The Bays Healthcare Group

Medical Staff

By-Laws

November 2021

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The Bays Hospital, Policies & Procedures - Medical Staff By-Laws - V2 - AUTHORISED - 10/11/2021 - ISSUING AUTHORITY Hospital Executive

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1. Preface

The Bays Hospital is a not-for-profit, community owned, hospital that offers a comprehensive range of acute medical, surgical, intensive care and obstetric services. The hospital has onsite radiology, pathology and pharmacy services and offers specialist consulting suites.

Mission Statement

The Bays Healthcare Group's vision is:

- The best care, provided efficiently and with compassion.
- A community that is confident in our services and our commitment to the Mornington Peninsula.
- A professional, cohesive, team-based culture that attracts and retains the best people.
- Demonstrated support for our community through investment in buildings, equipment, our people and the development of services.
- A culture that reflects social and environmental awareness and responsibility.

2. Values of Facility

The Bays Healthcare Group Values are:

Integrity - Being honest in our dealings with others.

By demonstrating **Integrity** we embrace high ethical standards including honesty, truthfulness and social responsibility.

This means we develop trusted, long-term relationships with each other, our patients and residents, our suppliers, service providers and our wider community.

Compassion - Recognising the physical, social and emotional needs of our patients, residents and families as well as our staff.

By demonstrating **Compassion** we embrace feelings of distress and pity for the suffering or misfortune of another, including the desire to alleviate it.

This means we feel with another in their discomfort or suffering and striving to understand the other's experience with a willingness to reach out.

Accountability - Being responsible for and mindful of the consequences of our actions.

By demonstrating **Accountability** we accept responsibility for our own actions and decisions and demonstrate commitment to accomplish work in an ethical, efficient and cost-effective manner.

Respect - Acknowledging the rights and opinions of others as we work together as a team.

By demonstrating **Respect** we recognise individual needs, show tolerance and treat others as equals. This means we demonstrate a personal commitment to create a hospitable, courteous and welcoming environment

Excellence - Continually improving quality and efficiency.

We strive for **Excellence**. Working with agility, speed and a customer service focus, we will achieve best practice.

Embracing Excellence enables innovation because we strive to continuously apply fresh thinking that adds value to all aspects of our business including people, services and processes.

Part A – Definitions and introduction

3. Definitions and interpretation

3.1 Definitions

In these By-laws, unless indicated to the contrary:

Accreditation means the process provided in these By-laws by which a person is Accredited.

Accredited means the status conferred on a Medical Practitioner, Dentist, Allied Health Professional or other approved category of health practitioner to provide services within the Facility after having satisfied the Credentialing and Scope of Practice requirements provided in these By-laws.

Accredited Practitioner means a Medical Practitioner, Dentist, Allied Health Professional or other approved category of health practitioner who has been Accredited to provide services within the Facility, and who may be an **Accredited Medical Practitioner, Accredited Dentist** or **Accredited Allied Health Professional**.

Adequate Professional Indemnity Insurance means insurance, including run off/tail insurance, to cover all potential liability of the Accredited Practitioner, that is with a reputable insurance company acceptable to the Facility, and is in an amount and on terms that the Facility considers in its absolute discretion to be sufficient. The insurance must be adequate for Scope of Practice and level of activity.

AHPRA means the Australian Health Practitioner Regulation Agency established under the *Health Practitioner Regulation National Law Act* 2009 (as in force in each State and Territory).

Allied Health Privileges means the entitlement to provide treatment and care to Patients as an Allied Health Professional within the areas approved by the Chief Executive Officer of the Facility in accordance with the provisions of these By-laws.

Allied Health Professional means a person registered by AHPRA as an Allied Health Professional pursuant to the *Health Practitioner Regulation National Law Act* 2009 as in force in each State and Territory in which the Facility is located, or other categories of appropriately qualified health professionals as approved by the Chief Executive Officer.

Behavioural Sentinel Event means an episode of inappropriate or problematic behaviour which indicates concerns about an Accredited Practitioner's level of functioning and suggests potential for adversely affecting Patient safety and welfare or organisational outcomes.

Behavioural Standards means the standard of conduct and behaviour expected of an Accredited Practitioner arising from personal interactions, communication and other forms of interaction with other Accredited Practitioners, employees of the Facility, Board members, executive of the Facility, third party service providers, Patients, family members of Patients and others. The minimum standard required of Accredited Practitioners in order to achieve the Behavioural Standards is compliance with the Code of Conduct (if any), policies in place at the Facility relating to behaviour, the expectations set out in the *Good Medical Practice: A Code of Conduct for Doctors* in Australia (as applicable), and the values set out in By-law 2.

Board means the Board of Directors of the Facility.

By-laws means these By-laws.

Chief Executive Officer means the person appointed to the position of Chief Executive Officer, or equivalent position by whatever name such as General Manager or Managing Director, of the Facility or any person acting, or delegated to act, in that position.

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Clinical Practice means the professional activity undertaken by Accredited Practitioners for the purposes of investigating Patient symptoms and preventing and/or managing illness, together with associated professional activities related to clinical care.

Code of Conduct means the relevant code of conduct in place at the Facility.

Competence means, in respect of a person who applies for Accreditation or Re-Accreditation, that the person is possessed of the necessary knowledge, skills, training, decision making ability, judgment, insight, interpersonal communication and Performance necessary for the Scope of Practice for which the person has applied and has the demonstrated ability to provide health services at an expected level of safety and quality.

Credentials means, in respect of a person who applies for Accreditation or Re-Accreditation, the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees / awards / fellowships / certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, current registration and status, indemnity insurance, and other skills/attributes (for example training and experience in leadership, research, education, communication and teamwork) that contribute to the Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services at the Facility. This may include (where applicable and relevant) history of and current status with respect to Clinical Practice and outcomes during previous periods of Accreditation, disciplinary actions, By-law actions, compensation claims, complaints and concerns – clinical and behavioural, professional registration and professional indemnity insurance.

Credentialing means, in respect of a person who applies for Accreditation or Re-Accreditation, the formal process used to match the skills, experience, and qualifications to the role and responsibilities of the position. This will include actions to verify and assess the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees / awards / fellowships / certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, current registration and status, indemnity insurance, and other skills/attributes (for example training and experience in leadership, research, education, communication and teamwork) for the purpose of forming a view about their Credentials, Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services within specific environments. Credentialing involves obtaining evidence contained in verified documents to delineate the theoretical range of services which an Accredited Practitioner is competent to perform.

Current Fitness is the current fitness required of an applicant for Accreditation or Re-Accreditation to carry out the Scope of Practice sought or currently held, including with the confidence of peers and the Facility, having regard to any relevant physical or mental impairment, disability, condition or disorder (including due to alcohol, drugs or other substances) which detrimentally affects or there is a reasonably held concern that it may detrimentally affect the person's capacity to provide health services at the expected level of safety and quality having regard to the Scope of Practice sought or currently held.

Dentist means, for the purposes of these By-laws, a person registered as a dentist by the Dental Board of Australia governed by the AHPRA pursuant to the *Health Practitioner Regulation National Law Act* 2009 as in force in each State and Territory.

Director of Clinical Services means the person appointed to the position of Director of Clinical Services or Director of Nursing, or equivalent position by whatever name, of the Facility or any person acting, or delegated to act, in that position.

Disruptive Behaviour means aberrant behaviour manifested through personal interaction with Accredited Practitioners, hospital personnel, health care professionals, Patients, family members, or

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others, which interferes with Patient care or could reasonably be expected to interfere with the process of delivering quality care or which is inconsistent with the values of the Facility.

Emergency Accreditation means the process provided in these By-laws whereby a Medical Practitioner, Dentist or Allied Health Professional is Accredited for a specified short period on short notice in an emergency situation.

External Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) external to the Facility.

Facility means the hospital or facility to which an application for Accreditation is made.

Internal Review means evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) internal to the Facility.

Medical Advisory Committee means the Medical Advisory Committee (or equivalent) of the Facility.

Medical Director means the person appointed to the position of Medical Director or Director of Medical Services, or equivalent position by whatever name, of the Facility or any person acting, or delegated to act, in that position.

Medical Practitioner means, for the purposes of these By-laws, a person registered as a medical practitioner by the Medical Board of Australia governed by the AHPRA pursuant to the *Health Practitioner Regulation National Law Act* 2009 as in force in each State and Territory.

New Clinical Services means clinical services, treatment, procedures, techniques, technology, instruments or other interventions that are being introduced into the organisational setting of the Facility for the first time, or if currently used are planned to be used in a different way, and that depend for some or all of their provision on the professional input of Accredited Practitioners.

Organisational Capability means the Facility's ability to provide the facilities, services, clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational Capability will be determined by consideration of, but not limited to, the availability, limitations and/or restrictions of the services, staffing (including qualification and skill-mix), facilities, equipment, technology and support services required and by reference to the Facility's private health licence (where applicable), clinical service capacity, clinical services plan and clinical capability framework.

Organisational Need means the extent to which the Facility considers it necessary to provide a specific clinical service, procedure or other intervention, or elects to provide a specific clinical service, procedure or other intervention, or elects to provide additional resources to support expansion of an existing clinical service, procedure or other intervention (including additional operating theatre utilisation), in order to provide a balanced mix of safe, high quality health care services that meet the Facility's consumer and community needs and aspirations. Organisational Need will be determined by, but not limited to, allocation of limited resources, clinical service capacity, funding, clinical services, strategic, business and operational plans, and the clinical services capability framework.

Patient means a person admitted to, or treated as an outpatient at, the Facility.

Performance means the extent to which an Accredited Practitioner provides, or has provided, health care services in a manner which is considered consistent with good and current Clinical Practice and results in expected patient benefits and outcomes. When considered as part of the Accreditation process, Performance will include an assessment and examination of the provision of health care services over the prior periods of Accreditation (if any).

Re-accreditation means the process provided in these By-laws by which a person who already holds Accreditation may apply for and be considered for Accreditation following the probationary period or any subsequent term.

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Scope of Practice means the extent of an individual Accredited Practitioner's permitted Clinical Practice within the Facility based on the individual's Credentials, Competence, Performance and professional suitability, and the Organisational Capability and Organisational Need of the organisation to support the Accredited Practitioner's scope of clinical practice. Scope of Practice may also be referred to as delineation of clinical privileges.

Specialist Medical Practitioner means a Medical Practitioner who has been recognised as a specialist in their nominated category for the purpose of the *Health Insurance Act 1973* (Cth) and has received specialist registration from the AHPRA.

