CLINICAL BY LAWS

Coburg Endoscopy Centre and Dr Scope

Responsibility: Chair Clinical Governance Committee
Next review: December 2026

History

Created	March 2016	Director of Nursing
Updated	May 2017	Director of Nursing to include Coburg
Updated	December 2019	Director of Nursing new Clinical Governance structure
Updated	January 2020	Medical Advisory Committee
Approved	June 2022	Medical Advisory Committee
Approved	February 2024	Medical Advisory Committee

Contents

Section **Page**

Schedule 2 – Appointments and Credentialing Committee – Terms of Reference 50

1.0 PURPOSE

These By laws mandated the Accreditation, Credentialing and Reaccreditation and process for defining Scope of Practice for all Health Care Practitioners at Coburg Endoscopy Centre and Dr Scope.

The process will assess the training, experience, competence, judgement, professional capabilities, knowledge, fitness and character of the Healthcare Practitioner who is seeking accreditation or reaccreditation with our facilities. This document also provides a process for the amendment, suspension or termination of Accreditation in the interest of patient safety, changes in the needs of the facilities.

2.0 INTERPRETATION

2.1 Definitions

Accreditation means the authorisation in writing conferred on a person by the CEO, and the acceptance in writing by such person, to deliver medical, surgical, dental or other services to patients at the Facilities in accordance with:

(a) the specified Accreditation Classification where applicable and Scope of Clinical Practice;

(b) any specified Conditions;

(c) the Code of Conduct;

(d) the policies and procedures at the Facilities; and

(e) these By-Laws.

Accredited Practitioner means a Health Practitioner authorised to treat patients at the Facilities in accordance with a specified Accreditation Classification and Scope of Clinical Practice

Act means all relevant legislation applicable to and governing:

(a) the Facilities and its operation;

(b) the support services, staff profile, minimum standards and other requirements to be met in the Facilities; and

(c) the health services provided by, and the conduct of, the Accredited Practitioner.

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) which came into effect on 1 July 2010.

Application Form means the form (which may be electronic) approved by the Facilities from time to time for use to apply for Accreditation at the Facilities.

Appointment means the employment, engagement or authorisation of an Accredited Practitioner to provide services within the Facilities according to the By-Laws, any Conditions defined by law and which may be supplemented by a Contract of Employment or Contract of Engagement, or howsoever named by the Facilities.

By-Laws means these By-Laws, including any Schedules, as amended from time to time.

Clinical Governance Committee means a committee established to ensure systems are in place and are being monitored for the purposes of providing information to the Chief Executive to ensure:

(a) all clinical risks are being appropriately managed;

(b) safe, quality clinical care is being provided to patients, clients or residents; and

(c) a culture of clinical quality improvement is being fostered and is inherent.

Code of Conduct means the relevant code of conduct of the Facilities.

Committee means a committee or sub-committee established by the Facilities in accordance with these By-Laws to perform the following functions:

(a) Appointment and Credentialing in accordance with these By-Laws;

(b) Defining the Scope of Clinical Practice in accordance with these By-Laws; and

(c) Appeals in accordance with these By-Laws.

Competence means, in respect of a person who applies for Accreditation or Re- accreditation, or holds current Accreditation, that the person is assessed to have the required knowledge, skills, training, decision-making ability, judgement, insight and interpersonal communication necessary for the Scope of Clinical Practice and has the demonstrated ability to provide health services at an expected level of safety and quality.

Condition means as applicable with respect to an Accredited Practitioner:

(a) any condition imposed by a Regulatory Authority including the National Practitioner Board under the Health Practitioner Regulation National Law Act 2009; or

(b) any condition imposed pursuant to the processes set out in these By-laws.

Contract of Employment means an enforceable written agreement in whatever form that establishes an employment relationship between the Facilities and an Accredited Practitioner and defines the rights and obligations of each party.

Contract of Engagement means an enforceable written agreement in whatever form that establishes a contractual relationship between the Facilities and an Accredited Practitioner and defines the rights and obligations of each party.

Credentialing means 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 Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services within specific Facilities environments. Credentialing involves obtaining evidence contained in

verified documents to delineate the theoretical range of services which an Accredited Practitioner is competent to perform.

Credentials means 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 Facilities. This may include (where applicable and relevant) history of and current status with respect to clinical practice and outcomes during period previous of Accreditation, disciplinary actions, By-Law actions, compensation claims, complaints and concerns – clinical and behavioural, professional registration and Professional Indemnity Insurance.

Current Fitness means the current fitness required of an Accredited Practitioner to carry out the Scope

of Clinical Practice sought or currently held, including with the confidence of peers and the Facilities, 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 (in the CEO's opinion) 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 Clinical Practice sought or currently held.

DON means Director of Nursing

Designated Authority means a person acting in the position or specifically delegated to carry out a responsibility conferred by these By-Laws.

Facilities means Coburg Endoscopy Centre, Dr Scope and Dr Gastroenterology

Health Practitioner means a person registered as a health practitioner by the relevant Board governed by AHPRA pursuant to the *Health Practitioner Regulation National Law Act* 2009 as in force in each State and Territory.

National Law means *the Health Practitioner Regulation National Law Act* (2009) as in force in each State and Territory from time to time.

New Clinical Services, Procedures, or Other Interventions (including medical or surgical procedures, and the use of prostheses and implantable devices or diagnostic procedures) means that which would be considered by a reasonable body of medical opinion to be significantly different from existing clinical practice or if currently used are planned to be used in a different way or significantly altered from that previously approved. It includes a procedure that has not been performed at the Facilities, as well as variations to an existing procedure or treatment where a new device or item of equipment is introduced.

Notifiable Conduct means conduct as defined in the *Health Practitioner Regulation National Law Act* 2009, as in force in each State and Territory, and amended from time to time, in relation to a registered health practitioner, and currently means the practitioner has:

(a) practiced the practitioner's profession while intoxicated by alcohol or drugs;

(b) engaged in sexual misconduct in connection with the practice of the practitioner's profession;

(c) placed the public at risk of substantial harm in the practitioner's practice of the profession because the practitioner has an impairment; or

(d) placed the public at risk of harm because the practitioner has practiced the profession in a way that constitutes a significant departure from accepted professional standards.

Organisational Capabilities means the Facilities' 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 qualifications and skill-mix), facilities, equipment, technology and support services required and by reference to the Facilities' private health license, clinical service capacity, clinical services plan and clinical services capability framework.

Organisational Need means the extent to which the Facilities considers it necessary 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 Facilities, 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 of the Facilities and the clinical services capability framework.

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).

Professional Indemnity Insurance means the insurance of an Accredited Practitioner taken out in accordance with By-Law 9.7.

Professional Misconduct has the same meaning prescribed to that term in the *Health Practitioner Regulation National Law Act* 2009

Prohibited Person means a person prohibited under any applicable child protection legislation in any jurisdiction, from being employed or engaged in a child related area of activity,

Re-accreditation means the formal process used to re-confirm the Credentials, including qualifications, experience and professional standing (including history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal record) of Accredited Practitioners, for the purpose of forming a view about their ongoing Competence, Performance and professional suitability to provide safe, high quality health care services within specific organisational environments.

Recency of practice means the minimum hours required to maintain competence to maintain professional skills and knowledge.

Regulatory Authority means any government or any governmental, semi- governmental, administrative, fiscal or judicial body, department, commission authority, tribunal, registration authority, agency or entity including for the avoidance of doubt AHPRA.

Reportable Conduct means any serious offence against children, as envisaged by applicable child protection legislation in any jurisdiction, including but not limited to neglect, assault, abuse or sexual offence committed against, with or in the presence of a child (including child pornography offences).

Scope of Clinical Practice means the process following on from Credentialing and involves delineating the extent of an Accredited Practitioner's clinical practice within a particular Facilities based on the individual's Credentials, Competence, Performance, Current Fitness, professional suitability and the Organisational Need and Organisational Capabilities of the Facilities to support the Accredited Practitioner's Scope of Clinical Practice.

Show cause means an opportunity for the Accredited Practitioner to provide reasons or evidence as to why a penalty or outcome should not be actioned.

Temporary Appointment means an appointment of an Accredited Practitioner for a limited specified short-term period.

Unprofessional Conduct or Unsatisfactory Professional Conduct has the same meaning prescribed to those terms in the *Health Practitioner Regulation National Law Act* 2009 in force in each State and Territory.

2.2 General Interpretation

(a) Rules for Interpreting these By-Laws

The following rules apply in interpreting these By-Laws, except where the context makes it clear that the rule is not intended to apply:

(i) Headings are for convenience only and do not affect interpretation.

(ii) In reference to legislation (including subordinate legislation) is to that legislation as amended, re-enacted or replaced, and includes any subordinate legislation issued under it.

(iii) A reference to a document or agreement, or a provision of a document or agreement, is to that document, agreement or provision as amended, supplemented, replaced or novated.

(iv) A singular word includes the plural, and vice versa.

(v) A word which suggests one gender includes the other gender.

(vi) If a word is defined, another part of speech has a corresponding meaning.

(vii) If an example is given of something (including a right, obligation or concept) such as by saying it includes something else, the example does not limit the scope of that thing.

(b) Titles

In these By-Laws, where there is use of the title "chairperson" the incumbent of that position for the time being may choose to use whichever designation that person so wishes.

(c) Quorum

Except where otherwise specified in these By-Laws or where otherwise determined by the CEO, the following quorum requirements will apply:

(i) where there is an odd number of members of the Committee or group, a majority of the members; or

(ii) where there is an even number of members of the Committee or group, one half of the number of the members plus one.

(d) Resolutions without meetings

A decision may be made by a Committee or group established pursuant to these By-Laws (except that established by By-Law 15) without a meeting if a consent in writing, including electronic means, setting forth such a decision is signed by all the Committee or group members, as the case may be.

(e) Meeting by electronic means

A Committee or group established pursuant to these By-Laws (except that established by By-Law 15) may hold any meeting by electronic means whereby participants can be heard and can hear but are not necessarily in the same place. The requirements of these By-Laws will nonetheless apply to such a meeting.

(f) Voting

Unless otherwise specified in these By-Laws, voting will be on a simple majority basis and only by those in attendance at the meeting of the relevant Committee or group and there will be no proxy vote.

(i) Delegation

Where these By-Laws confers a function or responsibility on the CEO responsibility may be performed wholly or in part by a Designated Authority (except where the context of a By-Law or the delegations applicable requires that function or responsibility to be exercised personally).

(ii) Compensation

Unless there is a jurisdictional provision for compensation of such services, members of Committees or groups established under these By-Laws are not entitled to receive, and will not receive, compensation for any services rendered in their capacities as Committee members.

3 PRIVACY AND CONFIDENTIALITY

3.1 Privacy

Accredited Practitioners will comply with, and assist the Facilities to comply with, the *Privacy Act 1988* (Cth) and associated Australian Privacy Principles and the various statutes governing the privacy of health information within each State and Territory jurisdictions.

3.2 Accredited Practitioners

Subject to By-Laws 3.1, 3.5 and 3.8, every Accredited Practitioner must keep confidential the following information:

3.2.1 business information concerning the Facilities;

3.2.2 information concerning the insurance arrangements and claims of the Facilities

3.2.3 personal, sensitive, health or identifying information (including images) concerning any patient, including contained in medical and other Facilities records, whether in paper, electronic or digital format;

3.2.4 personal, sensitive, health or identifying information relating to other Accredited Practitioners or staff of the facilities and

3.2.5 information obtained as result of participation in quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services of the Accredited Practitioner, other Accredited Practitioners, the Facilities.

