Mater Misericordiae Ltd

By-Laws

Updated May 2018

Mater

Exceptional People. Exceptional Care.

Contents

1. Foreword

Mater Group (Mater Misericordiae Limited) began in Brisbane in 1906, as a healthcare ministry of the Sisters of Mercy. Mater has since grown to become one of Australia's most significant not-for-profit providers of health care, education and research.

In April 2013 the canonical stewardship and legal membership of Mater was transferred to Mercy Partners, a public juridic person established to ensure the continued Catholic stewardship of ministries established by the Sisters of Mercy.

Our core healthcare ministry Mater Health operates six hospitals at three campuses and delivers contemporary, evidence-based healthcare services for insured and uninsured patients, without discrimination.

Mater's commitment to clinical excellence in the context of our Mission to meet unmet need drives our approach to healthcare in the hospital, and beyond.

As partners in the delivery of our Mission, we expect our Accredited Practitioners to deliver high-quality, low-variability, evidence-based care for all patients each and every time. The Mater By-Laws have been created in support of Mater's goal to provide the highest standards of clinical excellence, and in line with the organisation's Mission, Vision and Values.

These By-Laws apply to Mater hospitals and any other health services established and operated by Mater. This means Mater Hospital Brisbane, Mater Children's Private Brisbane, Mater Mothers' Hospital, Mater Mothers' Private Brisbane, Mater Private Hospital Brisbane, Mater Private Hospital Redland, Mater Private Hospital Springfield and any other health services or hospitals established by Mater.

The By-Laws describe medico administrative processes which apply to any and all Accredited Practitioners providing clinical services at Mater. The Board and Group Executive of Mater welcome the opportunity to work within the By-Laws for the advancement of quality patient care, clinical education and research in a safe and harmonious environment for all.

Brian Flannery
Chairman

2. Mission, Values and Ethics

2.1 Mission

In the spirit of the Sisters of Mercy, Mater offers compassionate service to the sick and needy, promotes an holistic approach to health care in response to changing community needs and fosters high standards of health-related education and research.

Following the example of Christ the healer, we commit ourselves to offering these services without discrimination.

As a Catholic not-for-profit ministry, we are committed to a holistic approach to health care in response to ever-changing community needs. We continually strive to improve how we deliver patient care, keep our knowledge and skills relevant, advance our understanding of illness and health and manage resources effectively.

2.2 Mater Values

Mater staff are dedicated to providing highest quality health care services, through a sincere commitment to Mater's core values of Mercy, Dignity, Care, Commitment and Quality. Using these values as a guide for our interactions with our patients and their families, each other and our business partners, Mater staff promotes the professionalism and care that has been a part of the Mater since its beginnings. These values will be used to guide the application of the By-Laws.

Our Values

Mercy	**the spirit of responding to one another**. By being merciful we can bring forgiveness, joy, peace, kindness, compassion and hope to all in our care.
Dignity	**the spirit of humanity, respecting the worth of each person**. Each person we encounter in our working day—patients, visitors, co-workers—deserve our respect.
Care	**the spirit of compassion**. We show that we care for one another by being sensitive to each other's needs and showing kindness.
Commitment	**the spirit of integrity**. Being commited to those who entrust themselves to us is a responsibility we take seriously.
Quality	**the spirit of professionalism**. We strive to be leaders in our fields and to combine those skills with humanity and warmth.

2.3 Ethics

As a Catholic health care provider Mater follows a code of ethics as outlined in the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia.

Part A – Definitions and Introduction

3. Definitions and Interpretation

3.1 Definitions

In these By-Laws, unless indicated to the contrary or the context otherwise requires:

Accreditation Category means as part of Accreditation, the appointment of an Accredited Practitioner to one or more of the following categories: Allied Health Professional, Clinical Visitor, Dentist, Endorsed Registered Nurse/Midwife, Emeritus Consultant, Medical Observer, Medical Practitioner, Specialist Medical Practitioner, Surgical Assistant – Medical Practitioner. The Board may from time to time approve other Accreditation Categories.

Accreditation means the formal process provided for in these By-Laws by which a person is Accredited to provide services at a Mater facility meeting organisational need. The process serves to verify the qualifications, experience, professional standing and other relevant professional attributes of practitioners for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high-quality health care services within specific organisational environments.

Accreditation Type means as part of Accreditation, the appointment of an Accredited Practitioner with one or more of the following: admitting privileges, no admitting rights, anaesthetic privileges, assist privileges, consulting privileges, pathology or radiology procedures. The Board may from time to time approve other Accreditation Types.

Accredited means the status conferred on an Accredited Practitioner permitting them to provide services within the Facility after having satisfied the Credentialing requirements provided in these By-Laws.

Accredited Practitioner means a Medical Practitioner, Dentist, Allied Health Professional, Nursing or Midwifery Practitioner or other practitioner who has been Accredited to provide services within the Facility, with Accreditation to perform services at the Facility within the Accreditation Category, Accreditation Type, facility service capability and Scope of Practice notified in the appointment.

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

Allied Health Professional means a person registered under the applicable legislation to practise as an Allied Health Professional, or other categories of appropriately qualified health professionals as approved by the Board.

Amended Scope of Practice means amendment of existing Accreditation of an Accredited Practitioner.

Applicant means a Medical Practitioner, Dentist, Allied Health Professional, Nursing or Midwifery Practitioner or other health practitioners and / or those with scope of practice beyond the graduate level who are to apply for and be granted Accreditation in order to provide services within the Facility.

Board means the Board of Directors of Mater.

By-Laws means these By-Laws.

Chief Medical Officer (CMO) means the most senior executive in the Facility overseeing medical practitioners.

Chief Nursing & Midwifery Officer (CNMO) means the most senior executive in the Facility overseeing nursing and midwifery practitioners.

Chief Operating Officer (COO) means the most senior executive at Mater Health or any person acting, or delegated to act, in that position.

Clinical Council means the Committee that is responsible for the operation of certain clinical aspects of Mater Health by virtue of its Terms of Reference.

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

Clinical Visitors (Observer or Supervised) means any Health Practitioners registered with the Australian Health Practitioner Regulation Agency (AHPRA) attending to further their own professional development by either observing or undertaking supervised clinical practice depending on the individual's clinical qualifications, authorised scope of practice, experience and professional developmental goals.

Competence means, in respect of a person who applies for Accreditation, the possession of the necessary aptitude in the application of knowledge and skills in interpersonal relationships, decision making and Performance necessary for the Scope of Practice for which the person has applied and has the demonstrated ability to provide health services at an expected level of safety and quality.

Conflict of Interest means a situation in which a person or organisation is involved in multiple interest which has potential to corrupt the motivation of the individual or organisation independent of the occurrence of impropriety.

Credentialing means, in respect of a person who applies for Accreditation, the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of the applicant for the purpose of forming a view about their Credentials, Competence, Performance and professional suitability to provide safe, competent, ethical and high quality health care services within the Facility.

Credentialing Committee is a committee established under these By-Laws consisting of an appointed group of discipline specific representatives established for the purpose of recommending applications for accreditation and re-accreditation of Applicants within the Facility. The Committee will be established to satisfy the requirements of any statutory requirement applicable to the Facility in respect to Credentials and Clinical Privileges as well as any other internal requirements or standards.

Credentials means, in respect of a person who applies for Accreditation, the qualifications, professional training, clinical experience and training and experience in leadership, research, education, communication and teamwork that contribute to the person's Competence, Performance and professional suitability to provide safe, high quality health care services. The applicant's history of and current status with respect to professional registration, disciplinary actions, indemnity insurance and criminal regard are relevant to their Credentials.

Current Fitness is the current fitness required of an applicant for Accreditation to carry out the Scope of Practice sought or currently held. A person is not to be considered as having current fitness if that person suffers from any physical or mental impairment, disability, condition or disorder (including habitual drunkenness or addiction to deleterious drugs) which detrimentally affects or is likely to detrimentally affect the person's physical or mental capacity to safely practice medicine, nursing, midwifery, dentistry or allied health (as the case may be).

Dentist means, for the purposes of these By-Laws, a person registered under the applicable legislation to practise dentistry in the State in which the Facility is located.

Disruptive Behaviour means behaviour that can reasonably be considered unprofessional, inappropriate, intimidating, disruptive, threatening, aggressive or violent manifested through personal interactions (including physical, written, verbal, online or by any other means).

Egregious Behaviour means behaviour that may be considered inappropriate, unprofessional, intimidating, disruptive, threatening, aggressive or violent manifesting through personal interactions (including physical, verbal or online) which may indicate serious concerns about an Accredited Practitioner's level of functioning or performance and suggests potential for adversely affecting Patient safety, Facility staff, or Facility outcomes. This may manifest as a single episode or through multiple disruptive behavioural episodes.

Emergency Accreditation means the process provided in these By-Laws whereby a Practitioner is Accredited for a specified short period on short notice in an emergency situation.

Emeritus Consultant means a Medical Practitioner who has provided meritorious service at the Facility, who has retired from active clinical practice, and who holds appropriate specialist registration with Australian Health Practitioner Regulation Authority (AHPRA) or its successor.