Temporary Accreditation means the process provided in By-laws whereby a Medical Practitioner, Dentist or Allied Health Professional is Accredited for a limited period.

Threshold Credentials means the minimum credentials for each clinical service, procedure or other intervention which applicants for Credentialing, within the Scope of Practice sought, are required to meet before any application will be processed and approved. Threshold credentials are to be approved by the Chief Executive Officer, following consultation with the Chair of the Medical Advisory Committee, and may be incorporated into an Accreditation policy.

Visiting Allied Health Professional means an Allied Health Professional who is not an employee of the Facility, and who has been granted Allied Health Accreditation and Scope of Practice pursuant to these By-laws.

Visiting Dentist means a Dentist who is not an employee of the Facility, who has been granted Accreditation and Scope of Practice pursuant to these By-laws.

Visiting Medical Practitioner means a Medical Practitioner who is not an employee of the Facility, who has been granted Accreditation and Scope of Practice pursuant to these By-laws. Visiting Medical Practitioners include visiting Specialist Medical Practitioners.

3.2 Interpretation

Headings in these By-laws are for convenience only and are not to be used as an aid in interpretation.

In these By-laws, unless the context makes it clear the rule of interpretation is not intended to apply, words importing the masculine gender shall also include feminine gender, words importing the singular shall also include the plural, if a word is defined another part of speech has a corresponding meaning, if an example is given the example does not limit the scope, and reference to legislation (including subordinate legislation or regulation) is to that legislation as amended, re-enacted or replaced.

The Chief Executive Officer may delegate any of the responsibilities conferred upon him/her by the By-laws in his/her complete discretion, but within any delegation parameters approved by the Board.

Any dispute or difference which may arise as to the meaning or interpretation or application of these By-laws or as to the powers of any committee or the validity of proceedings of any meeting shall be determined by the Chief Executive Officer, following consultation with the Chair of the Medical Advisory Committee. There is no appeal from such a determination by the Chief Executive Officer.

3.3 Meetings

Where a reference is made to a meeting, the quorum requirements that will apply are those specified in the terms of reference of the relevant committee.

Committee resolutions and decisions, if not specified in the terms of reference, must be supported by a show of hands or ballot of committee members at the meeting.

Voting, if not specified elsewhere, shall be on a simple majority voting basis and only by those in attendance at the meeting (including attendance by electronic means). There shall be no proxy vote.

In the case of an equality of votes, the chairperson will have the casting vote.

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A committee established pursuant to these By-laws may hold any meeting by electronic means or by telephonic communication whereby participants can be heard.

Resolutions may be adopted by means of a circular resolution.

Information provided to any committee or person shall be regarded as confidential and is not to be disclosed to any third party or beyond the purpose for which the information was made available.

Any member of a committee who has a conflict of interest or material personal interest in a matter to be decided or discussed shall inform the chairperson of the committee and take no part in any relevant discussion or resolution with respect to that particular matter.

4. Introduction

4.1 Purpose of this document

(a) This document sets out the terms and conditions on which Medical Practitioners, Dentists, Allied Health Professionals and other approved categories of health professionals may apply to be Accredited within the defined Scope of Practice granted, the basis upon which a successful applicant may admit Patients and/or care and treat Patients at the Facility, and the terms and conditions for continued Accreditation.

(b) Every applicant for Accreditation will review the By-laws and Annexures before making an application. It is an expectation of the Facility that the By-laws are read in their entirety by the applicant as part of the application process. Ignorance of the By-laws will not be regarded as an acceptable excuse.

(c) Patient care is provided by Accredited Practitioners who have been granted access to use the Facility and its resources in order to provide that care. The By-laws define the relationship and obligations between the Facility and its Accredited Practitioners.

(d) The Facility aims to maintain a high standard of Patient care and to continuously improve the safety and quality of its services. The By-laws implement measures aimed at maintenance and improvements in safety and quality.

(e) Health care in Australia is subject to numerous legislation and standards. The By-laws assist in compliance with certain aspects of this regulation but are not a substitute for review of the relevant legislation and standards.

Part B – Terms and conditions of Accreditation

5. Compliance with By-laws

5.1 Compliance obligations

(a) It is a requirement for continued Accreditation that Accredited Practitioners comply with the By-laws at all relevant times when admitting, caring for or treating Patients, or otherwise providing services at the Facility.

(b) Any non-compliance with the By-laws may be grounds for suspension, termination, or imposition of conditions.

(c) Unless specifically determined otherwise by the Chief Executive Officer in writing for a specified Accredited Practitioner, the provisions of these By-laws in their entirety prevail to the extent of any inconsistency with any terms, express or implied, in a contract of employment or engagement that may be entered into. In the absence of a specific written

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determination by the Chief Executive Officer, it is a condition of ongoing Accreditation that the Accredited Practitioner agrees that the provisions of these By-laws prevail to the extent of any inconsistency or uncertainty between the provisions of these By-laws and any terms, express or implied, in a contract or employment or engagement.

5.2 Compliance with policies and procedures

Accredited Practitioners must comply with all policies and procedures of, or in place at, the Facility.

5.3 Compliance with legislation

Accredited Practitioners must comply with all relevant legislation, including but not limited to legislation that relates to health, public health, drugs and poisons, privacy, coroners, criminal law, end of life / voluntary assisted dying, health practitioner registration, research, environmental protection, workplace health & safety, occupational health and safety, anti-discrimination, bullying, harassment, industrial relations, care of children, care of the aged, care of persons with a disability, substituted decision making and persons with impaired capacity, mental health, Medicare, health insurance, competition and consumer law, intellectual property, and other relevant legislation regulating the Accredited Practitioner, provision of health care or impacting upon the operation of the Facility.

In addition, Accredited Practitioners must ensure compliance with, or assist the Facility to comply with, any Commonwealth or State mandated service capability frameworks or minimum standards.

5.4 Insurance and registration

Accredited Practitioners must at all times maintain Adequate Professional Indemnity Insurance.

Accredited Practitioners must at all times maintain registration with AHPRA that is sufficient for the Scope of Practice granted.

Accredited Practitioners are required to provide evidence annually, or at other times upon request, of Adequate Professional Indemnity Insurance and registration, and all other relevant licences or registration requirements for the Scope of Practice granted. If further information is requested in relation to insurance or registration, the Accredited Practitioner will assist to obtain that information, or provide permission for the Facility to obtain that information directly.

5.5 Standard of conduct

(a) The Facility expects a high standard of professional and personal conduct from Accredited Practitioners, who must conduct themselves in accordance with:

(i) the Behavioural Standards;

(ii) the Code of Ethics of the Australian Medical Association or any other relevant code of ethics;

(iii) the Code of Practice of any specialist college or professional body of which the Accredited Practitioner is a member;

(iv) the Values of the Facility;

(v) the strategic direction of the Facility;

(vi) the limits of their registration or any conditions placed upon Scope of Practice in accordance with these By-laws; and

(vii) all reasonable requests made with regard to personal conduct in the Facility.

(b) Accredited Practitioners must continuously demonstrate Competence and Current Fitness, must not engage in Disruptive Behaviour, and must observe all reasonable requests with respect to conduct and behaviour.

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(c) Accredited Practitioners must not engage in any conduct that may be perceived as a reprisal against another person for making a report or supplying information relating to the Behavioural Standards.

(d) Upon request by the Chief Executive Officer the Accredited Practitioner is required to meet with the Chief Executive Officer and Medical Director and/or Chairperson of the Medical Advisory Committee, to discuss matters in (a) to (c) above, or any other matter arising out of these By-laws.

5.6 Notifications

Accredited Practitioners must immediately advise the Chief Executive Officer, and follow up with written confirmation within 2 days, should:

(a) an investigation or complaint be commenced in relation to the Accredited Practitioner, or about his/her Patient (irrespective of whether this relates to a Patient of the Facility), by AHPRA, the Accredited Practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency;

(b) an adverse finding (including but not limited to criticism or adverse comment about the care or services provided by the Accredited Practitioner) be made against the Accredited Practitioner by a civil court, AHPRA, the practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency, irrespective of whether this relates to a Patient of the Facility;

(c) the Accredited Practitioner's professional registration be revoked or amended, or should conditions be imposed, or should undertakings be agreed, irrespective of whether this relates to a Patient of the Facility and irrespective of whether this is noted on the public register or is privately agreed with a registration board;

(d) professional indemnity membership or insurance be made conditional or not be renewed, or should limitations be placed on insurance or professional indemnity coverage;

(e) the Accredited Practitioner's appointment, clinical privileges or Scope of Practice at any other facility, hospital or day procedure centre alter in any way, including through resignation or if it is withdrawn, suspended, restricted, or made conditional, and irrespective of whether this was done by way of agreement;

(f) any physical or mental condition or substance abuse problem occur that could affect his or her ability to practise or that would require any special assistance to enable him or her to practise safely and competently;

(g) the Accredited Practitioner believe that Patient care or safety is being compromised or at risk, or may potentially be compromised or at risk, by another Accredited Practitioner of the Facility;

(h) the Accredited Practitioner make a mandatory notification to a health practitioner registration board in relation to another Accredited Practitioner of the Facility; or

(i) the Accredited Practitioner be charged with having committed or is convicted of a sex, violence or other criminal offence. The Accredited Practitioner must provide the Facility with an authority to conduct at any time a criminal history check with the appropriate authorities;

In addition, Accredited Practitioners should inform themselves of their personal obligations in relation to external notifications and ensure compliance with these obligations, including for example mandatory reporting to AHPRA. The Facility expects the Accredited Practitioner to comply with these obligations.

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5.7 Continuous disclosure

(a) The Accredited Practitioner must keep the Chief Executive Officer continuously informed of every fact and circumstance which has, or will likely have, a material bearing upon:

(i) the Accreditation of the Accredited Practitioner;

(ii) the Scope of Practice of the Accredited Practitioner;

(iii) the ability of the Accredited Practitioner to safely deliver health services to his/her Patients within the Scope of Practice, including if the Accredited Practitioner suffers from an illness or disability which may adversely affect his or her Current Fitness;

(iv) the Accredited Practitioner's registration or professional indemnity insurance arrangements;

(v) the inability of the Accredited Practitioner to satisfy a medical malpractice claim by a Patient;

(vi) adverse outcomes or complications that result in injury, disability or harm in relation to the Accredited Practitioner's Patients (current or former) of the Facility;

(vii) complaints, compensation claims, reportable deaths and coronial investigations in relation to the Accredited Practitioner's Patients (current or former) of the Facility;

(viii) the reputation of the Accredited Practitioner as it relates to the provision of Clinical Practice; and

(ix) the reputation of the Facility.

