Mater Health

By-Laws for Accredited Practitioners

Updated July 2021

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1. Foreword

The Sisters of Mercy founded Mater ministries across Queensland with a Mission to improve health and wellbeing without discrimination.

Congregations in South East Queensland, Central Queensland and North Queensland established private and public hospitals which have delivered the highest standards of care for more than a century.

Today, Mater Health (Mater Misericordiae Limited) is a state-wide network of health services which aims to integrate expertise in health, education and research to deliver world-class health outcomes for our growing community.

As a Catholic ministry in healthcare under the stewardship of Mercy Partners, Mater Health strives for clinical excellence in the spirit of Mercy, with a commitment to holistic care which takes account of spiritual, emotional and physical wellbeing.

Our core healthcare ministry, Mater Health, provides care for insured and uninsured patients through seven hospital campuses and integrated community services which extend our care beyond the hospital.

In line with our commitment to excellence, we expect our Accredited Practitioners and partners in care to deliver high-quality, evidence-based best practice for every patient, each and every time. Our By-Laws link Mater Health's Mission and Values to the medico administrative processes which apply to any and all Accredited Practitioners providing clinical services at Mater Health. These By-Laws apply to all accredited Mater Health hospitals and any other health services or hospitals established by Mater Health.

On behalf of the Mater Health Board and Executive, I welcome health practitioners who seek to advance high-quality patient care in partnership, and who align to the Mission and Values of Mater Health.

Mr Francis Sullivan

Chairman

2. Mission, Values, Strategic Vision and Ethics

2.1 Mission

In the spirit of the Sisters of Mercy, Mater Health offers compassionate service to the sick and needy, promotes a 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 Mission, Values and Strategic Vision

Our Mission, Values and Strategic Vision guide everything we do at Mater Health. They are foundational to our work to transform healthcare and are reflected in strategic priorities as well as the behaviours that guide our interactions with each other, everyone we serve in our ministries, and within our communities.

2.2.1 Our Mission, Values and Strategic Vision

Mission	We serve together to bring God's mercy to our communities through compassionate, transforming, healing ministries.
Values	We honour and promote the dignity of human life and of all creation. We act with compassion and integrity. We strive for excellence.
Strategic Vision	Empowering people to live better lives through improved health and wellbeing.

2.3 Ethics

As a Catholic health care provider, Mater Health 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. General matters and definitions

3.1 Paramount considerations

a. Accreditation, Credentialing and Scope of Practice are key to the governance objective of Mater Health to maintain the quality of health care and safety of patients.

b. The quality of health care and safety of patients involves a mutual commitment from Mater Health, its clinical workforce and Accredited Practitioners. It is the expectation of Mater Health that all involved in the care of patients will work towards this mutual commitment.

c. In making decisions and taking action pursuant to these By-Laws, including the weighing of relevant factors, the quality of health care and safety of patients will be the paramount consideration.

3.2 Delegation and delegations register

a. The Board or CEO may delegate in writing any of the responsibilities conferred upon them by these By-Laws.

b. Board or CEO delegations will be set out in a By-Law delegation register, which may be updated from time to time following written approval by the Board or CEO as required.

3.3 Definitions

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

Accreditation	The formal process provided for in these By-Laws by which a person is accredited to provide services at a Mater Health facility following an assessment of credentials and having satisfied the credentialing and scope of practice requirements in these By-Laws, including meeting organisational capability and organisational need. The process serves to verify and assess the qualifications, experience, professional standing and other relevant professional attributes of practitioners for the purpose of forming a view about their competence, performance, current fitness and professional suitability to provide safe, high-quality health care services within specific Mater Health facility organisational environments.
Accreditation Category	As part of accreditation, Accredited Practitioners will be appointed to one or more of the following categories: Allied Health Professional, Clinical Visitor, Dentist, Emeritus Consultant, Endorsed Midwife/Registered Nurse, Medical Practitioner, Medical Proctor, Specialist Medical Practitioner, Surgical Assistant – Medical/Nurse Practitioner. The Board may from time to time approve other accreditation categories.
Accreditation Process	Processes that are undertaken in each facility utilising a risk-based assessment of the proposed applicant, determined by the CEO or their delegate. A full accreditation process will be applied to all applicants assessed by the CEO or their delegate as moderate to high risk based on their clinical practice, level of clinical intervention and complexity, and any other relevant circumstances as determined by the CEO or their delegate. A modified accreditation process can be applied to applicants assessed by the CEO or their delegate to be considered as low risk in their clinical practice, such as: surgical assistants, dental assistants, practice nurses, or visiting allied health. However, the CEO or their delegate can require full accreditation process for any applicant that they deem appropriate.
Accreditation Type	As part of accreditation, Accredited Practitioners will be appointed to one or more of the following: admitting privileges, no admitting privileges, anaesthetic privileges, consulting privileges, emeritus privileges, fellow privileges, pathology or radiology procedures. The Board may from time to time approve other accreditation types.
Accredited	The status conferred on an Accredited Practitioner permitting them to provide services within a Mater Health facility after undergoing an assessment of credentials and having satisfied the credentialing and scope of practice requirements provided in these By-Laws.
Accredited Practitioner	A health practitioner who has been accredited to provide services at a Mater Health facility: within a specified accreditation category, accreditation type,

	facility service capability and scope of practice notified in the appointment. If not employed by Mater Health, the Accredited Practitioner may additionally be referred to as a Visiting Allied Health Professional, Visiting Dentist or Visiting Medical Officer, and Visiting Nurse Practitioner / Practice Nurse.
Adequate Professional Indemnity Insurance	Insurance, including run off/tail insurance, to cover all potential liability (including legal costs) 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.
AHPRA	The Australian Health Practitioner Regulation Agency established under the Health Practitioner Regulation National Law Act 2009.
Allied Health Professional	A person registered with AHPRA to practise as an Allied Health Professional, or other categories of appropriately qualified health professionals as approved by the Board or professional body.
Applicant	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 seek to apply for and be granted accreditation to provide services within the Facility.
Behavioural Standards	The standards of conduct and behaviour expected of an Accredited Practitioner arising from personal interactions, communication and other forms of interaction with other Accredited Practitioners, clinical workforce of the Facility and Mater Health, Board members, executive of the Facility and Mater Health, third party service providers, patients, family members of patients and others. The minimum standard required of Accredited Practitioners to achieve the behavioural standards includes compliance with the Code of Conduct, the expectations set out in the Good Medical Practice: A Code of Conduct for Doctors in Australia (as applicable), and the Mission, Values and Ethics set out in By-Law 2.
Board	The Board of Directors of Mater Health.
By-Laws	These By-Laws.
Chief Executive Officer (CEO)	The most senior executive at Mater Misericordiae Ltd or any person acting, or delegated to act, in that position.
Clinical Practice	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.
Practice Improvement Meetings (PIMS)	Groups within Mater Heath and the Facility in which Accredited Practitioners participate in accordance with the clinical specialty of that Accredited Practitioner, including but not limited to clinical network, craft group, morbidity and mortality review and clinical audit review.
Clinical Visitor	A health practitioner registered with AHPRA or professional body other than a Medical Practitioner (see Medical Proctor), attending the Facility to further their own professional development, education and/or training through observation (no direct patient care) or supervised clinical practice.
Code of Conduct	The code of conduct and/or associated policies with respect to behaviour endorsed and operational within the Facility and Mater Health.
Competence	In respect of a person who applies for accreditation, that the person is assessed to have the required knowledge, skills, training, decision-making ability, judgment, insight and interpersonal communication 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	A situation in which a person or organisation is involved in multiple interests which has potential to impact the motivation, decisions or actions of the individual or organisation independent of the occurrence of impropriety.

Credentialing	In respect of an applicant for accreditation or re-accreditation, the formal process used to match the skills, experience and qualifications to the roles and responsibilities of that position. This will include actions to verify and assess the applicant's credentials, including the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate

	degrees/awards/fellowships/certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, and other skills/attributes (for example in leadership, research, education, communication, teamwork), for the purpose of forming a view about the applicant's competence, performance, current fitness and professional suitability to provide safe, high quality health care to the standard required by Mater Health and with respect to the scope of practice sought. This includes recognition that the role of a Visiting Medical Officer Visiting Dentist or Visiting Allied Health Professional, Visiting Nurse Practitioner/Practice Nurse involves unsupervised clinical practice.
Credentialing System	The software utilised by Mater Health in recording all applicant and accredited practitioner personal and business information.
Credentialing Committee	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 any statutory requirements applicable to the Facility with respect to credentials and scope of practice as well as any other internal requirements or external standards.
Credentials	In respect of an applicant for accreditation or re-accreditation, the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees/awards/fellowships/certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, and other skills/attributes (for example in leadership, research, education, communication, teamwork), that contribute to the person's competence, performance, current fitness and professional suitability to provide safe, high quality healthcare. The applicant's history of and current status with respect to clinical practice and outcomes at the Facility during prior periods of accreditation, disciplinary actions, By-Law actions, compensation claims, complaints and concerns – clinical and behavioural, professional registration and appropriate indemnity insurance are relevant to credentials.
Current Fitness	The current fitness required of an applicant for accreditation to carry out the scope of practice sought or currently held. Subject to compliance with relevant legislative requirements, a person is not to be considered as having current fitness if that person suffers from a physical or mental impairment, disability, condition, disorder or deterioration (including due to alcohol or drugs) which detrimentally affects, is likely to detrimentally affect or presents a reasonable risk of impacting on the person's capacity to provide health services at the expected level of safety and quality.
Dentist	Dentist means, for the purposes of these By-Laws, a person registered with AHPRA to practise dentistry.
Director of Medical Services	The most senior medical professional in the Facility overseeing Medical Practitioners, who may be delegated to undertake certain actions pursuant to these By-Laws by the CEO.
Disruptive Behaviour	Behaviour directed to, or, impacting upon others that can reasonably be considered to be: unprofessional, inappropriate, intimidating, disruptive, threatening, aggressive or violent (including physical, written, verbal, online or by any other means); or inconsistent with the Mission, Values and Ethics set out in By-Law 2.
Emeritus Consultant	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 AHPRA.
Endorsed Midwife / Registered Nurse	A nurse or midwife with advanced nursing practice who is registered with AHPRA and has (or is actively working towards) additional qualifications and specific expertise to practice within the additional advanced role (e.g. Endorsed Midwife, Nurse Practitioner, Perioperative Nursing Surgical Assistant).
Executive Officer	The most senior executive in the Facility overseeing Accredited Practitioners, who may be delegated to undertake certain actions pursuant to these By-Laws by the CEO.
External Review	Evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) external to the Facility.
Facility	One or more (as the context applies in these By-Laws) of the hospitals or health services owned or operated by Mater Health.
Hospital Executive	The senior hospital administrators (and delegates) responsible for the operational management of the Facility.

Internal Review	Evaluation of the performance of an Accredited Practitioner by an appropriately qualified and experienced professional person(s) internal to the Facility.
Locum Cover	An Accredited Practitioner who provides cover for another Accredited Practitioner for a specific time such as weekends or leave periods.
Mater Health	The internal Ministry of the Mater responsible for the operation of all Mater Health facilities within the corporate entity Mater Misericordiae Limited.
Medical Advisory Committee	The Medical Advisory Committee of each Facility.
Medical Practitioner	For the purposes of these By-Laws, a person registered with AHPRA to practise medicine.
Medical Proctor (also known as Medical Observer)	A medical practitioner not currently accredited at Mater Health, who will not participate directly in the care of a patient of Mater Health and is present to further their own education and training through observation or is present to provide mentoring and guidance to an Accredited Practitioner.
Mutual Recognition	Recognition of accreditation at another health organisation as part of the accreditation process under these By-Laws at another facility or healthcare organisation.
New Clinical Service, Procedure, Therapeutic Medicine, Therapeutic Good, Medical Device, Technology or other Intervention	Clinical services, treatments, procedures, techniques, instruments, therapeutic drugs / medicines, therapeutic goods, medical devices, products or other interventions that are being introduced by an Accredited Practitioner into the organisational setting of the Facility for the first time, or if currently used by the Accredited Practitioner are planned to be used in a different way or for something other than its registered or approved purpose. Further, the definition extends to a technology proposed to be used by an Accredited Practitioner directly or indirectly in the care of a patient (including as a communication tool or that will use / store/ transmit patient health information, images or data), that is introduced into the organisational setting of the Facility for the first time, or if currently used by the Accredited Practitioner is planned to be used in a different way or for something other than its registered or approved purpose, which is not currently the subject of a Facility policy for use. Such technologies include but are not limited to mobile devices, mobile health apps, analytical and decision-making or support tools.
No Admitting Privileges	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	The Facility's ability to provide the facilities, services, clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational capability will be determined by consideration of, but not limited to, the availability, limitations and/or restrictions of the services, clinical workforce (including qualifications and skill-mix), facilities, equipment, technology 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, based on Queensland Health Clinical Service Capability Framework for each facility/service.
Organisational Need	The extent to which the Facility considers it necessary to provide a specific clinical service, procedure or other intervention, or elects to provide additional resources to support expansion of an existing clinical service, procedure or other intervention, to provide a balanced mix of safe, high quality health care services that meet Facility, consumer and community needs and aspirations. Organisational need may be determined by factors including, but not limited to, the allocation of limited resources, funding, the strategic direction of Mater Health and the Facility, clinical services plans, business and operational plans and the Queensland Health Clinical Service Capability Framework for each facility/service.
Patient	A person admitted to or treated as a patient of the Facility (including outpatient or in receipt of community care).
Performance	The extent to which an Accredited Practitioner provides health care services in a manner which is consistent with known Good Clinical Practice and Mater's professional conduct expectations.
Professional Conduct	Behaving in a way that promotes professional and personal integrity that is consistent with relevant Codes of Conduct and supports Mater Health's approach to addressing disruptive behaviour.