3.3 Committees

All information made available to, or disclosed, in the context of a Committee of the Facilities will be kept confidential and be subject to all relevant privacy laws unless the information is of a general kind and disclosure outside the Committee is authorised specifically by the Committee, including the following information:

3.3.1 the proceedings for the Accreditation including designation of Scope of Clinical Practice of the Accredited Practitioner; and

3.3.2 the proceedings for any change to Scope of Clinical Practice of the Accredited Practitioner.

3.4 What confidentiality means

The confidentiality requirements of this By-Law prohibit the recipient of the confidential information from using or disclosing it for any unauthorised purpose, copying it, transmitting it, reproducing it or making it public.

3.5 When confidentiality can be breached

The confidentiality requirements of By-Laws 3.1, 3.2 and 3.3 do not apply in the following circumstances:

3.5.1 where disclosure is required or specifically authorised by law;

3.5.2 where use and/or disclosure of personal information is consistent with By- Law 3.1;

3.5.3 where disclosure is required by a regulatory body in connection with the Accredited Practitioner;

3.5.4 where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or

3.5.5 where disclosure is required in order to perform a requirement of these By- Laws or in accordance with a function of the Facilities

3.6 Privacy and confidentiality obligations continue

The privacy and confidentiality requirements of these By-Laws continue with full force and effect after the Accredited Practitioner ceases to hold Accreditation with any Facilities.

3.7 Information sharing

The Facilities will be entitled to disclose an Accredited Practitioner's confidential information (including personal information and sensitive information as those terms are defined in the *Privacy Act 1988* (Cth)) in relation to their appointment, conduct and any other matters related to these By-laws and to any College that the Accredited Practitioner is a member of.

3.7.1 As part of the application process for Accreditation or following approval of Accreditation, the Accredited Practitioner will be required to provide all necessary consents for the collection, holding, accessing, using and disclosing sensitive and confidential information relating to and/or about a breach of the Behavioral Standard or the conduct of the Accredited Practitioner.

3.7.2 Given the mandatory requirement for an applicant for Accreditation, or following Accreditation, Re-Accreditation or By-Law amendments, that the By-Laws and any amendments will be read in full, this By-Law will be taken as sufficient notice to the Accredited Practitioner pursuant to the Privacy Act 1988 (Cth).

3.8 Mandatory notification of Notifiable Conduct

Notwithstanding By-Laws 3.1 to 3.8, all registered health practitioners acting in a management role with the facilities must comply with their responsibilities under the National Law in regard to mandatory notification of Notifiable Conduct by another practitioner or a student undertaking clinical training where they have formed a reasonable belief that a health practitioner has behaved in a way that constitutes Notifiable Conduct in relation to the practice of their profession or suffers from an impairment that may place the public at substantial risk of harm

4.0 COMMITTEES

4.1 Power to establish Committees

4.1.1 The CEO may establish any Committees for the Facilities.

4.1.2 Subject to these By-Laws and any Act, the CEO can determine the membership, appointment term, limitation on number of re-appointments, powers, authorities and responsibilities that are delegated to a Committee and the administrative rules by which each Committee is to operate.

4.2 Terms of Reference for Committees

Schedule 2 provides the Terms of Reference for Committees.

4.3 Indemnification

The Facilities will indemnify the members of each Committee in respect of any actions or claims made provided the Committee members have:

4.3.1 acted in good faith;

4.3.2 acted in accordance with the terms of reference;

4.3.3 acted in accordance with their delegated authority; and

4.3.4 acted in accordance with any Act governing their conduct.

5.0 DISCLOSURE OF INTEREST OF MEMBERS OF COMMITTEES

5.1 Disclosure of interest

A member of any Committee or person authorised to attend any meeting who has a direct or indirect pecuniary interest, a conflict or potential conflict of interest, or a direct or indirect material interest:

(a) in a matter that has been considered, or is about to be considered, at a meeting, such a member or person must not, subject to By-Law 5.5, participate in the relevant discussion or resolution; or

(b) in a matter being considered or a decision being made by the Facilities and must as soon as possible after the relevant facts have come to the person's knowledge, disclose the nature of the interest at the meeting.

5.2 Nature of disclosure

Disclosure by a person at a meeting that the person:

5.2.1 is a member, or is in the employment, of a specified company or other body;

5.2.2 is a partner, or is in the employment, of a specified person;

5.2.3 is a family relative or personal partner, of a specified person; or

5.2.4 has some other specified interest relating to a specified company or other body or a specified person,

will be deemed to be a sufficient disclosure of the nature of the interest in any matter or thing relating to that company or other body or to that person which may arise after the date of the disclosure.

5.3 Chairperson to notify Chief Executive Officer

The chairperson of the relevant Committee will:

5.3.1 notify the CEO of any disclosure made under this By-Law; and

5.3.2 record the disclosure in the minutes of the relevant Committee.

5.4 Record of disclosure

The CEO must cause particulars of any disclosure notified under this By-Law to be recorded in a register kept for that purpose.

5.5 Determination to effect of matter disclosed

The CEO (in consultation with the chairperson of the Committee) will decide in relation to a disclosure under this By-Law. Such a determination may include, but is not limited to, making a determination that the member or person will not participate in the Committee meeting when the matter is being considered or that the member or person will not be present while the matter is being considered.

5.6 Matters that do not constitute direct or indirect material personal interest

Subject to By-Law 5.2, the fact that a member of any Committee, is a member of a particular clinical discipline will not be regarded as a direct or indirect material personal interest, if that person participates in the Appointment process, the process to consider amendment of the Scope of Clinical Practice, or the suspension or termination of an Accredited Practitioner in the same discipline

6.0 APPOINTMENT OF ACCREDITED PRACTITIONERS

6.1 Application Form

Any Health Practitioner who wishes to apply for Accreditation, Re-accreditation or an amendment of Scope of Clinical Practice at the Facilities (the **Applicant**) must obtain from the Facilities an Application Form (and any related material, including a copy of these By-Laws) and must read the By-Laws and complete the Application Form in its entirety and submit to the DON.

6.2 Applications for Appointment

A duly completed Application Form will be considered in accordance with the following process:

6.2.1 The application will considered in the context of its completeness, the applicant's Credentials, Organisational Need, Organisational Capabilities, and otherwise satisfying the requirements of the By-Laws, and may make any inquiries, consultation, request verification of information or documents, and request permission to contact third parties, that is relevant to that consideration as he or she thinks fit. Following this consideration, the CEO may determine to discontinue with the application process or consider the process as outlined at By-Law 6.2(2) – (14) below.

6.2.2 The CEO may contact up to three referees nominated by the Applicant, but receive no less than 2, and must also check the Applicant's qualifications, Professional Indemnity Insurance and Credentials (including verifying registration and current entitlement to practice).

6.2.3 Referees must include at least one current supervisor and or professional colleague at the Facilities (if the Applicant is currently appointed at the Facilities) or a supervisor and or head of department (if the Applicant is not currently appointed at the Facilities). Referees must be practicing in the same specialty as the Applicant.

6.2.4 The CEO may obtain verbal references or verbal confirmation of written references. A verbal reference must be obtained by completing the template for verbal references and all fields must be completed, including the minimum data sets for written reference reports.

6.2.5 The CEO may ask for advice or feedback from the head of the specialty of the Facilities most relevant to the application (where applicable).

6.2.6 The application, with all relevant material obtained or identified above, will then be considered by the appointments Committee or such equivalent Committee, and an assessment made by that Committee of the Credentials, Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services within specific Facilities environments, as well as the character and ability of the applicant to cooperate with management and staff at the Facilities.

6.2.7 The appointments Committee (or such other Committee as the CEO considers appropriate) will make a recommendation to the scope of clinical practice Committee or such equivalent Committee, as to the Accreditation and Scope of Clinical Practice sought by the applicant.

6.2.8 The scope of clinical practice Committee or such equivalent Committee, will then consider the recommendation of the appointments Committee or such equivalent Committee, and make an assessment of the Credentials, Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services within specific Facilities environments, as well as the character and ability of the applicant to cooperate with management and staff at the Facilities, and will make a recommendation to the CEO as to the Accreditation and Scope of Clinical Practice sought by the applicant.

6.2.9 If the appointments Committee (or equivalent) or scope of clinical Practice Committee (or equivalent) requires further information before making a recommendation, such request will be directed to the CEO.

6.2.10 The CEO (after receiving the recommendation from the appointments Committee) will make a

final determination on the application and will have complete discretion to seek further information before making a decision, approve or disapprove each application for Accreditation or Re-accreditation after following the provisions set out in By-Laws 8.2(a) to 8.2(j) (where applicable).

6.2.11 The CEO (after receiving the recommendation from the appointments Committee) may define additional categories and types of Scope of Clinical Practice or limit the Scope of Clinical Practice to be granted, as the individual circumstances may require.

6.2.12 The CEO must notify each applicant in writing of his or her decision.

6.2.13 Any delineation of approved Scope of Clinical Practice for the Applicant must be specifically defined on the Appointment letter.

6.2.14 On receiving notice of Appointment, the applicant must indicate his or her acceptance in writing of the Facilities By-Laws, policies and procedures.

6.3 Recency of Practice

6.3.1 To practice competently and safely, an accredited practitioner must have recent practice in the fields in which they intend to work and maintain an adequate connection with their profession.

6.3.2 The specific requirements for recency depend on the profession, the level of experience of the practitioner and, if applicable, the length of absence from the field.

6.3.3 The CEO may at any time make inquiry regarding concerns raised regarding an Accredited Practitioner's Recency of Practice where patient health and safety could be compromised. Inquiry and or investigation will take the form outlined in By-Law 9.1.

6.4 Period of Appointment

6.4.1 Unless otherwise determined by the CEO, Appointments to positions as Accredited Practitioners are made in accordance with the requirements of the Facilities and a periodic cycle determined by the CEO and will be for a period up to three years, which period will be determined by and within the complete discretion of the CEO. The date of Appointment being on the date the CEO approves the Appointment.

6.4.2 Where Accreditation is granted and it coincides with the commencement of any periodic cycle referred to in By-Law 8.4(a), the Accreditation will be for the specified period. Where Accreditation is granted after a periodic cycle has commenced, Accreditation will be for the unexpired portion of that specified period.

6.4.3 The period approved of up to three years for the purpose of these By-Laws will begin and conclude in accordance with the sequence customary at the Facilities.

6.5 Nature of appointment

6.5.1 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 or apply by reason of a public sector appointment or regulation.

6.5.2 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 Facilities, 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 Facilities or its resources, and while representatives of the Facilities 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 not doing so, other than by reason of regulation.

6.6 Temporary Appointment

6.6.1 The CEO may approve Temporary Appointment and may grant Accreditation to such temporarily appointed Health Practitioners.

6.6.2 In considering whether to approve the Temporary Appointment of a Health Practitioner, the CEO may consult with the chairperson of the appointments Committee and/or the head of the division or department most relevant to the applicant's specialty.

6.6.3 An individual seeking Temporary Appointment must submit an Application Form to the DON along with all required supporting documentation.

6.6.4 Accreditation granted under this By-Law will remain in force for a period of up to 90 days from the date of determination by the CEO, with the period of Temporary Appointment in the complete discretion of the CEO. Any extension is at the discretion of the CEO, will be no longer than an additional 90 days and must be approved in writing by the CEO.

6.6.5 Should any Health Practitioner granted Temporary Appointment wish to obtain Accreditation under By-Law 6.2, that Health Practitioner must lodge the Application Form and supporting material with the CEO at which time the process in By-Law 6.2 will be applied.

6.6.6 Temporary Appointment will automatically cease upon expiry of its term or at such other times as the CEO decides.

6.6.7 There will be no right of appeal pursuant to these By-Laws from decisions relating to the granting, termination or cessation of Temporary Appointment.

