical duties, for example:

- Update the term and definition of ‘operating theatres’ as not all procedural work is undertaken in operating theatres
- Inclusion of telehealth and supervision

Consultation Finding: Use of the term ‘scope of clinical practice’ appears to be well accepted to define the extent of an individual’s clinical practice within an organisation. There is confusion, however, around the term ’clinical privileges‘, with some considering it to be synonymous with scope of clinical practice, and others considering that it is wider, and includes a practitioner’s duties. Clarity of understanding and usage of these terms in legislation, policy and related documents would be of benefit.

3.2 Role Delineation

Some people were unclear that many decisions regarding an individual's SoCP are driven by the service's role delineation or capability which guides what may or may not be appropriate given the support and other services the hospital is able to provide. There are concerns that some practitioners may expect to utilise the SoCP process to request changes to service role delineation when it is service capability providing parameters for decisions about individuals' SoCP. Individual clinicians may request changes to a facility's role but this request will be determined by the LHD/SN in the context of many factors not just the willingness or availability of the clinician.

Consultation Finding: NSW Health policy could more clearly articulate the link between role delineation or service capability and individual SoCP.

3.3 Introduction of New Technology

There were concerns raised that having a defined SoCP would stifle innovation. The pace of change is fast and people will feel inhibited to adopt new practices/procedures if they feel they will be at risk (e.g. not covered by insurance or supported by the hospital) if they do something new, or the procedures required to update their SoCP will be too onerous.

It is difficult to know where to draw the line in terms of deciding what is 'new'. Some aspects of change of technology or models of care are relatively minor and straightforward and may not require a system-wide response especially in terms of defined SoCP. Others may require education, training and/or certification. Consultation revealed a desire for centralised guidance to assist LHDs to make such decisions. While most LHDs have a policy and/or process for introduction of new technology and procedures they are often not well integrated with procedures to update individual SoCPs. Some respondents questioned the lack of a state-wide policy when this appears to be an area of risk. Some other jurisdictions have a central policy and committees which examine these questions and define protocols.

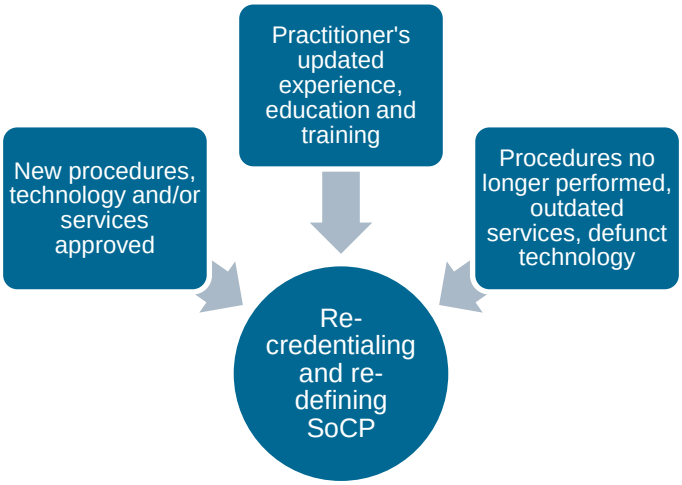
Consultation Finding: Current policy and business practices could be reviewed to ensure clarity around certain matters including

- ***Appropriate introduction of innovative clinical practices***
- ***What constitutes a new practice***
- ***When re-credentialing and changes to SoCP are required***
- ***Mechanisms to ensure that there are no unreasonable delays created by the credentialing processes to the introduction of new innovative practice, for example, by allowing temporary approval of an update to an individual's SoCP pending formal review.***

This issue also pertains to maintenance of the model SoCPs once developed.