Re-accreditation	The process provided in these By-Laws by which a person who already holds accreditation may apply for and be considered for re-accreditation following conclusion of the previous term of appointment.
Research Conduct	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	The extent of an individual Accredited Practitioner's permitted clinical practice within the Facility, that is assessed and documented in writing, based on the individual's credentials, competence, performance, current fitness, professional suitability, organisational capability and organisational need, to support the Accredited Practitioner's scope of practice. Scope of practice may also be referred to as delineation of clinical privileges.
Specialist Medical Practitioner	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 with AHPRA to practise medicine in that specialty.
Surgical Assistant Medical/Nurse Practitioner	A Medical/Nurse Practitioner who assists an Accredited Practitioner in the operating theatre.
Temporary Accreditation	The process provided in these By-Laws whereby a health practitioner is accredited for a specified short period of time, including in an emergency.
Threshold Credentials	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	An Allied Health Professional who is not an employee of the Facility, and who has been granted accreditation and scope of practice pursuant to these By-Laws.
Visiting Dentist	A Dentist who is not an employee of the Facility, who has been granted accreditation and scope of practice pursuant to these By-Laws.
Visiting Medical Officer (VMO)	A Medical Practitioner who is not an employee of the Facility, who has been granted accreditation and scope of practice pursuant to these By-laws. Visiting Medical Practitioners include visiting Specialist Medical Practitioners.

3.4 Interpretation

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

b. In these By-Laws, unless the context makes it clear the rule of interpretation is not intended to apply, interpretation of language will be gender and identity neutral and references to the singular will include plural.

c. The reference to specific legislation, standards and policies (including subordinate legislation or regulation) is also intended to include relevant amendments, re-enactments or replacement.

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.

e. Delegation from CEO is referenced throughout these By-Laws, as per By-Law 3.2 and as outlined in the Delegations Register.

3.5 Meetings

a. Matters of procedure for committees established pursuant to these By-Laws will be set out in terms of reference approved for that committee.

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

c. 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.

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

e. 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.

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

g. Resolutions may be adopted by means of a circular resolution.

h. 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 or formal written approval from the CEO.

i. 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, and where applicable shall absent themselves from the room. This will include a member the Medical Advisory Committee or Credentialing Committee whose application for accreditation is being considered.

j. Each Accredited Practitioner serving on any committee formed pursuant to these By-Laws is indemnified in respect of actions taken as a member of that committee or claims made against the member of the committee, provided the member has acted in good faith, with due care and diligence, in accordance with the By-Laws, in accordance with the terms of reference of the committee, Mater Health indemnity policies and in accordance with any common law or legislation governing their conduct or the committee.

3.6 Legal effect and nature of accreditation

a. These By-Laws do not of themselves:

   i. create a contractual or employment relationship, or any implied contractual terms, between Mater Health or the Facility 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 Health and Accredited Practitioners; and

ii. employment contracts or contracts for services entered into between Mater Health 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 arose (for example at a time previous By-Laws were in place) or if an issue or circumstance has been previously subject to contemplation in a previous version of the By-Laws.

d. 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.

e. Conferral of accreditation results in a conditional license to enter the Facility and provide services, in accordance with the terms of approval given. It provides the Accredited Practitioner with an ability on each occasion to make a request for access to the Facility for the treatment and care of a patient, within the limits of the Accredited Practitioner's scope of practice, and to utilise the Facility and resources for that purpose, subject always to the provisions of the By-Laws, Mater Health and Facility policies, resource limitations, and in accordance with organisational need and organisational capability at the time of the request for access.

f. The decision to grant access to facilities or particular resources for the treatment and care of a patient is on each occasion within the sole discretion of the CEO or delegate.

g. The CEO or delegate retains a right of refusal for a particular treatment, use of resources or particular patient, with there being no appeal pursuant to these By-Laws from such a decision of the CEO or delegate.

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

i. A condition of granting and accepting accreditation, and of ongoing accreditation, is that the Accredited Practitioner understands and agrees that:

i. these By-Laws (including any other documents referenced in the By-Laws) are the full extent of process and procedures available to them with respect to all matters relating to and impacting upon accreditation;

ii. no additional procedural fairness or natural justice principles will be incorporated or implied, other than processes and procedures that have been explicitly set out in these By-Laws;

iii. the By-Laws apply from the time of granting of accreditation (regardless of whether they were read by the Accredited Practitioner); and

iv. amendments to the By-Laws apply from the time of approval by the Board (regardless of whether they were read by the Accredited Practitioner).

j. Accredited Practitioners acknowledge and agree that as a condition of the granting of, and ongoing Accreditation, that:

i. the granting of accreditation establishes only that the Accredited Practitioner is a person able to provide services at the Facility, as well as the obligations and expectations with respect to the Accredited Practitioner while providing services for the period of accreditation;

ii. while representatives of Mater Health and the Facility will generally conduct themselves in accordance with these By-Laws, they are not legally bound to do so and there are no legal consequences for not doing so.

3.7 Application of these By-Laws

Where an obligation is placed upon an individual under these By-Laws and the individual is an employee of Mater Health, 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 and understanding of By-Laws

a. Mater Health is committed to providing safe and high-quality care to our patients. These By-Laws assist in achieving this objective by defining the requirements of accreditation within Mater Health and supporting the selection and retention of health practitioners who share and support our commitment.

b. The By-Laws define the relationship between Mater Health, the Facility and its Accredited Practitioners and provide clarity with respect to the obligations imposed upon Accredited Practitioners.

c. The By-Laws set out certain terms and conditions upon which an applicant may apply to be a ccredited, 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 a ccreditation.

d. 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 a ccreditation.

e. Every applicant for accreditation will be directed to a copy of this document and a nnexures 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 (or by electronic confirmation) that they have read and understood these By-Laws.

f. 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.

g. Healthcare 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, including but not limited to the terms and conditions of accreditation set out in By-Law 5, may be grounds for suspension, termination or imposition of conditions. As an alternative to suspension, termination or imposition of conditions for a breach of By-Law 5, the CEO or delegate may decide that the circumstances require a different approach, which may involve agreement with the Accredited Practitioner on actions to take or failing agreement a direction is given by the CEO or delegate to the Accredited Practitioner. If the agreement or direction is not complied with, this will be a breach of the By-Laws and the CEO or delegate may decide to suspend or terminate accreditation based upon breach of the agreement or direction.

c. Unless specifically determined otherwise by the CEO or delegate 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 CEO or delegate, 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 of employment or engagement.

5.2 Compliance with Mater Systems and Processes

Accredited Practitioners must comply with all policies and procedures, guidelines, work instructions, clinical pathways, forms and clinical systems of Mater Health and the Facility.

5.3 Compliance with legislation

a. Accredited Practitioners must comply with all relevant legislation. This includes but is 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, human rights, care of children, care of persons with a disability, substituted decision making and persons with impaired capacity, mental health, Medicare, health insurance, fair trading, competition, consumer protection, intellectual property, and other relevant legislation regulating the Accredited Practitioner, provision of health care or impacting upon the operation of the Facility.

b. 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 conduct in the matter.

b. Accredited Practitioners must at all times maintain eligibility for membership of their professional association and registration with AHPRA as applicable that is sufficient for the scope of practice granted.

c. Accredited Practitioners are required to provide evidence annually, or at other times upon request, of adequate professional indemnity insurance and registration with AHPRA, 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 written permission for the Facility to obtain that information directly.

d. It is a proactive responsibility of the Accredited Practitioner to submit the written evidence referred to in By-Law 5.4(c) annually or at times of any change to insurance or registration. The information can be gained from the Accredited Practitioner's insurer through digital platforms with the Accredited Practitioner's

permission. At the election of the Facility, a failure to do so may result in accreditation becoming 'inactive' until compliance to the satisfaction of the Facility. The consequence of inactive accreditation is that patients of the Accredited Practitioner will not be admitted to the Facility or the Accredited Practitioner cannot exercise accreditation until this occurs.

5.5 Standard of conduct and behaviour

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

   i. the Mission, values and ethics of Mater Health, including demonstrating appropriate respect for these matters;

   ii. the Mater Health Code of Conduct;

   iii. the Behavioural Standards;

   iv. any Facility directive that sets out expectations for professional conduct;

   v. specific requests and directions made with regard to conduct and behaviour in the Facility;

   vi. the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia or its replacement;

   vii. the Code of Ethics of the Australian Medical Association or any other relevant professional code of ethics;

   viii. 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;

   ix. the strategic direction and vision of the Facility, and any directions given by the Board;

   x. the limits of their registration or any conditions placed upon scope of practice in accordance with these By-Laws.

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. at a minimum, achieve the Behavioural Standards;

   iv. not engage in disruptive behaviour or behaviour inconsistent with By-Law 5.5(a);

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

   vi. observe all specific requests and directions made with regard to conduct and behaviour in the Facility.

c. Upon request by the CEO or delegate, the Accredited Practitioner is required to meet with the CEO or delegate and any other person that the 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.

d. An Accredited Practitioner is expected to promptly report to the CEO or delegate a breach or potential breach by another Accredited Practitioner of any of the matters set out in (a) or (b) above.

e. Any action by an Accredited Practitioner that may be perceived as a reprisal against another Accredited Practitioner, employee of Mater Health, patient, family member of a patient or third party due to the reporting of a matter in breach or potential breach of the requirements set out in (a) or (b) above will be regarded as a breach of the Behavioural Standards and consequently a breach of By-Law 5.5.

5.6 Notifications

a. Accredited Practitioners must immediately advise the 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 in relation to the Accredited Practitioner's

provision of patient care or research conduct. This notification obligation extends to an investigation or process commenced by the Accredited Practitioner's registration board, AHPRA, disciplinary body, Police, Coroner (excluding reportable deaths where the Coroner is able to advise that a cause of death certificate will be issued and no further action is to be taken by the Coroner), a health complaint 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. The notification obligation is irrespective of whether this relates to a patient of the Facility or conduct at the Facility;

ii. the Accredited Practitioner provide notification to the Coroner of a reportable death in relation to a patient of the Facility (excluding reportable deaths where the Coroner is able to advise that a cause of death certificate will be issued and no further action is to be taken by the Coroner);

iii. the Accredited Practitioner receive a written complaint from a patient of the Facility, or notification of a complaint from AHPRA or the Office of Health Ombudsman (or equivalent body in another state or territory) in relation to a patient of the Facility;

iv. the Accredited Practitioner receive an initial notice or notice of claim pursuant to the Personal Injuries Proceedings Act, or be served with court proceedings (or from any other State or Territory jurisdiction), making a compensation claim in relation to a patient of the Facility;

v. the Accredited Practitioner receive communication from a private health insurance fund, Medicare or Professional Services Review in relation to concerns or an investigation relating to services provided to a patient of the Facility;

vi. 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 in relation to or against the Accredited Practitioner by a civil court, the Accredited Practitioner's registration board, AHPRA, disciplinary body, Coroner, a health complaints body including the Office of Health Ombudsman, or another statutory authority, State or Government agency, ?or any other relevant body/organization. The notification obligation is irrespective of whether this relates to a patient of the Facility or conduct at the Facility;

vii. 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 arose in relation 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;

viii. the Accredited Practitioner's accreditation with a professional college as a supervisor and/or membership of a professional association be denied/withdrawn relevant for their accreditation at Mater;

ix. the Accredited Practitioner be subject to any complaint and/or investigation relating to research conduct, including a breach of research ethics, protocols or procedures;

x. 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;

xi. 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;

xii. any physical or mental condition or substance abuse problem or deterioration occur that could affect the Accredited Practitioner's ability to safely practice or that would require any special assistance to enable him or her to practice safely and competently;

xiii. the Accredited Practitioner be charged with having committed or is convicted of any criminal offence, regardless of whether tis relates to the provision of patient or health care. The Accredited Practitioner must provide the Facility with an authority to conduct at any time a criminal history check with the appropriate authorities;

xiv. 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

xv. the Accredited Practitioner make a mandatory notification to AHPRA or the Office of Health Ombudsman 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.

c. It is expected that Accredited Practitioners will conduct themselves in an open and transparent way with Mater Health and the Facility, and arising from this, in interpreting this By-Law and assessing matters requiring notification pursuant to this By-Law, the interpretation and action should favour notification.