Eminent Visitors are specialist Medical Practitioners of significant reputation in their clinical field attending to provide patient care and / or advice via consultation in conjunction with Accredited Practitioners; and or clinical education.

Endorsed Registered Nurse/Midwife means a nurse or midwife with advanced nursing practice who is registered with the Nursing and Midwifery Board (NMBA) of Australia and has (or is actively working towards) additional qualifications and specific expertise to practice within the additional advanced role (e.g. Eligible Midwife, Nurse Practitioner, Perioperative Nursing Surgical Assistant).

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

Facility means the Hospitals or health services owned or operated by Mater.

Full Accreditation means the process provided in these By-Laws by which a person who holds Initial Accreditation may apply for and be considered for Accreditation following the probation period. Applications are managed in accordance with the Re-Accreditation process.

Group Chief Executive Officer (GCEO) means the most senior executive at Mater or any person acting, or delegated to act, in that position.

Initial Accreditation means the process provided in By-Laws whereby a Practitioner is accredited for a probation period.

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

Locum Cover means an Accredited Practitioner who provides cover for another Accredited Practitioner for a specific time period such as weekends or leave periods.

Mater Health means the internal division of the Mater responsible for the operation of all Mater health Facilities.

Medical Advisory Committee means the medical advisory committees of the Facility.

Medical Observers are Medical Practitioners not registered with AHPRA (or its successor) who are seeking to further their own experience and training.

Medical Practitioner means, for the purposes of these By-Laws, a person registered under the applicable Commonwealth and State legislation to practise medicine in the State in which the Facility is located.

Mutual Recognition means recognition of accreditation at another Health Organisation as part of the Accreditation process under these By Laws.

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

No Admitting Privileges means the entitlement to provide treatment and care to Patients without the right to admit a patient to the Facility within the areas approved by the Board in accordance with the provisions of these By-Laws.

Organisational Capability means the Facility's ability to provide the facilities, services and 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 the availability, limitations and/or restrictions of the services, staffing, facilities, equipment, and support services required. In some jurisdictions the approved level of service capability may be specified on the Facility licence to operate. Organisational Capability may also be referred to as service capability.

Organisational Need means the extent to which the Facility is required or intends to provide a specific clinical service, procedure or other intervention in order to provide a balanced mix of safe, high quality health care services that meet consumer and community needs and aspirations.

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

Performance means the extent to which an Accredited Practitioner provides health care services in a manner which is consistent with known good Clinical Practice & Mater's Professional Conduct expectations.

Professional Conduct means behaving in a way that promotes Professional and Personal Integrity that is consistent with relevant Codes of Conduct and supports Mater's approach to addressing Disruptive Behaviour.

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

Research Conduct means the accredited practitioner undertaking responsible research practices in accordance with the National Health & Medical Research Council (NHMRC) Australian Code for the Responsible Conduct of Research (the Code).

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

Specialist Medical Practitioner means a Medical Practitioner who has been recognised as a specialist in their nominated category for the purpose of the Health Insurance Act 1973 (Cth) and is registered under the applicable legislation to practise medicine in that speciality.

Surgical Assistant Medical Practitioner means a Medical Practitioner who assists an Accredited Practitioner in the operating theatre.

Temporary Accreditation means the process provided in the By-Laws whereby an Accredited Practitioner is accredited for a limited period pending formal approval process by the Credentialing Committee.

Threshold Credentials means the minimum credentials for each clinical service, procedure or other intervention which applicants for Credentialing, within the Scope of Practice sought, are required to meet before any application will be processed and approved. Threshold credentials are to be approved by the Board and may be incorporated into an Accreditation policy and procedure.

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

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

3.2 Interpretation

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

(a) In these By-Laws, unless the context makes it clear the rule of interpretation is not intended to apply, which extends to include examples like gender neutral, singular including plural references. The reference to specific legislation, standards and policies (including subordinate legislation or regulation) is also intended to include relevant amendments, re-enactments or replacement.

(b) The Group CEO or delegate may delegate any of the responsibilities conferred by the By-Laws with complete discretion, but only within any delegation parameters approved
by the Board.

(c) The Board may delegate certain matters of decision-making or management of a particular matter as set out in these By-Laws to a nominated Board member or the Group CEO or delegate, other than the determination of an appeal.

(d) Any dispute or difference which may arise as to the meaning or interpretation or application of these By-Laws or as to the powers of any committee or the validity of proceedings of any meeting shall be determined by the Board. There is no appeal from such a determination by the Board.

3.3 Meetings

(a) Where a reference is made to a meeting, the quorum requirements that will apply are those specified in the terms of reference of the relevant committee. If there are no terms of reference, where there is an odd number of members a quorum will be a majority of the members, or where there is an even number of members a quorum will be half of the number of the members plus one.

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

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

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

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

(f) Resolutions may be adopted by means of a circular resolution.

(g) Information provided to any committee or person shall be regarded as confidential and is not to be disclosed beyond the purpose for which the information was made available, subject to the exceptions set out in these By-Laws.

(h) Any member of a committee who has a conflict of interest or material personal

interest in a matter to be decided or discussed shall inform the chairperson of the committee and subject to any agreed resolution on the matter shall take no part in any relevant discussion or resolution with respect to that particular matter. This will include a member the Medical Advisory Committee or Credentialing Committee whose application for Accreditation is being considered.

3.4 Legal Effect

(a) These By-Laws do not of themselves:

(i) create a contractual or employment relationship between Mater and any Accredited Practitioners; or

(ii) confer on any Accredited Practitioners any legally enforceable right, or create in any Accredited Practitioners any legitimate expectation, in relation to any matter or thing referred to in them,

(b) However, it is contemplated that these By-Laws, or parts of these By-Laws, may be given legal effect (including by imposing binding legal obligations upon Accredited Practitioners) by being adopted or applied, in whole or in part, in:

(i) contracts, licences and other binding legal arrangements entered into between Mater and Accredited Practitioners; and

(ii) cmployment contracts or contracts for services entered into between Mater and Accredited Practitioners.

(c) These By-Laws will take effect and supersede any previous published version. These By-Laws will be operational and effective regardless of when an issue or circumstance arises or if an issue or circumstance has been previously subject to contemplation of previous By-Laws.

3.5 Application of these By-Laws

Where an obligation is placed upon an individual under these By Laws and the individual is an employee of the Mater then by virtue of the terms of employment of that individual that obligation may be able to be satisfied under the terms of employment of that individual (for example indemnification and insurance obligations).

4. Introduction

4.1 Purpose of this Document and Understanding of By-Laws

(a) The By-Laws provide direction to the Board of Directors, the Group CEO or delegate to exercise certain aspects of their managerial and governance responsibility.

(b) Patient care is provided by Accredited Practitioners who have been granted access to use the Facility in order to provide that care.

(c) The By-Laws define the relationship and obligations between the Facility and its Accredited Practitioners.

(d) The By-Laws set out certain terms and conditions upon which an applicant may apply to be Accredited, the basis upon which an Accredited Practitioner may admit Patients and/or care and treat Patients at the Facility, and the terms and conditions for continued Accreditation.

(e) This document sets out the entirety of the processes and procedures available to Accredited Practitioners with respect to all matters relating to and impacting upon Accreditation.

(f) Every applicant for Accreditation will be directed to a copy of this document and Annexures before or at the time of making an application. It is expected that the By-Laws are read in their entirety by the applicant as part of the application process. Applicants will be required to confirm in writing that they have read and understood these By-Laws.

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

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

Part B – Terms and Conditions of Accreditation

5. Compliance with By-Laws

5.1 Compliance Obligations

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

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

(c) Unless specifically determined otherwise by the Board in writing for a specified Accredited Practitioner, the provisions of these By-Laws in their entirety prevail to the extent of any inconsistency with any terms, express or implied, in a contract of employment or engagement that may be entered into. In the absence of a specific written determination by the Board, it is a condition of ongoing Accreditation that the Accredited Practitioner agrees that the provisions of these By-Laws prevail to the extent of any inconsistency or uncertainty between the provisions of these By-Laws and any terms, express or implied, in a contract or employment or engagement.

5.2 Compliance with Policies and Procedures

Accredited Practitioners must comply with all policies and procedures of the Facility.

5.3 Compliance with Legislation

Accredited Practitioners must comply with all relevant legislation, including but not limited to legislation that relates to health, public health, drugs and poisons, aged care, privacy, coronial matters, criminal law, health practitioner registration, research, environmental protection, workplace health & safety, occupational health and safety, antidiscrimination, bullying, harassment, industrial relations, care of children, care of persons with a disability, substituted decision making and persons with impaired capacity, mental health, Medicare, health insurance, fair trading and trade practices, intellectual property, and other relevant legislation regulating the Accredited Practitioner, provision of health care or impacting upon the operation of the Facility.

In addition, Accredited Practitioners must ensure compliance with, or assist the Facility to comply with, any Commonwealth or State mandated service capability frameworks, licensing requirements or minimum standards, and any legislation imposing obligations upon the Facility.