(b) Subject to restrictions directly relating to or impacting upon legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the Chief Executive Officer informed and updated about the commencement, progress and outcome of compensation claims, coronial investigations or inquests, police investigations, Patient complaints, health complaints body complaints or investigations, or other inquiries involving Patients of the Accredited Practitioner that were treated at the Facility.

5.8 Representations and media

Unless an Accredited Practitioner has the prior written consent of the Chief Executive Officer, an Accredited Practitioner may not use the Facility's name, letterhead, logo, or in any way suggest that the Accredited Practitioner represents these entities.

The Accredited Practitioner must obtain the Chief Executive Officer's prior approval before interaction with the media regarding any matter involving the Facility or a Patient.

5.9 Committees

(a) The Facility requires Accredited Practitioners, as reasonably requested by the Chief Executive Officer, to assist it in achieving its objectives through membership of committees of the Facility. This includes committees responsible for developing, implementing and reviewing policies in all clinical areas; participating in medical, nursing and other education programs; and attending meetings of Accredited Practitioners.

5.10 Confidentiality

(a) Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with the Facility's policy and the 'Australian Privacy Principles' established by the *Privacy Act (Cth),* and other legislation and regulations relating to privacy and confidentiality, and will not do anything to bring the Facility in breach of these obligations.

(b) Accredited Practitioners will comply with the various legislation governing the collection, handling, security, storage and disclosure of health information, as well as notification of data breaches.

(c) Accredited Practitioners will comply with common law duties of confidentiality.

(d) The following will be kept confidential by Accredited Practitioners:

(i) Commercially in confidence business information concerning the Facility;

(ii) The particulars of these By-Laws;

(iii) Information concerning the Facility's insurance arrangements;

(iv) information concerning any Patient or staff of the Facility;

(v) information which comes to their knowledge concerning Patients, Accredited Practitioners, Clinical Practice, quality assurance, peer review and other activities, including from membership of or participation in Facility committees.

(e) In addition to statutory or common law exceptions to confidentiality, the confidentiality requirements do not apply in the following circumstances:

(i) where disclosure is required to provide continuing care to the Patient;

(ii) where disclosure is required by law;

(iii) where disclosure is made to a regulatory or registration body in connection with the Accredited Practitioner, another Accredited Practitioner, or the Facility;

(iv) where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or

(v) where disclosure is required in order to perform some requirement of these By-Laws.

(f) The confidentiality requirements continue with full force and effect after the Accredited Practitioner ceases to be Accredited.

5.11 Communication within the Facility

Accredited Practitioners are required to familiarise themselves with the organisational structure of the Facility.

Accredited Practitioners acknowledge that in order for the organisation to function, effective communication is required, including between the Board, Chief Executive Officer, Director of Clinical Services, Executive of the Facility, Committees of the Facility, staff of the Facility and other Accredited Practitioners.

Accredited Practitioners acknowledge and consent to communication between these persons and entities of information, including their own personal information, that may otherwise be restricted by the *Privacy Act*. The acknowledgment and consent is given on the proviso that the information will be dealt with in accordance with obligations pursuant to the *Privacy Act* and only for proper purposes and functions.

6. Safety and quality

6.1 Admission, availability, communication, & discharge

(a) Visiting Medical Practitioners, Visiting Dentists and Visiting Allied Health Professionals will admit (if applicable) and treat Patients at the Facility on a regular basis and be an active provider of services at the Facility.

(b) Visiting Medical Practitioners or Visiting Dentists who admit Patients to the Facility for treatment and care must ensure that they are available to treat and care for those Patients at

all times, or failing that, that other arrangements as permitted by the By-laws are put in place to ensure the continuity of treatment and care for those Patients. Visiting Allied Health Professionals who treat Patients must ensure they are available to treat and care for those Patients at all times or ensure continuity for treatment and care.

(c) Accredited Practitioners must visit all Patients admitted or required to be treated by them as frequently as is required by the clinical circumstances of those Patients and as would be judged appropriate by professional peers. While the clinical circumstances may require more frequent attendance, at a minimum personal attendance upon a Patient will be at least within 24 hours of admission and thereafter every 48 hours.

(d) An Accredited Practitioner will be contactable to review the Patient in person or their on-call or locum cover is available as requested by nursing staff to review the Patient in the Facility. If locum or back-up cover is not available to attend and review the Patient, this must be immediately notified to the Chief Executive Officer or Director of Clinical Services.

(e) Accredited Practitioners must ensure that all reasonable requests by Facility staff are responded to in a timely manner and in particular Patients are promptly attended to when reasonably requested by Facility staff for clinical reasons. If Accredited Practitioners are unable to provide this level of care personally, he/she shall secure the agreement of another Accredited Practitioner to provide the care and treatment, and shall advise the staff of the Facility of this arrangement. If locum or back-up cover is not available to attend and review the Patient, this must be immediately notified to the Chief Executive Officer or Director of Clinical Services.

(f) Accredited Practitioners must be available and attend upon Patients of the Accredited Practitioner in a timely manner when requested by Facility staff or be available by telephone in a timely manner to assist Facility staff in relation to the Accredited Practitioner's Patients. Alternatively, the Accredited Practitioner will make arrangements with another Accredited Practitioner to assist or will put in place with prior notice appropriate arrangements in order for another Accredited Practitioner to assist, and shall advise the staff of the Facility of this arrangement. If locum or back-up cover is not available to attend and review the Patient, this must be immediately notified to the Chief Executive Officer or Director of Clinical Services.

(g) It is the responsibility of the Accredited Practitioner to ensure any changes to contact details are notified promptly to the Chief Executive Officer or Director of Clinical Services. Accredited Practitioners must ensure that their communication devices are functional and that appropriate alternative arrangements are in place to contact them if their communication devices need to be turned off for any reason.

(h) A locum must be approved in accordance with these By-laws and the Accredited Practitioner must ensure that the locum's contact details are made available to the Facility and all relevant persons are aware of the locum cover and the dates of locum cover.

(i) Accredited Practitioners must only treat Patients within the Scope of Practice granted.

(j) Accredited Practitioners are required to work with and as part of a multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care for Patients. Accredited Practitioners must at all times be aware of the importance of effective communication with other members of the health care team, referring doctors, the Facility executive, Patients and the Patient's family or next of kin, and at all times ensure appropriate communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.

(k) The Accredited Practitioner must appropriately supervise the care that is provided by the Facility staff and other practitioners. This includes providing adequate instructions to, and

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supervision of, Facility staff to enable staff to understand what care the Accredited Practitioner requires to be delivered.

(l) Adequate instructions and clinical handover is required to be given to the Facility staff and other practitioners (including their on-call and locum cover) to enable them to understand what care the Accredited Practitioner requires to be delivered. The Accredited Practitioner must appropriately supervise the care that is provided by the Facility staff and other practitioners.

(m) If care is transferred to another Accredited Practitioner, this must be noted on the Patient medical record and communicated to the Director of Clinical Services or other responsible nursing staff member.

(n) Accredited Practitioners must give consideration to their own potential fatigue and that of other staff involved in the provision of patient care, when making patient bookings and in utilising operating theatre and procedure room time;

(o) Where hospital initiated on-call arrangements are in place for a particular speciality, Accredited Practitioners may elect to opt in to participate in those on call arrangements and must be available when on-call or ensure that there is appropriate back up on call cover. Persons providing on-call or cover services must be Accredited at the Facility.

(p) The Accredited Practitioner must ensure that their Patients are not discharged without the approval of the Accredited Practitioner, complying with the discharge policy of the Facility and completing all Patient discharge documents required by the Facility. It is the responsibility of the Accredited Practitioner to ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the referring practitioner, general practitioner or other treating practitioner.

6.2 Surgery

(a) Accredited Practitioners must effectively utilise allocated theatre sessions that have been requested by the Accredited Practitioner.

(b) Accredited Practitioners acknowledge the importance of, and will strictly adhere to, various measures aimed at ensuring safety and quality during surgery, which includes but is not limited to participating in or allowing to occur procedures relating to correct site surgery, team time out, infection control and surgical item counts.

(c) Accredited Practitioners who utilise a surgical or procedural assistant (the Assistant), who is not an Accredited Practitioner, will comply or ensure compliance with the following requirements:

(i) The Accredited Practitioner must have personally verified by sighting relevant documentation that the Assistant holds professional registration and adequate professional indemnity insurance to cover the services provided by the Assistant;

(ii) The Accredited Practitioner must notify and have the prior written approval of the Chief Executive Officer to the use of the Assistant, provide requested information and documents to the Chief Executive Officer, and ensure that the Assistant complies with any conditions of the approval;

(iii) The Accredited Practitioner acknowledges and agrees that they remain responsible for the Assistant and must provide effective and adequate supervision of the Assistant at all times;

(iv) The Accredited Practitioner's own professional indemnity insurance must cover their supervision of the Assistant;

(v) The Accredited Practitioner must ensure that contemporaneous records are maintained in the Facility medical record of the Patient relating to the services provided by the Assistant;

(vi) The Assistant must comply with any direction or requirement of the Chief Executive Officer (which may include the requirement for the Assistant to obtain Accreditation at the Facility), as well as the policies and procedures of the Facility.

6.3 Facility, State Based and National Safety Programs, Initiatives and Standards

Accredited Practitioners acknowledge the importance of ongoing safety and quality initiatives that may be instituted by the Facility based upon its own safety and quality program, or safety and quality initiatives, programs or standards of State or Commonwealth health departments, statutory bodies or safety and quality organisations (including for example the national Australian Commission on Safety and Quality in Health Care, a State based division of a Health Department such as the Office of Safety and Quality in Healthcare in Western Australia, or a State based independent statutory body).

Accredited Practitioners will participate in and ensure compliance with these initiatives and programs (including if they are voluntary initiatives that the Facility elects to participate in or undertake), whether these apply directly to the Accredited Practitioner or are imposed upon the Facility and require assistance from the Accredited Practitioner to ensure compliance, including but not limited to the National Safety and Quality Health Service Standards and Clinical Care Standards of the Australian Commission on Safety and Quality in Health Care.