5.7 Obligations to disclose

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

   i. any of the matters notified or that ought to have been notified pursuant to By-Law 5.6;

   ii. the accreditation of the Accredited Practitioner;

   iii. the scope of practice of the Accredited Practitioner;

   iv. the ability of the Accredited Practitioner to safely deliver health services to his/her patients within their scope of practice;

   v. the Accredited Practitioner's registration or professional indemnity insurance arrangements;

   vi. 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 or a significant increase in the deductible or excess);

   vii. the reputation of the Accredited Practitioner as it relates to the provision of clinical practice; and

   viii. the reputation of Mater Health or 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 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.

c. It is expected that Accredited Practitioners will conduct themselves in an open and transparent way with Mater Health and the Facility, and arising from this, in interpreting this By-Law and assessing matters and information requiring disclosure pursuant to this By-Law, the interpretation and action should favour disclosure.

5.8 Representations and media

a. Unless an Accredited Practitioner has the prior consent of the CEO or delegate or is authorised by virtue of his/her employment, an Accredited Practitioner may not use the Facility's name (which for the purposes of this provision includes a corporate or business name of the Facility, its parent companies or subsidiary companies), letterhead or 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.

b. The Accredited Practitioner must obtain the CEO or delegate's prior written consent before interaction with the media regarding any matter involving or relating to Mater Health or the Facility, a patient of the Accredited Practitioner admitted to or previously admitted to the Facility, a patient admitted to or previously admitted to the Facility, or any matter involving or relating to Mater Health or the Facility.

c. If written consent in accordance with this By-Law is given by the CEO or delegate, the Accredited Practitioner must comply with the Mater Health media policy and any requirements set out in the written consent.

d. If there is any instance of non-compliance with any of the matters set out above, in addition to this constituting a breach of the By-Laws, the Accredited Practitioner is required to follow the directions of the CEO or delegate in managing the consequence of non-compliance, including a retraction or agreed public statement.

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 Mater Health and the Facility;

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

   iii. information concerning Mater Health's insurance arrangements;

   iv. information concerning any patient, relation of a patient, or staff of the Facility;

   v. information which comes to their knowledge concerning patients, clinical practice (including of another Accredited Practitioner), 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.

g. If a breach of any of the confidentiality obligations set out above occurs, including through inadvertence or a third-party cyber security breach, then the Accredited Practitioner must immediately notify the CEO or delegate and actively assist to resolve the breach.

5.10 Sharing information

a. Accredited Practitioners are required to familiarise themselves with the Mater Health and individual Facility's organisational and clinical governance structure, and specifically that of the Health Executive.

b. Accredited Practitioners acknowledge that in order for the organisation to function, effective communication is required, including between the Board, CEO or delegate, Director of Medical Services, Executive Members and Committees of the Facility, staff of the Facility and other Accredited Practitioners (Refer to sub-delegation procedure).

c. 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

a. Accredited Practitioners will acknowledge the importance of ongoing safety and quality initiatives that Mater Health and the Facility initiate and shall comply with and take all reasonable actions to facilitate their implementation including, but not limited to, the use of any defined clinical guidelines.

b. Accredited Practitioners will actively assist Mater Health and 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.

b. Accredited Practitioners will comply with all Mater Health and /or Facility requirements that are in place to optimise patient outcomes. This includes well-recognised quality standards developed by the Facility itself and external standards, for example but not limited to, the National Safety and Quality in Health Care Standards and Clinical Care Standards set by the Australian Commission on Safety and Quality in Health Care.

c. In order to meet relevant standards, Accredited Practitioners will:

   i. recognise, assist to achieve and comply with the Facility's safety and quality performance objectives and policies/ procedures and frameworks 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, recognising and responding to acute clinical deterioration).

d. Patient care and clinical service review processes are established within the Facility as part of a broader quality and safety (or clinical governance) 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.

e. The processes referred to above may take a number of forms such as Clinical Specialty Groups 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 minimum this will include to attend and participate (in person, via videoconference, telephone, in writing with chair of group or in discussion with chair of group) in at least two meetings per year and any meeting where that Accredited Practitioner's cases / care / clinical services are being discussed; and

   ii. attend and participate in Facility safety, quality, risk management, education and training activities as requested, and as required by relevant legislation, standards and guidelines. This will include 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.

f. Failure to comply with a reasonable request to participate in patient care and service review processes, as set out in this By-Law, will at the discretion of the CEO or delegate constitute a breach of the terms and conditions of Accreditation.

g. Accredited Practitioners must not engage in any conduct that may be perceived, regardless of the intention of the Accredited Practitioner, as a reprisal against another person for making a report or supplying information relating to issues of safety, quality or behaviour of the Accredited Practitioner or about a patient of the Accredited Practitioner (including as part of any speaking up for safety initiative in place at the Facility). If this occurs, it will be regarded as a breach of the Behavioural Standards and consequently a breach of By-Law 5.5.

6.2 Risk management and regulatory agencies

a. Accredited Practitioners will comply and fully cooperate with any Mater Health or Facility 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 CEO or delegate.

b. Accredited Practitioners will assist with Facility incident management, investigation and reviews (including root cause analysis, system reviews, or as required by health funders), complaints management and open disclosure processes, or for any other reasonable requirement of Mater Health or the Facility relating to review of patient care and outcomes.

c. Accredited Practitioners will participate in risk management activities and programs as reasonably required by Mater Health or the Facility, including the implementation of risk management strategies and recommendations arising from system reviews and root cause analysis.

d. Accredited Practitioners will provide requested information and assistance in circumstances where Mater Health or the Facility requires information and assistance from the Accredited Practitioner to fully investigate a clinical incident, patient outcome or any other event.

e. Accredited Practitioners will provide requested information and assistance to permit Mater Health and 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, from a health complaint's body (including the Office of Health Ombudsman or successor), AHPRA, 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.

f. Accredited Practitioners will provide requested information and assistance in circumstances where Mater Health or 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

a. Arising from the matters set out in By-Law 3.6, Accredited Practitioners understand and accept that despite the granting of accreditation, the Facility has the right to allocate theatre and procedural suite access and time as it sees fit and retains the right to re-allocate theatre/procedural suite sessions depending upon its needs and expectations.

b. In making decisions about the matters set out in (a) above, it is expected that Accredited Practitioners will effectively utilise, to the satisfaction of the Facility, allocated theatre/procedural suite sessions that have been made available to the Accredited Practitioner.

c. Accredited Practitioners are permitted to only utilise surgical assistants who are accredited pursuant to the By-Laws and with scope of practice as a surgical assistant.

d. Accredited Practitioners accept complete responsibility for, and must directly supervise, surgical assistants who assist the Accredited Practitioner with surgical and other procedures.

e. Accredited Practitioners must give consideration to their own potential fatigue and that of other staff involved in the provision of patient care, when making patient bookings and in utilising operating theatre and procedural time. This includes the total number of patients, number of consecutive patients in one day or on a list, number of consecutive working days, total hours worked in a day and over the preceding days, responsibilities at other health facilities and matters unrelated to surgery that have an impact on fatigue. Absent an unexpected occurrence or emergency on a particular day, for elective surgery to commence beyond 10pm will require the written approval of the CEO or delegate.

f. Accredited Practitioners must familiarise themselves with and strictly adhere to Facility policies with respect to consent and surgical safety. This includes but is not limited to completing and participating in pre-procedure and pre-anaesthetic checks, leading team time out and end of procedure checks, and allowing Facility staff sufficient time to complete surgical safety requirements.

6.4 Practice Improvement Meetings (PIMs)

a. The CEO or delegate may establish committees or Practice Improvement Meetings for the purpose of reviewing and advising the CEO or delegate on performance and outcomes of the clinical specialty by reference to the Facility's clinical services, organisational capability and organisational need.

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

c. The terms of reference referred to in (b) above will include the minimum number of attendances expected each year by an Accredited Practitioner. If no minimum number of attendances is set in the terms of reference, pursuant to these By-Laws the requirement will be to attend at least two meetings per year and any meeting in which a case, outcome or patient of that Accredited Practitioner is being considered. Attendances will be audited and considered by the CEO or delegate on an ongoing basis and as part of re-accreditation.

d. Accredited Practitioners will assist the Facility with its functions and objectives, and personally engage in continuous education, reflection and improvement, through membership of and active participation in committees and Clinical Specialty Groups. The functions, objectives and engagement will include:

   i. developing, implementing and reviewing policies, protocols, pathways, decision support tools and best practice guidelines in clinical areas to support best practice on the best available evidence;

   ii. participating in medical, nursing and other training and education programs;

   iii. supporting accreditation and credentialing activities;

   iv. clinical oversight;

   v. peer review, including but not limited to review of clinical outcomes and statistics relating to their own cases and cases of other Accredited Practitioners;

   vi. practicing in audit of outcome and processes of care;

   vii. supporting safety and quality initiatives and programs of Mater Health and the Australian Commission on Safety and Quality in Health Care (including clinical care standards).

e. Accredited Practitioners will engage with clinical governance (quality and safety) representatives of Mater Health and the Facility to monitor variation in their own practice against expected health outcomes, to receive feedback on variation in practice and health outcomes, to review performance against external measures, to engage in any review of that Accredited Practitioner's practice (which may include a review stablished through these By-Laws) and to inform improvements in safety and quality systems.

f. Accredited Practitioners who are based outside of the immediate geographical vicinity of the Facility are expected to contribute in the same way as other locally based Accredited Practitioners. The extent and manner of participation, and the means by which that participation occurs, will be as agreed with the CEO or delegate.

g. Peer review will be consistent with relevant college guidelines and the Australian Commission on Safety and Quality in Health Care guidelines and standards.

h. Peer review will extend beyond clinical outcomes and will encompass broader matters as set out in the definition of credentials in the By-Laws.

6.5 New clinical service, procedure, therapeutic medicine, therapeutic good, medical device, technology or other intervention

a. Accredited Practitioners proposing to introduce, provide or use a New Clinical Service, Procedure, Therapeutic Medicine, Therapeutic Good, Medical Device, Technology or other Intervention will provide the CEO or delegate with supportive evidence to the satisfaction of the CEO or delegate in keeping with the agreed governing policy and procedures of Mater Health and the Facility, in accordance with the timeframe set out in the policy and procedure.

b. Supportive evidence referred to in (a) above will depend on the specific circumstances. It may require evidence relating to:

   i. safety and efficacy;

   ii. the benefit from introduction, including to the patient relating to improved outcomes and experience, or to Mater Health/the Facility when compared to existing clinical practice and clinical services;

   iii. medical research and clinical trials;

   iv. regulatory approvals, licenses and consents for use;

   v. relevant contracts;

   vi. education and training of the Accredited Practitioner and any other person proposed to be involved;

   vii. supervision plan;

   viii. associated costs, available funding (including from Medicare and private health insurers) and savings anticipated if introduced (including from efficiencies);

   ix. resources required from Mater Health and the Facility;

   x. insurance and indemnities;

   xi. privacy impact assessment and information management plan if health information is to be collected / used/ analysed/ stored/ transmitted;

   xii. details of third party and overseas access to or transmissions of information;

   xiii. a plan for safe introduction into the organisational setting of Mater Health and the Facility including reference to the clinical service capability framework; and/or

   xiv. a plan for quality and safety monitoring and oversight if introduced into the organisational setting of Mater Health and the Facility.

c. Any provision of clinical care that requires the use of a therapeutic medicine, therapeutic good or a medical device for which there is not an approved indication by the relevant regulator for its intended use will be subject to the same requirements as set out in (a) and (b) above.

d. Before treating patients with respect to a New Clinical Service, Procedure, Therapeutic Medicine, Therapeutic Good, Medical Device, Technology or other Intervention:

   i. written approval of the CEO or delegate must be obtained;

   ii. what is proposed must fall within the Accredited Practitioner's scope of practice or an amendment to scope of practice must firstly be approved;

   iii. what is proposed must fall within the licensed service capability of the Facility; and

   iv. if there is a risk to the Facility, then confirmation must be received that the insurance arrangements of Mater Health will extend insurance coverage to Mater Health, the Facility and its employees.

e. The Accredited Practitioner must provide evidence of adequate professional indemnity insurance (where appropriate) to cover their own potential liability, and if requested, evidence that Medicare and private health funds will adequately fund the New Clinical Service, Procedure, Therapeutic Medicine, Therapeutic Good, Medical Device, Technology or other Intervention.

f. If the conduct of research is involved, then By-Law 6.11 dealing with research must be complied with.

g. The CEO or delegate's decision about all matters set out in this By-Law is final and there shall be no right of appeal from denial of a request.

h. The Accredited Practitioner must update the CEO or delegate on the outcomes and benefits of implementation of the New Clinical Service, Procedure, Therapeutic Medicine, Therapeutic Good, Medical Device, Technology or other Intervention as reasonably requested by the CEO or delegate.

i. Following consideration of the reported outcomes and benefits referred to in (h) above, the CEO or delegate may withdraw approval for the continuation of the New Clinical Service, Procedure, Therapeutic Medicine, Therapeutic Good, Medical Device, Technology or other Intervention, or may impose restrictions, with there being no right of appeal from this decision.

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 CEO or delegate in relation to a specific clinical specialty. The objective of this requirement is 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. Audit of compliance may be conducted and disseminated to Accredited Practitioners or Clinical Specialty Groups. Accredited Practitioners will be responsive to audit results.