5.4 Insurance and Registration

(a) Accredited Practitioners must at all times maintain Adequate Professional Indemnity Insurance to the satisfaction of Mater. An Accredited Practitioner may satisfy the Mater on this requirement through the Accredited Practitioner's employment arrangements (see clause 3.5). However all Accredited Practitioners are encouraged to consider the advantages of having individual professional indemnity insurance coverage for matters such as legal assistance in the event of a matter under the By-Laws, or at a coronial or other enquiry where the Mater and the Accredited Practitioner may not have identical interests in the matter.

(b) Accredited Practitioners must at all times maintain registration with their relevant health registration board (local and/or national) that regulates the provision of services in the State where the Facility is located.

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

5.5 Standard of Conduct and Behaviour

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

(i) the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia or its replacement;

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

(iii) the Codes of Practice and Conduct, as well as associated Guidelines and Policies, of any specialist college or professional body or regulatory body of which the Accredited Practitioner is a member or registered. This includes for Medical Practitioners the Good Medical Practice: A Code of Conduct for Doctors in Australia and Sexual Boundaries: Guidelines for Doctors;

(iv) the Philosophy, Mission and Values of Mater;

(v) the strategic direction of the Facility, and any directions given by the Board;

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

(vii) Mater Health Code of Conduct and Behavioural Standards and/or any other Facility directive that sets out expectations of professional conduct and behavioural standards;

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

(b) Accredited Practitioners must:

(i) continuously provide clinical care based on best available evidence and/or standards of care that are well recognised by peers;

(ii) demonstrate Competence and Current Fitness;

(iii) not engage in Egregious Behaviour or Disruptive Behaviour;

(iv) understand and comply with the codes, policies, mandatory compliance requirements and procedures of the Facility in relation to these matters;

(v) observe all reasonable requests with respect to conduct and behaviour.

(c) Upon request by the Group CEO or delegate, the Accredited Practitioner is required to meet with the Group CEO or delegate and any other person that the Group CEO or delegate may ask to attend the meeting, to discuss matters in (a) or (b) above, or any other matter arising out of these By-Laws.

5.6 Notifications

(a) Accredited Practitioners must immediately advise the Group CEO or delegate, and follow up with written confirmation within 2 days, should:

(i) the Accredited Practitioner be made aware of an investigation or process that has been commenced in relation to the Accredited Practitioner, or about the Accredited Practitioner's provision of Patient Care or Research Conduct (irrespective of whether this relates to a Patient of the Facility), by the Accredited Practitioner's registration board, disciplinary body, Coroner (excluding reportable deaths where the Coroner takes no further action), a health complaint's body including the Office of Health Ombudsman, or another statutory authority, State or Government agency or any other relevant body/organisation including those outside Australia;

(ii) any finding (including but not limited to criticism or adverse comment about the care or services provided or research undertaken by the Accredited Practitioner) be made against the Accredited Practitioner by a civil court, the practitioner's registration board, disciplinary body, Coroner(excluding reportable deaths where the Coroner takes no further action), a health complaints body including the Office of Health Ombudsman, or another statutory authority, State or Government agency, or any other relevant body/organisation irrespective of whether this relates to a Patient of the Facility;

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

(iv) the Accredited Practitioner's accreditation with a College as a supervisor is removed or withdrawn;

(v) the Accredited Practitioner be subject to any complaint and/or investigation relating to a breach of research ethics, protocols or procedures;

(vi) the Accredited Practitioner's professional indemnity membership or insurance be made conditional, reduced or not renewed, or should limitations be placed on insurance or professional indemnity coverage;

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

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

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

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

(xi) the Accredited Practitioner makes a mandatory notification to a health practitioner registration board in relation to another Accredited Practitioner of the Facility.

(b) In addition, Accredited Practitioners will keep themselves informed of their obligations in relation to external notifications (including mandatory notifications) and ensure compliance with these obligations.

5.7 Obligations to Disclose

(a) The Accredited Practitioner must keep the Group CEO or delegate informed of every fact and circumstances which has, or will likely have, a material bearing upon:

(i) the Accreditation of the Accredited Practitioner;

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

(iii) the ability of the Accredited Practitioner to safely deliver health services to his/her Patients within the Scope of Practice;

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

(v) the ability of the Accredited Practitioner to resolve a medical malpractice claim by a Patient (for example the refusal by an insurer to cover a claim or the imposition of conditions or restrictions upon the coverage provided by an insurer for a claim);

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

(vii) the reputation of the Facility.

(b) Subject to restrictions directly relating to or impacting upon legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the Group CEO or delegate informed and updated about the commencement, progress and outcome of compensation claims, coronial investigations or inquests, police investigations, Patient complaints (where the Accredited Practitioner seeks professional advice or notifies an insurer), health complaints body complaints or investigations including by the Office of Health Ombudsman, or other inquiries involving Patients of the Accredited Practitioner that were treated at the Facility or another health care organisation where accreditation is held.

5.8 Representations and Media

Unless an Accredited Practitioner has the prior written consent of the Group CEO or delegate or is authorised by virtue of his/her employment, an Accredited Practitioner may not use the Facility's (which for the purposes of this provision includes a corporate or business name of the Facility, its parent companies or subsidiary companies) name, letterhead which in any way suggest that the Accredited Practitioner represents these entities. This does not include use of the Facility's name as an identifier to the location of the Accredited Practitioner.

The Accredited Practitioner must obtain the Group CEO or delegate's prior approval before interaction with the media regarding any matter involving the Facility.

5.9 Confidentiality

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

(b) Accredited Practitioners will comply with the various legislation governing the collection, handling, storage and disclosure of health information.

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

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

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

(ii) the particulars of matters being dealt with in relation to the Accredited Practitioner under these By-Laws;

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

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

(v) information which comes to their knowledge concerning Patients, Clinical Practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services whilst performing a role in a quality assurance or peer review process.

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

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

(ii) where disclosure is required by law;

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

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

(v) where legal advice is being sought and received by the Accredited Practitioner;

(vi) where consent to disclosure for a specified purpose has been granted by Mater Health; or

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

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

5.10 Sharing Information

Accredited Practitioners are required to familiarise themselves with the Facility's organisational and clinical governance structure, and specifically that of the Health Executive. Accredited Practitioners acknowledge that in order for the organisation to function, effective communication is required, including between the Board, Group CEO or delegate, Chief Medical Officer, Chief Nursing and Midwifery Officer, Chief Operating Officer, Group Executive Members and Committees of the Facility, staff of the Facility and other Accredited Practitioners.

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

6. Commitment to Safety and Quality

Accredited Practitioners will acknowledge the importance of ongoing safety and quality initiatives that the Facility initiates and shall comply with and take all reasonable actions to facilitate their implementation including, but not restricted to, the use of any defined clinical guidelines. Accredited Practitioners will specifically and actively assist the Facility to comply with any accreditation standards applying to the Facility and contractual requirements relating to safety, quality and adverse/preventable events agreed with private health insurers or public health funders.

6.1 Clinical Practice and Continuous Improvement

(a) Accredited Practitioners will provide clinical care based on best available evidence and/or standards of care that are well recognised by peers and in keeping with the Code of Ethical Standards for Catholic Health and Aged Care Services and other recognised ethical standards. This commitment extends to complying with all Facility directives that are in place to optimise patient outcomes. This includes those evidenced by agreed, well-recognised quality standards such as the National Clinical Care Standards set by the Australian Commission on Safety and Quality in Health Care and also those developed by the Facility itself. In achieving this Accredited Practitioners will:

(i) recognise the Facility's safety and quality performance objectives and policies as they exist from time to time; and

(ii) comply with any reasonable request to participate in review of their own performance and peer comparison against such objectives (including but not restricted to hand hygiene, medication prescribing, safety in surgery, clinical handover, prescribing blood and blood products and recognising and responding to acute clinical deterioration).

(b) Patient care and clinical service review processes are established within the Facility as part of a broader quality program. Accredited Practitioners will participate in review of their clinical practice against best clinical evidence focusing on reducing unwarranted variation and meeting organisationally expected standards of patient care.

(c) These processes may take a number of forms such as Morbidity and Mortality reviews, Clinical Audits or Clinical Craft Group Meetings and will also provide a platform to consider system improvements, learning and continual improvement. Accredited Practitioners will:

(i) attend and participate in patient care and clinical service review processes that have been established within the Facility specific to his/her clinical specialty, at a frequency determined by the Group CEO or delegate dependent on the clinical activity of the Practitioner, designation and scope of practice;

(ii) attend and participate in Facility safety, quality, risk management, education and training activities, and as required by relevant legislation, standards and guidelines (including those standards and guidelines set by relevant Commonwealth or State governments, health departments or statutory health organisations charged with monitoring and investigating safety and quality of health care as well as facility or service accreditation bodies).

(d) Failure to comply with a reasonable request to participate in patient care and service review processes at the direction of the Group CEO or delegate will constitute a breach of the terms and conditions of Accreditation.