6.7 Locum tenens

6.7.1 When an Accredited Practitioner nominates a Locum Tenens to provide services to his or her patients during a period of absence from the Facilities and the nominee is not currently an Accredited Practitioner, the nominee must receive approval from the CEO for Accreditation.

6.7.2 Accreditation of a Locum Tenens may be made through the process for Temporary Appointment.

6.7.3 There will be no right of appeal pursuant to these By-Laws from decisions relating to a Locum Tenens.

6.8 Accreditation of other health practitioners

6.8.1 The CEO may establish an Accreditation process at the Facilities with respect to all or some categories of allied health professional or nurse practitioner.

6.8.2 Prior to the Accreditation of an allied health professional or nurse practitioner, the CEO will ensure appropriate registration and professional indemnity insurance arrangements.

6.8.3 The CEO will decide and implement the most appropriate Accreditation process in the circumstances, which may incorporate all or some of these By- Laws.

6.8.4 There is no right of appeal pursuant to these By-Laws with respect to decisions made regarding Accreditation (including decisions not to grant), Re- Accreditation (including decisions not to grant), Scope of Clinical Practice and conclusion of Accreditation with respect to an allied health professional or nurse practitioner.

6.9 Third party providers

6.9.1 If certain services are delivered by a third party provider, , the CEO may require Health Practitioners delivering the services on behalf of the third party provider to firstly be granted Accreditation pursuant to these By-Laws.

6.9.2 Despite paragraph (a) above, Accreditation pursuant to these By-Laws is Health Practitioners performing procedural and interventional clinical services at the Facilities.

6.9.3 If a contract with a third-party provider is terminated, the Accreditation of any Health Practitioner delivering the services on behalf of the third party provider will also immediately terminate and there will be no appeal permitted pursuant to these By-Laws.

6.10 Options with respect to ongoing and conclusion of Accreditation

6.10.1 An Accredited Practitioner may resign Accreditation by giving one (1) months' notice of the intention to do so to the CEO, unless a shorter period is otherwise agreed by the CEO.

6.10.2 If the Accredited Practitioner's Accreditation or Scope of Clinical Practice is no longer supported by Organisational Need or Organisational Capabilities or if the Accredited Practitioner is no longer able to meet the terms and conditions of Accreditation, the CEO will raise these matters in writing with the Accredited Practitioner and invite a meeting to discuss. Arising from this meeting, the CEO and Accredited Practitioner may mutually agree to a voluntary reduction in Scope of Clinical Practice, resignation of Accreditation or expiry of Accreditation, and a date that this will occur.

6.11 Monitoring of Accreditation

6.11.1 The Facilities will implement processes to monitor and audit Accreditation processes and compliance with approved Scope of Clinical Practice.

6.11.2 Accredited Practitioners must comply with and provide all information necessary to assist the Facilities with monitoring and audit pursuant to this By- Law.

Urgent or Temporary Credentialing

-100 points of ID to be checked by DON
- For endoscopists to be currently re-certified for colonoscopies as per the public register at :https://recert.gesa.org.au/
- For non-Australian citizens to have the correct visa with appropriate work rights
- Application form to be completed correctly by the VMO
- At least 1 referee to be checked by DON initially, where longer term credentialing would depend on the other 2 referees to be checked by DON later

The DON maintains a register of Medical Officers and the register indicates the status of their compliance to the above.

The DON will follow up Medical Officers whose information is not complete and updated, and if necessary, escalate the non-compliant files to the CEO.

The Facilities will implement processes to monitor and improve the effectiveness of Credentialing and Accreditation processes

7.0 TERMS AND CONDITIONS OF APPOINTMENT OF ACCREDITED PRACTITIONERS

7.1 Compliance with By-Laws

Appointment as an Accredited Practitioner is conditional on the Accredited Practitioner complying with all matters, terms and Conditions set out in these By- Laws, and any non-compliance may be grounds for suspension, termination or imposition of conditions pursuant to these By-Laws.

7.2 General terms and conditions

Accredited Practitioners must:

7.2.1 comply with rules, policies and procedures of the Facilities;

7.2.2 strictly adhere to their authorised Scope of Clinical Practice;

7.2.3 comply with the provisions of the Act, all applicable legislation and general law;

7.2.4 comply with their responsibilities under the National Law in regard to mandatory notification of notifiable conduct by another practitioner or a student undertaking clinical training where the Accredited Practitioner has formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of their profession or suffers from an impairment that may place the public at substantial risk of harm;

7.2.5 maintain their professional registration with AHPRA and furnish annually to the Facilities when requested to do so, evidence of registration and advise the CEO immediately of any material changes to the conditions or status of their professional registration (including suspension and cancellation);

7.2.6 consent to the sharing of information relating to their conduct within the facilities and to any College that they are a member of;

7.2.7 observe all requests made by the Facilities about his or her conduct in the Facilities and with regard to the provision of services within the Facilities and, upon request, meet with and discuss with the CEO any matters arising out of these By-Laws;

7.2.8 adhere to the generally accepted ethics of clinical practice, including the ethical codes and codes of good medical practice of the Australian Medical Association and the Australian Dental Association (as applicable) and all relevant standards or guides issued by the Medical and Dental Boards of Australia as issued from time to time in relation to his or her colleagues, Facilities employees and patients;

7.2.9 adhere to general Conditions of clinical practice applicable at the Facilities;

7.2.10 observe the rules and practices of the Facilities in relation to the admission and discharge of patients including admission exclusion criteria and the requirement to ensure patients are discharged into the care of a responsible adult

7.2.11 attend and, when reasonably required by the CEO, prepare for and participate in relevant clinical meetings, seminars, lectures and other teaching/training programs organised by the Facilities or provide evidence of attendance of these at alternative venues;

7.2.12 seek relevant approvals from the relevant Committee and, where applicable, the relevant research and ethics Committee in regard to any research, experimental or innovative treatments, including any new or revised technology in accordance with the requirements of these By-Laws;

7.2.13 not aid or facilitate the provision of health care to patients at the Facilities by Health Practitioners who are not Accredited Practitioners;

7.2.14 provide all reasonable and necessary assistance where the Facilities requests assistance from the Accredited Practitioner in order to comply with or respond to requests or enquires, including a legal request or information requests from external agencies;

7.2.15 not purport to represent the facilities in any circumstances, including the use of the letterhead of the Facilities unless with the express written permission of the CEO; and

7.2.16 subject to the requirement of relevant laws, keep confidential details of all information which comes to your knowledge concerning patients, clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services.

7.3 Responsibility for patients

Accredited Practitioners must:

7.3.1 obtain and document fully informed patient consent prior to treatment (except where it is not practical in cases of emergency) from the patient or their legal guardian or substituted decision maker in accordance with accepted medical and legal standards and any Facilities requirements. To avoid any doubt, these requirements apply to anaesthetic consent;

7.3.2 where applicable, provide full financial disclosure to patients and obtain and document fully informed financial consent from patients in accordance with medical, legal, ethical and health fund obligations, including with respect to medical out of pocket expenses;

7.3.3 admit to the Facilities only those patients who, in the opinion of the CEO, can be properly managed in the Facilities (the CEO may notify Accredited Practitioners from time to time of any categories of patients who are considered inappropriate for admission to the Facilities);

7.3.4 observe the rules and requirements applicable in the Facilities with respect to the admission of patients;

7.3.5 accept full responsibility for his or her patients from admission until discharge, or until the care of the patient is formally transferred to another Accredited Practitioner

7.3.6 be readily available for contact at all times when that Accredited Practitioner has a patient admitted to the Facilities, or must nominate another Accredited Practitioner with equivalent Accreditation to continue the care of their patient during their absence (such nomination to be notified to the Facilities in writing). Accredited Practitioners must attend upon patients in a timely manner, using their best endeavours to attend promptly after being requested to do so, or being available by telephone in a timely manner to assist Facilities staff in relation to Accredited Practitioner's patients;

7.3.7 work with and as part of the multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care for Accredited Practitioners' patients. This includes communication to other members of the team, referring doctors, Facilities executive, patients and the patient's family or next of kin;

7.3.8 provide adequate instructions and clinical handover to Facilities staff and other Accredited Practitioners to enable them to understand what care the Accredited Practitioner requires to be delivered to his or her patients, appropriately supervising the care that is provided by the Facilities staff and other Accredited Practitioners.

7.3.9 note the details of a transfer of care to another Accredited Practitioner on the patient's Facilities medical record and communicate the transfer to the Nurse Unit Manager or other responsible nursing staff member;

7.3.10 attend his or her patients properly, and with the utmost care and attention, after considering the requirements of the Facilities and Scope of Clinical Practice granted to the Accredited Practitioner;

7.3.11 attend patients subject to the limits of any Conditions imposed by the CEO;

7.3.12 upon request by staff of the Facilities, attend in person upon patients under their care for the

purposes of the proper care and treatment of those patients;

7.3.13 except in an emergency, not give instructions in relation to a patient where another Accredited Practitioner is responsible for the management of that patient without a formal request for consultation from the consulting clinical team;

7.3.14 carry out procedures, give advice and recommend treatment within the generally accepted areas of practice applicable to the category of Appointment of the Accredited Practitioner and to his or her Accreditation;

7.3.15 be willing, in an emergency or on request by the CEO (or another person authorised by the CEO for this purpose) to assist the staff and other practitioners, where possible and necessary;

7.3.16 consider the policies of the Facilities when exercising judgement regarding the length of stay of patients at the Facilities and the need for ongoing hospitalisation of patients; and

7.3.17 the Accredited Practitioner must ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the patient, patient's carer, referring practitioner, general practitioner and/or other treating practitioners.

7.4 All admissions subject to approval

7.4.1 The ability of an Accredited Practitioner to admit a patient to the Facilities will, at all times, be subject to approval of the CEO and within the sole discretion of the CEO;

(a) The CEO will be entitled to refuse permission for the admission of any patient without giving a reason;

(b) Conferral of Accreditation provides the Accredited Practitioner with an ability on each occasion to make a request to access the Facilities for the treatment and care of a Patient, within the limits of the Accredited Practitioner's Scope of Clinical Practice, and to utilise the resources of the Facilities for that purpose, subject always to the provisions of the By-Laws, Facilities policies and procedures, resource limitations, and in accordance with Organisational Need and Organisational Capabilities at the time of request for access;

(c) The grant of Accreditation contains no general entitlement to or right of access to the Facilities;

(d) The grant of Accreditation does not, of itself, constitute an employment contract nor does it establish a contractual relationship or any implied contractual terms between the Accreditation Practitioner and the Facilities

(e) The decision of the CEO with respect to the matters set out in By-Law 7.4 is final and there is no right of appeal pursuant to these By-Laws.

7.5 Right to request discharge or transfer of patient

7.5.1 The ability of an Accredited Practitioner to admit a patient to the Facilities will, always, be subject to the right of the CEO to require the removal or transfer of a patient.

7.5.2 The CEO will make reasonable efforts to notify the Accredited Practitioner and the patient if he or she requires the removal or transfer of the patient. The Accredited Practitioner will be required to make all necessary arrangements for the removal or transfer of the patient, including notifying the relatives of the patient and, where necessary, arranging the admission of the patient to another hospital.

7.5.3 Should the Accredited Practitioner fail to make such arrangements when requested under By-Law 9.5, or fail to make adequate arrangements, the CEO will be entitled to do all such necessary acts and things to arrange for the removal or transfer of the patient.