6.4 Treatment and financial consent

Accredited Medical Practitioners and Dentists must obtain from the Patient or their legal guardian or substituted decision maker fully informed consent for treatment (except where it is not practical in cases of emergency) in accordance with accepted medical and legal standards and in accordance with the policy and procedures of the Facility.

For the purposes of this provision, an emergency exists where immediate treatment is necessary in order to save a person's life or to prevent serious injury to a person's health.

The consent will be evidenced in writing and signed by the Medical Practitioner/Dentist and Patient or their legal guardian or substituted decision maker.

It is expected that fully informed consent will be obtained by the Accredited Medical Practitioner/Dentist under whom the Patient is admitted or treated, in accordance with the Medical Practitioner's/Dentist's non delegable duty of care. The consent process will ordinarily include an explanation of the Patient's condition and prognosis, treatment and alternatives, inform the Patient of material risks associated with treatment and alternatives, and then obtain the consent to treatment. The consent process must also satisfy the Facility's requirements from time to time as set out in its policy and procedures.

Accredited Practitioners must provide full financial disclosure and obtain fully informed financial consent from their Patients in accordance with the relevant legislation, health fund agreements, policy and procedures of the Facility.

6.5 Patient Records

Accredited Practitioners must ensure that:

(a) Patient records held by the Facility are adequately maintained for Patients treated by the Accredited Practitioner;

(b) Patient records satisfy the Facility policy requirements, legislative requirements, accreditation requirements, and health fund obligations;

(c) they maintain full, accurate, legible and contemporaneous medical records, including in relation to each attendance upon the Patient, with the entries dated, time and signed;

(d) they comply with all legal requirements and standards in relation to the prescription and administration of medication, and properly document all drugs orders clearly and legibly in the medication chart maintained by the Facility;

(e) Patient records include all relevant information and documents reasonably necessary to allow Facility staff and other Accredited Practitioners to care for Patients;

(f) A procedure report is completed including a detailed account of the findings, technique undertaken, complications and post procedure orders;

(g) An anaesthetic report is completed, as well as documentation evidencing fully informed anaesthetic consent and post-anaesthetic evaluation;

(h) A discharge summary is completed that includes all relevant information reasonably required by the referring practitioner, general practitioner or other treating practitioner for ongoing care of the Patient.

6.6 Financial information and statistics

(a) Accredited Practitioners must record all data required by the Facility to meet health fund obligations, collect revenue and allow compilation of health care statistics.

(b) Accredited Practitioners must ensure that all Pharmaceutical Benefits Scheme prescription requirements and financial certificates are completed in accordance with Facility policy and regulatory requirements.

6.7 Quality improvement, risk management and regulatory agencies

(a) Accredited Practitioners are encouraged to attend and meaningfully participate in clinical practice review and peer review activities, including review of their clinical data and outcomes and respond to requests for information regarding statistical outliers, adverse events and cases flagged in incidents, clinical indicator or key performance indicator reporting.

(b) Accredited Practitioners are encouraged to participate in the Facility's safety, quality, risk management, education and training activities and peer reviews if required, although noting that mandatory participation may be required if mandated by a regulatory body or the Medical Advisory Committee.

(c) Accredited Practitioners will report to the Facility incidents, complications or, adverse events that result in injury, disability or harm, deaths and complaints relating to Patients of the Accredited Practitioner in accordance with the Facility policy and procedures and where requested by the Chief Executive Officer will assist with incident management, investigation and reviews (including root cause analysis and other systems reviews), complaints management, and open disclosure processes.

(d) Accredited Practitioners will participate in risk management activities and programs, including the implementation by the Facility of risk management strategies and recommendations from system reviews, and will maintain and comply with the ongoing minimum competency and continuing professional development requirements of their professional college with respect to the approved Scope of Practice. Where requested and, as part of Accreditation applications, Accredited Practitioners will provide evidence of external education and continuing professional development.

(e) Accredited Practitioners must provide all reasonable and necessary assistance in circumstances where the Facility requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction, including for example where that direction is pursuant to a court order, or from a health complaints body, AHPRA, Coroner,

Police, State Health Department and its agencies or departments, Private Health Unit, and Commonwealth Government and its agencies or departments.

(f) Accredited Practitioners shall comply with, and take all reasonable actions to assist the Facility to comply with, each of the National Safety and Quality Health Service Standards issued by the Australian Commission on Safety and Quality in Health Care and any associated clinical guidelines.

6.8 Clinical speciality committees

The Chief Executive Officer, in consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), may establish clinical speciality committees for the purpose of reviewing and advising the Chief Executive Officer on performance of the clinical speciality by reference to the Facility's clinical services, Organisational Capability and Organisational Need. These committees may include but are not limited to peer review and quality activities.

Each clinical speciality committee, in consultation with the Chief Executive Officer, Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), will establish terms of reference for the committee and will report annually, or as required by the Chief Executive Officer, on its activities to the Medical Advisory Committee, and make recommendations to the Medical Advisory Committee on issues relevant to the clinical speciality.

6.9 Participation in clinical teaching activities

Accredited Practitioners, if requested, are required to reasonably participate in the Facility's clinical teaching program.

6.10 Research

(a) The Facility approves, in principle, the conduct of research (including a clinical trial) in the Facility. However, no research will be undertaken without the prior approval of the Chief Executive Officer and a Human Research Ethics Committee, following written application by the Accredited Practitioner.

(b) The activities to be undertaken in the research must fall within the Scope of Practice of the Accredited Practitioner.

(c) For aspects of the research falling outside an indemnity from a third party (including the exceptions listed in the indemnity), the Accredited Practitioner must have in place adequate insurance with a reputable insurer to cover the medical research.

(d) Research will be conducted in accordance with National Health and Medical Research Council requirements, National Statement on Ethical Conduct in Human Research 2007 (as amended and updated from time to time), and other applicable legislation.

(e) An Accredited Practitioner has no power to bind the Facility to a research project (including a clinical trial) by executing a research agreement.

(f) There is no right of appeal from a decision to reject an application for research.

6.11 Obtain written approval for New Clinical Services

(a) Before treating patients with New Clinical Services, an Accredited Practitioner is required to obtain the prior written approval of the Chief Executive Officer (who will consult with the Medical Director, Director of Clinical Services and Chairperson of the Medical Advisory Committee), and if approval is received it will be subject to minimum requirements of compliance with the requirements of Facility policy (if any) for New Clinical Services, fall within the Accredited Practitioner's Scope of Practice or an amendment to the Scope of Practice has been obtained and fall within the licensed service capability of the Facility.

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(b) The Accredited Practitioner must provide evidence of Adequate Professional Indemnity Insurance to cover the New Clinical Service, and if requested, evidence that private health funds will adequately fund the New Clinical Services.

(c) The Accredited Practitioner must provide progress reports, at intervals set out in the written approval, to the Chief Executive Officer and Medical Director, who will include the progress reports in briefing material for the Medical Advisory Committee, and must comply with any subsequent directions received from the Chief Executive Officer (who will consult with the Medical Director and Chairperson of the Medical Advisory Committee before giving any direction).

(d) If research is involved, then the By-law dealing with research must be complied with.

(e) The Chief Executive Officer's decision is final and there shall be no right of appeal from denial of requests for New Clinical Services.

6.12 Utilisation

Accredited Practitioners will be advised upon Accreditation or Re-Accreditation, or at other times as determined by the Chief Executive Officer, of the expectations in relation to exercising Accreditation and utilisation of the facility. Absent special circumstances, the Accredited Practitioner must exercise Accreditation or utilise the Facility in accordance with the specified expectations.

6.13 Students

(a) An Accredited Practitioner may be accompanied by a student provided that the following requirements are complied with:

(i) The student must be enrolled to undertake training at a recognised tertiary institution and the Accredited Practitioner is responsible for verifying that enrolment;

(ii) The student must have the prior approval of the Chief Executive Officer to attend the Facility and supply any requested information or documents;

(iii) The Accredited Practitioner must provide effective and adequate supervision of the student at all times;

(iv) The student is not permitted to perform any direct clinical services upon or provide clinical care to a Patient;

(v) The Accredited Practitioner must seek the consent of the Patient for the attendance of student and clearly inform the Patient that the status of the individual is a student;

(vi) The student must comply with any direction or requirement of the Chief Executive Officer, as well as the policies and procedures of the Facility.

Part C – Accreditation of Medical Practitioners

7. Credentialing and Scope of Practice

7.1 Eligibility for Accreditation as Medical Practitioners

Accreditation as Medical Practitioners will only be granted if Medical Practitioners demonstrate adequate Credentials, are professionally competent, satisfy the requirements of the By-laws, and are prepared to comply with the By-laws and the Facility policies, and provide written acknowledgment of such preparedness.

7.2 Responsibility and basis for Accreditation and granting of Scope of Practice

The Chief Executive Officer, subject to ratification by the Board, will determine the outcome of applications for Accreditation as Medical Practitioners and defined Scope of Practice for each

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applicant. In making any determination, the Chief Executive Officer will make independent and informed decisions and in so doing will have regard to the matters set out in these By-laws and will have regard to the recommendations of the Medical Advisory Committee. The Chief Executive Officer may, at his/her discretion, consider other matters as relevant to the application when making his/her determination.

7.3 Medical Advisory Committee

The Chief Executive Officer shall convene a Medical Advisory Committee (MAC) in accordance with the terms of reference established for the MAC.

The MAC members, including the chairperson, will be appointed by a closed vote by Accredited Practitioners pursuant to parameters set by the Board, for such period as determined by the Board and may be removed from membership of the committee by the Board.

The Board may establish a Credentialing Committee, which will be a sub-committee of the MAC. The Credentialing Committee will function in accordance with the terms of reference established for that committee. The primary role of a Credentialing Committee will be to conduct some aspects of the Credentialing requirements set out in these By-laws and make recommendations to the MAC. In the event a Credentialing Committee is established, the responsibilities set out in these By-laws in relation to Credentialing will still ultimately remain with the MAC.

In the absence of a Credentialing Committee, the role will be performed by the MAC. If the jurisdiction in which the Facility is located requires a separate Credentialing Committee to consider and make recommendations relating to Credentialing, but the role is performed by the MAC, the terms of reference for the Credentialing Committee will include a process that provides for closing the MAC meeting and reconvening it as a Credentialing Committee meeting, including recording of separate minutes.

In addition to the terms of reference established for the MAC or Credentialing Committee, the Committees must be constituted according to and the members of the Committees must conduct themselves in accordance with any legislative obligations, including standards that have mandatory application to the Facility and Committee members. For example, the obligations imposed pursuant to the Health Services Act 1988 (the Act), and the Health Services (Private Hospitals and Day Procedure Centres) Regulations 2013 (the Regulations).