6.2 Risk Management and Regulatory Agencies

(a) Accredited Practitioners will comply and fully cooperate with any Facility directive or review of incidents, complications, adverse events, (including as set out in lists prepared by private health insurers/health funds and public health funders), and complaints (including in relation to the Accredited Practitioner's Patients) in accordance with the Facility's policy and procedures and where required by the Group CEO or delegate.

(b) Accredited Practitioners will assist with incident management, investigation and reviews (including root cause analysis and other system reviews), complaints management, and open disclosure processes including any review or investigation processes relevant to any health funder's requirements or for any other reasonable requirement set out by the Facility.

(c) Accredited Practitioners will participate in risk management activities and programs as reasonably directed by the Facility, including the implementation of risk management strategies and recommendations from system reviews.

(d) Accredited Practitioners must provide all reasonable and necessary information and assistance in circumstances where the Facility requires assistance from the Accredited Practitioner in order to fully investigate a clinical incident or any event or circumstance. Further the Accredited Practitioner will provide all reasonable and necessary information and assistance to permit the Facility to comply with, or respond to a legal request or direction or contractual obligation, including for example where that direction is pursuant to a court order, or from a health complaint's body (including the Office of Health Ombudsman or successor), Coroner, Police, State Health Department and its agencies or departments, State Private Health Regulatory/Licensing Units, Commonwealth Government and its agencies or departments, or private health insurers/health funds.

(e) Accredited Practitioners must provide all reasonable and necessary information and assistance in circumstances where the Facility is undertaking investigation into the conduct of Research within the Facility or where there is another relevant organisation or regulatory body undertaking such investigation.

6.3 Surgery

Accredited Practitioners acknowledge the importance of and will participate in agreed processes aimed at ensuring safety and quality in surgical interventions and procedures. This includes full compliance with all Facility policies in place from time to time regarding the conduct of surgery.

The Facility has the right to allocate theatre and procedural suite access and timing as it sees fit from time to time. Accredited Practitioners must effectively utilise allocated theatre/procedural suite sessions that have been made available to the Accredited Practitioner to the satisfaction of the Facility who retain the right to re-allocate sessions depending upon its needs and expectations.

6.4 Clinical Speciality Committees

The Group CEO or delegate may establish clinical speciality Committees for the purpose of reviewing and advising the Group CEO or delegate on performance and outcomes of the clinical speciality by reference to the Facility's clinical services, Organisational Capability and Organisational Need.

Each Committee in consultation with the Group CEO or delegate, will establish the objectives or terms of reference for the group and will report as required by the Group CEO or delegate, on its activities through the governing Committee structures set out by the Board and Mater Group Executive.

6.5 New Clinical Services

(a) Accredited Practitioners proposing to provide a New Clinical Service will provide the Group CEO or delegate with supportive clinical evidence to the satisfaction of the Group CEO or delegate in keeping with the agreed governing policy and procedures of the Facility.

(b) Any provision of clinical care that requires the use of therapeutic goods or medicines for which there is no approved indication will be subject to the same requirements as a New Clinical Service.

(c) Before treating patients with a New Clinical Service, written approval of the Group CEO or delegate must be sought and the New Clinical Service proposed must fall within the Accredited Practitioner's Scope of Practice, or an amendment to their Scope of Practice will need to be approved by the Facility and must also fall within the licensed service capability of the Facility.

(d) The Group CEO or delegate's decision on the proposed introduction of the New Clinical Service is final and there shall be no right of appeal from denial of requests for a New Clinical Service.

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

(f) If the conduct of research is involved in the New Clinical Service, then any By-Law dealing with research must be complied with.

(g) The Accredited Practitioner must update the Group CEO or delegate on the outcomes and benefits of implementation of a New Clinical Service as reasonably requested by the Facility. In consideration of the reported outcomes and benefits, the Group CEO or delegate may withdraw approval for the continuation of the New Clinical Service.

6.6 Admission, Availability, Resources, Communication, and Discharge

(a) Accredited Practitioners will admit or consult Patients at the Facility on a regular basis within any twelve month period or as reasonably determined by the Facility in relation to a specific clinical specialty in order to maintain an appropriate level of familiarity with the Facility's practices, policies and procedures.

(b) Accredited Practitioners will admit and treat Patients only within the Accreditation Category, Accreditation Type, facility service capability and Scope of Practice granted, including any terms or conditions attached to the approval of Accreditation.

(c) Accredited Practitioners will not provide services or practice outside of the defined service capability of the Facility.

(d) Accredited Practitioners will, subject to clinical considerations, comply with all reasonable requests with regard to the procurement and use of medical supplies, prostheses and equipment and the provision of services at the Facility.

(e) Accredited Practitioners accepting care of Patients being transferred from other hospitals or locations for admission to the Facility must take all reasonable steps to ensure the Patient is transferred safely and that arrangements to support the Patient's care have been established with the admitting clinical department, including the arrangements where Facility staff consider immediate clinical review and assessment is required on admission of the patient.

(f) Accredited Practitioners who admit Patients to the Facility for treatment and care accept that they are at all times responsible for the care of their Patient and must ensure that they are available to treat and care for those Patients at all times, or failing that, that other arrangements as permitted by the By-Laws are put in place to facilitate the continuity of treatment and care for those Patients.

(g) An Accredited Practitioner who is unable, for whatever reason, to provide continuity of care for a patient must notify the Hospital administration (for example Hospital Unit Manager) of the name of the alternate Accredited Practitioner to whom the care of the patient has been delegated and for what period of time. A Practitioner who is unavailable whilst having a patient admitted to the Facility is deemed to be unable to provide continuity of care. Such delegation must be documented in the patient record.

(h) Accredited Practitioners must review all Patients admitted by them as frequently as is required by the clinical circumstances of those Patients and as would be judged appropriate by peers.

(i) An Accredited Practitioner or their on-call or locum Accredited Practitioner will be contactable and available by telephone to clinical staff to discuss their Patients within a clinically acceptable period of time. Alternatively, the Accredited Practitioner will make arrangements with another Accredited Practitioner to provide the requisite care and on-call arrangements and shall advise the staff of the Facility of this arrangement.

(j) Accredited Practitioners or their on-call or locum cover who may reasonably be required to attend to a Patient in-person (as assessed by the Facility) will be available to attend within a clinically acceptable period of time, relative to the clinical condition of the Patient or because of other factors relating to the Patient's care as determined by the Facility.

(k) If Accredited Practitioners are unable to provide this level of care personally, they will secure the agreement of another Accredited Practitioner to provide the care and treatment and will advise the staff of the Facility of this arrangement.

(l) It is the responsibility of the Accredited Practitioner to ensure any changes to contact details are notified promptly to the Group CEO or delegate. Accredited Practitioners

must ensure that their communication devices are functional and that appropriate alternative arrangements are in place to contact them if their communication devices need to be turned off for any reason or fail to function for a period of time.

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

(n) Accredited Practitioners are required to work with and as part of a multi-disciplinary health care team and ensure expectations of care are established through verbal and written communication, documentation, consultation and clinical handovers to facilitate the best possible care for Patients.

(o) Accredited Practitioners (including their on-call and locum cover) must at all times be aware of the importance of effective communication with other members of the health care team, referring doctors, the Facility executive, Patients and the Patient's family/carers or next of kin, and at all times ensure appropriate, timely communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.

(p) If care is transferred to another Accredited Practitioner, this must be documented in the Patient medical record and communicated to the relevant hospital manager and/or other responsible nursing staff member.

(q) Accredited Practitioners must participate in formal on-call arrangements as reasonably required by the Facility. Persons providing on-call or cover services must be accredited at the Facility.

(r) The Accredited Practitioner must facilitate appropriate and timely discharge of their Patients to promote efficient and effective use of the Facility's clinical resources. Patients will be discharged by the Facility only with the approval of the Accredited Practitioner who shall comply with the discharge policy of the Facility and complete all Patient focused discharge documentation (including medication discharge plan and instructions) required by the Facility. It is the responsibility of the Accredited Practitioner to ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the referring practitioner, general practitioner and/or other treating practitioner.

(s) Accredited Practitioners transferring patients to other Facilities or within Mater Facilities will take all reasonable steps to ensure the Patient is transferred safely and that the arrangements to support the patient's care during transfer and at the time of arrival to the other Facility have been established with the relevant clinical teams involved.

6.7 Treatment and Financial Consent

(a) Accredited Practitioners must provide and obtain fully informed consent for 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 (including applicable legislation) and in accordance with the policy and procedures of the Facility.

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

(c) The consent will be evidenced in writing and signed by the Accredited Practitioner and Patient or their legal guardian or substituted decision maker and will be compliant with the current applicable policy or policies.

(d) It is expected that fully informed consent will be obtained by the Accredited Practitioner under whom the Patient is admitted or treated, this being the legal responsibility of the Accredited Practitioner. The consent process will ordinarily include an explanation of the Patient's condition and prognosis, treatment and alternatives, inform the Patient of material risks associated with treatment and alternatives, following which consent to the treatment will be obtained. The Accredited Practitioner shall take all reasonable steps to ensure that the Patient has the appropriate level of understanding regarding the treatment as part of the process of obtaining a fully informed consent.