7.6 Safety and quality

Accredited Practitioners must:

7.6.1 familiarise themselves with, support and strictly adhere to Facilities policies and procedures with respect to patient deterioration;

(a) familiarise themselves with and strictly adhere to Facilities policies and procedures with respect to surgical safety, including but not limited to completing and participating in pre-procedure checks, leading time out, end of procedure checks and allowing Facilities staff enough time to comply with these requirements;

(b) familiarise themselves with and comply with Facilities targeted programs with respect to safety and quality of patient care, including but not limited to medication, falls and infection control / hand hygiene

(c) consider their own potential fatigue and that of other staff involved in the provision of patient care, when making patient bookings and in utilising procedural Facilities time;

(d) report to the CEO any safety and quality concerns, including if it relates to the care provided by another Accredited Practitioner or Facilities staff member;

(e) co-operate with and participate in any safety, clinical quality assurance, quality improvement or risk management process, project or activities as required by the Facilities and these By-Laws, including implementation of recommendations from root cause analysis and system reviews;

(f) comply with and assist the Facilities to comply with programs or standards of State or Commonwealth health departments, statutory bodies or safety and quality organisations, 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;

(g) adhere to general Conditions of clinical practice applicable at the Facilities;

(h) meaningfully participate in clinical review and peer review Committee meetings, including review of 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;

(i) maintain and comply with the ongoing minimum competency and continuing professional development requirements of their professional college with respect to the approved Scope of Clinical Practice; and

(j) where required by the CEO, assist with, provide relevant information and participate in incident management, complaint management, investigation, reviews (including root cause analysis and other system reviews) and open disclosure

7.7 Professional Indemnity Insurance

Accredited Practitioners must maintain a level of Professional Indemnity Insurance (including run off/tail insurance where appropriate) consistent with requirements of the relevant Regulatory Authority, and:

7.7.1 which covers all potential liability of the Accredited Practitioner in respect of the Facilities and patients, including any employees or agents of the Accredited Practitioner, and covering the period of Accreditation (even if a claim were to be made following the conclusion of Accreditation);

7.7.2 which appropriately reflects and covers the Accredited Practitioner's Scope of Clinical Practice and activities performed at the Facilities;

7.7.3 that is in an amount and on terms and conditions acceptable to the Facilities; and

7.7.4 that is with an insurance company acceptable to the Facilities.

7.8 Annual disclosure

Accredited Practitioners must furnish annually to the Facilities evidence of:

7.8.1 appropriate Professional Indemnity Insurance, including the level of cover and any material changes to cover that occurred during the previous twelve months;

7.8.2 health practitioner registration (as applicable); and

7.8.3 continuous registration with the relevant specialist college or professional body

7.8.4 compliance with the annual mandatory continuing education requirements of his or her specialist college or professional body.

7.9 Continuous disclosure

Each Accredited Practitioner must keep the CEO continuously informed of matters which have a material bearing upon his or her:

7.9.1 Credentials;

7.9.2 Scope of Clinical Practice;

7.9.3 ability to deliver health care services to patients safely and in accordance with his or her authorised Scope of Clinical Practice;

7.9.4 Professional Indemnity Insurance status;

7.9.5 Registration with the relevant professional registration board, including any Conditions or limitations placed on such registration; and

7.9.6 Matters requiring notification or notified pursuant to By-Law 7.10.

7.10 Advice of material issues

Without limiting By-Law 7.9, Accredited Practitioners must advise the CEO in writing as soon as possible but at least within two (2) business days if any of the following matters occur or come to the attention of the Accredited Practitioner:

7.10.1 an adverse outcome or serious complication in relation to the Accredited Practitioner's patient or patients (current or former) of the Facilities;

7.10.2 an adverse or critical finding (formal or informal) made against him or her by a Regulatory Authority, any registration, disciplinary, investigative or professional body, civil court, criminal court, Coroner, health care complaints body, irrespective of whether it relates to a patient of the Facilities;

7.10.3 his or her professional registration being revoked, suspended or amended, the imposition of any Conditions or should undertakings be agreed, irrespective of whether this relates to a patient of the Facilities;

7.10.4 the initiation or conclusion of any process, inquiry or investigation by a Regulatory Authority, the relevant registration board, AHPRA, relevant college, police, coroner, tribunal (or equivalent body in any other jurisdiction, as applicable), a health care complaints body (howsoever described), Medicare, Professional Services Review or private health fund involving the Accredited Practitioner or the initiation or conclusion of a legal process relevant to medical practice which impacts or arises from their practice of medicine, irrespective of whether this

relates to a patient of the Facilities;

7.10.5 any change in his or her Professional Indemnity Insurance, including but not limited to the attaching of Conditions, limitations, non-renewal or cancellation;

7.10.6 his or her Appointment to, Accreditation at, or Scope of Clinical Practice at, any other facilities, hospital or day procedure centre is altered in any way other than at the request of the Accredited Practitioner, including if withdrawn, terminated, suspended, restricted or made conditional;

7.10.7 he or she incurs an illness or disability which may adversely affect his or her Current Fitness;

7.10.8 death of a patient of the Facilities that requires reporting to the Coroner or has been reported to the Coroner in which the Accredited Practitioner has been involved in any way in the care, or notification has been received that a coronial inquest will be held in relation to such patient;

7.10.9 receipt of a written complaint from a patient of the Facilities or notification of a complaint being received by an external agency, including but not limited to a complaint relating to an adverse outcome, injury, incident, loss, unexpected expense or charge that has been levied;

7.10.10 any claim, notification of an intention to make a claim or any circumstance which may give rise to a claim, in respect of the management of a patient of that Accredited Practitioner in the Facilities (including all relevant details);

7.10.11 matters regarded as Reportable Conduct; and

7.10.12 he or she being charged with, under investigation or convicted of, any indictable offence, or sex/violence/child related offence, or under any laws that regulate the provision of health care or health insurance.

7.11 Medical records

Accredited Practitioners must:

7.11.1 maintain full, accurate, legible and contemporaneous medical records for each patient under his or her care or ensure that such adequate clinical records are maintained in the patient's Facilities medical record:

a) in compliance with the Act, any applicable codes or guidelines published by AHPRA, Facilities policies and procedures, accreditation requirements and health fund obligations;

b) such that, in an emergency, another suitably qualified Accredited Practitioner can expeditiously take over the care of the patient;

c) in a way which enables the t Facilities to collect revenue in a timely manner and any other data reasonably required in respect of a Facilities, including as a minimum:

d) pre-admission notes or a letter on the patient's condition and plan of management, including notifying the Facilities of significant co-morbidities;

e) full and informed written patient consent;

f) completing admission forms authorised by the Facilities

g) recording an appropriate patient history, reason for admission, physical examination, diagnosis or provisional diagnosis, and treatment plan before treatment is undertaken, unless involving an emergency;

h) therapeutic orders

i) Particulars of all procedures including pathology and radiology reports

j) Observations of the patient progress

k) Notes of any issues or complications

l) Discharge instructions and arrangements for follow up
m) Any additional information to meet contractual health fund obligations

7.11.2 complete an operation, procedure or anaesthetic report (as the case may be) that shall include a detailed account of the findings during the procedure, the technique undertaken, anaesthetic used, complications and post-operative orders, and the full name of any, anaesthetist and other Health Practitioner present.

7.11.3 ensure the provision of CMBS Item Numbers and prompt notification to the Facilities of any subsequent change or addition to the Item Numbers;

7.11.4 where orders are given by telephone to a registered nurse (who will read back those orders to the Accredited Practitioner for confirmation),

7.11.5 ensure that the medical records maintained by that Accredited Practitioner are sufficient for the review of patient care;

7.11.6 ensure that complications, incidents, variations and deviations from standard clinical pathways and expectations are recorded in the Facilities medical record;

7.11.7 cooperate and assist the Facilities to comply with any audits relating to documents and associated requests for clarification of information recorded; and

7.11.8 acknowledge and agree that medical records of patients of the Facilities are owned by the the Facilities, so that access to or disclosure of that medical record by the Accredited Practitioner other than for the direct and primary purpose of providing health care to the patient must occur through the appropriate Facilities mechanisms, in accordance with Facilities policy and in compliance with applicable legislation.

7.12 Continuing education

Accredited Practitioners must:

7.12.1 by involvement in continuing education, keep informed of current practices and trends in the Accredited Practitioner's area of practice, by regularly attending and participating in clinical meetings, seminars, lectures and other educational programs on the Facilities campus and elsewhere, to maintain and improve their knowledge and to maintain and increase their skills;

7.12.2 meet all reasonable requests to participate in the education and training of other clinical staff of the Facilities, the effect of which is to raise the level of competence of staff in general and improving patient care and relations between Accredited Practitioners and other staff; and

7.12.3 co-operate and participate in appropriate quality improvement activities,

7.13 Clinical activity and utilisation

Accredited Practitioners must maintain a sufficient level of clinical activity, admissions and utilisation (including of allocated procedural service time) in the Facilities to enable the CEO, acting reasonably, to be satisfied that:

7.13.1 the Accredited Practitioner's knowledge and skills are current;

7.13.2 the Accredited Practitioner is familiar with the operational policy, procedures and practices of the Facilities;

7.13.3 Facilities resources are being appropriately managed and utilised to maximum potential;

7.13.4 the Accredited Practitioner can contribute actively and meaningfully to the division or department relevant to his or her Scope of Clinical Practice and to the Committees;

7.13.5 Facilities resources are being appropriately managed and utilised to maximum potential:

7.13.6 If the CEO is not satisfied about any of the above matters over the preceding 12 months, a show cause process may be initiated pursuant to this provision of the By-Laws. The show cause process may result in notification of inactivation or withdrawal of Accreditation due to insufficient utilisation and there will be no appeal available pursuant to these By-laws if such a decision is made by the CEO.

7.14 Participation in Committees

7.14.1 Accredited Practitioners must meet all reasonable requests to participate in, and contribute actively to, Committees established to co-ordinate and direct the various functions of the Facilities.

7.14.2 Without limiting By-Law 9.14(a), the CEO may require an Accredited Practitioner to nominate him or herself to act as a member of a Committee. Before doing so, the CEO must have regard to:

a) the Accredited Practitioner's current, or recent historical contribution to Committee or Committees (absolutely and relative to the Accredited Practitioner's peers);

b) the Accredited Practitioner's clinical activity in the Facilities (absolutely and relative to the Accredited Practitioner's peers); and

c) any extenuating circumstances which the CEO considers may reasonably preclude the Accredited Practitioner from acting as a member of a particular Committee (for example, extraordinary responsibilities as a carer or extraordinary voluntary commitments to the medical or general communities).

7.15 Emergency/disaster planning

Accredited Practitioners must:

7.15.1 be aware of their role in relation to emergency and disaster planning;

7.15.2 be familiar with the Facilities's safety and security policies and procedures; and

7.15.3 participate in emergency drills and exercises which may be conducted at the Facilities.

7.16 Working with children checks/criminal record checks

7.16.1 The Appointment of Accredited Practitioners is conditional on the person satisfactorily completing any forms that the facilities may require for the purpose of fulfilling Facilities obligations under applicable child protection legislation.

7.16.2 The Accredited Practitioner must undertake to the Facilities that he or she is not a Prohibited Person, and:

7.16.2.1 has never, to the Accredited Practitioner's knowledge, been included on any list of persons not to be employed or engaged in a child related area of activity;

7.16.2.2 has not retired or resigned from, or had any previous employment or engagement terminated on the grounds that the Accredited Practitioner engaged in Reportable Conduct;

7.16.2.3 has never been charged with or been the subject of an investigation as to whether he or she engaged in any Reportable Conduct; and

7.16.2.4 will not engage in Reportable Conduct;

7.16.3 The Accredited Practitioner must inform Facilities immediately if he or she is unable to give

the undertakings set out in By-Law 7.14(b).

7.16.4 Accredited Practitioners must provide the Facilities with a criminal history check with the appropriate authorities in any jurisdiction at any time.