The Chief Executive Officer, Medical Director and Director of Clinical Services will be entitled to attend meetings of the MAC as ex-officio members, such that they will not have an entitlement to vote in relation to decisions or recommendations of the MAC and Credentialing Committee.

In making determinations about applications for Accreditation there will ordinarily be at least one member of the same speciality as the applicant on the MAC, which may mean co-opting a committee member in order to assist with the determination. It is, however, recognised that this may not always be possible or practicable in the circumstances, and a failure to do so will not invalidate the recommendation of the MAC.

Members of the Medical Advisory Committee and sub-committees will be indemnified by the Facility through its insurance program, in accordance with the terms and conditions of that insurance (relevant parts of that insurance will be made available upon request), and subject to the person acting in accordance with the By-Laws (including the roles and responsibilities specified in the By-Laws and any position description), within the terms of reference, and in good faith.

8. The process for appointment and re-appointment

8.1 Applications for Initial Accreditation and Re-Accreditation as Medical Practitioners

(a) Applications for Initial Accreditation (where the applicant does not currently hold Accreditation at the Facility) and Re-Accreditation (where the applicant currently holds Accreditation at the

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Facility) as Medical Practitioners must be made in writing on the prescribed form. All questions on the prescribed form must be fully completed and all required information and documents supplied before an application will be considered. Applications should be forwarded to the Chief Executive Officer at least six weeks prior to the Medical Practitioner seeking to commence at the Facility or such shorter time permitted by to the Facility due to Organisational Need or patient needs. Temporary Accreditation or Emergency Accreditation will be considered at the discretion of the Chief Executive Officer, following consultation with the Chair of the Medical Advisory Committee.

(b) Applications must include a declaration signed by the Medical Practitioner to the effect that the information provided by the Medical Practitioner is true and correct, that the Medical Practitioner will comply in every respect with the By-laws in the event that the Medical Practitioner's application for Accreditation is approved.

(c) The Chief Executive Officer may interview and/or request further information from applicants that the Chief Executive Officer considers appropriate.

(d) The Chief Executive Officer will ensure that applications are complete and requests for further information complied with, and upon being satisfied will refer applications, together with notes from any interview conducted, to the Medical Advisory Committee for consideration.

8.2 Consideration by the Medical Advisory Committee

(a) The Medical Advisory Committee will consider all applications for Accreditation and Re-Accreditation referred to it by the Chief Executive Officer.

(b) Consideration by the Medical Advisory Committee will include but not be limited to information relevant to Credentials, Competence, Current Fitness, Organisational Capability and Organisational Need.

(c) The Medical Advisory Committee will make recommendations to the Chief Executive Officer as to whether the applications should be approved and if so, on what terms, including the Scope of Practice to be granted.

(d) The Medical Advisory Committee will act and make recommendations in accordance with its terms of reference and any relevant policy, as amended from time to time, including in relation to the consideration of applications for Accreditation and Re-Accreditation.

(e) In instances where the Medical Advisory Committee has doubts about a Medical Practitioner's ability to perform the services, procedures or other interventions which may have been requested for inclusion in the Scope of Practice, they may recommend to the Chief Executive Officer to:

(i) initiate an Internal Review;

(ii) initiate an External Review;

(iii) grant Scope of Practice for a limited period of time followed by review;

(iv) apply conditions or limitations to Scope of Practice requested; and/or

(v) apply requirements for relevant clinical services, procedures or other interventions to be performed under supervision or monitoring.

(f) If the Medical Practitioner's Credentials and assessed Competence and performance do not meet the Threshold Credentials (if any) established for the requested Scope of Practice (if any), the Medical Advisory Committee may recommend refusal of the application.

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8.3 Consideration of applications for Initial Accreditation by the Chief Executive Officer

(a) The Chief Executive Officer, in consultation with the Medical Director and Director of Clinical Services, will consider applications for Initial Accreditation as Medical Practitioners referred to the Chief Executive Officer by the Medical Advisory Committee and will decide whether the applications should be rejected or approved and, if approved, whether any conditions should apply.

(b) In considering applications, the Chief Executive Officer will give due consideration to any other information relevant to the application as determined by the Chief Executive Officer, but the final decision is that of the Chief Executive Officer and the Chief Executive Officer is not bound by the recommendation of the Medical Advisory Committee. In addition to considering the recommendations of the Medical Advisory Committee, including Organisational Capability and Organisational Need, the Chief Executive Officer may consider any matter assessed as relevant to making the determination in the circumstances of a particular case.

(c) The Chief Executive Officer may adjourn consideration of an application in order to obtain further information from the Medical Advisory Committee, the Medical Practitioner or any other person or organisation.

(d) If the Chief Executive Officer requires further information from the Medical Practitioner before making a determination, they will forward a letter to the Medical Practitioner:

(i) informing the Medical Practitioner that the Chief Executive Officer requires further information from the Medical Practitioner before deciding the application;

(ii) identifying the information required. This may include, but is not limited to, information from third parties such as other hospitals relating to current or past Accreditation, Scope of Practice and other issues relating to or impacting upon the Accreditation with that other hospital; and

(iii) requesting that the Medical Practitioner provide the information in writing or consent to contacting a third party for information or documents, together with any further information the Medical Practitioner considers relevant within fourteen (14) days from the date of receipt of the letter.

(e) In the event that the information or documents requested by the Chief Executive Officer is not supplied in the time set out in the letter, the Chief Executive Officer may, at their discretion, reject the application or proceed to consider the application without such additional information.

(f) The Chief Executive Officer will refer decisions made by the Chief Executive Officer in relation to applications for Accreditation to the Board for ratification. Accreditation will only be finalised following receipt of ratification from the Board. If the Board does not ratify a decision made by the Chief Executive Officer, the Board may send back the matter for further consideration to the Chief Executive Officer, specifying the reasons and/or further queries and/or further actions that may be required. The Chief Executive Officer will address these matters and resubmit to the Board for ratification. The Board may elect to ratify or not ratify the decision of the Chief Executive Officer. If the Board elects not to ratify the decision of the Chief Executive Officer then Accreditation is taken to be rejected. If the Board elects to ratify the decision of the Chief Executive Officer then Accreditation is taken to be approved.

(g) Following ratification or non-ratification by the Board of the decision of the Chief Executive Officer, the Chief Executive Officer will forward a letter to the Medical Practitioner advising the Medical Practitioner whether the application has been approved or rejected. If the application has been approved, the letter will also contain details of the Scope of Practice granted.

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(h) There is no right of appeal from a decision to reject an initial application for Accreditation, or any terms or conditions that may be attached to approval of an application for initial Accreditation.

8.4 Initial Accreditation tenure

(a) Initial Accreditation as a Medical Practitioner at the Facility may, at the election of the Chief Executive Officer, be for a probationary period of one year.

(b) Prior to the end of any probationary period established pursuant to By-law 8.4(a), a review of the Medical Practitioner's level of Competence, Current Fitness, Performance, compatibility with Organisational Capability and Organisational Need, and confidence in the Medical Practitioner will be undertaken by the Chief Executive Officer, in consultation with the Medical Director and Director of Clinical Services. The Chief Executive Officer will seek input from the relevant Medical Advisory Committee or Speciality Committee where established. The Chief Executive Officer may initiate the review at any time during the probationary period where concerns arise about Performance, Competence, Current Fitness of, or confidence in the Medical Practitioner, or there is evidence of Behavioural Sentinel Events exhibited by the Medical Practitioner.

(c) In circumstances where, in respect of a Medical Practitioner:

(i) a review conducted by the Chief Executive Officer at the end of the probationary period, or

(ii) a review conducted by the Chief Executive Officer at any time during the probationary period,

causes the Chief Executive Officer to consider:

(iii) the Medical Practitioner's Scope of Practice should be amended, or

(iv) the probationary period should be terminated, or

(v) the probationary period should be extended, or

(vi) the Medical Practitioner should not be offered Re-accreditation,

the Medical Practitioner will be:

(vii) notified of the circumstances which have given rise to the relevant concerns, and

(viii) be given an opportunity to be heard and present his/her case.

(d) Should the Medical Practitioner have an acceptable probationary Accreditation review outcome, or in circumstances where Initial Accreditation is granted without a probationary period, the Chief Executive Officer, following consultation with the Medical Director and Director of Clinical Services, and following receipt of input from the relevant Medical Advisory Committee or Speciality Committee where established, may grant an Accreditation period of up to five years on receipt of a signed declaration from the Medical Practitioner describing any specific changes, if any, to the initial information provided and ongoing compliance with all requirements as per the By-laws.

(e) Should the probationary Accreditation review outcome be unacceptable to the Chief Executive Officer, they may, following consultation with the Medical Director and Director of Clinical Services, and following receipt of input from the relevant Medical Advisory Committee or Speciality Committee where established:

(i) amend the Scope of Practice granted; or

(ii) decide that Accreditation will not be granted.

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(f) The Chief Executive Officer (following the consultation set out above) will make a final determination on Accreditation for all Medical Practitioners, including at the end of the probationary period, which will be forwarded for ratification by the Board. The Board may elect to ratify or not ratify the decision of the Chief Executive Officer. If the Board elects not to ratify the decision of the Chief Executive Officer then Accreditation is taken to be rejected. If the Board elects to ratify the decision of the Chief Executive Officer then Accreditation is taken to be approved.

(g) There will be no right of appeal at the end of the probationary period for a determination that Accreditation will not be granted following conclusion of the probationary period, or to any terms or conditions that may be attached to the grant of any Accreditation following the probationary period. All Medical Practitioners shall agree with this as a condition of Initial Accreditation.

8.5 Re-Accreditation

(a) The Chief Executive Officer will, at least three months prior to the expiration of any term of Accreditation of each Medical Practitioner (other than a probationary period), provide to that Medical Practitioner an application form to be used in applying for Re-Accreditation.

(b) Any Medical Practitioner wishing to be Re-Accredited must send the completed application form to the Chief Executive Officer at least two months prior to the expiration date of the Medical Practitioner's current term of Accreditation.

(c) The Chief Executive Officer and Medical Advisory Committee will deal with applications for Re-Accreditation in the same manner in which they are required to deal with applications for Initial Accreditation as Medical Practitioners, including the requirement for ratification by the Board.