(e) The consent process must also satisfy the Facility's requirements from time to time as set out in its policy and procedures, including in relation to such documentation evidencing consent to be provided to the Facility.

(f) Accredited Practitioners must also provide full financial disclosure and obtain fully informed financial consent from their Patients in accordance with the relevant legislation, health fund agreements, policy and procedures of the Facility. This requirement extends to the disclosure of anticipated costs associated with the treatment that is to be provided by other Accredited Practitioners or Health Service Providers as much as it is practicable and feasible (for example in preparation for planned elective surgery). The Facility may in its discretion require evidence that full financial disclosure has occurred in any particular case.

(g) This section 6.7 does not apply when the Patient is an eligible public patient (or other category of patient) funded through an arrangement with the State or the Commonwealth.

6.8 Patient Health Records (also includes Patient Medical Records)

Accredited Practitioners must ensure that:

(a) Patient records held by the Facility are adequately maintained for Patients treated by the Accredited Practitioner, with ownership and copyright of entries contained in the Facility records vesting in the Facility.

(b) Patient records satisfy the Facility policy requirements, legislative requirements, State based standards, standards set for hospitals accreditation, and health fund obligations.

(c) They maintain full, accurate, legible and contemporaneous medical records, including in relation to each attendance upon the Patient, relevant evidence of consent to procedures, with the entries dated, time and signed and contained in the Facility medical records.

(d) They respond positively to any organisational review and feedback on clinical documentation that is aimed to facilitate improved written communication and capture of clinical assessment, interventions and patient outcomes for clinical coding.

(e) If introduced within the Facility or a part of the Facility, they participate in electronic medical record and ehealth initiatives.

(f) They comply with all legal and Facility policy requirements and standards in relation to the prescription and administration of medication, and properly document all drug orders clearly and legibly in the medication chart maintained by the Facility.

(g) Patient records maintained by the Facility include all relevant information and documents reasonably necessary to allow Facility staff and other Accredited Practitioners to care for Patients, including provision of pathology, radiology and other investigative reports in a timely manner.

(h) A procedure report is completed including a detailed account of the procedure or procedures undertaken, findings, procedural techniques undertaken, complications and post procedure orders.

(i) An anaesthetic report is completed (where an anaesthetic is administered to a patient), as well as documentation of the pre-anaesthetic evaluation, fully informed anaesthetic consent and post-anaesthetic evaluation.

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

6.9 Financial Information and Statistics

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

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

6.10 Participation in Clinical Teaching Activities

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

6.11 Research

(a) The Facility approves, in principle, the conduct of research (including a clinical trial) in the Facility. However, no research will be undertaken without the prior approval of the Group CEO or delegate and the Human Research Ethics Committee (where required), following submitted application by the Accredited Practitioner.

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

(c) For aspects of the research falling outside an indemnity from a third party (including the exceptions listed in the indemnity), the Accredited Practitioner must have in place appropriate insurance with a reputable insurer to cover the medical research and provide evidence of such insurance upon request by the Facility.

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

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

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

6.12 Utilisation of Accreditation

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

Part C – Accreditation of Medical Practitioners

7. Credentialing and Scope of Practice

7.1 Eligibility for Accreditation as a Medical Practitioner

(a) Accreditation as a Medical Practitioner will only be granted if the Medical Practitioner demonstrates adequate Credentials, is professionally competent, satisfies the requirements of the By-Laws, and is prepared to comply with the By-Laws and the Facility's policies and procedures.

(b) By the granting of Accreditation, the Medical Practitioner accepts compliance with, and agrees to abide by the By-Laws and the Facility's policies and procedures.

(c) Any Medical Practitioner who falls outside of Accreditation requirements and therefore is not subject to a Credentialing process, before being permitted to attend the Facility and be involved in clinical care of Patients, will be provided with and agree to 'terms of attendance' (however phrased) that will govern attendance at the Facility, including appropriate supervision.

7.2 Entitlement to Treat Patients at the Facility

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

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

7.3 Responsibility and Basis for Accreditation and Granting of Scope of Practice

(a) The Board (or its delegate) will determine the outcome of applications for Accreditation as Medical Practitioners and defined Scope of Practice for each applicant.

(b) In making any determination, the Board will make independent and informed decisions and in so doing will have regard to the matters set out in these By-Laws, the recommendations of the Credentialing Committee and any feedback from the Group CEO or delegate and CMO.

(c) The Board may, at their discretion, consider other matters as relevant to the application when making their determination.

7.4 Credentialing and Accreditation

(a) The Board will establish the process and mechanism by which practitioners applying for accreditation will be credentialed within the Facility.

(b) Credentialing processes will be facilitated by appropriately appointed Credentialing Committees which will act as Committees and comply with any relevant requirements or standards applicable to the Facility.

(c) The primary role of a Credentialing Committee will be to review the Credentialing requirements set out in these By-Laws and make recommendations on the suitability of the Applicant to the Board or delegate.

(d) With the approval of the Group CEO or delegate, the Medical Advisory Committee membership shall constitute the Medical Credentialing Committee and shall reserve the right to establish Medical Specialist Credentialing panels to assist in meeting their obligations.

(e) Nursing and Midwifery and Allied Health Credentialing Committees will be constituted as directed by the Group CEO and/or delegate.

(f) In making determinations about applications for Accreditation the Board or delegate will be advised by at least one member of the Credentialing Committee of the same speciality as the applicant, which may mean co-opting a member in order to assist with the determination.

(g) It is however recognised that this may not always be possible or practicable in the circumstances, and a failure to do so will not invalidate the recommendation of the Medical Advisory Committee.

(h) The following principles will be considered and guide those persons involved in making decisions in the Credentialing and Accreditation process:

(i) credentialing and Accreditation are organisational governance responsibilities that are conducted with the primary objective of meeting the Facility's health service needs and maintaining and improving the safety and quality of health services;

(ii) processes of Credentialing and Accreditation are complemented by registration requirements and individual professional responsibilities that protect the community;

(iii) effective processes of Credentialing and Accreditation benefit patients, communities, health care organisations and health care professionals;

(iv) credentialing and Accreditation are essential components of a broader system of organisational management of relationships with health care professionals;

(v) credentialing and Accreditation and any reviews of clinical performance are to be carried out with the objective of maintaining and improving the safety and quality of health care services;

(vi) the effectiveness of the processes for Credentialing and Accreditation depend on strong partnerships between health care organisations and professional colleges, associations, societies and the Accredited Practitioners;

(vii) processes of Credentialing and Accreditation should be just and transparent, although recognising the ultimate ability of the Board and Group CEO or delegate to make decisions that they consider to be in the best interests of the organisation, its current and future patients;

(viii) processes for Credentialing and Accreditation may be done via electronic means with the option for face to face meetings to be held in accordance with the terms of reference.

7.5 Medical Advisory Committees

(a) The Group CEO or delegate will establish Medical Advisory Committees of the Facility. The Medical Advisory Committees will function in accordance with approved terms of reference, requirements set out in these By-Laws and pursuant to any legislative obligations including standards that have mandatory application to the Facility and Committee members.

(b) The Medical Advisory Committee members, including the chairperson, will be Accredited Practitioners (or at least a majority of Accredited Practitioners) and appointed for periods as determined by the Group CEO or delegate.

(c) The Group CEO or delegate and members of the Clinical Council or delegates will be entitled to attend meetings of the Medical Advisory Committee as ex-officio members, and as such they will not have an entitlement to vote in relation to decisions or recommendations of the Medical Advisory Committee.

8. The Process for Accreditation and Re-accreditation

8.1 Applications for Initial, Re-Accreditation and Mutual Recognition as Medical Practitioners

(a) Applications for Initial Accreditation (where the applicant does not currently hold Accreditation at the Facility) and Re-Accreditation (where the applicant currently holds Accreditation at the Facility) and Mutual Recognition (where the applicant does not currently hold Accreditation at the Facility) must be submitted by the Practitioner. The Application must be completed in its entirety for consideration. Applications should be forwarded to the Credentialing Office at least 2 weeks before the Medical Practitioner is seeking to commence at the Facility, or at least two months prior to expiration of their existing Accreditation. Under exceptional circumstances due to urgent patient need Emergency Accreditation will be considered and approved at the discretion of the Group CEO or delegate or CMO. If that Practitioner is then requiring on-going Accreditation they will need to adhere to the Initial Accreditation process.

(b) Applications will include a signed declaration endorsed by the Medical Practitioner to the effect that the information provided is true and correct, and that the Medical Practitioner has read the By-Laws and will comply in every respect with the By-Laws in the event that the Application for Accreditation is approved.

(c) The Group CEO or delegate may interview Medical Practitioners and/or request further information, if required.

(d) The Group CEO or delegate will ensure applications are complete and requests for further information complied with, and upon being satisfied will refer applications, together with notes and feedback to the Medical Advisory Committee, and/ or Credentialing Committee for consideration.

(e) The Medical Advisory Committee, and/or Credentialing Committee will consider all applications for Initial Accreditation and Re-Accreditation referred to it by the Group CEO or delegate.