3.4 Re-credentialing and Review of Individual SoCP

During the consultation phase, one metropolitan hospital had an issue with accreditation wherein the surveyors did not believe the hospital was meeting all the requirements of Standard 1.10.2 and EQUIP Standards 13.5.2 and 13.8.2. Specifically, there was no audit process to ensure practitioners were working within their SoCP; there was no time limit to individual's SoCPs; Performance Development Reviews (PDRs) were not conducted for all practitioners and there was no link between the PDR process and Medical and Dental Appointments Advisory Committees (MDAAC). Several other NSW public hospitals have had similar findings in recent years.



Whilst the national standard indicates that each individual's SoCP should be time limited and reviewed every three to five years, consultation revealed no consensus on how often SoCP should be reviewed. There is general support that SoCP should be addressed more specifically in the PDR process for staff specialists and VMOs for all categories of medical and dental practitioners. However, there was also a differing view that SoCP should only need to be reviewed on an ad hoc basis when required at the request of the health service or the individual practitioner.

There was acknowledgement of a need for a better way to flag and record changes. The business of MDAAC is commonly focussed on new appointments, not those already employed. Changes to SoCP and PDRs tend to happen locally. Several metropolitan hospitals have indicated a preference for their existing model where the accountability for updating SoCP and ensuring SMPDs are working within their SoCP sits with the Heads of Departments (HoDs). However, in rural/regional areas, the position of HoD does not always exist and the work often falls to medical administration.

Whilst the subject of clinical privileges may be included in a PDR as a general question, there are often no specific questions to address currency of an individual's credentials and SoCP. Note that the VMO PDR template has some questions related to SoCP but does not specify a link to SoCP, and the staff specialist PDR template has a question about clinical privileges but this is too broad to be of much relevance. With no consensus on the meaning of 'clinical privileges' it is difficult to know what would be discussed when this subject is raised during a PDR.

Consultation Finding: The requirements regarding re-credentialing are unclear and would benefit from clarification. NSW Health policy could consider:

- ***The link between reviewing scope of practice and performance review processes and the involvement of the MDAAC in reviewing/endorsing findings in this regard***
- ***The need for any formal re-credentialing process through the MDAAC at specified intervals (e.g. five years)***
- ***Any other matters that should trigger a formal re-credentialing process (e.g. procedures requiring specific credentialing)***

As mentioned, changes to SoCP tend to happen at a department level, and may be approved by a Head of Department or medical administration without necessarily being subjected to formal credentialing processes via MDAAC. If each individual's SoCP is to be reviewed on an annual basis via the PDR process, this will result in a significant administrative burden in processes and recording results. Formal review of credentials and SoCP is not required annually under the national standard.

Concerns were expressed about how eCredential will be utilised in terms of keeping SoCP up to date for each doctor. SoCP changes are frequent and don't necessarily always get notified to the credentialing committees. Furthermore,

- When SoCP is changed, there may be an administrative delay in updating the system, yet another appointment process could be occurring in another LHD which may be relying on the information in the eCredential system.
- Temporary changes to SoCP may not be adequately reflected in the eCredential system.

3.5 Sharing Appointment Information

The introduction of the eCredential system cannot be considered a panacea for the recruitment and appointment processes for senior medical practitioners and dentists. Whilst the system may hold a certain amount of information that can be shared, a certain amount of due diligence is still required when recruiting a doctor or dentist from one health service to another. As an example, it would be wise to undertake up to date referee checks, which should bring to light any performance concerns that may not have been reflected in an out-dated SoCP in the eCredential system.

Consultation Finding: Guidance could be given in NSW Health policy regarding the currency of information in eCredential, the purposes for which the information should be used, and any due diligence that should be undertaken when utilising that information.

3.6 Credentialing Dentists

There was a range of views presented in regards to credentialing and defining SoCP for all levels of dental officers and dental specialists. Some respondents believe that all levels of dental officers (levels 1 to 4 under the Health Employees Dental Officers (State) Award) should be excluded from credentialing processes. There are a minority who feel that only Level 1 dentists, and potentially Level 2 dentists should not be included in the same credentialing processes as their more senior counterparts because their SoCP changes all the time as they learn in the early stages of their role, and they have adequate supervision.