(d) The rights of appeal conferred upon Medical Practitioners who apply for Re-Accreditation as Medical Practitioners are set out in these By-Laws.

8.6 Re-Accreditation tenure

Granting of Accreditation and Scope of Practice subsequent to the any probationary period will be for a term of up to five years, as determined by the Chief Executive Officer.

8.7 Nature of appointment of Visiting Medical Practitioners

(a) Medical Practitioners who have received Accreditation pursuant to the By-laws are entitled to make a request for access to facilities for the treatment and care of their Patients within the limits of the defined Scope of Practice attached to such Accreditation at the Facility and to utilise facilities provided by the Facility for that purpose, subject to the provisions of the By-laws, Facility policies, resource limitations, and in accordance with Organisational Need and Organisational Capability.

(b) The decision to grant access to facilities for the treatment and care of a Medical Practitioner's Patients is on each occasion within the sole discretion of the Chief Executive Officer and the grant of Accreditation contains no conferral of, or general expectation relating to, a 'right of access' to the Facility or its resources.

(c) A Medical Practitioner's use of the facilities for the treatment and care of Patients is limited to the Scope of Practice granted and subject to the conditions upon which the Scope of Practice is granted, resource limitations, and Organisational Need and Organisational Capability. Accredited Practitioners acknowledge that admission or treatment of a particular Patient is subject always to bed availability, the availability or adequacy of nursing or allied health staff or facilities given the treatment or clinical care proposed.

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(d) Accreditation does not of itself constitute an employment contract nor does it establish a contractual relationship between the Medical Practitioner and the Facility.

(e) Accreditation is personal and cannot be transferred to, or exercised by, any other person.

(f) It is a condition of accepting Accreditation, and of ongoing Accreditation, that the Accredited Practitioner understands and agrees that these By-laws are the full extent of processes and procedures available to the Accredited Practitioner with respect to all matters relating to and impacting upon Accreditation, and no additional procedural fairness or natural justice principles will be incorporated or implied, other than processes and procedures that have been explicitly set out in these By-laws.

(g) Accredited Practitioners acknowledge and agree as a condition of the granting of, and ongoing Accreditation, that the granting of Accreditation establishes only that the Accredited Practitioner is a person able to provide services at the Facility, as well as the obligations and expectations with respect to the Accredited Practitioner while providing services for the period of Accreditation, the granting of Accreditation creates no rights or legitimate expectation with respect to access to the Facility or its resources, and while representatives of the Facility will generally conduct themselves in accordance with these By-laws they are not legally bound to do so and there are no legal consequences for the Facility and its representatives in not doing so.

9. Extraordinary Accreditation

9.1 Temporary Accreditation

(a) The Chief Executive Officer, in consultation with the Medical Director and/or Chairperson of the Medical Advisory Committee, may grant Medical Practitioners Temporary Accreditation and Scope of Practice on terms and conditions considered appropriate by the Chief Executive Officer. Temporary Accreditation will only be granted on the basis of Patient need, Organisational Capability and Organisational Need. The Chief Executive Officer may consider Emergency Accreditation for short notice requests.

(b) Applications for Temporary Accreditation as Medical Practitioners must be made in writing on the prescribed form as for initial applications. All questions on the prescribed form must be fully completed and required information and documents submitted before an application will be considered.

(c) Temporary Accreditation may be terminated by the Chief Executive Officer for failure by the Medical Practitioner to comply with the requirements of the By-laws or following provisions of Temporary Accreditation requirements. Temporary Accreditation will automatically cease upon a determination of the Medical Practitioner's application for Accreditation or at such other time following such determination as the Chief Executive Officer decides.

(d) The period of Temporary Accreditation shall be determined by the Chief Executive Officer, which will be for a period of no longer than three (3) months.

(e) There can be no expectation that a grant of Temporary Accreditation will mean that there is be a subsequent granting of Accreditation.

(f) The Medical Advisory Committee and Board will be informed of all Temporary Accreditation granted.

(g) There will be no right of appeal from decisions relating to the granting of Temporary Accreditation or termination of Temporary Accreditation.

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9.2 Emergency Accreditation

(a) In the case of an emergency, any Medical Practitioner, to the extent permitted by the terms of the Medical Practitioner's registration, may request Emergency Accreditation and granting of Scope of Practice in order to continue the provision of treatment and care to Patients. Emergency Accreditation may be considered by the Chief Executive Officer (and where time permits, will occur in consultation by the Chief Executive Officer with the Medical Director and/or Chairperson of the Medical Advisory Committee) for short notice requests, to ensure continuity and safety of care for Patients and/or to meet Organisational Need.

(b) As a minimum, the following is required:

(i) verification of identity through inspection of relevant documents (eg driver's licence with photograph);

(ii) immediate contact with a member of senior management of an organisation nominated by the Medical Practitioner as their most recent place of Accreditation to verify employment or appointment history;

(iii) verification of professional registration and insurance as soon as practicable;

(iv) confirmation of at least one professional referee of the Medical Practitioner's Competence and good standing;

(v) verification will be undertaken by the Chief Executive Officer (or delegate) and will be fully documented.

(c) Emergency Accreditation will be followed as soon as practicable with Temporary Accreditation or Initial Accreditation application processes if required.

(d) Emergency Accreditation will be approved for a limited period as identified by the Chief Executive Officer, for the safety of Patients involved, and will automatically terminate at the expiry of that period or as otherwise determined by the Chief Executive Officer.

(e) The Medical Advisory Committee and Board will be informed of all Emergency Accreditations.

(f) There will be no right of appeal from decisions on granting, or termination, of Emergency Accreditation.

9.3 Locum Tenens

Locums must be approved by the Chief Executive Officer (in consultation with the Medical Director and/or Chairperson of the Medical Advisory Committee) before they are permitted to arrange the admission of and/or to treat Patients on behalf of Visiting Medical Practitioners.

Temporary Accreditation requirements must be met before approval of locums is granted.

There will be no right of appeal from decisions in relation to locum appointments.

10. Variation of Accreditation or Scope of Practice

10.1 Practitioner may request amendment of Accreditation or Scope of Practice

(a) An Accredited Medical Practitioner may apply for an amendment or variation of their existing Scope of Practice or any term or condition of their Accreditation, other than in relation to the general terms and conditions applying to all Accredited Practitioners as provided in these By-laws.

(b) The process for amendment or variation is the same for an application for Re-Accreditation, except the Medical Practitioner will be required to complete a Request for Amendment of Accreditation or Scope of Practice Form and provide relevant documentation and references in support of the amendment or variation.

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(c) The process to adopt in consideration of the application for amendment or variation will be as set out in By-Laws 8.1 to 8.3.

(d) The rights of appeal conferred upon Medical Practitioners who apply for amendment or variation are set out in these By-Laws, except an appeal is not available for an application made during a probationary period, or in relation to Temporary Accreditation, Emergency Accreditation, or a Locum Tenens.

11. Review of Accreditation or Scope of Practice

11.1 Authorised Person may initiate review of Accreditation or Scope of Practice

(a) The Chief Executive Officer, in consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), may at any time initiate a review of a Medical Practitioner's Accreditation or Scope of Practice where concerns or an allegation are raised about any of the following:

(i) Patient health or safety could potentially be compromised;

(ii) the rights or interests of a Patient, staff or someone engaged in or at the Facility has been adversely affected or could be infringed upon;

(iii) non-compliance with the Behavioural Standards

(iv) the Medical Practitioner's level of Competence;

(v) the Medical Practitioner's Current Fitness;

(vi) the Medical Practitioner's Performance;

(vii) compatibility with Organisational Capability and Organisational Need;

(viii) the current Scope of Practice granted does not support the care or treatment sought to be undertaken by the Medical Practitioner;

(ix) confidence in the Medical Practitioner;

(x) compliance with these By-laws, including terms and conditions;

(xi) a possible ground for suspension or termination of Accreditation may have occurred;

(xii) the efficient operation of the Facility could be threatened or disrupted, the potential loss of the Facility's licence or accreditation, or the potential to bring the Facility into disrepute;

(xiii) a breach of a legislative or legal obligation of the Facility or imposed upon the Accredited Practitioner may have occurred; or

(xiv) as elsewhere defined in these By-laws.

(b) The Chief Executive Officer, in consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), will determine whether the process to be followed is an;

(i) Internal Review; or

(ii) External Review.

(c) Prior to determining whether an Internal Review or External Review will be conducted, the Chief Executive Officer may in his or her absolute discretion meet with the Medical Practitioner, along with any other persons the Chief Executive Officer considers appropriate, advise of the concern or allegation raised, and invite a preliminary response from the Medical Practitioner (in writing or orally as determined by the Chief Executive Officer) before the Chief

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Executive Officer, in consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), makes a determination whether a review will proceed, and if so, the type of review.

(d) The review may have wider terms of reference than a review of the Medical Practitioner's Accreditation or Scope of Practice.

(e) The Chief Executive Officer, in consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), must make a determination whether to impose an interim suspension or conditions upon the Accreditation of the Medical Practitioner pending the outcome of the review and, if imposed, there is no right of appeal from this interim decision pursuant to the By-laws.

(f) In addition or as an alternative to conducting an internal or external review, the Chief Executive Officer will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised if required by legislation, otherwise the Chief Executive Officer may notify if the Chief Executive Officer considers it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, or it is considered that the registration board or professional body is more appropriate to investigate and take necessary action. Following the outcome of any action taken by the registration board and/or other professional body the Chief Executive Officer may elect to take action, or further action, under these By-laws.

11.2 Internal Review of Accreditation and Scope of Practice

(a) The Chief Executive Officer, in consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), will establish the terms of reference of the Internal Review, and will co-ordinate with the Medical Advisory Committee or co-opted Medical Practitioners or personnel from within the Facility who bring specific expertise to the Internal Review as determined by the Chief Executive Officer.

(b) The terms of reference, process, and reviewers will be as determined by the Chief Executive Officer, in consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee). The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral.

(c) The Chief Executive Officer will notify the Medical Practitioner in writing of the review, the terms of reference, process and reviewers.

(d) A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewers to the Chief Executive Officer.

(e) Following consideration of the report, the Chief Executive Officer is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate a Medical Practitioner’s Accreditation in accordance with these By-laws. Prior to making a determination, the Chief Executive Officer will consult with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee).

(f) The Chief Executive Officer must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.

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(g) The Medical Practitioner shall have the rights of appeal established by these By-laws in relation to the final determination made by the Chief Executive Officer if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.