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

(g) The Medical Advisory Committee and/or Credentialing Committee will make recommendations to the Board or delegate as to whether the application should be approved and if so, on what terms, including the Accreditation Category, Accreditation Type and Scope of Practice to be granted.

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

(i) In instances where there is any valid referral made to the Medical Advisory Committee and/or Credentialing Committee regarding concerns about a Medical Practitioner's ability to perform the services, procedures or other interventions which may have been requested for inclusion in the Scope of Practice, they may recommend to the Board or Group CEO to:

(i) initiate an Internal Review;

(ii) initiate an External Review;

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

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

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

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

8.2 Consideration of Applications for Initial (including Mutual Recognition) Accreditation by the Board

(a) The Board (or delegate) will consider applications for Initial Accreditation (including Mutual Recognition) as Medical Practitioners referred to the Board by the Medical Advisory Committee and/or Credentialing Committee to decide whether the applications should be rejected or approved and, if approved, whether any conditions should apply.

(b) In considering applications, the Board or delegate will give due consideration to the recommendations of the Medical Advisory Committee and/or Credentialing Committee as well as any feedback from the Group CEO or delegate and/or CMO, but the final decision is that of the Board and the Board is not bound by the recommendation of the Medical Advisory Committee and/or Credentialing Committee. In addition to considering the recommendations of the Medical Advisory Committee and/or Credentialing Committee, including Organisational Capability and Organisational Need, the Board or delegate may consider any matter assessed as relevant to making the determination in the circumstances of a particular case.

(c) The Board or delegate may defer consideration of an application in order to obtain further information from the Group CEO or delegate and Medical Advisory Committee and/or Credentialing Committee, the Medical Practitioner or any other person or organisation.

(d) If the Board or delegate requires further information from the Medical Practitioner before making a determination, they will notify the Medical Practitioner:

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

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

(iii) requesting that the Medical Practitioner provide the information in writing or consent to the Facility contacting a third party for information or documents, together with any further information the Medical Practitioner considers relevant and likely to be of assistance in this process within fourteen (14) days from the date of notification.

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

(f) The Group CEO or delegate will forward a notification to the Medical Practitioner advising the Medical Practitioner whether the application has been approved or rejected. If the application has been approved, the letter will also contain details of the Accreditation Category, Accreditation Type and Scope of Practice granted.

(g) The Group CEO or delegate will ensure that information relating to Accreditation Category, Accreditation Type and Scope of Practice is accessible to those providing clinical services within the Facility.

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

8.3 Initial Accreditation Tenure

(a) Initial Accreditation as a Medical Practitioner at the Facility will be for a probationary period of one year.

(b) Prior to the end of the probationary period, a review of the Medical Practitioner's level of Competence, Current Fitness, Performance, compatibility with Organisational Capability and Organisational Need, and confidence in the Medical Practitioner will be undertaken by the Group CEO or delegate. The Group CEO or delegate may seek assistance with the review from the relevant Medical Advisory Committee and/or Credentialing Committee or Speciality Committee where established, and may seek input from the CMO or CNMO or any other person the Group CEO or delegate considers is in a position to contribute. The Group CEO or delegate may also initiate the review at any time during the probationary period where concerns arise about Performance, Competence, Current Fitness of, or confidence in the Medical Practitioner, or there is evidence of Egregious or Disruptive Behaviour exhibited by the Medical Practitioner.

(c) A review conducted by the Group CEO or delegate during or at the end of an Accredited Practitioner's probationary period (in respect to the Accredited Practitioner) will cause the Group CEO or delegate to consider if:

(i) the Medical Practitioner's Scope of Practice should be amended for any subsequent Accreditation granted, or

(ii) the probationary period should be terminated, or

(iii) the probationary period should be extended, or

(d) If there are concerns regarding the Medical Practitioner and/or the Medical Practitioner's performance, the Medical Practitioner will be:

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

(ii) be given an opportunity to be heard and present their case.

(e) Should the probationary review outcome, including information obtained in paragraph (c) above, be considered by the Group CEO or delegate to be unacceptable, insufficient or below the standard required by the Board, the Group CEO or delegate may recommend to the Board to:

(i) amend the Scope of Practice that will be granted for any subsequent Accreditation; or

(ii) reject the continuation of Accreditation.

(f) Probationary Accredited Practitioners meeting the requirements of the probationary period may be recommend by the Group CEO or delegate to the Board that it grant an additional Accreditation period of up to three years, on receipt of a signed declaration from the Medical Practitioner describing any specific changes, if any, to the initial information provided and ongoing compliance with all requirements as defined by the By-Laws.

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

8.4 Re-Accreditation (including Mutual Recognition)

(a) The Credentialing Office will, at least two months prior to the expiration of any term of Accreditation of each Medical Practitioner (other than a probationary period), provide to that Medical Practitioner an application form to be used in applying for Re-Accreditation (including Mutual Recognition).

(b) Any Medical Practitioner wishing to be Re-Accredited must submit a completed application to the Credentialing Office at least one month prior to the expiration date of the Medical Practitioner's current term of Accreditation.

(c) If an Accredited Practitioner in the preceding 12 months prior to receipt of the application has not admitted or treated a Patient at the Facility, the Group CEO or delegate may elect to notify the Accredited Practitioner that the application for

Re-Accreditation has not been accepted due to the failure to exercise Accreditation sufficiently and any future application will need to be in accordance with the process for an Initial Accreditation.

(d) The Board, Group CEO or delegate, Medical Advisory Committee and/or Credentialing Committee will deal with applications for Re-Accreditation in the same manner in which they are required to deal with applications for Initial Accreditation as Medical Practitioners.

(e) The rights of appeal conferred upon Medical Practitioners who apply for Re-Accreditation as Medical Practitioners (excepting applications for Accreditation after the probationary period) are set out in these By-Laws.

(f) If, upon receiving an application for Re-accreditation, the Medical Advisory Committee or Credentialing Committee considers that it has information before it which may lead to a recommendation not to grant Re-accreditation of the applicant, they shall (prior to the Committees forwarding its recommendation under clause 8.4(d)):

(i) provide the applicant with a copy of that information;

(ii) seek a written submission from the applicant in relation to the information and any reasons why the application should still be approved; and

(iii) provide the applicant with an opportunity to address the Medical Advisory Committee and/ or Credentialing Committee. The Accredited Practitioner may be accompanied by a support person in this process.

8.5 Re-Accreditation Tenure

Granting of Accreditation and Scope of Practice subsequent to the probationary period will be for a term of up to three years, as determined by the Board.

8.6 Nature of Appointment

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

(b) The granting of Accreditation establishes only that the Accredited Practitioner is a person able to provide services at the Facility, as well as the obligations and expectations of the Accredited Practitioner while providing services at the Facility for the period of Accreditation.

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

9. Extraordinary Accreditation

9.1 Temporary Accreditation

(a) Medical Practitioners may be granted Temporary Accreditation and Scope of Practice on terms and conditions considered appropriate by the Group CEO and/or delegate. Temporary Accreditation will only be granted on the basis of Patient need, Organisational Capability and Organisational Need. The Group CEO or delegate may consider Emergency Accreditation for short notice requests.

(b) Applications for Temporary Accreditation as Medical Practitioners must be made in writing by completing the Initial Accreditation Application with relevant supporting documentation as directed by the Facility.

(c) Temporary Accreditation may be terminated by the Group CEO or delegate for failure by the Medical Practitioner to comply with the requirements of the By-Laws or failure to comply with Temporary Accreditation requirements.

(d) Temporary Accreditation will automatically cease upon a determination of the Medical Practitioner's application for Accreditation or at such other time as the Group CEO or delegate decides.

(e) The period of Temporary Accreditation shall be determined by the Group CEO or delegate, which will be for a period of no longer than three (3) months.

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

(g) The Medical Advisory Committee and/or Credentialing Committee, and the Board will be informed of all Temporary Accreditations granted.

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

9.2 Emergency Accreditation

(a) In the case of an emergency, any Medical Practitioner, to the extent permitted by the terms of the Medical Practitioner's registration, may request Emergency Accreditation and granting of Scope of Practice in order to continue the provision of treatment and care to Patients. Emergency Accreditation may be considered by the Group CEO and/or delegate for short notice requests, subject to professional body registration and identity verification, to ensure continuity and safety of care for Patients and/or to meet Organisational Need.

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

(i) verification of identity through relevant documents (e.g. current driver's licence with photograph);

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

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

(iv) nomination of at least one registered professional referee within the same clinical specialty;

(v) verification will be undertaken by the Group CEO or delegate and/or CMO and will be fully documented.

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

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

(e) The Medical Advisory Committee and /or Credentialing Committee will be informed of all Emergency Accreditation granted.

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

9.3 Locum Tenens

Locums must be approved by the Group CEO or delegate before they are permitted to arrange the admission of and/or to treat Patients on behalf of Medical Practitioners. Temporary Accreditation requirements must be met before approval of locums is granted. There will be no right of appeal from decisions in relation to locum appointments.