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. To ensure efficient use of Facility resources, the Facility makes available certain medical supplies, drugs, prostheses and equipment. Accredited Practitioners are expected, where at all possible, to utilise the medical supplies, prostheses and equipment that are made available, and to do this in an efficient way to minimise wastage and generation of unnecessary costs. If certain high cost or high value medical supplies, drugs, prostheses or equipment are required, absent an emergency, a written request may be submitted through the appropriate channels which will include clinical indication, why existing resources are not satisfactory, overall cost, reimbursement (if any) under funding arrangements and any proposed co-payments.

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 in advance with the admitting clinical department. Necessary arrangements including immediate clinical review and assessment on admission of the patient, which may occur through the care plan established by the Accredited Practitioner or upon request being made for this to occur by the admitting clinical department or Facility staff.

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 the patient and must ensure that they are available to treat and care for those patients at all times. If this requirement cannot be met, the Accredited Practitioner must put in place other arrangements as permitted by the By-Laws 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 Facility 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 over what period of time this will occur. An Accredited Practitioner who is unavailable whilst having a patient admitted to the Facility is deemed to be unable to provide continuity of care. Such delegation and the period of time this will occur must be documented in the patient medical record and in any other document prescribed by the Facility for documenting and communicating such arrangements.

h. Accredited Practitioners must review and attend in person upon all patients admitted by them as frequently as is required by the clinical circumstances of those patients, as would be judged appropriate by peers and as reasonably requested by the appropriate Facility staff. Absent special circumstances, an Accredited Practitioner will initially review a patient in person within 12 -24 hours of the patient being admitted under the Accredited Practitioner, or within a shorter timeframe if clinically appropriate or if requested by Facility staff. Prior to the initial attendance, the Accredited Practitioner will provide adequate written instructions to Facility staff for management of the patient. Absent special circumstances that are recorded in the medical record, an Accredited Practitioner will thereafter review the patient within clinically appropriate timeframes, which at a minimum will ordinarily be in person 24 hourly or through their on-call or locum cover. If Accredited

Practitioners are unable to personally provide this level of care, the Accredited Practitioner will secure the agreement of another Accredited Practitioner to provide the care and will notify the Facility in writing of this arrangement.

i. Accredited Practitioners must familiarise themselves with, support and strictly adhere to Mater Health and Facility policies and procedures with respect to patient deterioration, including but not limited to the actions required to be taken with respect to deterioration.

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

k. An Accredited Practitioner or their on-call or locum cover will be contactable and available by telephone to Facility staff to discuss their patients within a clinically acceptable period of time (with Facility staff to be aware of the on-call and locum cover, including through documentation prescribed by the Facility for documenting and communicating such arrangements). Alternatively, the Accredited Practitioner will make arrangements with another Accredited Practitioner to provide the requisite care and shall advise the Facility staff of this arrangement. On-call and locum cover arrangements must be communicated in writing to the Facility including name, contact details and period of cover.

l. Accredited Practitioners will accept as part of ongoing Accreditation that if Facility staff caring for a patient are unable to contact the Accredited Practitioner or on-call/locum cover within what the Facility staff considers to be a clinically acceptable period of time, then Facility staff may escalate and utilise alternative arrangements available through Mater Health, such as making a Medical Emergency Team (MET) call.

m. Prior to taking a period of leave, the Accredited Practitioner will ensure that adequate handover has occurred and where possible will avoid undertaking major surgery or procedures in circumstances where post-procedure care is to be transferred to locum cover or an on-call Accredited Practitioner.

n. If an Accredited Practitioners or their on-call or locum cover is requested to attend a patient in person, they will be available to attend within a clinically acceptable period of time, relative to the clinical condition of the patient and any other factors relating to the patient's care or circumstances as determined by the Facility.

o. If an Accredited Practitioner is unable to provide the required level of care personally or intend to transfer the care of a patient to another Accredited Practitioner, he/she will secure the agreement of another Accredited Practitioner to provide the care and treatment, will advise Facility staff of this arrangement and record this arrangement in the patient medical record and in any other document prescribed by the Facility for documenting and communicating such arrangements.

p. Accredited Practitioners will ensure that any changes to contact details are notified promptly to the CEO or delegate and, ensure that this is recorded in any other document prescribed by the Facility for documenting and communicating such changes.

q. Accredited Practitioners will 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.

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

s. Accredited Practitioners are required to work with and as part of a multi-disciplinary health care team and must ensure the requirements for patient care are established and understood through verbal and written communication, documentation, involvement of and consultation with appropriate medical and other expertise, and provision of adequate clinical handovers to facilitate the best possible care for patients. It is the Accredited Practitioner's responsibility to arrange referrals/engagement of other specialists for safe delivery of patient care, this includes surgeons and proceduralists being responsible for engaging anaesthetists to provide anaesthetic services for patients under their care.

t. 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. Accredited Practitioners must at all times ensure appropriate, timely communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.

u. Accredited Practitioners must provide adequate supervision to junior practitioners involved in care (including when assisting in surgery or involved in ward care). The frequency and extent of supervision will depend on

the level of experience of the junior practitioner and the complexity of patient care required. The Accredited Practitioner retains ultimate responsibility for patient care regardless of whether more junior practitioners are involved.

v. Accredited Practitioners must participate in formal on-call arrangements as reasonably required by the Facility. This includes working collaboratively with the Facility to organise and ensure on-call rosters are completely filled, sufficient after-hours support is in place and there is appropriate back-up for Accredited Practitioners including those on-call. The Facility will determine the requirements for on-call rosters, taking into account patient safety, continuity of care, anticipated service demand, organisational capability, organisational need and private hospital licensing requirements. Persons providing on-call or cover services must be accredited at the Facility.

w. The Accredited Practitioner must facilitate appropriate and timely discharge of their patients to promote efficient and effective use of the Facility's resources. Patients will be discharged from the Facility only with the written 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, with all relevant discharge documentation to be placed in the patient medical record) required by the Facility. It is the responsibility of the Accredited Practitioner to ensure that all information reasonably necessary to ensure continuity of care after discharge is provided to the referring practitioner, general practitioner and/or other treating practitioner.

x. Accredited Practitioners transferring patients to other Facilities or within Mater Facilities will take all reasonable steps to ensure that 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 (transferring and receiving teams).

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, see paragraph (b) below) from the patient or their legal guardian or substitute decision maker. This will occur in accordance with accepted medical and legal standards (including professional college guidelines, the Good Medical Practice: A Code of Conduct for Doctors in Australia and sections 20-22 of the Civil Liability Act (QLD)) 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 to save a person's life or to prevent serious injury to a person's health.

c. For the avoidance of any doubt, these requirements apply to anaesthetic consent.

d. The consent will be evidenced in writing, will be signed by the Accredited Practitioner and the patient or their legal guardian or substitute decision maker and will be compliant with the current policy and procedures of the Facility. For public patients, it will be permissible if the resident to registrar undertakes consent, under the indirect supervision of the Accredited Practitioner, pursuant to facility policy and procedures.

e. It is expected that fully informed consent will be obtained or directly supervised by the Accredited Practitioner under whom the patient is admitted or treated. 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 will 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 fully informed consent, as well as responding to questions raised by the patient.

f. The consent process must satisfy the Facility's requirements from time to time as set out in its policy and procedures, including in relation to documentation evidencing consent to be provided to the Facility. Completion of Facility verification of consent forms is not a substitute for the Accredited Practitioner obtaining and documenting fully informed consent for treatment and of itself a verification of consent form is not sufficient documentation of fully informed consent.

g. If an Accredited Practitioner chooses to complete their own informed consent document for a private patient and elects not to additionally complete the Facility's verification of consent documentation, all additional consents set out in the verification of consent document must be obtained by the Accredited Practitioner. In addition, the Accredited Practitioner must provide written confirmation that fully informed consent has been obtained.

h. Given the importance of the consent process and supporting documentary evidence, there will be zero-tolerance for non-compliance with associated policies and procedures. Admissions will not be accepted

and, surgery/procedures will not proceed until complete compliance has occurred. Non-compliance includes, but is not limited to, provision of incomplete documentation, unsigned documentation, incomplete signed documentation, or if there is not a match between the documentation that has been supplied and the information obtained from the patient during the verification process in relation to the procedure to be performed.

i. If, following completion of the surgery/procedure, it has been identified that there is not a complete match between the surgery/procedure actually performed and that which was planned or that which was documented as intended to be performed, this will be immediately notified by the Accredited Practitioner to the CEO or delegate, regardless of whether notification of the discrepancy has also been made by Facility staff. The Accredited Practitioner will provide all necessary and requested assistance to resolve the discrepancy or address the issue that has occurred. Notification will occur not only if there is an apparent divergence between what was planned and that performed, but if additional surgeries/procedures appear to have been performed or if planned surgeries/procedures appear not to have been performed.

j. Accredited Practitioners must provide full financial disclosure and obtain fully informed financial consent from their patients. This will occur in accordance with the relevant legislation, health fund agreements, policy and procedures of the Facility and medical standards (including Good Medical Practice: A Code of Conduct for Doctors in Australia). 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.

k. By-Law 6.7(j) 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 and no payment is to be made by the patient. However, the Facility staff must confirm verification of consent with the documentation before them and in discussion with the patient or their substitute decision maker.

6.8 Patient health records (also includes patient medical records)

Accredited Practitioners must ensure that:

a. Patient records contain complete and adequate information relating to care and treatment provided to the patient by the Accredited Practitioner. For the purposes of these By-Laws, patient records will include health records, medical records and any other information repositories that are held relating to the patient in a documentary or electronic form.

b. Their access to and use of Facility patient records is compliant with privacy and confidentiality obligations owed to the patient. Arising from this, Accredited Practitioners may only access and if necessary, obtain a copy (including photograph) of Facility patient records to facilitate the on-going care of the patient. In addition, to comply with privacy and confidentiality obligations set out in the By-Laws and in accordance with legal obligations, if access to or copies of Facility patient records is sought for a purpose other than ongoing care of the patient, the Accredited Practitioner will ensure that they obtain the written consent of the patient and the Facility.

c. They act at all times on the basis of, and accept that, ownership and copyright of entries contained in the Facility patient records vest in the Facility.

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

e. They maintain full, accurate, legible and contemporaneous records. This will include in relation to each attendance upon the patient, procedures, orders and consent to procedures. The entries will be dated, time and signed and contained in the Facility patient records. The entries must be sufficient to allow any person involved in care, at any point in time, to understand the Accredited Practitioner's instructions, orders and treatment plan.

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), including documentation of the pre-anaesthetic evaluation, fully informed anaesthetic consent, post-anaesthetic evaluation, complications and post anaesthetic orders.

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

k. They respond positively to any organisational review and feedback about clinical documentation of the Accredited Practitioner, including where this is to facilitate improved written communication and capture of clinical assessment, interventions and patient outcomes for clinical coding.

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

m. If technology is being utilised to facilitate communication by the Accredited Practitioner between the health care team or with patients, that:

    i. the technology is permitted;

    ii. the technology is managed in accordance with any applicable Facility policy and procedure;

    iii. privacy and confidentiality obligations of the patient are strictly adhered to (including pursuant to the *Privacy Act (Cth)*); and

    iv. the communication is additionally documented in a timely and comprehensive way in the Facility patient record.

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, including being appropriate to allow clinical coding to occur.

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

c. Accredited Practitioners will respond in a timely manner to queries, requests for information and completion of documentation relating to these matters.

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 CEO or delegate and the Human Research Ethics Committee (where required), following submitted application by the Accredited Practitioner in the required form and with all required information.

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 research and provide evidence of such insurance upon request by the Facility. An exception to this will be if Mater Health insurance arrangements will apply and if so, the Accredited Practitioner must receive written confirmation of such coverage and supply the confirmation with the application.

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), the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia and any applicable legislation.

e. Research conduct will occur in accordance with expected guidelines and standards, with any breach or potential breach, including arising from the possibility of a research integrity matter or misconduct, to be immediately reported to the CEO or delegate.

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

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

6.12 Utilisation of accreditation

a. Accredited Practitioners will be advised upon accreditation or re-accreditation, or at other times as determined by the CEO or delegate, of the expectations in relation to exercising accreditation and utilisation of the Facility.

b. Absent special circumstances, the Accredited Practitioner must exercise accreditation or utilise the Facility in accordance with the specified expectation.

c. Management of any concerns in relation to insufficient utilisation will occur in accordance with the process set out in By-Law 6.6(a).

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 applicant demonstrates to the satisfaction of the CEO or delegate adequate Credentials, meets requirements of organisational capability and organisational need, otherwise 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 successful applicant 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 and to utilise services, equipment and other resources provided by the Facility for that purpose, within the limits of the accreditation category, accreditation type and scope of practice attached to such accreditation at the Facility. This will at all times be subject to the provisions of the By-Laws, Facility policies and procedures, resource limitations, and in accordance with organisational need and organisational capability.

b. Accredited Practitioners acknowledge that admission or treatment of a particular patient is subject to bed availability, the availability or appropriate skill mix of Facility clinical workforce and the availability of appropriate facilities, equipment and other resources, given the treatment or clinical care proposed.

c. Accreditation, attendance at the Facility, access to facilities, equipment and other resources is also subject to the terms set out in By-Law 3.6.