(h) In addition or as an alternative to taking action in relation to the Accreditation follow receipt of the report, the Chief Executive Officer will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation, otherwise the Chief Executive Officer may notify if the Chief Executive Officer considers it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of the Facility.

11.3 External Review of Accreditation and Scope of Practice

(a) The Chief Executive Officer, in consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), will make a determination about whether an External Review will be undertaken.

(b) An External Review will be undertaken by a person(s) external to the Facility and of the Accredited Medical Practitioner in question and such person(s) will be nominated by the Chief Executive Officer at his/her discretion, in consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee).

(c) The terms of reference, process, and reviewers will be as determined by the Chief Executive Officer, in consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee). The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral.

(d) The Chief Executive Officer will notify the Medical Practitioner in writing of the review, the terms of reference, process and reviewers.

(e) The external reviewer is required to provide a detailed report on the findings of the review in accordance with the terms of reference to the Chief Executive Officer.

(f) The Chief Executive Officer will review the report from the External Review and make a determination of whether to continue (including with conditions), amend, suspend or terminate the Medical Practitioner’s Accreditation or Scope of Practice in accordance with these By-laws. Prior to making a determination, the Chief Executive Officer will consult with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee).

(g) The Chief Executive Officer must notify the Medical Practitioner in writing of the determination made in relation to the Accreditation, the reasons for it, and advise of the right of appeal, the appeal process and the timeframe for an appeal.

(h) The Medical Practitioner shall have the rights of appeal established by these By-laws in relation to the final determination made by the Chief Executive Officer if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.

(i) In addition or as an alternative to taking action in relation to the Accreditation follow receipt of the report, the Chief Executive Officer will notify the Medical Practitioner's registration board and/or other professional body responsible for the Medical Practitioner of details of the concerns raised and outcome of the review if required by legislation, otherwise the Chief Executive Officer may notify if the Chief Executive Officer considers it is in the interests of

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Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, it is considered appropriate that the registration board or professional body consider the matter, or it should be done to protect the interests of the Facility.

12. Suspension, termination, imposition of conditions, resignation and expiry of Accreditation

12.1 Suspension of Accreditation

(a) The Chief Executive Officer, following consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), may immediately suspend a Medical Practitioner's Accreditation should the Chief Executive Officer believe, or have a sufficient concern:

(i) it is in the interests of Patient care or safety. This can be based upon an investigation by an external agency including a registration board, disciplinary body, Coroner or health complaints body, and may be related to a patient or patients at another facility not operated by the Facility;

(ii) the continuance of the current Scope of Practice raises a significant concern about the safety and quality of health care to be provided by the Medical Practitioner;

(iii) it is in the interests of staff welfare or safety;

(iv) serious and unresolved allegations have been made in relation to the Medical Practitioner. This may be related to a patient or patients of another facility not operated by the Facility, including if these are the subject of review by an external agency including a registration board, disciplinary body, Coroner or a health complaints body;

(v) the Medical Practitioner fails to observe the terms and conditions of his/her Accreditation;

(vi) the behaviour or conduct is in breach of a direction or an undertaking, or the Facility By-Laws, policies and procedures;

(vii) the behaviour or conduct is such that it is unduly hindering the efficient operation of the Facility at any time, is bringing the Facility into disrepute, does not comply with the Behaviour Standards, is considered disruptive or a Behavioural Sentinel Event or inconsistent with the values of the Facility;

(viii) the Medical Practitioner has been suspended by their registration board;

(ix) there is a finding of professional misconduct, unprofessional conduct, unsatisfactory professional conduct or some other adverse professional finding (however described) by a registration board or other relevant disciplinary body or professional standards organisation for the Medical Practitioner;

(x) the Medical Practitioner's professional registration is amended, or conditions imposed, or undertakings agreed, irrespective of whether this relates to a current or former Patient of the Facility;

(xi) the Medical Practitioner has made a false declaration or provided false or inaccurate information to the Facility, either through omission of important information or inclusion of false or inaccurate information;

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(xii) the Medical Practitioner fails to make the required notifications required to be given pursuant to these By-laws or based upon the information contained in a notification suspension is considered appropriate;

(xiii) the Accreditation, clinical privileges or Scope of Practice of the Medical Practitioner has been suspended, terminated, restricted or made conditional by another health care organisation;

(xiv) the Medical Practitioner is the subject of a criminal investigation about a serious matter (for example a drug related matter, or an allegation of a crime against a person such as a sex or violence offence) which, if established, could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Facility and the broader community;

(xv) the Medical Practitioner has been convicted of a crime which could affect his or her ability to exercise his or her Scope of Practice safely and competently and with the confidence of the Facility and the broader community;

(xvi) based upon a finalised Internal Review or External Review pursuant to these By-laws any of the above criteria for suspension are considered to apply;

(xvii) an Internal Review or External Review has been initiated pursuant to these By-laws and the Chief Executive Officer considers that an interim suspension is appropriate pending the outcome of the review; or

(xviii) there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for suspension.

(b) The Chief Executive Officer shall notify the Medical Practitioner of:

(i) the fact of the suspension;

(ii) the period of suspension;

(iii) the reasons for the suspension;

(iv) if the Chief Executive Officer considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider the suspension should be lifted;

(v) if Chief Executive Officer considers it applicable and appropriate in the circumstances, any actions that must be performed for the suspension to be lifted and the period within which those actions must be completed; and

(vi) the right of appeal, the appeal process and the time frame for an appeal.

(c) As an alternative to an immediate suspension, the Chief Executive Officer may elect to deliver a show cause notice to the Medical Practitioner advising of:

(i) the facts and circumstances forming the basis for possible suspension;

(ii) the grounds under the By-Laws upon which suspension may occur;

(iii) invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider suspension is not appropriate;

(iv) if applicable and appropriate in the circumstances, any actions that must be performed for the suspension not to occur and the period within which those actions must be completed; and

(v) a timeframe in which a response is required from the Medical Practitioner to the show cause notice;

Following receipt of the response the Chief Executive Officer, following consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), will determine whether the Accreditation will be suspended. If suspension is to occur notification will be sent in accordance with paragraph (b). Otherwise the Medical Practitioner will be advised that suspension will not occur, however this will not prevent the Chief Executive Officer from taking other action at this time, including imposition of conditions, and will not prevent the Chief Executive Officer from relying upon these matters as a ground for suspension or termination in the future.

(d) The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by the Chief Executive Officer.

(e) The affected Medical Practitioner shall have the rights of appeal established by these By-laws.

(f) The Chief Executive Officer will notify the Board and Medical Advisory Committee of any suspension of Accreditation.

(g) If there is held, in good faith, a belief that the matters forming the grounds for suspension give rise to a significant concern about the safety and quality of health care provided by the Medical Practitioner including but not limited to patients outside of the Facility, it is in the interests of Patient care or safety to do so, it is in the interests of protection of the Public (including patients at other facilities) to do so, it is required by legislation, or for other reasonable grounds, the Chief Executive Officer will notify the Medical Practitioner's registration board and/or other relevant regulatory agency of the suspension and the reasons for it.

(h) Accredited Practitioners accept and agree that, as part of the acceptance of Accreditation, a suspension of Accreditation carried out in accordance with these By-laws is a safety and protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

12.2 Termination of Accreditation

(a) Accreditation shall be immediately terminated by the Chief Executive Officer if the following has occurred, or if it appears based upon the information available to the Chief Executive Officer the following has occurred:

(i) the Medical Practitioner ceases to be registered with their relevant registration board;

(ii) the Medical Practitioner ceases to maintain Adequate Professional Indemnity Insurance covering the Scope of Practice;

(iii) a term or condition that attaches to an approval of Accreditation is breached, not satisfied, or according to that term or condition results in the Accreditation concluding; or

(iv) a contract of employment or to provide services is terminated or ends, and is not renewed.

(b) Accreditation may be terminated by the Chief Executive Officer, following consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), if the following has occurred, or if it appears based upon the information available to the Chief Executive Officer the following has occurred:

(i) based upon any of the matters in By-Law 12.1(a) and it is considered suspension is an insufficient response in the circumstances;

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(ii) based upon a finalised Internal Review or External Review pursuant to these By-laws and termination of Accreditation is considered appropriate in the circumstances or in circumstances where the Chief Executive Officer does not have confidence in the continued appointment of the Medical Practitioner;

(iii) the Medical Practitioner is not regarded by the Chief Executive Officer as having the appropriate Current Fitness to retain Accreditation or the Scope of Practice, or the Chief Executive Officer does not have confidence in the continued appointment of the Medical Practitioner;

(iv) conditions have been imposed by the Medical Practitioner's registration board on clinical practice that restricts practice and the Facility elects not to accommodate the conditions imposed;

(v) the Medical Practitioner has not exercised Accreditation or utilised the facilities at the Facility for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Medical Practitioner by the Chief Executive Officer;

(vi) the Scope of Practice is no longer supported by Organisational Capability or Organisational Need;

(vii) the Medical Practitioner becomes permanently incapable of performing his/her duties which shall for the purposes of these By-laws be a continuous period of six months' incapacity; or

(viii) there are other unresolved issues or other concerns in respect of the Medical Practitioner that is considered to be a ground for termination.

(c) The Accreditation of a Medical Practitioner may be terminated as otherwise provided in these By-laws.

(d) The Chief Executive Officer shall notify the Medical Practitioner of:

(i) the fact of the termination;

(ii) the reasons for the termination;

(iii) if the Chief Executive Officer considers it applicable and appropriate in the circumstances, invite a written response from the Medical Practitioner why they may consider a termination should not have occurred; and

(iv) if a right of appeal is available in the circumstances, the right of appeal, the appeal process and the time frame for an appeal.

(e) As an alternative to an immediate termination, the Chief Executive Officer may elect to deliver a show cause notice to the Medical Practitioner advising of:

(i) the facts and circumstances forming the basis for possible termination;

(ii) the grounds under the By-Laws upon which termination may occur;

(iii) invite a written response from the Medical Practitioner, including a response why the Medical Practitioner may consider termination is not appropriate;

(iv) if applicable and appropriate in the circumstances, any actions that must be performed for the termination not to occur and the period within which those actions must be completed; and

(v) a timeframe in which a response is required from the Medical Practitioner to the show cause notice;

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Following receipt of the response the Chief Executive Officer, following consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with paragraph (d). Otherwise the Medical Practitioner will be advised that termination will not occur, however this will not prevent the Chief Executive Officer from taking other action at this time, including imposition of conditions, and will not prevent the Chief Executive Officer from relying upon these matters as a ground for suspension or termination in the future.