10. Variation of Accreditation or Scope of Practice

10.1 Amendment to Accreditation or Scope of Practice

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

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

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

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

11. Review of Accreditation or Scope of Practice

11.1 Review of Accreditation or Scope of Practice

(a) The Board or the Group CEO may at any time initiate a review of a Medical Practitioner's Accreditation or Scope of Practice where concerns have been raised or allegations made about any of the following:

(i) patient health or safety has been, or could potentially be, compromised through the actions or inactions of the Medical Practitioner;

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

(iii) the Medical Practitioner's behaviour;

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

(v) the Medical Practitioner's Current Fitness;

(vi) the Medical Practitioner's Performance;

(vii) the Medical Practitioner's compatibility with Organisational Capability or Organisational Need;

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

(ix) confidence held in the Medical Practitioner;

(x) the Medical Practitioner's compliance with these By-Laws, including the terms and conditions, or a possible ground for suspension or termination of Accreditation that may have occurred;

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

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

(xiii) as elsewhere defined in these By-Laws.

(b) A review may be requested by any other person or organisation, including external to the Facility, however the commencement of a review remains within the sole discretion of the Board.

(c) The Board or the Group CEO will determine whether the process to be adopted is an:

(i) internal review; or

(ii) external review.

(d) Prior to determining whether an Internal Review or External Review will be conducted, the Group CEO or delegate may in their absolute discretion meet with the Medical Practitioner (the Medical Practitioner may choose to bring along a support person), along with any other persons the Group CEO or delegate considers appropriate, advise of the concern or allegation raised, and invite a preliminary response from the Medical Practitioner (in writing or orally, as determined by the Group CEO or delegate) before the Board makes a determination whether a review will proceed, and if so, the type of review.

(e) The Accredited Practitioner who is the subject of a review:

(i) will ordinarily be offered an opportunity to make a written submission to the reviewers and offered an opportunity to attend before the reviewers (with a support person if required by the Accredited Practitioner) to speak to the matters contained in the written submission and any other matters the Accredited Practitioner wishes to address; and

(ii) must cooperate fully with the reviewers, including providing information reasonably required to inform the reviewers, failing which the Board may make a determination to immediately proceed to suspension or termination of Accreditation.

(f) As the review process, the terms of reference, access to information and reviewers are within the complete discretion and determination of the Board or the Group CEO, any deviations from the established process will not result in a flawed process and appropriate actions and response to deviations will be as determined by the Board or the Group CEO.

(g) The review may have wider terms of reference than a review of the Medical Practitioner's Accreditation or Scope of Practice. The scope of the review is entirely in the Board's discretion.

(h) The Board or the Group CEO may in their complete discretion, make a determination regarding the interim suspension or the placing of conditions on the Accreditation of the Accredited Practitioner pending the outcome of the review. There is no right of appeal available against a decision to impose an interim suspension or conditions.

    (i) circumstances may arise where the Board, Group CEO or delegate determines that, in addition to undertaking a review, they are mandated by legislation or believe it is in the public's (including patients at other facilities) or Patient's interest to notify the Medical Practitioner's registration board and/or other accrediting professional organisations of the details of the concerns that have been raised regarding the Medical Practitioner.

The Board or Group CEO, in their absolute discretion, may decide that as an alternative to conducting an internal or external review the concerns that have been raised regarding the Medical Practitioner should immediately be notified to the Medical Practitioner's registration board and/or other accrediting professional organisations for them to take the requisite action.

Following the outcome of any such action the Board or Group CEO may, at their absolute discretion, elect to take any further action they consider appropriate under these By-Laws.

11.2 Internal Review of Accreditation and Scope of Practice

(a) The Group CEO or delegate will draft the terms of reference of the Internal Review, and may seek assistance from the Medical Advisory Committee and/or Credentialing Committee or co-opted Medical Practitioners or personnel from within the Facility who bring specific expertise to the Internal Review as determined by the Group CEO or delegate.

(b) The terms of reference, process, access to information and reviewer(s) will be as determined by the Board or the Group CEO. The Group CEO or delegate will notify the Medical Practitioner in writing of the review, the terms of reference, process, material to be provided and reviewer(s). The process will ordinarily allow for:

    (i) the Accredited Practitioner to be notified of the nominated reviewer(s);

    (ii) the Accredited Practitioner to make a submission to the Group CEO or delegate on the appropriateness of reviewer(s); this submission will not impose any obligations whatsoever on the Group CEO or delegate and the decision to nominate the Reviewer(s) will remain the sole discretion of the Board or the Group CEO or delegate;

(iii) the Practitioner's written submission to be provided to the reviewer(s);

(iv) attendance before the reviewer(s) (with a support person if required by the Accredited Practitioner) to speak to the matters contained in the written submission and any other matters the Accredited Practitioner wishes to address including but not limited to responding to the issues of concern, and the opportunity for review of relevant material or a summary of relevant aspects of that material in order to respond.

(c) A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewer(s) to the Group CEO or delegate and the Board.

(d) On consideration of the report the Board will determine, in accordance with the By-Laws, what if any action should be taken regarding the Practitioner's Accreditation which may include but is not limited to: unchanged Accreditation; termination of Accreditation; Accreditation with conditions; suspension of the Accreditation.

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

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

(g) The Board or Group CEO, in their absolute discretion, may decide that in addition to or as an alternative to taking action regarding the Practitioner's Accreditation, they are mandated by legislation or believe it is in the public's (including patients at other facilities) or Patient's interest to notify the Medical Practitioner's registration board and/or other accrediting professional organisations of the details of the concerns that have been raised regarding the Medical Practitioner, the review findings and/or the Board's decision regarding Accreditation.

11.3 External Review of Accreditation and Scope of Practice

(a) The Board or the Group CEO will make a determination about whether an External Review will be undertaken.

(b) An External Review will be undertaken by a person(s) external to the Facility and independent of the Accredited Medical Practitioner in question and such person(s) will be nominated by the Board or the Group CEO as the case may be. The Board or the Group CEO will notify the Accredited Medical Practitioner the name/s of the proposed reviewer/s prior to appointment and seek the Practitioner's confirmation that no conflict or association exists with the reviewer(s).

(c) The terms of reference, process, access to information and reviewer(s) will be as determined by the Board, the Group CEO or delegate. The process will ordinarily allow for:

(i) the Accredited Practitioner to be notified of the nominated reviewer(s);

(ii) the Accredited Practitioner to make a submission to the Group CEO or delegate on the appropriateness of reviewer(s); this submission will not impose any obligations whatsoever on the Group CEO or delegate and the decision to nominate the Reviewer(s) will remain the sole discretion of the Board or the Group CEO or delegate;

(iii) the Practitioner's submission to be provided to the reviewer(s);

(iv) attendance before the reviewer(s) (with a support person if required by the Accredited Practitioner) to speak to the matters contained in the written submission and any other matters the Accredited Practitioner wishes to address including but not limited to responding to the issues of concern, and the opportunity for review of relevant material or a summary of relevant aspects of that material in order to respond.

(d) The Group CEO or delegate will notify the Medical Practitioner in writing of the review, the terms of reference, process, material to be provided and reviewer(s).

(e) The external reviewer(s) is required to provide a detailed report on the findings of the review in accordance with the terms of reference to the Group CEO or delegate and Board.

(f) The Board will review the report and make a determination of whether to continue (including with conditions), amend, suspend or terminate the Medical Practitioner's Accreditation or Scope of Practice in accordance with these By-Laws.

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

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

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

12. Suspension, Termination, Imposition of Conditions, Resignation and Expiry of Accreditation

12.1 Suspension of Accreditation

(a) The Board, the Group CEO or delegate may suspend a Medical Practitioner's Accreditation should the Board or Group CEO or delegate believe, or have a sufficient concern that:

(i) it is in the interests of Patient care or safety. This is to be based upon circumstances reasonably assessed by the decision maker to justify such an action, which may include an investigation by an external agency including a registration board, disciplinary body, Coroner or health complaints body (including the Office of Health Ombudsman), an adverse event or events, a clinical incident or incidents, and may be related to a patient or patients at another facility not operated by the Facility;

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

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

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

(v) the Medical Practitioner fails to observe the terms and conditions of their Accreditation including holding Current Fitness to retain Accreditation;

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

(vii) the behaviour or conduct is such that it is unduly hindering the efficient operation of the Facility at any time, or is bringing the Facility into disrepute or seriously impacting upon its reputation;

(viii) the behaviour or conduct is considered Disruptive Behaviour or Egregious Behaviour;

(ix) the behaviour or conduct of the Medical Practitioner is inconsistent with the values of the Mater;

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

(xi) the Medical Practitioner is subject to allegations or findings of fraud, bribery or corruption;

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

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

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

(xv) the Medical Practitioner fails to make the required notifications required to be given pursuant to these By-Laws;

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

(xvii) the Medical Practitioner is the subject of a criminal investigation about a serious matter which, if established, could affect their ability to exercise their Scope of Practice safely and competently and with the confidence of the Facility and the broader community;

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

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

(xx) an Internal Review or External Review has been initiated pursuant to these By-Laws and the Board considers that an interim suspension is appropriate pending the outcome of the review; or

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

(b) The Group CEO or delegate shall notify the Medical Practitioner:

(i) of the suspension of Accreditation;

(ii) of the period of suspension;

(iii) of the reasons for the suspension;

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

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

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

(c) As an alternative to an immediate suspension, the Group CEO or delegate may elect to deliver a show cause notice to the Medical Practitioner advising of:

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

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

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

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

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

(d) Following receipt of the response the Board or the Group CEO will determine whether the Accreditation will be suspended. If suspension is to occur notification will be sent in accordance with paragraph (b). Otherwise the Medical Practitioner will be advised that suspension will not occur, however this will not prevent the Board or the Group CEO from taking other action at this time, including imposition of conditions, and will not prevent the Board or the Group CEO from relying upon these matters as a ground for suspension or termination in the future.