7.3 Responsibility and basis for accreditation and granting of scope of practice

a. The CEO or delegate will determine the outcome of applications for accreditation as Medical Practitioners and the defined scope of practice.

b. In making the determination, the CEO or delegate 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 other feedback received.

c. The CEO or delegate may, at their discretion, consider other matters as they consider relevant to the application when making the determination.

7.4 Credentialing and accreditation

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

b. Mater Health will also establish any requirements that must be met if accreditation is approved and prior to the exercise of accreditation, which may apply to all applicants or certain applicants based upon specified criteria. This may include requirements for vaccination, police checks and fit testing for masks.

c. 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.

d. The primary role of a Credentialing Committee will be to review the credentialing requirements set out in these By-Laws, along with any associated approved policies and procedures, and make recommendations to the CEO or delegate about the suitability of the a pplicant to receive accreditation and the sought after scope of practice.

e. With the approval of the CEO or delegate, the Medical Advisory Committee membership may constitute the Medical Credentialing Committee and may establish medical specialist credentialing panels to assist in meeting their obligations.

f. Nursing, Midwifery and Allied Health Credentialing Committees will be constituted as directed by the CEO or delegate.

g. In making determinations about applications for accreditation, the Credentialing Committee will consist of at least one member of the same specialty as the applicant, which may mean co-opting a member in order to assist with the determination. It is however recognised that this may not always be possible or practicable in the circumstances, and a failure to do so will not invalidate the recommendation provided to the CEO or delegate.

h. Applications will include a signed declaration (or will be electronically agreed) by the applicant that the information provided is true and correct, that the applicant has read the By-Laws and in the event the application is successful they will comply in every respect with the By-Laws.

i. Prior to proceeding with an application or at any time during the credentialing process, the CEO or delegate may request the applicant to attend an interview (along with any other representative of Mater Health or the Facility) to:

    i. discuss the application;

    ii. request further information or documents;

    iii. request verification of certain information or documents (for example if original documents are not provided);

    iv. request permission to directly contact third parties to discuss the applicant or any information set out in the application; and/or

    v. to discuss and assess aspects of organisational need (delegation of this aspect of the discussion and assessment may be conducted with a representative of Mater Heath business development team).

j. As determined by the CEO or delegate, any refusal or failure to fully respond to the requests made in (i) above may result in rejection of the application.

k. Prior to proceeding with an application for re-accreditation or at any time during the credentialing process for re-accreditation, the CEO or delegate may seek out any information regarding the applicant during prior periods of accreditation at Mater Health or the Facility in order to fully assess the application. As a condition of submitting the application, applicants understand and consent to such internal communication and access to information (including personal information) within Mater Health and the Facility, including as it relates to competence, performance, current fitness and professional suitability to provide safe, high quality health care.

l. Unless specific dispensation is received, any written references submitted with the application must have been completed and signed by the referee in the preceding six months before the application was submitted. If referees are unknown to the CEO or delegate, or the written reference is considered insufficient to assist with consideration of the application, the CEO or delegate may seek consent from the applicant for direct contact to be made by the CEO or delegate with the referee or a senior medical administrator at other health care organisations listed in the application to discuss the applicant and to discuss matters relevant to competence, performance, current fitness and professional suitability to provide safe, high

quality healthcare. As determined by the CEO or delegate, any refusal or failure to consent may result in rejection of the application.

m. Unless specific dispensation is received, for an application for re-accreditation, at least one referee must be from the applicant's Clinical Specialty Group. Any written references submitted with the application must be compliant with the requirements of the current policy and procedures of the Facility at the time the application is submitted and completed.

n. 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. Re-accreditation requirements may be defined by the organisation based on organisational need, activity and any other reasonable requirement outlined in relevant policies and procedures required for all practitioners and individual specialties;

   vii. the effectiveness of the processes for credentialing and accreditation depend on strong partnerships between healthcare organisations and professional colleges, associations, societies and the Accredited Practitioners;

   viii. processes of credentialing and accreditation should be just and transparent, although recognising the ultimate ability of the Board and CEO or delegate to make decisions that they consider to be in the best interests of the organisation, its current and future patients;

   ix. 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 and By-Laws.

7.5 Medical Advisory Committees

a. The CEO or delegate will establish Medical Advisory Committees to support each Facility. The Medical Advisory Committees will function in accordance with approved terms of reference, requirements set out in these By-Laws along with any associated policies and procedures, 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 CEO or delegate.

c. The CEO or delegate and members of the Hospital Executive 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, re-accreditation and mutual recognition

8.1 Applications for initial accreditation, re-accreditation and mutual recognition as medical practitioners

a. Applications for initial accreditation, re-accreditation and mutual recognition must be submitted within the timeframe set out in relevant policy and procedure documents of the Facility.

b. Under exceptional circumstances due to urgent patient need, temporary accreditation may be approved by the CEO or delegate pending final consideration of an application.

c. The CEO or delegate will consider applications for initial accreditation, re-accreditation and mutual recognition in order to undertake his/her responsibility of credentialing in accordance with these By-Laws and any associated policy and procedures.

d. The 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 with responsibility for consideration of applications at the particular Facility will consider all applications for initial accreditation and re-accreditation referred to it by the 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 CEO 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.

i. If the Medical Advisory Committee and/or Credentialing Committee has concerns about an application or insufficient information, as an alternative to recommendation that the application be refused, the Medical Advisory Committee and/or Credentialing Committee may recommend to the CEO or delegate 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.

k. Following receipt of the recommendation from the Medical Advisory Committee and/or Credentialing Committee, the CEO or delegate will decide:

    a. whether the application should be rejected or approved; and

    b. if the application is approved, the scope of practice, period of accreditation (see By-Law 8.3) and whether any additional terms or conditions will apply.

l. In considering applications, the CEO or delegate will give due consideration to any recommendations or other information relevant to the application as determined by the CEO or delegate, and may make any additional enquiries as the CEO or delegate determines appropriate, with the final decision that of the CEO or delegate.

m. Accreditation tenures, for initial and re-accreditation, will be for the periods set out in By-laws 8.3 and 8.5 respectively.

8.2 Consideration of applications for initial accreditation by the CEO or delegate

a. The CEO or delegate will consider applications for initial accreditation, following receipt of a recommendation from the Medical Advisory Committee and/or Credentialing Committee, to decide whether the applications should be rejected or approved and, if approved, the scope of practice, accreditation period and whether any additional terms or conditions will apply.

b. In considering applications, the CEO or delegate will give due consideration to the recommendations of the Medical Advisory Committee and/or Credentialing Committee as well as any feedback from other key stakeholders in executive operational roles, but the final decision is that of the CEO or delegate. The CEO or delegate 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 CEO or delegate may consider any matter assessed as relevant to making the determination in the circumstances of a particular case.

c. The CEO or delegate may defer consideration of an application in order to obtain further information from other stakeholders in executive operational roles, the Medical Advisory Committee and/or Credentialing Committee, the applicant or any other person or organisation.

d. If the CEO or delegate requires further information from the Medical Practitioner before making a determination, they will notify the Medical Practitioner informing the Medical Practitioner that the CEO or delegate requires further information from the Medical Practitioner before deciding the application. This may include, but is not limited to:

    i. information from third parties such as other hospitals relating to current or past accreditation, scope of practice and/or other issues relating to or impacting upon the accreditation with those other third parties; and

    ii. 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 a specified period of time.

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

f. The 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, accreditation period (see By-Law 8.3), any additional terms and conditions and the orientation that will occur prior to commencement. If an application has been rejected, no reasons are required to be supplied.

g. The CEO or delegate will ensure that an adequate level of information relating to the 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 pursuant to these By-Laws from a decision to reject an application for initial accreditation or with respect to the scope of practice granted, accreditation period, or any additional terms and conditions incorporated as part of the 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 period up to a maximum of 5 years, as determined by the CEO or delegate.

b. Periods of initial accreditation less than 5 years may be considered where the CEO or delegate considers more regular formal assessment is required of competence, performance and/or current fitness through a rigorous credentialing process. This may include but is not limited to a lack of recency of practice in general or with respect to a particular scope of practice sought or where it is determined that ongoing medical assessment and clearance will be required with respect to a physical or mental impairment, disability, condition, disorder or deterioration.

8.4 Consideration of applications for re-accreditation by the CEO or delegate

a. The Credentialing Office will, within the timeframe set out in relevant policy and procedures of the Facility, provide to the Medical Practitioner an application form to be used in applying for re- accreditation.

b. Any Medical Practitioner wishing to be re-accredited must submit a completed application to the Credentialing Office within the timeframe set out in relevant policy and procedure documents of the Facility prior to the expiration date of the Medical Practitioner's current term of accreditation.

c. If an Accredited Practitioner in the 12 months prior to receipt by the Facility of the application has not admitted or treated a patient at the Facility, the 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 CEO or delegate, Medical Advisory Committee and/or Credentialing Committee will deal with applications for re-accreditation in the same way they are required to deal with applications for initial accreditation as Medical Practitioners.

e. If, upon receiving an application for re-accreditation, the Medical Advisory Committee or Credentialing Committee considers that it has information or concerns 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 to the CEO or Delegate), and in addition to the options set out in By-Law 8.1(i):

   i. write to the applicant stating the information and/or concerns;

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

   iii. offer the applicant 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.

f. The CEO or delegate will consider applications for re-accreditation as Medical Practitioners referred to the CEO or delegate by the Medical Advisory Committee and/or Credentialing Committee to decide whether the applications:

   i. should be rejected or approved; and

   ii. if approved, the Scope of Practice, Accreditation period (see By-Law 8.5) and whether any additional terms or conditions will apply.

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

8.5 Re-accreditation tenure

a. Re-Accreditation as a Medical Practitioner at the Facility will be for a period up to a maximum of 5 years, as determined by the CEO or delegate.

b. Periods of Re-Accreditation less than 5 years may be considered where the CEO or delegate considers more regular formal assessment is required of Competence, Performance and/or Current Fitness through a rigorous Credentialing process. This may include a circumstance where it is determined that ongoing medical assessment and clearance will be required with respect to a physical or mental impairment, disability, condition, disorder or deterioration.

8.6 Mutual recognition

a. In the complete discretion of the CEO or delegate, a process for mutual recognition may be established involving the local Hospital and Health Service, that allows for Medical Practitioners from the public sector attending the Facility to treat public patients (see (b) below) or accreditation to occur between Mater Health Facilities where the applicant already holds accreditation at one Mater Health Facility (see (c)) below).

b. Mutual Recognition may incorporate a streamlined process to rely upon information supplied by the local Hospital and Health Service regarding its accreditation of that Medical Practitioner, in order to process the application for accreditation at the Facility. The CEO or delegate will determine how this By-Law 8 will apply in the circumstances of a particular application.

c. If an applicant holds accreditation at one Facility and seeks accreditation at another Facility, the CEO or delegate will determine whether the application will be treated as an application for initial accreditation or a more streamlined process will be established to rely upon information supplied by the Facility at which the Accredited Practitioner holds accreditation. In these circumstances, specific scope of practice must still be determined at the Facility to which the application is made. The CEO or delegate will determine how this By-Law 8 will apply in the circumstances of a particular application.

8.7 Surgical assistants, employed junior medical practitioners or fellowships

a. In the complete discretion of the CEO or delegate, a more streamlined process may be established for the accreditation category of Surgical Assistant – Medical/Nurse Practitioner or with respect to an employed Medical Practitioner as per the relevant Enterprise Agreement.

b. The CEO or delegate may determine that the standard process set out in By-Law 8, rather than the streamlined process, will apply to a particular application.

8.8 Third party providers

a. If certain services are delivered by third party providers, such as medical imaging or pathology, the CEO or delegate may require Medical Practitioners or other categories of health practitioner delivering the servicers on behalf of the third-party provider to firstly be granted accreditation pursuant to these By-Laws. Alternatively, the CEO or delegate may require the third party provider to undertake its own accreditation process and to ensure that the credentials, professional registration and professional indemnity insurance are strictly verified and then to provide confirmation that this has occurred and/or to provide suitable evidence to the CEO or delegate.

b. Despite paragraph (a) above, accreditation pursuant to these By-Laws is required for procedural and interventional Medical Practitioners and other categories of health practitioner performing procedural and interventional clinical services within Mater Health or the Facility.

c. In the event a third-party provider undertakes its own accreditation process, scope of practice and access to the Facility by a particular Medical Practitioner or other category of health practitioner at all times will be decided by and remains the responsibility of the CEO or delegate.

d. If a contract with a third-party provider is terminated, the accreditation of the Medical Practitioner or other category of health practitioner delivering services on behalf of the third-party provider will also immediately terminate and there will be no appeal permitted pursuant to these By-Laws from this decision.