7.17 Teaching and supervision

Unless otherwise determined by the CEO, Accredited Practitioners must participate in the education, training and supervision of students and other accredited health practitioners as required from time to time, attending the Facilities including facilitating the availability of patients for clinical teaching subject to:

7.17.1 any contrary instructions by either the treating practitioner, or the nurse unit manager (or other designated manager at the Facilities); and

7.17.2 consent being given by the patient.

7.18 Notifiable Conduct and mandatory reporting

All Accredited Practitioners must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009, as in force in each State and Territory.

7.19 Notice of leave

Where Accreditation has been granted in respect of the Facilities, an Accredited Practitioner must

7.19.1 notify the CEO in writing, at least eight weeks in advance of holidays or other planned absences, and provide the name the Accredited Practitioner who will cover their sessions during the Accredited Practitioner's absence

8.0 RE-ACCREDITATION AND PRACTITIONER REQUESTS TO AMEND SCOPE OF CLINICAL PRACTICE

8.1 Notice to Accredited Practitioner

Not less than three months before the date fixed for expiry of the Accreditation of an Accredited Practitioner, the CEO must notify the Accredited Practitioner of the pending expiry of their Accreditation and the processes for applying for Re- accreditation and review of their Scope of Clinical Practice.

8.2 Apply for Re-accreditation

An Accredited Practitioner must apply for Re-accreditation before the expiration of the term of Accreditation in order to maintain Accreditation with the Facilities.

8.3 Amendments

An Accredited Practitioner may make an application to the CEO for amendment of his or her Scope of Clinical Practice:

8.3.1 at the same time as making an application for Re-accreditation; or

8.3.2 at any other time.

8.4 Process

Subject to the Facilities policy or as otherwise determined by the CEO for a specific application, the processes for Re- accreditation and/or amending the Scope of Clinical Practice of Accredited Practitioners under this By-Law 8 will otherwise be the same as for an initial Accreditation pursuant to By-Law 6.

8.5 Review

All Accredited Practitioners will be subject to the processes of Re-accreditation and review of their Scope of Clinical Practice in accordance with the appointments cycle

9.0 INQUIRY ARISING FROM CONCERNS, ALLEGATIONS OR COMPLAINTS

9.1 Chief Executive Officer may make investigations

The CEO may make inquiry regarding a concern raised, allegation or complaint against an Accredited Practitioner if the CEO considers that any of the following consequences may occur or may have already occurred:

9.1.1 non-compliance with the By-Laws;

9.1.2 non-compliance with Scope of Clinical Practice;

9.1.3 potential ground for suspension or termination of Accreditation;

9.1.4 patient health or safety could be compromised;

9.1.5 concerns have been raised or identified that all or a component of Scope of Clinical Practice may not be in accordance with current or best practice;

9.1.6 concerns may arise with respect to Competence, Performance or Current Fitness;

9.1.7 incompatibility with Organisational Capabilities or Organisational Need;

9.1.8 loss of confidence in the Accredited Practitioner;

9.1.9 the efficient operation of the Facilities could be hindered;

9.1.10 the reputation of the Facilities' could be threatened or brought into disrepute;

9.1.11 the potential loss or breach of the Facilities' accreditation or licence, including associated terms or conditions;

9.1.12 the potential imposition of any conditions on the Facilities's licence;

9.1.13 non-compliance with the Behavioural Standards;

9.1.14 the interests of a patient, staff, another Accredited Practitioner or someone engaged in or at the Facilities could be impacted or affected adversely; or

9.1.15 a law may be contravened.

9.2 Notice to Accredited Practitioners and procedural matters

9.2.1 The CEO will advise the Accredited Practitioner in respect of whom the concern, allegation or complaint has been made of the substance of the concern, allegation or complaint and provide the Accredited Practitioner with an opportunity to respond.

9.2.2 The CEO will decide on all procedural matters relevant to advising the Accredited Practitioner under By-Law 13.2(a), which may include a determination on:

a) how the concern or issue in respect of the Accredited Practitioner will be dealt with under these By-Laws;

b) requirement for any other person to be present at the time the Accredited Practitioner is advised and the designation of that person, for example a senior manager at the Facilities or the chairperson of a Committee where a Committee has been involved in the concern or issue to be raised with the Accredited Practitioner;

c) the extent and nature of any relevant records or documents to be provided or produced in connection with the concern or issue; and

d) any appropriate time frames and format of response by the Accredited Practitioner.

9.2.3 The Accredited Practitioner will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 13. The support person is not to participate in the process. Should the support person be a lawyer, that same person must not act as a legal representative for the Accredited Practitioner.

9.3 Action by Chief Executive Officer

If, having considered the Accredited Practitioner's response (if any), then:

9.3.1 the CEO may decide to take no further action;

9.3.2 if in the opinion of the CEO the matter can be dealt with appropriately by reviewing the Accredited Practitioner's Scope of Clinical Practice, the CEO may request a review of the Accredited Practitioner's Scope of Clinical Practice in accordance with By-Law 14;

9.3.3 if in the opinion of the CEO the matter cannot be dealt with appropriately by a review of the Accredited Practitioner's Scope of Clinical Practice, the CEO in consultation with the chairperson of any relevant Committee may establish a Committee to consider the matter further; and/or

9.3.4 the CEO may suspend or impose conditions on the Accreditation of the Accredited Practitioner until such time as the CEO is satisfied that the concern, allegation or complaint has been resolved.

9.4 Committee to assess issue of concern

A Committee to assist the CEO established under By-Law 13.3(c):

9.4.1 must ensure the Accredited Practitioner has been advised in writing of the particulars of the allegation and invite the Accredited Practitioner to respond;

9.4.2 may invite the Accredited Practitioner to meet with the relevant Committee in person; and

9.4.3 must provide the CEO with its written conclusions and/or opinions in a timely manner and supported by reasons.

9.5 Notifiable Conduct and mandatory reporting in relation to any investigation

The CEO must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009, as in force in each State and Territory.

10 REVIEW OF ACCREDITATION OR SCOPE OF CLINICAL PRACTICE

10.1 Surveillance of AHPRA registration database

The CEO will put in place processes to conduct periodic and active surveillance of the AHPRA registration database to ensure currency of registration and accuracy of any Conditions imposed.

10.2 Grounds for review

The CEO may initiate a review, if the CEO considers that any of the following consequences may occur or may have already occurred:

10.2.1 non-compliance with the By-Laws;

10.2.2 non-compliance with Scope of Clinical Practice;

10.2.3 potential ground for suspension or termination of Accreditation;

10.2.4 patient health or safety could be compromised;

10.2.5 concerns may arise with respect to Competence, Performance or Current Fitness;

10.2.6 all or a component of Scope of Clinical Practice may not be in accordance with current or best practice;

10.2.7 incompatibility with Organisational Capabilities or Organisational Need;

10.2.8 loss of confidence in the Accredited Practitioner;

10.2.9 the efficient operation of the Facilities could be hindered;

10.2.10 the reputation of the Facilities, be threatened or brought into disrepute;

10.2.11 the potential loss of the Facilities' accreditation or licence;

10.2.12 the potential imposition of any conditions on the Facilities' licence;

10.2.13 the interests of a patient, staff, another Accredited Practitioner or someone engaged in or at the Facilities could be affected adversely; or

10.2.14 a law may be contravened.

10.3 Chief Executive Officer initiated internal review

10.3.1 The CEO may, at any time, initiate an internal review to examine a ground or grounds set out in By-Law 10.2 and following such review the CEO will decide concerning the continuation, amendment, suspension or termination of Accreditation.

10.3.2 An internal review will be undertaken by a person or persons or Committee that is internal to the Facilities

10.3.3 The CEO will make a final determination in relation to the matter, subject to the provisions of By-Law 15.2.

10.4 Chief Executive Officer initiated external review

10.4.1 The CEO may, at any time, initiate an external review to examine a ground or grounds set out in By-Law 10.2 and following such review the CEO will make a decision concerning the continuation, amendment, suspension or termination of Accreditation.

10.4.2 An external review will be undertaken by a person or persons that is external to the Facilities.

10.4.3 The CEO will make a final determination in relation to the matter, subject to the provisions of By-Law 15.2.

10.5 Notice to Accredited Practitioners

10.5.1 The CEO will advise the Accredited Practitioner in respect of whom a review is being conducted under either By-Law 14.3 or 14.4 of the commencement, ground(s) and substance of the review, the extent to which the Accredited Practitioner may participate in the review and the opportunity to respond that will be provided.

10.5.2 The CEO will make a determination whether to impose an interim suspension or conditions pending the outcome of the review, and if this occurs, it will be done in accordance with By-Law 15, except that the appeal provisions pursuant to these By-Laws will not apply with respect to an interim suspension or conditions, and the Accredited Practitioner will be advised of the fact of the interim suspension or conditions and that an appeal is not available pursuant to these By-Laws.

10.5.3 The CEO will decide on all procedural matters with respect to the review, which may include a determination on:

a. terms of reference, process and reviewers;

b. opportunity for submissions, oral and/or written;

c. timeframes;

d. the extent and nature of any relevant records or documents to be provided or

produced in connection with the review;

e. format for review findings; and

f. how the review findings in respect of the Accredited Practitioners will be dealt with under these By-Laws.

10.5.4 The Accredited Practitioner will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 10. The support person is not to participate in the process. Should the support person be a lawyer that same person must not act as a legal representative for the Accredited Practitioner.

10.6 Action the Chief Executive Officer may take following review

Following a review under By-Law 10.3 or 10.4 the CEO will consider the review findings and make a decision, which will include a determination whether or not to continue (including with conditions), amend, suspend or terminate Accreditation in accordance with the provisions set out in these By-Laws and, in the event a decision is make to continue with conditions this may include a decision that the Accredited Practitioner will:

10.6.1 cease performing surgical, anaesthetic or dental procedures or perform only defined procedures;

10.6.2 perform surgical, anaesthetic or dental procedures only when assisted by another Accredited Practitioner qualified in the same field of practice;

10.6.3 practice a restricted range of medical, surgical, anaesthetic or dental procedures; or

10.6.4 not admit or manage patients unless in consultation with another Accredited Practitioner qualified in the same field of practice.

10.7 Notice of outcome of the review

10.7.1 The CEO must give written notice to the Accredited Practitioner of the decision made pursuant to this By-Law and, in the event that a decision is made to amend, suspend, terminate or impose conditions upon Accreditation, the notice will include reference to those By-Laws and will include all information required to be set out pursuant to those By-Laws.

10.7.2 The CEO must notify the Group Chief Medical Officer and the CEO of the outcome of any review undertaken under By-Law 14.

10.8 Notifiable Conduct and mandatory reporting in relation to review of scope of clinical practice

10.8.1 The CEO must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009, including in relation to any mandatory reporting obligations in relation to actions taken by the CEO following a review under By-law 14, as enforced in each State and Territory.