(f) All terminations must be notified to the Board and Medical Advisory Committee.

(g) For a termination of Accreditation pursuant to By-law 12.2(a), there shall be no right of appeal.

(h) For a termination of Accreditation pursuant to By-law 12.2(b), the Medical Practitioner shall have the rights of appeal established by these By-laws.

(i) Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by the Chief Executive Officer to the Medical Practitioner's registration board and/or other relevant regulatory agency.

(j) Accredited Practitioners accept and agree, as part of the acceptance of Accreditation, that a termination of Accreditation carried out in accordance with these By-laws is a safety and protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

12.3 Imposition of conditions

(a) At the conclusion of or pending finalisation of a review, or in lieu of a suspension or in lieu of a termination the Chief Executive Officer, following consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee), may elect to impose conditions on the Accreditation or Scope of Practice.

(b) The Chief Executive Officer must notify the Medical Practitioner in writing of the imposition of conditions, the reasons for it, the consequences if the conditions are breached, and advise of the right of appeal, the appeal process and the timeframe for an appeal.

(c) If the Chief Executive Officer considers it applicable and appropriate in the circumstances, they may also invite a written response from the Medical Practitioner as to why the Medical Practitioner may consider the conditions should not be imposed.

(d) If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Chief Executive Officer, following consultation with the Director of Clinical Services and Medical Director (or in the absence of the Medical Director, the Chairperson of the Medical Advisory Committee).

(e) The affected Medical Practitioner shall have the rights of appeal established by these By-laws.

(f) If there is held, in good faith, a belief that the continuation of the unconditional right to practise in any other organisation would raise a significant concern about the safety and quality of health care for patients and the public, the Chief Executive Officer will notify the Medical Practitioner's registration board and/or other relevant regulatory agency of the imposition of the conditions and the reasons the conditions were imposed.

(g) Accredited Practitioners accept and agree, as part of the acceptance of Accreditation, that an imposition of conditions carried out in accordance with these By-laws is a safety and

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protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

12.4 Resignation and expiry of Accreditation

A Medical Practitioner may resign his/her Accreditation by giving one month's notice of the intention to do so to the Chief Executive Officer, unless a shorter notice period is otherwise agreed by the Chief Executive Officer.

A Medical Practitioner who intends ceasing treating Patients either indefinitely or for an extended period must notify his/her intention to the Chief Executive Officer, and Accreditation will be taken to be withdrawn one month from the date of notification unless the Chief Executive Officer decides a shorter notice period is appropriate in the circumstances.

If an application for Re-Accreditation is not received within the timeframe provided for in these By-laws, unless determined otherwise by the Chief Executive Officer, the Accreditation will expire at the conclusion of its term. If the Medical Practitioner wishes to admit or treat Patients at the Facility after the expiration of Accreditation, an application for Accreditation must be made as an application for Initial Accreditation.

If the Medical Practitioner's Scope of Practice is no longer supported by Organisational Capability or Organisational Need, if the Medical Practitioner will no longer be able to meet the terms and conditions of Accreditation, or where admission of Patients or utilisation of services at the Facility is regarded by the Chief Executive Officer to be insufficient, the Chief Executive Officer will raise these matters in writing with the Accredited Practitioner and invite a meeting to discuss, following which the Chief Executive Officer and Accredited Practitioner may agree that Accreditation will expire and they will agree on the date for expiration of Accreditation. Following the date of expiration, if the Medical Practitioner wishes to admit or treat Patients at the Facility, an application for Accreditation must be made as an application for initial Accreditation.

The provisions in relation to resignation and expiration of Accreditation in no way limit the ability of the Chief Executive Officer to take action pursuant to other provisions of these By-laws, including by way of suspension or termination of Accreditation.

13. Appeal rights and procedure

13.1 Rights of appeal against decisions affecting Accreditation

(a) There shall be no right of appeal against a decision to not approve initial Accreditation, Temporary Accreditation, Emergency Accreditation, locum Accreditation, continuation of Accreditation at the end of a probationary period or with respect to the period of Temporary Accreditation, Emergency Accreditation or locum Accreditation.

(b) Subject to paragraph a) above, a Medical Practitioner shall have the rights of appeal as set out in these By-laws.

13.2 Appeal process

(a) A Medical Practitioner shall have fourteen (14) days from the date of notification of a decision to which there is a right of appeal in these By-laws to lodge an appeal against the decision.

(b) An appeal must be in writing to the Chief Executive Officer and received by the Chief Executive Officer within the fourteen (14) day appeal period or else the right to appeal is lost.

(c) Unless decided otherwise by the Chief Executive Officer in the circumstances of the particular case, which will only be in exceptional circumstances, lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly.

(d) Upon receipt of an appeal notice the Chief Executive Officer will immediately forward the appeal request to the chairperson of the Board.

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(e) The chairperson of the Board will nominate an Appeal Committee to hear the appeal, establish terms of reference, and submit all relevant material to the chairperson of the Appeal Committee.

(f) The Appeal Committee shall comprise at least three (3) persons and will include:

(i) a nominee of the chairperson of the Board, who may be an Accredited Practitioner, who must be independent of the decision under appeal regarding the Medical Practitioner, and who will be the chairperson of the Appeal Committee;

(ii) a nominee of the Chief Executive Officer, who may be an Accredited Practitioner, and who must be independent of the decision under appeal regarding the Medical Practitioner;

(iii) any other member or members who bring specific expertise to the decision under appeal, as determined by the chairperson of the Board, who must be independent of the decision under appeal regarding the Medical Practitioner, and who may be an Accredited Practitioner. The chairperson of the Board in their complete discretion may invite the appellant to make suggestions or comments on the proposed additional members of the Appeal Committee (other than the nominees in (i) and (ii) above), but is not bound to follow the suggestions or comments.

(g) Before accepting the appointment, the nominees will confirm that they do not have a known conflict of interest with the appellant and will sign a confidentiality agreement. Once all members of the Appeal Committee have accepted the appointment, the chairperson of the Board will notify the appellant of the members of the Appeal Committee.

(h) Unless a shorter timeframe is agreed by the appellant and the Appeal Committee, the appellant shall be provided with at least 14 days notice of the date for determination of the appeal by the Appeal Committee. The notice from the Appeal Committee will ordinarily set out the date for determination of the appeal, the members of the Appeal Committee, the process that will be adopted, and will invite the appellant to make a submission about the decision under appeal. Subject to an agreement to confidentiality from the appellant, the chairperson of the Appeal Committee may provide the appellant with copies of material to be relied upon by the Appeal Committee.

(i) The appellant will be given the opportunity to make a submission to the Appeal Committee. The Appeal Committee shall determine whether the submission by the appellant may be in writing or in person or both.

(j) If the appellant elects to provide written submissions to the Appeal Committee, following such a request from the Appeal Committee for a written submission, unless a longer time frame is agreed between the appellant and Appeal Committee the written submission will be provided within 7 days of the request.

(k) The Chief Executive Officer (or nominee) may present to the Appeals Committee in order to support the decision under appeal.

(l) If the appellant attends before the Appeal Committee to answer questions and to make submissions, the appellant is not entitled to have formal legal representation at the meeting of the Appeal Committee. The appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the Appeal Committee.

(m) The appellant shall not be present during Appeal Committee deliberations except when invited to be heard in respect of his/her appeal.

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(n) The chairperson of the Appeal Committee shall determine any question of procedure for the Appeal Committee, with questions of procedure entirely within the discretion of the chairperson of the Appeal Committee.

(o) The Appeal Committee will make a written recommendation regarding the appeal to the chairperson of the Board, including provision of reasons for the recommendation. The recommendation may be made by a majority of the members of the Appeal Committee and if an even number of Appeal Committee members then the chairperson has the deciding vote. A copy of the recommendation will be provided to the appellant.

(p) The Board will consider the recommendation of the Appeal Committee and make a decision about the appeal.

(q) The decision of the Board will be notified in writing to the appellant.

(r) The decision of the Board is final and binding, and there is no further appeal allowed under these By-Laws from this decision.

(s) If a notification has already been given to an external agency, such as a registration Board, then the Board will notify that external agency of the appeal decision. If a notification has not already been given, the Board will make a determination whether notification should now occur based upon the relevant considerations for notification to an external agency as set out in these By-laws relating to the decision under appeal.

Part D – Accreditation of Dentists

14. Accreditation and Scope of Practice of Dentists

By-laws 7 to 13 are hereby repeated in full substituting where applicable Dentist for Medical Practitioner.

Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the Chief Executive Officer.

Part E– Accreditation of Visiting Allied Health Professionals

15. Accreditation and Scope of Practice of Visiting Allied Health Professionals

By-laws 7 to 13 are hereby repeated in full substituting where applicable Visiting Allied Health Professional for Visiting Medical Practitioner and Allied Health Professional for Medical Practitioner.

Where other categories of health practitioner have been approved, this By-law 15 may be utilised.

Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the Chief Executive Officer.

Part F – Amending By-laws, annexures, and associated policies and procedures

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16. Amendments to, and instruments created pursuant to, the By-laws

(a) Amendments to these By-laws can only be made by approval of the Board.

(b) All Accredited Practitioners will be bound by amendments to the By-laws from the date of approval of the amendments by the Board, even if Accreditation was obtained prior to the amendments being made. If amendments are to have retrospective application, this must be specifically stated by the Board.

(c) The Board may approve any annexures that accompany these By-laws, and amendments that may be made from time to time to those annexures, and the annexures once approved by the Board are integrated with and form part of the By-laws. The documents contained in the annexures must be utilised and are intended to create consistency in the application of the processes for Accreditation and granting of Scope of Practice.

(d) The Board may approve forms, terms of reference and policies and procedures that are created pursuant to these By-laws or to provide greater detail and guidance in relation to implementation of aspects of these By-laws.

17. Audit and Compliance

The Chief Executive Officer will establish a regular audit process, at intervals determined to be appropriate by the Chief Executive Officer or as may be required by a regulatory authority, to ensure compliance with and improve the effectiveness of the processes set out in these By-laws relating to Credentialing and Accreditation, and any associated policies and procedures, including adherence by Accredited Practitioners to approved Scope of Practice.

The audit process will include identification of opportunities for quality improvement in the Credentialing and Accreditation processes that will be reported to the Board by the Chief Executive Officer.

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