(e) Ordinarily suspension will be suspension of Accreditation in its entirety, however the Board or the Group CEO may determine that the suspension will be a specific part of the Scope of Practice previously granted and these By-Laws in relation to suspension will apply to the specified part of the Scope of Practice that is suspended.

(f) The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by the Board or the Group CEO.

(g) The Medical Practitioner shall at all times have the rights of appeal as set out in these By-Laws.

(h) The Board or the Group CEO will notify the Medical Advisory Committee and/or Credentialing Committee of any suspension of Accreditation or any change to the Accreditation of the Practitioner.

(i) The Board or Group CEO may decide, in their absolute discretion, that the matters that have been raised regarding the Practitioner and the basis for the Practitioner's suspension are of sufficient concern to justify immediate notification to the Medical Practitioner's registration board and/or other accrediting professional organisations. Such concerns may relate to, but are not limited to, legislated mandatory reporting requirements or the belief that it is in the public's (including patients at other facilities) or Patient's interest for such notification to be made.

12.2 Termination of Accreditation

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

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

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

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

(iv) a contract of employment or to provide services is terminated or ends, and is not renewed (and the Accredited Practitioner does not hold accreditation unrelated to the services provided under this contract).

(b) Accreditation may be terminated by the Board, if the following has occurred, or if it appears based upon the information available to the Board, the following has occurred:

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

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

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

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

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

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

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

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

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

(d) The Board shall notify the Medical Practitioner of:

(i) of the fact of the termination;

(ii) of the reasons for the termination;

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

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

(e) As an alternative to an immediate termination, the Board or the Group CEO may elect to deliver a show cause notice to the Medical Practitioner advising of:

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

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

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

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

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

(vi) following receipt of the response the Board will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with paragraph (d). Otherwise the Medical Practitioner will be advised that termination will not occur, however this will not prevent the Board or the Group CEO from taking other action at this time, including imposition of conditions, and will not prevent the Board or the Group CEO from relying upon these matters as a ground for suspension or termination in the future.

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

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

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

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

12.3 Imposition of Conditions

(a) At the conclusion of or pending finalisation of an Internal or External Review, or in lieu of a suspension, or in lieu of a termination, the Board or the Group CEO may elect to impose conditions on the Accreditation or Scope of Practice.

(b) The Board or the Group CEO (as the case may be) must notify the Medical Practitioner in writing of the imposition of conditions, the reasons for it, the consequences if the conditions are breached, and advise of the right of appeal (if applicable), the appeal process and the timeframe for an appeal.

(c) If the Board or the Group CEO considers it applicable and appropriate in the circumstances, they may also invite a written response from the Medical Practitioner as to why the Medical Practitioner may consider the conditions should not be imposed or not imposed in the manner proposed by the Board or Group CEO.

(d) If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Board or the Group CEO.

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

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

12.4 Resignation and Expiry of Accreditation

(a) A Medical Practitioner may resign his/her Accreditation by giving one month's notice of the intention to do so to the Group CEO or delegate, unless a shorter notice period is otherwise agreed by the Group CEO or delegate.

(b) A Medical Practitioner who intends to cease treating Patients either indefinitely or for an extended period must notify their intention to the Group CEO or delegate, and Accreditation will be taken to be withdrawn one month from the date of notification unless the Group CEO or delegate decides a shorter notice period is appropriate in the circumstances.

(c) If an application for Re-Accreditation is not received within the timeframe provided for in these By-Laws, unless determined otherwise by the Group CEO or delegate to provide a period of extension at their discretion, the Accreditation will expire at the conclusion of its term. If the Medical Practitioner wishes to admit or treat Patients at the Facility after the expiration of Accreditation, an application for Accreditation must be made as an application for Initial Accreditation. The Group CEO or delegate will seek a written submission and a face to face discussion regarding the continuation of Accreditation in the following circumstances:

(i) the Medical Practitioner's Scope of Practice is no longer supported by Organisational Capability or Organisational Need;

(ii) the Medical Practitioner is no longer able to meet the terms and conditions of Accreditation;

(iii) where the Practitioner's admission of Patients or utilisation of services at the Facility is regarded by the Group CEO to be insufficient.

(d) If, having regard to the written and verbal submissions by the Medical Practitioner, the Board or Group CEO determine that Accreditation will be withdrawn on the listed grounds, the Group CEO or delegate and the Accredited Practitioner will attempt to reach a mutually agreed date for the expiration of the Accreditation. Failing an agreement, the Group CEO or delegate will make a unilateral decision regarding the timing of the Accreditation expiry.

(e) Following the expiry of the Accreditation the Practitioner must apply for and receive an Initial Accreditation before renewed treating or admitting privileges are established.

(f) The resignation and/or expiration provisions of Accreditation in no way limits the ability of the Board or Group CEO or delegate to take action pursuant to any provisions within these By-Laws.

13. Appeal Rights and Procedure

13.1 Rights of Appeal Against Decisions Affecting Accreditation

(a) There shall be no right of appeal against a decision to not approve Initial Accreditation, Mutual Recognition, Temporary Accreditation, Emergency Accreditation, a locum appointment, or continued Accreditation at the end of a probationary period or Temporary Accreditation, Emergency Accreditation or locum period, or for matters specified elsewhere in these By-Laws that there will be no right of appeal.

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

13.2 Appeal Process

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

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

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

(d) Upon receipt of an appeal notice the Group CEO or delegate will immediately forward the appeal request to the chairperson of the Board.

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

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

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

  (ii) a nominee of the Group CEO or delegate, who may be an Accredited Practitioner, and who must be independent of the decision under appeal regarding the Medical Practitioner;

  (iii) any other member or members who bring specific expertise to the decision under appeal, as determined by the chairperson of the Board, and who must be independent of the decision under appeal regarding the Medical Practitioner, but who may be an Accredited Practitioner.

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

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

(i) The appellant will be given the opportunity to make a submission to the Appeal Committee, including with respect to the issues of concern and action taken with respect to those issues of concern. The Appeal Committee shall determine whether the submission by the appellant may be in writing or in person or both.

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

(k) The Group CEO or delegate (or nominee) may present to the Appeals Committee in order to support the decision under appeal. That nominee may be a lawyer.

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

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

(n) The chairperson of the Appeal Committee shall determine any question of process and procedure for the appeal and Appeal Committee, with questions of process and procedure entirely within the discretion of the chairperson of the Appeal Committee, subject to the requirement to act in accordance with the established terms of reference. Any deviations by the Appeal Committee from the established process will not result in a flawed process and appropriate actions and response to deviations will be as determined by the chairperson of the Appeal Committee.

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

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

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

(r) The decision of the Board will be notified in writing to the Group CEO or delegate and appellant.

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

Part D – Accreditation of Other Accredited Health Practitioners

14. Accreditation and Scope of Practice of Other Accredited Health Practitioners (not employed by Mater)

By-Laws 7 to 13 are hereby repeated in full substituting where applicable Dentists, Allied Health Professional or Advance Practice Nurse Practitioners, Eligible/Endorsed Midwives for accredited Medical Practitioner.

This By-Law 14 may also be utilised for other health practitioners (registered and non-registered) who do not fall into the categories outlined above with the process as modified by the Group CEO or delegate to suit the particular circumstances of the case.

Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the Group CEO or delegate.

Part E – Amending By-Laws, Annexures, and Associated Policies and Procedures, and Other Matters

15. Amendments to, and Instruments Created Pursuant to the By-Laws

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

(b) All Accredited Practitioners will be bound by amendments to the By-Laws from the date of approval of the amendments by the Board, even if Accreditation was obtained prior to the amendments being made.

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

(d) The Board may approve forms, terms of reference and policies and procedures that are created pursuant to these By-Laws or to provide greater detail and guidance in relation to implementation of aspects of these By-Laws. These may include but are not limited to Accreditation and Scope of Practice requirements and the further criteria and requirements will be incorporated as criteria and requirements of these By-Laws.

16. Audit and Compliance

(a) The Group CEO or delegate will establish a regular audit process, at intervals determined to be appropriate by the Group CEO or delegate or as may be required by a regulatory authority, to ensure compliance with the processes set out in these By-Laws relating to Credentialing and Accreditation, and any associated policies and procedures.

(b) The audit process will include identification of opportunities for quality improvement in the Credentialing and Accreditation processes that will be reported to the Board by the Group CEO or delegate.

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