10.9 Interrelationship with By-Law 9

10.9.1 For the avoidance of any doubt, the CEO is not required to comply with By- Law 8 before proceeding with a review pursuant to By-Law 9

11 SUSPENSION

11.1 Grounds for Suspension

The CEO may immediately suspend Accreditation, in whole or in part, and afford the Accredited Practitioner an opportunity to "show cause" as to why their accreditation should not be terminated. Suspension pursuant to this section may be exercised should the CEO believe, or have a concern, about any of the following matters:

11.1.1 it is in the interests of patient care or safety;

11.1.2 patient health or safety is compromised, including by reason that all or a component of Scope of Clinical Practice is not considered to be in accordance with current or best practice;

11.1.3 continuance of the current Scope of Clinical Practice raises concern about the safety and quality of health care to be provided;

11.1.4 professional registration has been suspended in whole or in part;

11.1.5 professional registration has been amended, conditions imposed, or undertakings agreed;

11.1.6 Scope of Clinical Practice at another health care organisation has been suspended, terminated, restricted or made conditional;

11.1.7 it is in the interests of staff welfare or safety;

11.1.8 the Accredited Practitioner has breached any Conditions of Accreditation;

11.1.9 the Accredited Practitioner has breached the By-Laws;

11.1.10 the behaviour or conduct does not comply with the Behavioural Standards, a direction given, is such that it is unduly hindering the efficient operation of the Facilities at any time, is bringing the Facilities into disrepute or is otherwise damaging the reputation of the Facilities;

11.1.11 the behaviour or conduct of the Accredited Practitioner is inconsistent with the Facilities' mission statement

11.1.12 based upon information notified pursuant to By-Laws 7.7 or 7.8;

11.1.13 a failure to notify or provide continuous disclosure of a matter required pursuant to By-Laws 7.7 or 7.8;

11.1.14 the Accredited Practitioner has not provided satisfactory evidence on demand of his or her professional qualifications, current registration or sufficient and current Professional Indemnity Insurance;

11.1.15 the Accredited practitioner has been found to have made a false declaration or provided inaccurate information to the Facilities either through omission of

important information or inclusion of false, incomplete or inaccurate information (regardless of whether this is intentional or not);

11.1.16 based upon the outcome of a review carried out pursuant to By-Law 10;

11.1.17 based upon an ongoing criminal investigation or conviction; or

11.1.18 there are other issues or unresolved concerns (including with respect to an ongoing or

completed investigation that is internal or external) in respect of the Accredited Practitioner that the CEO considers is a ground for suspension.

11.2 Suspension framework

11.2.1 Suspension by the CEO will, at a minimum, be consistent with that imposed by the professional registration board or AHPRA with respect to the professional registration of the Accredited Practitioner.

11.2.2 A ground for suspension may relate to matters external to the Facilities'.

11.2.3 Accredited Practitioners will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 11. The support person is not to participate in the process. Should the support person be a lawyer that same person must not act as a legal representative for the Accredited Practitioner.

11.2.4 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.

11.3 Notification of suspension decision

11.3.1 The CEO will notify the Accredited Practitioner of:

a. the fact of the suspension;

b. the period of suspension;

c. the reasons for the suspension;

d. if the CEO considers it appropriate in the circumstances, invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider suspension should be lifted;

e. if the CEO considers it appropriate in the circumstances, any actions that must be performed for the suspension to be lifted and the timeframe for the actions to occur; and

f. the right of appeal (if available).

11.3.2 As an alternative to an immediate suspension, the CEO may elect to deliver a show cause notice to the Accredited Practitioner advising of:

a) the facts and circumstances forming the basis for possible suspension;

b) the grounds upon which suspension may occur;

c) invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider suspension is not appropriate;

d) 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;

e) a timeframe in which a response is required from the Accredited Practitioner to the show cause notice; and

11.3.3 Following receipt of a response to the show cause notice above, the CEO will determine whether the Accreditation will be suspended. If suspension is to occur, then notification will be sent in accordance with paragraph (a) above. Otherwise the Accredited Practitioner will be

advised that suspension will not occur, however this will not prevent the CEO from taking other action at this time, including imposition of conditions, and will not prevent the CEO from relying upon these matters as a ground for suspension or termination of Accreditation in the future.

11.4 Suspension effective immediately

11.4.1 Suspension will become effective immediately upon notification to the Accredited Practitioner.

11.4.2 Suspension is ended either by terminating Accreditation or lifting the suspension.

11.5 Alternative arrangements for patients

The CEO will have the authority to arrange medical care for the patients of the suspended Accredited Practitioner.

11.6 Appeal rights

Unless otherwise provided in these By-Laws, the affected Accredited Practitioner will have the rights of appeal established by these By-Laws, noting that an appeal is not available for an interim suspension pursuant to By-Law 14.5(b).

11.7 Notifiable Conduct and Mandatory Reporting

11.7.1 The CEO must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009*,* (including in relation to any suspension of

Accreditation of an Accredited Practitioner under By-law 11, as enforced in each State and Territory.

11.8 Interrelationship with By-Laws 8 and 9

For the avoidance of any doubt, the CEO is not required to comply with By- Laws 8 or 9 before proceeding with action pursuant to By-Law 11

12 TERMINATION OF ACCREDITATION

12.1 Immediate termination

Accreditation of Accredited Practitioners will be terminated immediately by the CEO if the following has occurred, or if it appears based upon the information available to the CEO that the following has occurred:

12.1.1 the Accredited Practitioner is found guilty of Professional Misconduct (or equivalent) by any inquiry, investigation or hearing by any disciplinary body or professional standards organisation;

12.1.2 the Accredited Practitioner ceases to be registered in the relevant profession, specialty and jurisdiction for which Accreditation has been given;

12.1.3 the Accredited Practitioner is convicted of an offence involving a child, sex or violence or any offence in relation to the Accredited Practitioner's practice as a Health Practitioner

12.1.4 the Accredited Practitioner fails, refuses or is unable to comply with the requirements and undertakings set out in By-Law 9.10, or is dishonest in respect of the undertakings given in By-Law 9.10;

12.1.5 any relevant screening authority in the Accredited Practitioner's jurisdiction determines that the Accredited Practitioner poses an unacceptable level of risk to children; or

12.1.6 the Accredited Practitioner's Professional Indemnity Insurance is cancelled, lapses or no longer covers the Accredited Practitioner's Scope of Clinical Practice to the reasonable satisfaction of the CEO (unless the situation is rectified by the Accredited Practitioner within 24 hours from when he or she becomes aware that his or her Professional Indemnity Insurance has been cancelled, lapsed or does not cover his or her Scope of Clinical Practice)

12.2 Unprofessional Conduct

Accreditation of Accredited Practitioners may be terminated immediately if the Accredited Practitioner is found guilty of Unprofessional Conduct (or equivalent) by any inquiry, investigation or hearing by any disciplinary body or professional standards organisation.

12.3 Termination when not immediate

In the event of a decision to terminate Accreditation, an Accredited Practitioner in accordance with any of the items below, the CEO may, in considering circumstances that may impact on patient safety, agree to a limited period of time for the termination to take affect enabling the Accredited Practitioner to continue to manage inpatients within the facilities.

12.3.1 based upon any of the matters in By-Law 15.1 and it is considered by the CEO that suspension is an insufficient response in the circumstances;

12.3.2 based upon the findings of a review carried out pursuant to By-Law 14 it is identified that the Accredited Practitioner, previously suspended, failed to observe the terms and Conditions of his or her Accreditation or failed to abide by these By-Laws or the Facilities' policies and procedures and failed to rectify the breach;

12.3.3 the Accredited Practitioner is not considered by the CEO as having Current Fitness to retain Accreditation or the Scope of Clinical Practice, or the CEO does not have confidence in the continued appointment of the Accredited Practitioner;

12.3.4 conditions have been imposed by, or undertakings agreed with, the Accredited Practitioner's registration board that restricts practice or imposes supervision and the CEO does not have the capacity to meet or is not willing to meet the results of the conditions imposed or undertakings agreed;

12.3.5 the Accreditation or Scope of Clinical Practice is no longer supported by the Organisational Need or Organisational Capabilities of the Facilities;

12.3.6 the Facilities ceases to provide support services required within the Scope of Clinical Practice of the Accredited Practitioner;

12.3.7 the conduct or continuing Accreditation of the Accredited Practitioner compromises the efficient operation or the interests of the Facilities'

12.3.8 the Accredited Practitioner's agreement with a contracted services provider for whom the Accredited Practitioner provides services terminates, or if the Accredited Practitioner's employment engagement with the contracted service provider terminates;

12.3.9 the Accredited Practitioner does not, without prior approved leave, provide services at the Facilities for a period of twelve months;

12.3.10 the Accredited Practitioner becomes incapable of performing his or her duties for a continuous period of six months or for a cumulative period of six months in any 12 month period; or

12.3.11 there are issues or concerns in respect of the Accredited Practitioner that are considered to be a ground for termination.

12.4 Termination framework

12.4.1 A ground for termination may relate to matters external to the Facilities‘

12.4.2 The Accredited Practitioner will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this

By-Law 12. The support person is not to participate in the process. Should the support person be a lawyer that same person must not act as a legal representative for the Accredited Practitioner.

12.4.3 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.

12.5 Notification of termination decision

12.5.1 The CEO will notify the Accredited Practitioner of:

a) the fact of the termination;

b) the reasons for the termination;

c) if the CEO considers it appropriate in the circumstances, invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider termination should not have occurred; and

d) the right of appeal (if available).

12.5.2 As an alternative to an immediate termination, the CEO may elect to deliver a show cause notice to the Accredited Practitioner advising of:

a) the facts and circumstances forming the basis for possible termination;

b) the grounds upon which termination may occur;

c) invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider termination is not appropriate;

d) 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

e) a timeframe in which a response is required from the Accredited Practitioner to the show cause notice.

f) Following receipt of a response to the show cause notice in paragraph above, the CEO will determine whether the Accreditation will be terminated. If termination is to occur then notification will be sent in accordance with paragraph (a) above. Otherwise the Accredited Practitioner will be advised that termination will not occur, however this will not prevent the CEO from taking other action at this time, including imposition of conditions, and will not prevent the CEO from relying upon these matters as a ground for suspension or termination of Accreditation in the future.

12.6 Appeal rights

12.6.1 No right of appeal will exist in respect of immediate termination of Accreditation pursuant to By-Laws 12.1 and 12.2.

12.6.2 For a termination of Accreditation pursuant to By-Law 12.3, the Accredited Practitioner shall have the rights of appeal established by these By-Laws.

12.7 Notifiable Conduct and Mandatory Reporting

The CEO must comply with his or her obligations of mandatory reporting of notifiable conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009, as in force in each State and Territory.

12.8 Interrelationship with By-Laws 10 and 11

For the avoidance of any doubt, the CEO is not required to comply with By- Laws 10 or 11 before proceeding with action pursuant to By-Law 12

13 IMPOSITION OF CONDITIONS

13.1 Imposing Conditions in lieu of suspension or termination

13.1.1 At the conclusion of or pending finalisation of a review pursuant to By-Law 14, or in lieu of a suspension of Accreditation pursuant to By-Law 15 or in lieu of a termination of Accreditation pursuant to By-Law 16.3, the CEO may elect to impose conditions upon Accreditation or Scope of Clinical Practice.

13.1.2 Conditions imposed will, at a minimum, be consistent with that imposed by the professional registration board or AHPRA.

13.1.3 The CEO will notify the Accredited Practitioner in writing of:

a. the conditions imposed;

b) the reasons for it;

c) the consequences if the conditions are breached;

d) the right of appeal (if available); and

e) if the CEO considers it appropriate in the circumstances, invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider the conditions should not be imposed.

13.1.4 If the Conditions are breached, then suspension of Scope of Clinical Practice or termination of Accreditation may occur.

13.1.5 If there is held, in good faith, a belief that the competence and/or Current Fitness to practice of the Accredited Practitioner is such that continuation of the unconditional right to practice in any other Facilities would raise a significant concern about the safety and quality of health care, the CEO will ensure that the imposition of Conditions is notified to the relevant professional registration board and relevant State or Commonwealth bodies.

13.1.6 The appeal procedure contained in these By-Laws will apply to an imposition of conditions under By-law 13.

13.1.7 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 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.

13.2 Notifiable Conduct and Mandatory Reporting

The CEO must comply with his or her obligations of mandatory reporting of notifiable conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009, as in force in each State and Territory (including in relation to the imposition of Conditions on the Accreditation or Scope of Clinical Practice of an Accredited Practitioner) under By-law 17.