9. Temporary accreditation and locum cover

9.1 Temporary accreditation

a. Medical Practitioners may be granted temporary accreditation and scope of practice on terms and conditions considered appropriate by the CEO or delegate.

b. Temporary accreditation will only be granted based on patient need, organisational capability and organisational need, including in an emergency.

c. Temporary accreditation processes may, at the election of the CEO or delegate, be utilised for a Medical Proctor (also known as a Medical Observer). The process will be modified to suit the specific circumstances and, will be confined to a particular attendance rather than a period of time.

d. Applications for temporary accreditation as Medical Practitioners must be made in writing by completing the relevant application and supporting documentation as required by the Facility and pursuant to any policy and procedures in place at the Facility.

e. Temporary accreditation may be terminated by the 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.

f. Temporary accreditation will automatically cease upon a determination of the Medical Practitioner's application for accreditation (if an application for accreditation has been made) or at such other time as the CEO or delegate decides.

g. The period of temporary accreditation shall be determined by the CEO or delegate. If the period of temporary accreditation is for a specified time rather than an episode of care or specific attendance, this will be for an initial period of no longer than three (3) months and then be limited to one extension of three (3) months. If in exceptional circumstances a further period of time may be required beyond that set out in these By-Laws, a specific request must be made to the CEO or delegate and the exceptional circumstances set out for consideration to be given to the request.

h. There will be no expectation that a granting temporary accreditation will mean that there will be a subsequent granting of initial accreditation.

i. In the case of an emergency, a Medical Practitioner, to the extent permitted by the terms of the Medical Practitioner's registration, may request temporary accreditation and granting of scope of practice to continue the provision of treatment and care to a patient or patients. In circumstances of an emergency, temporary accreditation may be considered by the CEO 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.

j. At a minimum in the case of an emergency request for temporary accreditation, the following is required (with the timing of all or some of these requirements dependent on the nature of the emergency, although ordinarily will occur prior to provision of Patient care):

    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; and

    iv. nomination of at least one registered professional referee within the same clinical specialty.

k. If temporary accreditation was granted based upon an emergency request, it will be approved for a limited period as identified by the CEO or delegate, for the safety of patients and will automatically terminate at the expiry of that period or as otherwise determined by the CEO or delegate.

l. If temporary accreditation was granted pending a determination of the Medical Practitioner's application for accreditation, then accreditation processes should progress and be completed as soon as practicable.

m. The CEO (if undertaken by a delegate), Medical Advisory Committee and /or Credentialing Committee will be informed of all temporary accreditations granted.

n. There will be no right of appeal from decisions on granting, or termination, of temporary accreditation.

9.2 Locum cover

a. Locums must be approved for locum cover by the CEO or delegate before they are permitted to arrange the admission of and/or to treat patients on behalf of Medical Practitioners.

b. Temporary a ccreditation requirements must be met before approval of locums is granted for locum cover.

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

10. Variation of or amendment to accreditation or scope of practice

10.1 Variation of or 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 in relation to temporary accreditation or locum cover.

11. Review of accreditation and/or scope of practice

11.1 Review of accreditation and/or scope of practice

a. The CEO or delegate may at any time initiate a review of an Accredited Practitioner's Accreditation and/or Scope of Practice where concerns have been identified or allegations made about any of the following in relation to the Medical Practitioner:

   i. patient health or safety has been, or could potentially be, compromised;

   ii. the rights or interests of a patient, staff or someone engaged at or attending the Facility has been, or could potentially be, adversely affected or infringed upon, or a workplace health and safety concern has arisen;

   iii. Behaviour including in relation to the Behavioural Standards;

   iv. competence;

   v. current Fitness;

   vi. performance;

   vii. 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. compliance with these By-Laws, including the terms and conditions;

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

   xii. the efficient operation of the Facility could be threatened or disrupted;

   xiii. the potential loss of the Facility's licence or accreditation;

   xiv. the potential to bring the Facility into disrepute;

   xv. a breach of a legislative or legal obligation of the Facility or imposed upon the Accredited Practitioner may have occurred; or

   xvi. as elsewhere defined in these By-Laws.

b. The Board may request that the CEO or delegate undertake a review pursuant to this By-Law, and if this occurs, then the CEO or delegate must undertake the review.

c. 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 or the CEO (other than if the Board has requested that the CEO or delegate undertake a review, then the CEO or delegate must undertake the review).

d. The CEO or delegate will determine whether the process to be adopted is an:

   i. Internal Review; or

   ii. External Review.

e. Prior to determining whether an Internal Review or External Review will be conducted, the CEO or delegate may in their absolute discretion seek further information from Hospital Executive and /or may in their absolute discretion meet with the Accredited Practitioner (the Accredited Practitioner may choose to bring along a support person), along with any other persons the CEO or delegate considers appropriate. In advance of or at the meeting the CEO or delegate will advise of the concern or allegation raised, and invite a preliminary response from the Medical Practitioner (in writing or orally, as determined by the CEO or delegate), which response may be given at and/or following the meeting. Thereafter, the CEO or delegate will make a determination whether a review will proceed, and if so, the type of review.

   i. The Medical Practitioner who is the subject of a review, whether an Internal Review or External Review:

   ii. 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 requested by the Medical

Practitioner) to speak to the matters contained in the written submission and any other matters the Medical Practitioner wishes to address; and

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

f. Given that the review process, the terms of reference, access to information and reviewers are within the complete discretion and determination of the CEO or delegate, 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 CEO or delegate.

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 CEO or delegate's discretion.

h. The CEO or delegate may, in their complete discretion, make a determination regarding interim suspension of Accreditation or placing conditions on Accreditation 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 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 Office of Health Ombudsman, AHPRA and/or other accrediting professional organisations of the details of the concerns that have been raised regarding the Medical Practitioner.

j. The CEO or delegate in their absolute discretion, may decide that as an alternative to conducting an Internal Review or External Review the concerns that have been raised regarding the Medical Practitioner should immediately be notified to the Office of Health Ombudsman or AHPRA for those organisations to take the requisite action. Following the outcome of any such action, the 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/or scope of practice

a. The 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 CEO or delegate.

b. The terms of reference, process, access to information and reviewer(s) will be as determined by the CEO or delegate.

c. The 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 Medical Practitioner to be notified of the nominated reviewer(s);

ii. the Medical Practitioner to make a submission to the CEO or delegate on the appropriateness of reviewer(s). This submission will not impose any obligations whatsoever on the CEO or delegate and the decision to nominate the reviewer(s) will remain the sole discretion of the CEO or delegate;

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

iv. attendance before the reviewer(s) (with a support person if requested by the Medical Practitioner) to speak to the matters contained in the written submission and any other matters the Medical 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. 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 CEO or delegate.

e. On consideration of the report the CEO or delegate will determine, in accordance with the By-Laws, what (if any) action will be taken regarding the Medical Practitioners Accreditation. This may include but is not limited to unchanged Accreditation; termination of Accreditation; Accreditation with conditions; suspension of Accreditation.

f. Prior to making a decision following receipt of the report, the CEO or delegate, in their absolute discretion, may elect to provide all or relevant portions of the report to the Medical Practitioner to provide a further submission about matters set out in the report and about proposed action that may be taken by the CEO or delegate.

g. The CEO or delegate 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 CEO or delegate if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.

i. The CEO or delegate, 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 Office of Health Ombudsman, AHPRA 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 CEO or delegate's.

11.3 External review of accreditation and/or scope of practice

a. The CEO or delegate will draft the terms of reference of the External Review.

b. The terms of reference, process, access to information and reviewer(s) will be as determined by the CEO or delegate.

c. The 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 Medical Practitioner to be notified of the nominated reviewer(s);

   ii. the Medical Practitioner to make a submission to the CEO or delegate on the appropriateness of reviewer(s). This submission will not impose any obligations whatsoever on the CEO or delegate and the decision to nominate the reviewer(s) will remain the sole discretion of the CEO or delegate;

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

   iv. attendance before the reviewer(s) (with a support person if requested by the Medical Practitioner) to speak to the matters contained in the written submission and any other matters the Medical 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. 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 CEO or delegate.

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

f. Prior to making a decision following receipt of the report, the CEO or delegate, in their absolute discretion, may elect to provide all or relevant portions of the report to the Medical Practitioner to provide a further submission about matters set out in the report and about proposed action that may be taken by the CEO or delegate.

g. The CEO or delegate 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 CEO or delegate if a decision is made to amend, suspend, terminate or impose conditions on the Medical Practitioner's Accreditation.

i. The CEO or delegate, in their absolute discretion, may decide that in addition to or as an alternative to taking action regarding the Accredited 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 Office of Health Ombudsman, AHPRA 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 CEO or delegate's decision regarding Accreditation.

12. Suspension, termination, imposition of conditions, conclusion and expiry of accreditation

12.1 Suspension of accreditation

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

i. it is in the interests of patient care or safety;

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. the Medical Practitioner is considered to no longer hold or maintain sufficient Competence, Current Fitness or Performance;

iv. it is in the interests of staff welfare or safety;

v. it is in the interests of workplace health or safety;

vi. serious and unresolved concerns or allegations have arisen in relation to the Medical Practitioner. This may be related to a patient or patients at another facility not operated by the Facility, and may relate to an ongoing review by an external agency including a registration board, disciplinary body, Coroner or a health complaints body (including the Office of Health Ombudsman);

vii. the Medical Practitioner has failed to comply with the By-Laws, including the terms and conditions of Accreditation;

viii. the behaviour or conduct is in breach or apparent breach of a direction or an undertaking, the Facility By-Laws, Code of Conduct, Behavioural Standards, policies or procedures regarding behaviour or conduct;

ix. the behaviour or conduct is such that it is unduly hindering the efficient operation of the Facility at any time;

x. the behaviour or conduct is bringing the Facility into disrepute or seriously impacting upon its reputation;

xi. the behaviour or conduct is considered Disruptive Behaviour;

xii. the behaviour or conduct is inconsistent with the Mission, Values or Ethics as set out in By-Law 2;

xiii. the Medical Practitioner has been suspended by their registration board or AHPRA;

xiv. the Medical Practitioner is subject to allegations or findings of dishonesty, fraud, bribery or corruption;

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

xvi. 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;

xvii. 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;

xviii. the Medical Practitioner fails to make the required notifications required to be given pursuant to these By-Laws;

xix. 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;

xx. 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;

xxi. 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;

xxii. based upon a finalised Internal Review or External Review, with any of the above criteria for suspension considered to apply;

xxiii. an Internal Review or External Review has been initiated pursuant to these By-Laws and an interim suspension (refer to By-Law 11.1(i)) is considered appropriate pending the outcome of the review, with any of the above criteria for suspension considered to apply; A lower threshold of satisfaction is permitted with respect to the criteria for interim suspension given the review is not completed and the paramount consideration will be patient safety;

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

b. Other than in a case of emergency, if a delegate of the CEO intends to initiate this By-Law, then consultation ought to firstly occur with the CEO. If an emergency, then notification must be provided to the CEO as soon as reasonably practicable following initiation of this By-Law.

c. The 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 CEO or delegate 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 CEO or delegate 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 (noting there is no appeal available for an interim suspension), the appeal process and the time frame for an appeal.

d. As an alternative to an immediate suspension, the 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.

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

f. Ordinarily suspension will be suspension of Accreditation in its entirety, however the CEO or delegate 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.

g. The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by CEO or delegate.

h. The Accredited Practitioner shall at all times have the rights of appeal as set out in these By-Laws (noting that an appeal is not available for an interim suspension- refer to By-Law 11.1 (i)).

i. The CEO or delegate will notify Board and the Medical Advisory Committee and/or Credentialing Committee of any suspension of Accreditation or any change to the Accreditation of the Practitioner.

j. The CEO or delegate may decide, in their absolute discretion, that the matters that have been raised regarding the Medical Practitioner and the basis for suspension are of sufficient concern to justify immediate notification to the Office of Health Ombudsman, AHPRA, 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 CEO or delegate if the following has occurred, or if it appears based upon the information available to the CEO or delegate, the following has occurred:

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

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

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

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

b. Accreditation may be terminated by the CEO or delegate, if the following has occurred, or if it appears based upon the information available to the CEO or delegate, 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;

   iii. the CEO or delegate does not have confidence in the continued Accreditation of the Medical Practitioner;

   iv. conditions have been imposed by the Medical Practitioner's registration board or AHPRA and the Facility is unable or unwilling 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 CEO or delegate;

   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 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. Other than in a case of emergency, if a delegate of the CEO intends to initiate this By-Law, then consultation ought to firstly occur with the CEO. If an emergency, then notification must be provided to the CEO as soon as reasonably practicable following initiation of this By-Law.

e. The CEO or delegate shall notify the Medical Practitioner:

   i. of the fact of the termination;

   ii. of the reasons for the termination;

   iii. if the CEO or delegate 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.

f. As an alternative to an immediate termination, the 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 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.

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

h. All terminations must be notified to the Board and Medical Advisory Committee and/or Credentialing Committee.

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

j. 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.

k. Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified to the Office of Health Ombudsman, AHPRA, and/or other accrediting professional organisations.