However, there was a majority view put forward during site visits and from written responses that all dental officers should be included in the SSoCPU project and credentialing processes because:

- they are independent practitioners who generally work unsupervised
- they are registered by AHPRA for independent practice following graduation, with no internship similar to medical practitioners
- their skills may be different depending on where they trained
- the SoCP for dental officers is generally different according to their level (1 to 4)

Consultation Finding: There is support for the concept that the unsupervised mode of practice of dental officers distinguishes them from junior medical officers, and that there is merit in considering a policy requirement to credential and define SoCP for all dentists, not just higher level dental officers and specialists.

3.7 Appointment of Individual Practitioners Across Multiple NSW Health Organisations

NSW Health Pathology (NSWHP) is a state-wide service divided into 5 networks, 4 of which are pathology networks that cover geographical regions aligned to 2 or more LHD/SN in NSW. NSWHP currently utilises the MDAAC of the LHD/SN in which the pathologist will be providing clinical services. Where the pathologist will provide a clinical service across more than one LHD/SN, initial approval is sought from the LHD/SN that the pathologist spends the majority of their time providing a clinical service to. Subsequent approval is then sought from all other LHD/SN that the pathologist will provide a clinical service to (this can include up to 6 LHDs for some networks). There are also pathologists employed by NSWHP who have a dual appointment (i.e., the pathologist role encompasses both laboratory and clinical work) and so laboratory and clinical privileges need to be granted by the relevant LHD/SN to support those appointments.

There are a number of services that face similar problems, such as BreastScreen NSW which has 9 screening centres based in NSW Health LHD/SNs that each covers multiple LHD/SNs, and radiologists credentialed in multiple LHD/SNs via appointments with private radiology companies. Views were expressed during consultation that such duplication of appointment and credentialing processes causes unnecessary inefficiencies and the issue warrants further investigation.

Consultation Finding: Arrangements for credentialing and delineation of SoCP of SMPDs in services that cross multiple LHD/SNs should be further considered as part of the current policy review.

3.8 Training for Those Responsible for Credentialing and Defining SoCP

Whilst there was some difference of opinion regarding the need for training for those who undertake the credentialing defining SoCP processes in NSW Health, the majority who commented on this question were in support. Such training could include, but not be limited to policy, legislation and legal aspects, procedures, clinical practice standards, maintenance of competence requirements, conflict of interest, transparency and accountability, potential pitfalls and scenarios.

Consultation Finding: Many respondents considered training in credentialing policy and processes would be useful.

3.9 SoCP for Other Medical Officers

The question was frequently raised as to whether this project will extend to Junior Medical Officers, Career Medical Officers and Hospitalists. The general feedback is that it should, and some suggested it may be of more use than delineating SoCP for senior medical practitioners and dentists. It was interesting to note feedback received that SoCP is closely managed for some groups of JMOs in Victoria, and this makes it easier to delineate SoCP for seniors, as by the time they reach senior levels they have become accustomed to it.

Consultation Finding: There was support for future consideration of applying similar processes for defining SoCP to the junior medical workforce (including Junior Medical Officers, Career Medical Officers and Hospitalists).

Appendix 1 – Consultation Process

Written Consultation

The Discussion Paper with a covering letter seeking comment was sent to the following:

- All NSW Health Local Health District and Specialty Network Chief Executives
- NSW Health Pillars Chief Executives
- 62 specialist medical colleges and specialty societies or associations
- Five industrial associations
- Five medical defence organisations
- Health Consumers NSW
- Chief Nursing Officer, NSW Health
- Chief Allied Health Officer, NSW Health
- Chief Dental Officer, NSW Health
- Representative from the Ministry of Health for TMF
- Representative of the ACSQHC

Written responses have been received from:

- Nine individual senior medical practitioners from within NSW Health
- Six NSW Health Local Health Districts and Specialty Network Chief Executives
- 17 specialist medical colleges and specialty societies or associations
- Three industrial associations
- Representative from the Ministry of Health for TMF
- One Private Hospital

Face to Face Consultation

The project team visited each LHD/SN to speak with members of their MDAACs and other relevant stakeholders. Note that a minority of these meetings were held via teleconference. The project team requested to meet with the LHD/SN's Chief Executive, Director Medical Services/Workforce, members of the MDAAC, members of the Medical Staff Executive Council, clinical directors (including for Oral Health), heads of departments, and any other senior medical practitioners and dentists or clinical and non-clinical staff who may have an interest in this project. The decision regarding who to invite to meet with the project team was made within LHD/SNs, and some extended the invitation broadly, whilst others restricted the invitation to MDAAC members only. As a result of these visits, the project team has spoken with approximately

- 39 Chief Executives and Medical Administrators
- 132 SMPDs
- 38 administrative staff such as directors of workforce and staff in senior medical management units

Other meetings have been held with representatives from:

- The Agency for Clinical Innovation
- NSW Health Pathology
- The Health Education and Training Institute

- The Australian Medical Association
- The Cancer Institute NSW
- BreastScreen NSW

The Senior Medical and Dental Unit Managers (or equivalents) have been consulted about the project via a regular agenda item at the Senior Medical and Dental Unit Managers' Forum meetings.

The SSoCPU Medical Administration Reference Committee has been consulted via regular monthly meetings.

Some issues have been referred to the State Directors of Medical Services meetings for consideration.

Appendix 2 – Draft SoCP Template

The SoCP template on the following pages is intended to demonstrate the type of information that may be contained within a SoCP. Please note that the final SoCP format as presented in the Mercury eCredential system may appear differently to the format in this Report.

See next page

Scope of Clinical Practice for [specialty field]

Core Scope of Clinical Practice for the Specialty of [insert specialty & sub-specialty field as per AHPRA designations]	Core Scope of Clinical Practice granted?
This section will contain a description of the type of work that can reasonably be expected to be undertaken by all practitioners holding particular qualification, having undergone the requisite training. The credentialing committee reviewing the core scope of clinical practice for a health practitioner should not assume that all subjects or competencies in a training program have been completed by the applicant. *Lorem ipsum dolor sit amet, dicat tation voluptatibus cum ne, nam n quis facete. An magna audire docendi pri, justo diceret cum cu. Ea dolorum invidunt liberavisse vim. Solum reque cum ei. Ei cum autem movet antiopam, audire adversarium ut sed, ne brute prompta mei.* *Eum eu mazim laoreet nostrum. Congue aeterno ad quo, te eos mutat tincidunt, modus vulputate vel et. Sumo expetenda eum ei. Amet vocibus sapientem ex has. Has altera assueverit in, vim ut quis dico mazim, nihil civibus ancillae sit at. Cetero animal persius eam id, ei habeo dolorem his.* *Te duo eripuit bonorum moderatius. Usu eruditi commune ad. Est et iriure euripidis efficiendi, ne eum modus ceteros pertinax, pri augue nihil cu. Accusata repudiare cotidieque no eos.*	☐ **Yes** ☐ **No**

This section to be developed with specialty working groups. Colleges/specialty societies will be invited to participate

Qualifications Required for Core Scope of Clinical Practice	Qualifications Met?
• *Specialist Registration with the Medical Board of Australia in the field of [insert specialty or specialties]* • *Fellowship of the [insert specialist medical or dental college] or demonstrated equivalent training and education* • *[insert any additional requirements]*	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**

This document is focused on defining qualifications related to competency to exercise scope of clinical practice. The applicant must also adhere to any additional organisational, regulatory, or accreditation requirements that the organisation is obligated to meet.