14 APPEAL RIGHTS

14.1 No appeal rights against refusal of initial or probationary Appointment

There will be no right of appeal against a decision not to make an initial Appointment, not to extend a provisional Appointment, in relation to the specific Scope of Clinical Practice granted or where otherwise stated in these By-Laws, except in a public Facilities that is governed by relevant State legislation and/or policy that provides otherwise.

14.2 Appeal rights generally

Except where these By-Laws state otherwise, a Health Practitioner who has Accreditation in respect of the Facilities and whose Accreditation is amended, made conditional, suspended, terminated, not renewed or conditionally renewed by the Facilities, will have the rights of appeal set out in By-Law 15.

14.3 Concurrent appeal rights

Despite any other provision of these By-Laws, where an Accredited Practitioner has appeal rights under these By-Laws concurrently with appeal rights under any legislation or mandatory directive and/or policy in respect of the same circumstances, the appeal rights under these By-Laws will cease to be available to the Accredited Practitioner. For the avoidance of doubt, if this By-Law 18.3 applies, the Accredited Practitioner will not have appeal rights under these By-Laws but will continue to have the appeal rights available under any legislation or mandatory directive or policy

15 APPEAL PROCEDURE

15.1 Appeal must be lodged in fourteen days

15.1.1 An Accredited Practitioner will have 14 days from the date of notification of a decision to which there is a right in appeal provided for in these By-Laws in which to lodge an appeal against the decision. Such an appeal must be in writing and be lodged with the CEO within the 14-day timeframe, or else the right to appeal is lost.

15.1.1 Unless decided otherwise by the CEO, lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly.

15.2 Relevant Committee established to hear appeal

The CEO will establish an appeals Committee to hear the appeal. The appeals Committee must at a minimum include:

15.2.1 a nominee of the CEO who may be an Accredited Practitioner, who must be independent of the decision under appeal and who will be the chairperson of the appeals Committee;

15.2.2 a nominee of the CEO, who may be an Accredited Practitioner, and who must be independent of the decision under appeal; and

15.2.3 any other member or members who bring specific expertise to the decision under appeal, with at least one member preferably but not necessarily practicing in the same area of practice or

specialty of the appellant, who must be independent of the decision under appeal and who may be an Accredited Practitioner.

15.2.4 The CEO in his or her complete discretion may invite the appellant to make suggestions or comments with respect to the proposed additional members of the appeals Committee, but is not bound to follow the suggestions or comments.

15.3 Commissioning and Commencement

15.3.1 Before accepting the appointment, the nominees to the appeals Committee will confirm that they do not have a known conflict of interest with the appellant and will sign a confidentiality agreement, following which the CEO will notify the appellant of the members of the appeals Committee.

15.3.2 The CEO will prepare terms of reference and submit relevant material to the chairperson of the appeals Committee.

15.4 Procedure for appeal

15.4.1 Unless a shorter timeframe is agreed by the appellant and the appeals Committee, the appellant shall be provided with at least 14 days written notice of the date for determination of the appeal by the appeals Committee.

15.4.2 The Chairperson of the appeals Committee will determine any question of procedure, which will be entirely within the discretion of the Chairperson.

15.4.3 The notice from the appeals Committee will ordinarily set out the date for determination of the appeal, the members of the appeals Committee, the process that will be adopted, information and documents that will be provided, and any conditions that must be met before provision of the information or documents, such as a confidentiality agreement, and invite the appellant to make a submission about the decision under appeal.

15.4.4 The appeals Committee will determine whether the submission of the appellant will be in writing or in person, or both. The appellant must provide written submissions for the appeals Committee within the timeframe required by the appeals Committee.

15.4.5 If the appellant attends before the appeals Committee in order to make a submission, the appeals Committee may request that the appellant answers questions in addition to making a submission.

15.4.6 The CEO (or nominee) may make a submission to the appeals Committee in order to support the decision under appeal. The appeals Committee will determine whether the submission of the CEO will be in writing or in person, or both. The CEO must provide written submissions for the appeals Committee within the timeframe required by the appeals Committee.

15.4.7 Neither the appellant nor any party will have any legal representation at any meeting of the appeals 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 appeals Committee, as the appeal is intended to be conducted through direct communication between the appellant and appeals Committee.

15.4.8 The appellant and CEO are not entitled to be present during deliberations of the appeals Committee.

15.5 Recommendation of appeals Committee

15.5.1 The appeals Committee will make a written recommendation regarding the appeal in accordance with the terms of reference, including provision of reasons for the recommendation, and submit this to the CEO.

15.5.2 The recommendation of the appeals Committee may be made by a majority of the members of

the appeals Committee and, if an even number, the Chairperson has the deciding vote.

15.5.3 The CEO will provide a copy of the written recommendation of the appeals Committee to the appellant.

15.5.4 The CEO will consider the recommendation of the appeals Committee, and any information or documents before the appeals Committee that they may require, and the CEO will decide regarding the appeal.

15.5.5 The decision of the CEO will be notified in writing to the appellant.

15.5.6 Any actions required arising from the decision of the CEO including notifications that may be required internally and externally, will be the responsibility of the CEO .

15.5.7 The decision of the CEO will be final and binding, and there is no further appeal allowed under these By-Laws from this decision.

16 EXPERIMENTAL OR INNOVATIVE TREATMENT OR TECHNIQUES

16.1 Approval of experimental treatment or techniques

Experimental or innovative treatment or techniques (including any new or revised use of technology or incremental development of established treatments, techniques or therapies) will only commence if:

16.1.1 it is to be carried out by an Accredited Practitioner with appropriate Credentials and Scope of Clinical Practice granted in accordance with these By-Laws to cover the experimental or innovative treatment or technique;

16.1.2 the Accredited Practitioner has submitted details to the CEO for appropriate review and approval by the relevant Committee and, subject to By-Law 21.2, the approval of both has been given and the CEO is satisfied that appropriate insurance cover is in place; and

.

16.2 Approval by the CEO

16.2.1 The CEO may, having consulted with the head of the relevant Committee, approve experimental or innovative treatments or techniques where he or she is of the opinion that formal review and approval by the relevant Committee is not necessary.

16.2.2 The CEO must have regard to Facilities policy regarding the circumstances where formal review and approval of experimental or innovative treatments or techniques are required.

16.2.3 There is no appeal available pursuant to this By-Law from the decision of the CEO.

16.3 Ethical issues and human subjects

Where the proposed experimental or innovative treatment or technique raises ethical issues or the involvement of human subjects, such experimental or innovative treatment or technique will only commence if:

16.3.1 the treatment or technique has been referred to and approved by the relevant ethics Committee; and

16.3.2 such experimental or innovative treatment or technique is conducted in accordance with any approvals or conditions provided by that Committee.

16.4 New Clinical Services, Procedures or Other Interventions

16.4.1 An Accredited Practitioner who proposes to perform a New Clinical Service, Procedure or Other Intervention at the Facilities must apply in writing to the CEO for approval.

16.4.2 The CEO must refer the application to the relevant Committee which will advise on the safety, efficacy and role of the New Clinical Service, Procedure or Other Intervention in the context of the Facilities' Organisational Need and Organisational Capabilities.

16.4.3 The relevant Committee will advise the CEO :

a) whether, and under what conditions, the New Clinical Service, Procedure or Other Intervention could be introduced safely to the Facilities; and

b) whether the New Clinical Service, Procedure or Other Intervention or equipment is consistent with the Accredited Practitioner's Scope of Clinical Practice.

16.4.4 The CEO may seek additional advice about the financial, operational or clinical implications of the introduction of the New Clinical Service, Procedure or Other Intervention.

16.4.5 The CEO may refuse permission for the introduction of a New Clinical Service, Procedure or Other Intervention.

16.4.6 Before approving the introduction of a New Clinical Service, Procedure or Other Intervention the CEO must:

a) be satisfied that the New Clinical Service, Procedure or Other Intervention is consistent with the Organisational Need and Organisational Capabilities of the Facilities;

b) where the New Clinical Service, Procedure or Other Intervention involves research, be satisfied that the requirements of By-Law 20.1 has been met;

c) Be satisfied that the appropriate indemnity and/or insurance arrangements are in place;

d) If applicable in the circumstances, evidence will be provided that private health funds will adequately fund; and

e) notify the relevant Committee; and

f) there is no appeal available pursuant to these By-Laws from the decision of the CEO

17 MANAGEMENT OF EMERGENCIES

In cases of an emergency, or in other circumstances deemed appropriate, the CEO may take such actions as he or she deems fit in the interests of a patient. This may include a request for attention by an available Accredited Practitioner (other than the admitting Accredited Practitioner). In such cases, the following provisions will apply:

18.1 the available Accredited Practitioner may make appropriate arrangements for referrals for the purposes of urgent or necessary consultations or treatment and will inform the CEO of such arrangements;

18.2 the CEO will, as soon as possible, notify the Accredited Practitioner under whose care the patient was admitted of the circumstances, of the condition of the patient and of the actions taken;

18.3 the available Accredited Practitioner will advise the Accredited Practitioner under whose care the patient was admitted of the action taken; and

18.4 the patient's care will usually be returned, as soon as possible, to the Accredited Practitioner under whose care the patient was admitted, who will then resume the further management of the patient's condition.

18 REPUTATION OF THE FACILITIES

18.1 CEO may require cessation of certain types of procedures, advice or treatment

The CEO may, from time to time, on the basis of moral, religious or economic grounds, or upon the basis that certain types of medical practice may damage the reputation of the Facilities (or otherwise attract adverse publicity), require an Accredited Practitioner to immediately cease carrying out certain types of procedures, giving certain advice or recommending certain forms of treatment.

18.2 Accredited Practitioner to cease upon notice from the CEO

On being notified by the CEO of a requirement under By-Law 19.1, the Accredited Practitioner will immediately cease to carry out such procedures, give such advice, or recommend such treatment.

18.3 Scope of clinical practice Committee to make recommendation to the CEO

18.3.1 Following a decision of the CEO under By-Law 23.1, the Chief Executive Officer will refer the matter to the scope of clinical practice Committee for consideration and discussion. The scope of clinical practice Committee may convey comments or make recommendations to the CEO in relation to the decision. The CEO may, in its absolute discretion, affirm or vary the decision of the scope of clinical practice Committee.

18.3.2 There is no right of appeal against a decision of the CEO under this By-Law.

19 DISPUTES

19.1 By-Laws

Any dispute or difference which may arise as to the meaning or interpretation of these By-Laws will be determined by the Chair of the Clinical Governance Committee in consultation wit the CEO

19.2 Committees

Any dispute or difference which may arise as to the meaning or interpretation of the powers of any Committee established under these By-Laws or the validity of proceedings of any meeting, excluding the Appeals Committee, will be determined by the CEO

20 REVISION OF BY-LAWS

The Clinical Governance Committee may from time to time, make, amend, suspend or rescind any By-Law.