12.3 Imposition of conditions

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

b. Other than in a case of emergency, if a delegate of the CEO intends to initiate this By-Law, then consultation ought to firstly occur with the CEO. If an emergency, then notification must be provided to the CEO as soon as reasonably practicable following initiation of this By-Law.

c. The CEO or delegate must notify the Medical Practitioner in writing of the imposition of the condition or 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.

d. If the CEO or delegate 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 CEO or delegate.

e. If the conditions imposed are breached, then suspension or termination of Accreditation may occur, as determined by the CEO or delegate.

f. The affected Medical Practitioner shall have the rights of appeal established by these By- Laws, with an appeal not available from a decision to impose conditions pending finalisation of an Internal or External Review.

g. If there is held, in good faith, a belief that the continuation of the unconditional right to practice in any other organisation would raise a significant concern about the safety and quality of health care for patients and the public, the CEO or delegate will notify the Office of Health Ombudsman, AHPRA, and/or other accrediting professional organisations of the imposition of the conditions and the reasons the conditions were imposed.

12.4 Notification to other Mater Health facilities

a. An Accredited Practitioner may be subject to a process under By-Laws 12.1 to 12.3 relating to all Mater Health Facilities at which the Accredited Practitioner holds accreditation. If however the process under By Laws 12.1 to 12.3 does not relate to all Mater Health Facilities relating to that Accredited Practitioner then this By-Law can have effect.

b. If an Accredited Practitioner is Accredited at more than one Mater Health Facility, then the outcome in By-Law 12.1 to 12.3 above will be notified by the CEO or delegate to Hospital Executive at other Mater Health Facilities at which the Accredited Practitioner is Accredited, along with sufficient information relating to why the action was taken.

c. The CEO or delegate, following consultation with the Hospital Executive, will decide what action may be appropriate in the circumstances, including pending the outcome of any appeal. The fact of lodgement of an appeal does not stay the decision under appeal, therefore the CEO or delegate may decide immediate action is required rather than waiting for the outcome of the appeal.

d. Unless the CEO or delegate decides otherwise in the circumstances of a particular case, the termination of Accreditation at one Mater Health Facility will ordinarily result in automatic termination of Accreditation at all Mater Health Facilities without any further procedural steps required. Alternatively, the CEO or delegate may decide to ask the Accredited Practitioner to show cause why a termination of Accreditation should not occur at other Mater Health Facilities and following the response (if any), make a decision.

e. If a suspension of Accreditation or imposition of conditions has occurred at one Mater Health Facility, the CEO or delegate will decide whether this will automatically result in suspension of Accreditation or imposition of conditions at all Mater Health Facilities without any further procedural steps required. Alternatively, the CEO or delegate may decide to ask the Accredited Practitioner to show cause why a suspension of Accreditation or imposition of conditions should not occur at other Mater Health Facilities and following the response (if any), make a decision.

12.5 Conclusion and expiry of accreditation

a. An Accredited Practitioner may conclude his/her Accreditation by giving one month's notice of the intention to do so to the CEO or delegate, unless a shorter notice period is otherwise agreed by the 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 CEO or delegate, and Accreditation will be taken to be withdrawn one month from the date of notification unless the 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 specifically determined otherwise by the CEO or delegate, the Accreditation will automatically 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.

d. The CEO or delegate will seek a written submission and/or 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; or

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

e. If, having regard to the written and/or verbal submissions by the Medical Practitioner in response to matters raised in (d) above, the CEO or delegate may determine that Accreditation will be withdrawn on the listed grounds. If this occurs, the 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 CEO or delegate will make a unilateral decision regarding the timing of the Accreditation expiry.

f. Following the expiry of the Accreditation, the Accredited Practitioner must apply for and receive an Initial Accreditation before renewed treating or admitting privileges are established.

g. The conclusion and/or expiration provisions of Accreditation in no way limits the ability of the CEO or delegate to take action pursuant to any other 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 decisions to not approve Initial accreditation, mutual recognition, temporary accreditation, locum cover, an interim suspension of Accreditation (refer to By-Law 11.1 (i)), an interim imposition of conditions upon Accreditation, 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 to lodge an appeal against the decision.

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

c. Unless decided otherwise by the CEO or delegate in the circumstances of a 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 CEO or delegate will immediately forward the appeal request to the Board.

e. The Board will nominate a Board delegate (who will be a member of the Board) to manage the appeal, which will include to provide instructions regarding the appeal, establish an Appeal Committee to hear the appeal and establish terms of reference. The Board will confirm in writing whether the decision of the Board pursuant to the appeal process will be made by the Board or by the Board delegate (who will be a member of the Board).

f. The CEO or delegate will be responsible for provision of all relevant material to the chairperson of the Appeal Committee.

g. 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 not be involved in making the decision under appeal or involved in matters the subject of the appeal, and who will be the chairperson of the Appeal Committee;

    ii. a nominee of the CEO or delegate, who may be an Accredited Practitioner, and who must not be involved in making the decision under appeal or involved in matters the subject of the appeal;

    iii. any other member or members who bring specific expertise to the decision under appeal, as determined by the Board, and who must not be involved in making the decision under appeal or involved in matters the subject of the appeal, but who may be an Accredited Practitioner.

h. 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 Board delegate will notify the appellant of the members of the Appeal Committee.

i. 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.

j. The appellant will be given the opportunity to make a submission to the Appeal Committee, including with respect to the issues forming the basis for the decision under appeal and the action taken. The Appeal Committee shall determine whether the submission by the appellant may be in writing or in person or both.

k. 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.

l. The CEO or delegate (or nominee of the CEO or delegate) may present to the Appeal Committee in order to support the decision under appeal. The nominee may be a lawyer.

m. 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.

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

o. 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.

p. The Appeal Committee will make a written recommendation regarding the appeal to the Board or Board representative, 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 CEO (or delegate) and appellant.

q. The Board or Board delegate will consider the recommendation of the Appeal Committee and make a decision about the appeal in its absolute discretion.

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

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

t. If a notification has already been given to an external agency or agencies, then the CEO or delegate will notify that external agency or agencies of the appeal decision. If a notification has not already been given, the CEO or delegate, in consultation with the Board or Board delegate, 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)

a. By-Laws 7 to 13 are hereby repeated in full substituting where applicable Dentists, Allied Health Professional or Advance Practice Nurse Practitioners, Endorsed Midwives for accredited Medical Practitioner. In addition, Clinical Visitor will be substituted for Medical Observer.

b. 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 CEO or delegate to suit the particular circumstances of the case.

c. Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the 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. 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 CEO or delegate 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 CEO or delegate will establish a regular audit process, at intervals determined to be appropriate by the 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 CEO or delegate.

17. Annexures

17.1 Annexure A: Mater Health Medical Advisory Committee (MAC) Terms of Reference

Relationship between Practice Improvement Meeting (PIMs) and Medical Advisory Committee (MAC)

Mater Health recognises that we are on continuous improvement journey of developing our services through a practice improvement model, with our services, specialties and hospitals operating on a continuum from local morbidity and mortality or craft group meetings through to state-wide networks of clinicians participating in Practice Improvement Meetings (PIMS). This means that the responsibilities of the MAC will evolve in response to our progress towards state-wide Clinical Networks.

Where there are Clinical Networks in place, the Role of the Medical Advisory Committee is to:

a. Participate in the strategic planning, development and implementation of clinical programs, new clinical services procedures and other interventions and clinical education and research at the facility;

b. Advising the Regional Executive Director / Executive Officer / Director of Medical Services on:

   i. The range of clinical services, procedures and other interventions that can be provided safely in the hospital setting;

   ii. The minimum criteria necessary for a Medical Practitioner to fulfil competently the duties of a specific position i.e. Scope of Practice, within the facility;

   iii. The information that should be requested and provided by applicants for appointment to specific Medical Practitioner positions or for specific Scope of Practice.

c. Accepting requests to undertake the processes of credentialing and defining the Scope of Practice in line with the range of clinical services, procedures and other interventions:

   i. relevant to all Medical Practitioners applying for initial appointment at the Relevant Hospital;

   ii. at any time, from an Authorised Person, in respect of a review of the Accreditation of a Medical Practitioner or their Scope of Practice;

   iii. from any Accredited Medical Practitioner who requests a review of their Scope of Practice

d. Ensuring the Credentials of each Medical Practitioner are reviewed and verified in accordance with the By-laws and policies of the Relevant Hospital;

e. In respect of each Medical Practitioner, considering Credentials, Competence and performance in the context of the Organisational Need and Organisational Capability, and confidence in each individual and recommend Scope of Practice that is appropriate in the circumstance for each Medical Practitioner;

f. Advising the Regional Executive Director / Executive Officer /Director of Medical Services of the committee's recommendations in relation to the Scope of Practice of each Medical Practitioner; and

g. At the request of the Regional Executive Director / Executive Officer /Director of Medical Services with existing Accreditation at a Relevant Hospital undertake an internal review regarding the Credentials and Scope of Practice granted to a Medical Practitioner.

Where Clinical Networks have not yet been established, the Role of the Medical Advisory Committee is also to:

a. Advise the Regional Executive Director / Executive Officer /Director of Medical Services on

   i. clinical services, procedures or other interventions to ensure these are provided by competent Medical Practitioners within environments that support the provision of safe, high quality health care services.

   ii. the safety, efficacy and role of new clinical services, procedures and other interventions, and assist to determine the financial and operational implications of these;

   iii. appropriate services which may be required to meet identified health needs

iv. matters concerning suitability, format and content of clinical educational programs and research activities

b. Promote efficient clinical processes within the facility;

c. Provide a means whereby Medical Practitioners can participate in policy making and planning processes of the facility by being the formal organisational structure through which the views of the Medical Practitioners shall be formulated and communicated to the Regional Executive Director / Executive Officer / Director of Medical Services;

d. Participate in the planning, development and implementation of clinical programs at the facility, including ensuring formal mechanisms for review of clinical management and outcomes are in accordance with the requirements of these By-laws; and

e. Promote clinical education and research at the facility

Membership of MAC

a. The Medical Advisory Committee will be comprised of at least five Medical Practitioners who are accredited and have been granted Scope of Practice and represent the major clinical speciality at the Relevant Hospital.

b. The Medical Advisory Committee members, including the Chairperson will be appointed by the Regional Executive Director / Executive Officer Director of Medical Services.

c. The Regional Executive Director / Executive Officer / Director of Medical Services may accept nominations from Accredited Medical Practitioners representing major clinical specialities provided at the Relevant Hospital or individual Medical Practitioners or Allied Health Professionals for membership of the Medical Advisory Committee and may accept nominations from within the members of the Medical Advisory Committee for the position of Chairperson of that committee. The process to receive nominations will be established by the Regional Executive Director / Executive Officer.

d. Except in respect of the Regional Executive Director / Executive Officer / Director of Medical Services the maximum term of membership of the Medical Advisory Committee for any person appointed to the committee is for a maximum period of three consecutive years.

e. The Chairperson of the Medical Advisory Committee shall be appointed for a one year term only, but is eligible for re-appointment up to a maximum term of three consecutive years.

f. The Regional Executive Director / Executive Officer / Director of Medical Services may however at their absolute discretion determine to extend the appointment of any person appointed to the Medical Advisory Committee or as the Chairperson of the Medical Advisory Committee.

Entitlement to membership

To maintain entitlement to membership of the Medical Advisory Committee, members must maintain Accreditation, appointment or employment, as the case may be, at the facility.

Powers to co-opt

a. In order to discharge the committee functions in respect of Credentialing and defining Scope of Practice , the Medical Advisory Committee may co-opt the services of other Accredited Medical Practitioners and other Health Practitioners with specific clinical skills and experience relevant to the Scope of Practice sought by an applicant, or which are the subject of review, to assist the Medical Advisory Committee for the purposes of the relevant application, or request for review, and those persons will be deemed to be members of the Medical Advisory Committee for those purposes.

b. The facility Credentialing Committee will be a sub-committee of the Medical Advisory Committee, to make recommendations for Credentialing and Scope of Practice for Medical Practitioners.

c. Subject to approval by the Regional Executive Director / Executive Officer / Director of Medical Services, the Medical Advisory Committee may convene sub-committees, receive from and consider reports prepared by those sub-committees and make recommendations to the Regional Executive Director / Executive Officer / Director of Medical Services; on matters arising out of those reports. The Medical Advisory Committee may co-opt the services of any other person it considers necessary, however, that person or persons shall have no voting rights at any meeting of the Medical Advisory Committee or sub-committees thereof.

Rules of conduct

a. The Medical Advisory Committee, and any sub-committee convened for specific activities of the Medical Advisory Committee, must comply at all times with all legal requirements, including the common law and relevant Queensland and Commonwealth legislation.

b. Specifically, the committee must conduct itself according to the rules of natural justice, without conflicts of interest or bias, and in a manner which does not breach relevant legislation, including privacy, trade practices, whistle-blower or equal opportunity legislation.

c. Equity and merit must form the basis of all phases of the processes of Credentialing and defining Scope of Practice.

d. In particular, where conflict of interest may arise because:

    i. The member has a financial, pecuniary, personal or other interest in the application for Accreditation and Scope of Practice or;

    ii. The member is related to or is in a personal relationship with the Medical Practitioner;

    iii. The member must declare the conflict and shall not be involved in any way in considering applications for or requests for review of such applications.

e. For the purposes of these By-laws, membership of the same college or professional association of the applicant by any member of the Medical Advisory Committee shall not be regarded as conflict of interest.