Scope of Clinical Practice for [specialty field]

Service Role Delineation

Note that scope of clinical practice granted may only be exercised at the site(s) and/or setting(s) that have sufficient space, equipment, staffing, and other resources required to support the scope of clinical practice.

[Specialty field] at [location] is a level X service.	Patient Age Limitation for [specialty] at [facility]

[Pre-populated designated role delineation level for the relevant unit/department within a facility].

Auto-fill from NSW Health Guide to Role Delineation service level descriptors.

Pre-populated selection of age ranges included here

Clinical Duties may be part of the service/employment contract, or may be part of the scope of clinical practice

Clinical Duties

Admitting	May admit patients within the designated specialty under the practitioner's own name. May accept transfer of care to the nominated practitioner. (Restricted admitting rights means that limited rights can be exercised within specific parameters.)	☐ **Yes** ☐ **Restricted** ☐ **No**
On-call	Participation in the appropriate specialty on-call roster and other on call rosters as required and requested.	☐ **Yes** ☐ **No**
Consulting	May be invited for consultation on patients admitted (or being treated) by another practitioner.	☐ **Yes** ☐ **No**
Diagnostic	May report and sign out on diagnostic investigations requested by another practitioner.	☐ **Yes** ☐ **No**
Outpatients	May hold an outpatient or privately referred non-inpatient clinic in the practitioner's own name or to participate in a multidisciplinary clinic taking final responsibility for the care of patients attending.	☐ **Yes** ☐ **No**
Procedural	May open an operating theatre or a day procedure unit.	☐ **Yes** ☐ **No**
Teaching	May access patients for the purpose of teaching.	☐ **Yes** ☐ **No**
Research	May participate in research projects or clinical trials.	☐ **Yes** ☐ **No**
Supervision	May supervise junior doctors for the purposes of train	☐ **Yes** ☐ **No**
Quality Improvement	Participation in continuous quality improvement and mandatory training activities.	☐ **Yes** ☐ **No**

*Supervision and Quality Improvement are included in the latest **draft** ACSQHC Guidelines*

Scope of Clinical Practice for [specialty field]

This section will be developed with specialty working groups. This section should include:

- *Identified high risk or complex case management that requires specific additional qualifications or experience*
- *Services subject to state planning guidelines such as transplant practices*
- *Emerging or new technologies that require specific consideration of training, qualifications or experience*

Should local circumstances warrant, LHD/SNs may exclude a specific service or procedure from 'core' practice for all practitioners at a facility and add it with criteria to 'specific' credentialing, or note that it is not performed at that facility

Scope of Clinical Practice Requiring Specific Credentialing

This section describes procedures or practices which require specific credentialing for safe and effective performance, but which are within the practice of [insert specialty]. Specific credentialing and determination of a specific scope of clinical practice is required where it cannot be reasonably assumed the practitioner's qualifications include the specific competency. The gaining of the specific competency may involve additional training, experience, or both training and experience. Requests for specific scope of clinical practice should be specified in the credentialing application.

Areas of Practice Requiring Specific Credentialing	Qualifications/experience required	Standards	Patient Age Limitations	Specific Scope of Clinical Practice Granted?
Specific practice/procedure	*Training* *Qualification* *Experience*	*[hyperlink to relevant standards]*	**All ages**	☐ **Yes** ☐ **No** ☐ **Not performed at [facility]**
Specific practice/procedure	*Training* *Qualification* *Experience*	*[hyperlink to relevant standards]*	**All ages**	☐ **Yes** ☐ **No** ☐ **Not performed at [facility]**
Specific practice/procedure	*Training* *Qualification* *Experience*	*[hyperlink to relevant standards]*	**Al** *[pre-populated drop-down selection of age ranges]*	**Yes** ☐ **No** **Not performed at cility]**

Any standards for attainment or maintenance of competence suggested as a threshold are developed by specialist medical/dental colleges, specialty societies or NSW Health organisations with expert guidance. They are not intended as an automatic barrier to practice or service delivery. Such standards should be treated as a guideline only and a trigger for review. Regardless of the currency number, acceptable results must be demonstrated, especially for procedures with significant risk.