Schedule 1

Clinical Governance Committee - Terms of Reference

1. **Name of committee**
   Clinical Governance Committee

2. **Facilities**
   Coburg Endoscopy Centre and Dr Scope Sunshine

3. **Purpose of committee**

The Clinical Governance Committee is the senior advisory committee to the CEO and Facilities with respect to

(a) Ensuring optimal standards of patient care
(b) Clinical matters and standards related to Credentialing and Accreditation.
(c) Communication between Accredited Practitioners and the facilities Executive

4. Role and functions

The Clinical Governance Committee performs an advisory role to the CEO and shall carry out the following functions:

(a) support the Mission and Vision of the Facilities'

(b) understand and comply with the obligations set out in the By-Laws

(c) understand and comply with relevant legal obligations relevant to its role and functions

(d) act in an advisory role to the CEO and the Facilities Executive

(e) be the formal organisational structure through which the collective views of the Accredited Practitioners of the Facilities shall be formulated and communicated

(f) establish and oversight appropriate sub-committees, receive and, where necessary, act upon their reports and recommendations, including but not limited to the Appointments and Credentialing Committee, the Clinical Review Committee (or however named)

(g) provide a forum for communication between the Facilities, the Facilities' executive and Accredited Practitioners in relation to patient care and safety throughout the Facilities'

(h) provide a means whereby Accredited Practitioners can advise the Facilities of appropriate policies regarding the clinical organisation and service delivery of the Facilities, including contribute to policy making and planning processes

(i) contribute to and promote clinical education programs and research at the Facilities, undergraduate and post-graduate, and making recommendations concerning the suitability, format and content of clinical education programs and research activities

(j) assist in identifying health needs of the community and advise the Facilities on appropriate services which may be required to meet those needs

(k) ensure that the delivery of patient care in the Facilities' is maintained at an optimal level of safety, quality, efficacy and efficiency based on current best clinical practice and research, including where requested by providing input into policies, procedures, clinical reviews, safety, quality, audit and education

(l) establish and maintain a formal mechanism for monitoring and review of clinical outcomes and clinical management, including establishment of sub-committees and implementation of a robust peer review process

(m) ensure robustness of the Credentialing and Accreditation processes at the Facilities', in order to properly assess an applicant's Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services at the Facilities in the context of Organisational Capabilities and Need

(n) advising the CEO on minimum criteria that may be necessary to fulfil competency requirements specialty areas

(o) consider the recommendations of the Appointments and Credentialing Committee in relation to applications for appointment and re-appointment as Accredited Practitioners, including Scope of Clinical Practice, and make recommendations to the CEO in accordance with these By-Laws and any associated Facilities policies, with the paramount consideration the safety and quality of patients.

(p) at the request of the CEO, establish a sub-committee to conduct an internal review of an Accredited Practitioner to maintain that Accreditation and/or Scope of Clinical Practice, having considered the report of that sub-committee, make a recommendation to the CEO with regard to any action that might be taken

(q) review any research or experimental or innovative treatment or techniques and make a recommendation on any necessary amendment of the Scope of Clinical Practice of an Accredited Practitioner

5. Appointment, Composition, Resignation and Conclusion of Appointment Membership of the Clinical Governance Committee will be at least 3 current Accredited Practitioners who are representative of a specialty and/or craft groups, plus the CEO, Director of Nursing and a consumer representative.

The CEO appoints members to the Clinical Governance Committee and may in the absolution discretion of the CEO, establish a nomination process, with nominees to be considered and decided by the CEO.

The CEO may approve the co-opting of an Accredited Practitioner to the Clinical Governance Committee to assist with a specific purpose or function, and the co-opted member will be deemed a member of the Clinical Governance Committee for that purpose.

A member of the Clinical Governance Committee may resign with at least one month's notice to the CEO.

The CEO may conclude the membership of any member of the Clinical Governance Committee prior to their appointed term, may conclude the appointment as Chairperson, may suspend membership for a period of time (including if Accreditation is suspended) and membership will automatically conclude if Accreditation is terminated or ends. There are no appeal mechanisms available pursuant to the By-Laws arising from these decisions by the CEO.

6. Meetings

(a) **Frequency**
The Committee shall meet at least four (4) times per year, however, may meet more frequently as the circumstances require.

(b) Notice of meetings
The Committee secretary will provide a minimum of 2 weeks' notice of the next meeting.

(c) Committee papers
Papers shall be distributed to all members of the Clinical Governance Committee two weeks prior to the meeting

(d) Quorum
A quorum for the meeting is 50% plus one of the Committees' membership

(e) Declaration of conflict of interest
Members of the Clinical Governance Committee are expected to comply with By-Law 5 Members will be invited to declare any conflict of interest at the beginning of each meeting.

(f) Voting
Where a vote is required, voting will be on a majority basis and only by those in attendance at the meeting. There will be no proxy votes.

(g) Minutes

(a) Minutes of all meetings of the Clinical Governance Committee shall be recorded by the CEO or delegate

(b) Minutes shall be distributed to all members of the Clinical Governance Committee within fourteen days of each meeting

(c) No business shall be considered at a meeting of the Clinical Governance Committee until the minutes of the previous meeting have been confirmed

(d) Minutes of a meeting shall be confirmed by resolution and signed by the Chairperson at the next meeting and minutes so confirmed and signed shall be taken as evidence of proceedings at that meeting.

7. Term of office

Members of the Clinical Governance Committee will be appointed for a term of two (2) years. The CEO may, at his or her discretion, extend the members' term of appointment for additional terms of two (2) years on whatever conditions the CEO believes appropriate. However, any member of the Clinical Governance Committee who has served for three (3) consecutive terms is ineligible to be appointed unless the CEO determines that in the circumstances of the Facilities' and expertise required that this requirement will be waived.

8. Appointment to specified positions

(a) **Appointment of chair**
The Chairperson of the Clinical Governance Committee shall be elected for a term of two years from amongst the Accredited Practitioner members of the Committee.

(b) Appointment of committee secretary
The Secretariat will be nominated by the CEO.

9. Confidentiality

Appointees and re-appointees to the Clinical Governance Committee will be required to acknowledge in writing confidentiality obligations in accordance with By-Law 3,

10. Establishment of sub-committees

Each Clinical Governance Committee will have a minimum of two sub-committees. These include:

(a) Appointments and Credentialing Committee

Other sub-committees may include:

(b) Clinical review committee
(c) Infection control
(d) "Ad hoc" committees as required from time to time.

11. Assessment of committee performance

Committee performance will be assessed annually by the CEO through formal review.

12. Reporting arrangements

The Committee formally reports to the CEO.

13. Review of Terms of Reference

The Terms of Reference will be reviewed annually by the Committee at the first meeting of the calendar year and evaluation included in the meeting minutes.

SCHEDULE 2

Appointments and Credentialing Committee - Terms of Reference

1. **Name of committee**
   Appointments and Credentialing Committee

2. **Facilities**
   Dr Scope and Coburg Endoscopy Centre

3. **Purpose of committee**
   The purpose of the Appointments and Credentialing Committee is to review and make recommendations to the Clinical Governance Committee on formal applications for appointment as Accredited Practitioners and delineation of Scope of Clinical Practice in compliance with the requirements of the By-Laws and Facilities' policies and legislative requirements.

4. **Role and functions**
   The duties of the Appointments and Credentialing Committee are to:

   4.1. support the Mission and Vision of the Facilities'

   4.2. understand and comply with the obligations and process set out in the By-Laws

   4.3. understand and comply with relevant legal obligations relevant to its role and functions

   4.4. assess the Credentials, Competence, Performance, Current Fitness and professional suitability of applicants for Accreditation to ensure as best as possible that they are able to provide safe, high quality health care services within specific Facilities' environments taking into consideration Organisational Capabilities and Need, as well as the character and ability of the applicant to cooperate with management and staff at the Facilities', consistent with the terms and conditions set out in the By-Laws

   4.5. make a recommendation to the Clinical Governance Committee as to the Accreditation, Re-Accreditation, Scope of Clinical Practice and/or amendment to Scope of Clinical Practice sought by an applicant for Accreditation, consistent with the terms and conditions set out in the By-Laws

   4.6. if further information is required before making a recommendation to the Clinical Governance Committee as to the Accreditation and Scope of Clinical Practice sought by an applicant for Accreditation, to make such request directed to the CEO that will be communicated via the Clinical Governance Committee

   4.7. where request by the CEO, make recommendations regarding Temporary Appointments

   4.8. review any new or amended use of technology or procedures to treat patients including assessing the infrastructure of the Facilities' and other matters which are relevant, and make a recommendation on the amendment of the Scope of Clinical Practice of an Accredited Practitioner to the Clinical Governance Committee, consistent with the terms and conditions set out in the By-Laws.

5. **Appointment and Composition**
   The membership of the Appointments and Credentialing Committee shall consist of at least five (3) members, as follows:
   - Chair of the Clinical Governance Committee
   - Director of Nursing
   - Accredited Practitioners currently appointed to the Clinical Governance Committee
   - The CEO (ex-officio)

Other members may be co-opted as the Committee deems necessary and as approved by the

CEO. Co-opted persons shall not have voting rights at any meeting of the Appointment and Credentialing Committee.

A member of the Appointments and Credentialing Committee may resign with at least one month's notice to the CEO.

The CEO may conclude the membership of any member of the Appointments and Credentialing Committee prior to their appointed term, may suspend membership for a period of time (including if Accreditation is suspended) and membership will automatically conclude if Accreditation is terminated or ends. There are no appeal mechanisms available pursuant to the By-Laws arising from these decisions by the CEO.

6. Meetings

6.1. Frequency

Meetings will be held as is deemed necessary to review formal applications for appointment as Accredited Practitioners in a timely manner.

6.2. Notice of meetings

The Committee secretary will provide at least two weeks' notice of the next meeting.

6.3. Committee papers

Committee papers will be distributed to members at least 7 days prior to the scheduled meeting

6.4. Quorum

A quorum for the meeting is 50% plus 1 of members.

6.5. Declaration of conflict of interest

Members of the Appointments and Credentialing Committee are expected to comply with By-Laws Members will be invited to declare any conflict of interest at the beginning of each meeting.

6.6. Voting

Voting will be on a majority basis and only by those in attendance at the meeting. There will be no proxy votes.

6.7. Minutes

The Appointment and Credentialing Committee, as a sub-committee of the Clinical Governance Committee, will ensure that:

6.7.1. Minutes of all meetings of the Appointment and Credentialing Committee shall be recorded by the Minute Secretary

6.7.2. Minutes shall be distributed to all those entitled to attend meetings of the Appointment and Credentialing Committee within fourteen days of each meeting

6.7.3. No business shall be considered at a meeting of the Appointment and Credentialing Committee until the minutes of the previous meeting have been confirmed. No discussion of the minutes shall be permitted except as to their accuracy

6.7.4. Minutes of a meeting shall be confirmed by resolution and signed by the chairperson at the next meeting and minutes so confirmed and signed shall be taken as evidence of proceedings thereat.

7. Term of office

The term of office of members will be for two (2) years or the Accredited Practitioner members' term on the Clinical Governance Committee. The CEO may, at his or her discretion, extend the members' term of appointment for additional terms of two (2) years on whatever conditions the CEO believes appropriate. However, any member who has served for three (3) consecutive terms is ineligible to be appointed unless the CEO determines that in the particular circumstances of the Facilities' and expertise required that this requirement will be waived.

8. Appointments to specified positions

8.1. Appointment of chair / co-chair

The Chairperson of the Appointment and Credentialing Committee, will be an Accredited Practitioner, a current member of the Clinical Governance Committee and shall be elected for a term of two years from the Accredited Practitioner members of the committee

8.2. Appointment of committee secretary

The Secretariat will be nominated by the CEO

8.3. Appointment of members

The Accredited Members of the Appointment and Credentialing Committee shall be current members of the Clinical Governance Committee and determined by the CEO following consideration of recommendations from the Clinical Governance Committee.

9. Confidentiality

Appointees and Re-appointees to the Appointment and Credentialing Committee will be required to acknowledge in writing confidentiality obligations in accordance with By-Law 3

10. Reporting arrangements

The Committee formally reports to the Clinical Governance Committee

11. Review of Terms of Reference

The Terms of Reference will be reviewed annually by the Committee at the first meeting of the calendar year and evaluation included in the meeting minutes