Scope of Clinical Practice for [specialty field]

Extended Scope of Clinical Practice
This section is for areas of practice outside the range of [specialty] outlined above for which the practitioner may have training and experience. If the clinical work falls within the remit of a different specialty, the scope of clinical practice for that specialty may be applied.

Emergency Practice
Practitioners may use their clinical judgement and perform therapeutic activities beyond this SoCP in a life threatening emergency if risk of delay and/or transfer substantially increases risk to the patient.

Exclusions	
This section will list clinical work within the normal and customary practice of [specialty], which may not be conducted by the practitioner.	
Areas of Practice Excluded from SoCP	*[list here any clinical work that may not be undertaken by the practitioner, including temporary restrictions]*
Time frame for review (if exclusion is temporary)	*[specify time frame if applicable]*

Practice Conditions, Undertakings, Reprimands, Endorsements and Notations as per the Medical Board of Australia
[automatic feed from AHPRA public database]

Sign Off		
Practitioner Name		
Medical Registration Number:		
Head of Department		
Scope of Clinical Practice granted for the period of (maximum five years):	**Start Date**	**DD/MM/YYYY**
	Finish Date	**DD/MM/YYYY**

Appendix 3 – Draft Principles for Delineation of Scope of Clinical Practice

(1) The overarching objectives of credentialing and defining the scope of clinical practice for senior medical practitioners and dentists (SMPDs) are patient safety and quality of care. The public as well as health care managers and professionals should have confidence in the processes used.

(2) Credentialing and defining the scope of clinical practice is a governance responsibility. Each Public Health Organisation (PHO) has a responsibility to patients and the wider community to ensure the competence and an acceptable performance of all SMPDs practising in their organisation. Components of this governance include:
- Employer responsibility prior to appointment and continuing through appointment.
- Essential components of a broader system of organisational management of relationships with medical practitioners.
- Clarity of the PHO's responsibility towards ongoing monitoring and performance review.
- Training those responsible for these processes.

(3) SMPD credentialing and scope of clinical practice are complemented by registration and individual professional responsibilities that protect the community.
- To be effective, there must be strong partnerships between health care organisations, professional colleges, associations and societies.
- Professional bodies, employers and individual health practitioners have roles that are distinct and complementary.

(4) The principles of natural justice – merit, integrity, impartiality, openness, fairness – apply to credentialing and defining the scope of clinical practice.
- A practitioner has a right to know how and why decisions are made.
- Those undertaking credentialing should act with due care and diligence.
- There should be an appeals process.

(5) SoCP procedures should be legally robust, i.e. they should:
- Be consistent with bylaws and regulations
- Not discriminate on the basis of age, sex, race, colour, creed, national origin, marital status, disability, family responsibilities, or other factors not related to qualifications, training, experience or job performance

(6) Role delineation or service capability should be taken into account, as organisational capability, needs of health services and communities are different at different locations. An individual's SoCP should be organisation-specific and consistent with the service capability of the organisation.

(7) Delineation of SoCP should create a positive environment for SMPDs via,

- Recognition of resources required to support high quality services
- Having the goal of reducing duplication of appointment processes and sharing credentialing information between NSW Health hospitals
- Protection from unreasonable restrictions as well as from unreasonable expectations
- Accommodating a variety of practitioner working arrangements

(8) The assessment of SoCP should be undertaken by peers and associated health professionals, and the views of patients and the public should also be represented
- Medical and dental staff have an obligation in being appointed to the PHO to participate in recruitment, credentialing and defining SoCP processes for other SMPDs.

(9) Practitioners should have their SoCP reviewed at regular intervals, and there should be a mechanism to review an individual's SoCP at any time at the request of the health service or the practitioner.