Meetings of MAC

a. The Medical Advisory Committee will meet at least four times per year at regular intervals and as reasonably required by the Regional Executive Director / Executive Officer / Director of Medical Services.

b. The meetings of the Medical Advisory Committee must be minuted, and copies of minutes provided to the Regional Executive Director / Executive Officer/ Director of Medical Services.

c. Comprehensive records shall be maintained on all deliberations, supporting information considered and recommendations relevant to the processes of Credentialing and defining Scope of Practice.

Quorum

a. Quorum requirements for the Medical Advisory Committee are:

    i. Where there is an odd number of voting members of the committee, a majority of members.

    ii. Where there is an even number of voting members for the committee, one half of the members plus one

b. A decision may be made by a committee or group established pursuant to these "By-Laws" without a meeting if a consent in writing setting forth such a decision is signed by all members of the committee or group as the case may be. A committee or group established pursuant to these "By-Laws" may hold any meeting by electronic means whereby participants can be heard and can hear but are not necessarily in the same place. The requirements of these "By-Laws" shall nonetheless apply to such a meeting.

Confidentiality

Information provided to any committee or person which is provided in confidence shall be regarded as confidential and is not to be disclosed to any third party or beyond the particular forum purposes for which such information is made available.

Voting

Where required by these "By-Laws", matters shall be determined by consensus or by voting on a simple majority basis and only those in attendance at the meeting are entitled to vote at such meeting. There shall be no proxy vote.

Resignation from membership of the MAC

Any member of the MAC may resign from such membership by giving at least one month's notice in writing of their intention to resign such appointment to the Regional Executive Director / Executive Officer / Director of Medical Services.

Termination of membership of MAC

a. The Regional Executive Director / Executive Officer / Director of Medical Services may terminate membership or Chairmanship of the Medical Advisory Committee where the member:

   i. fails to attend the majority of meetings;

   ii. fails to attend three (3) consecutive meetings without prior approval from the Regional Executive Director / Executive Officer / Director of Medical Services

   iii. is determined, following review, by the Regional Executive Director / Executive Officer / Director of Medical Services; of the facility as not meeting the requirements of membership of the Medical Advisory Committee.

b. Membership of the Medical Advisory Committee will be terminated where the Medical Practitioner has Accreditation terminated.

c. Where a member of the Medical Advisory Committee is under review or suspended, the Regional Executive Director / Executive Officer / Director of Medical Services may suspend membership.

Insurance cover for MAC Members

a. Mater Health confirms that any activities performed by the Medical Advisory Committee in accordance with these terms of reference, or any person acting under the direction or request of the Committee, including consideration of granting and review of Credentialing and Scope of Practice at the hospital, provided they act in good faith, will be indemnified by Mater Health.

b. Committee member's details will be forwarded to the relevant insurance provider and updated as required from time to time. All requests by Mater Health to committee members relating to details for insurance must be complied with.

Reporting

The Executive Officer and Chairperson of the Medical Advisory Committee will facilitate a comprehensive assessment of the committee's activity annually to the Regional Executive Director on the committee's performance and contribution to the development of constructive relationships between Accredited Medical Practitioners and Allied Health Professionals; to the safety and quality in the Relevant Hospital and compliance by Accredited Medical Practitioners and Allied Health Professionals with Accreditation and Scope of Practice requirements.

Defining the scope of practice

Each Medical Advisory Committee in consultation with the Regional Executive Director / Executive Officer / Director of Medical Services will establish an approach to defining the requirements for clinical practice within each clinical speciality provided at the facility. In determining the preferred approach of the facility, the Medical Advisory Committee through the facility Credentialing Committee should consider the processes provided in the National Standard for Credentialing and Defining the Scope of Practice to ensure that decision making regarding the approach taken by the facility occurs in a consistent and transparent manner.

a. When defining the Scope of Practice for each Medical Practitioner the Medical Advisory Committee through the Credentialing Committee should:

   i. Review the clinical services, procedures or other interventions which have been requested for inclusion in Scope of Practice and consider whether:

   ii. A responsible body of medical opinion deems the relevant clinical services, procedures or other interventions to be beneficial to patients;

   iii. in the event that the clinical services, procedures or other interventions are not so recognised by a responsible body of medical opinion, they have been reviewed by the ethics committee of Mater Health and their introduction has been deemed to be acceptable in the circumstances (with or without conditions); and

   iv. in the event the clinical services, procedures or other interventions are new to the facility, they are being introduced in compliance with the facility and Mater Health policies for the introduction of New Clinical Services.

b. Review and consider the relevance to the specific circumstances in which the Scope of Practice are requested by reference to:

i. Policies or guidelines published by the professional colleges, associations and societies;

ii. Requirements of the professional colleges, associations and societies for current trainees to gain experience in the requested Scope of Practice;

iii. Credible or peer reviewed publications relating to Competence and performance (including the relationship between volume and quality) in the requested Scope of Practice; and

iv. Organisational Capability and Organisational Need to provide the Scope of Practice sought.

c. Consider the volume of the relevant activity undertaken by the Medical Practitioner over the past 12 months and the implications regarding the Medical Practitioners ongoing Competence and performance.

d. Review available sources of objective data about the Medical Practitioners Competence and performance including any available registry data and consider:

i. their validity as measures of the safety and quality of health care services including whether they are appropriately stratified and risk adjusted; and

ii. Whether they contribute to a reliable assessment of the Medical Practitioner's Competence and performance in the requested Scope of Practice.

e. Review current references and ensure that they confirm the Medical Practitioner's adequacy of clinical knowledge, technical skill, judgement, experience, Competence and performance in each of the specific areas within the Scope of Practice sought.

f. Review referees' comments on the Medical Practitioner's communication skills and teamwork ability insofar as these are likely to contribute to clinical performance.

g. Review referees' comments on overall professional performance.

h. Consider the specific Mater hospital circumstances in which the clinical services, procedures or other interventions will be provided.

i. Following deliberations on all of the relevant information make a recommendation to the Regional Executive Director / Executive Officer / Director of Clinical Services whether to approve, approve with conditions or reject the application.

j. The Medical Advisory Committee through the Credentialing Committee shall ensure appropriate documentation relating to deliberations is maintained.

Composition of committee

The committee is appointed annually by the Regional Executive Director / Executive Officer / Director of Medical Services. The Chair person of the Committee is appointed by the Regional Executive Director / Executive Officer / Director of Medical Services for a period of two years and other members of the Committee are annually elected from the community of the Visiting Medical Practitioners.

Membership of MAC:

Representatives from key clinical specialties, Executive Staff Members and other specialty areas as defined by Regional Executive Director / Executive Officer / Director of Medical Services.

Quorum – Half plus one

Frequency of meetings

At least 4 times per year.

Key performance indicators (KPI)

KPI	Target
Review and approval of all accreditation applications (including new and renewal) recommended by the Credentialing Committee	100% per year
Review and provide feedback on changes to Hospital policies, as required that require MAC input.	100% per year
Review relevant clinical incidents as referred by hospital executive	100% per year

Review and action internal and external audit results, relating to VMP clinical areas of concern	100% per year
Review Quality and Safety report provided on clinical indicators.	100% per year

Review and evaluation

a. Review and approve changes to By-Laws every two (2) years.

b. Annual Review

17.2 Annexure B: Mater Health Credentialing Committee terms of reference

The overarching policy for the Accreditation and Credentialing/ Scope of Practice for Mater Health is the By-Laws for Accredited Practitioners (2021)

The Credentialing Committee is charged with advising on credentialing and defining the Scope of Practice of medical practitioners by:

a. Advising the Medical Advisory Committee (MAC) on the minimum credentials necessary for a medical practitioner to fulfil competently the duties of a specific position or scope of practice within the facility;

b. Advising the MAC on the information that should be requested and provided by applicants for appointment to specific medical practitioner positions or including relevant scope of practice;

c. Accepting requests to undertake the processes of credentialing and defining scope of practice in line with the range of clinical services, procedures and other interventions:

    i. relevant to all medical practitioners applying for initial appointment at the Hospital;

    ii. at any time, from an authorised person in respect of a review of the accreditation of a medical practitioner and/or their scope of practice; and

    iii. from any accredited medical practitioner who requests a review of their scope of practice.

d. Ensuring the credentials of each medical practitioner are reviewed and verified in accordance with the "By-Laws";

e. Reviewing approved changes to Mater Health "By-laws" for implementation;

f. Review internal and external audits of Accreditation/Credentialing, to implement actions to improve committee performance;

g. In respect of each medical practitioner, considering credentials, competence and performance in the context of the organisational need and organisational capability and confidence in each individual, and recommend the scope of practice that is appropriate in the circumstance for each medical practitioner; and

h. Advising the Medical Advisory Committee of the Credentialing Committee's recommendations in relation to the scope of practice of each medical practitioner.

Membership of the Credentialing Committee

The Credentialing Committee will comprise at least three core members, including the Chair of the MAC, the Executive Officer and one other member of the MAC. The committee members will be appointed by the Chair of the MAC.

Chair of Credentialing Committee

The Executive Officer or their delegate will be the chair of the Credentialing Committee.

Powers to co-opt

In order to discharge the committee functions in respect of credentialing and defining scope of practice, the Credentialing Committee may co-opt the services of other accredited health professionals with specific clinical skills and experience relevant to the scope of practice sought by an applicant, or which are the subject of review, to assist the Credentialing Committee for the purposes of the relevant application or request for review, and those persons will be deemed to be members of the Credentialing Committee for those purposes.

Rules of conduct

a. The Credentialing Committee must comply at all times with all legal requirements, including the common law and relevant Queensland and Commonwealth legislation. Specifically, the committee must conduct itself according to the rules of natural justice without conflicts of interest or bias and in a manner which does not breach relevant legislation, including privacy, trade practices, whistleblower or equal opportunity legislation.

b. Equity and merit must form the basis of all phases of the processes of credentialing and defining scope of practice. In particular, where conflict of interest may arise because:

   i. The committee member has a financial, pecuniary, personal or other interest in the application for accreditation and scope of practice; or

   ii. The committee member is related to or is in a personal relationship with the medical practitioner or allied health professional;

   iii. The committee member must declare the conflict and shall not be involved in any way in considering applications for or requests for review of such applications.

c. For the purposes of these "By-Laws", membership of the same college or professional association of the applicant by any member of the Credentialing Committee shall not be regarded as conflict of interest.

Membership of Credentialing Committee

Membership of committee members is for a period of two (2) years, with the option of a further two (2) years extension.

Meetings of the Credentialing Committee

a. The Credentialing Committee will meet at least four times per year at regular intervals and as reasonably required by the General Manager and Chair of the MAC.

b. The meetings of the Credentialing Committee must be minuted, and copies of minutes provided to the Chair of the MAC.

c. Records shall be maintained on all deliberations, supporting information considered and recommendations relevant to the processes of credentialing and defining scope of practice.

Quorum

a. Quorum requirements for the Credentialing Committee are attendance by four core members and any co-opted members as required.

b. A decision may be made by a committee or group established pursuant to these "By-Laws" without a meeting if a consent in writing setting forth such a decision is signed by all members of the committee or group as the case may be. A committee or group established pursuant to these "By-Laws" may hold any meeting by electronic means whereby participants can be heard and can hear but are not necessarily in the same place. The requirements of these "By-Laws" shall nonetheless apply to such a meeting.

Confidentiality

Information provided to any committee or person which is provided in confidence shall be regarded as confidential and is not to be disclosed to any third party or beyond the particular forum purposes for which such information is made available.

Voting

Where required by these "By-Laws", matters shall be determined by consensus or by voting on a simple majority basis and only those in attendance at the meeting are entitled to vote at such meeting. There shall be no proxy vote.

Resignation from membership of the Credentialing Committee

Any member of the Credentialing Committee may resign from such membership by giving at least one month's notice in writing of their intention to resign such appointment to the Chair of the MAC.

Termination of membership of the Credentialing Committee

a. The General Manager may terminate membership or chairmanship of the Credentialing Committee where the member:

   i. Fails to attend the majority of meetings;

   ii. Fails to attend three (3) consecutive meetings without prior approval from the Regional Executive Director / Executive Officer / Director of Medical Services; of the Hospital;

iii. Is determined, following review by the Regional Executive Director / Executive Officer / Director of Medical Services; of the Hospital, as not meeting the requirements of membership of the Credentialing Committee; or

iv. On the recommendation of the Chair of the MAC.

b. Membership of the Credentialing Committee will be terminated where the medical practitioner has accreditation terminated.

c. Where a member of the Credentialing Committee is under review or suspended, the General Manager of the Hospital may suspend membership.

Insurance cover for Credentialing Committee members

a. Mater Health confirms that any activities performed by the Credentialing Committee in accordance with these Terms of Reference or any person acting under the direction or request of the Committee, including consideration of granting and review of credentialing and scope of practice at the Hospital, provided they act in good faith, will be indemnified by Mater Health.

b. Committee members' details will be forwarded to the relevant insurance provider and updated as required from time to time. All requests by Mater Health to committee members relating to details for insurance must be complied with.

Defining the scope of practice

The Credentialing Committee will establish an approach to defining the requirements for clinical practice within each clinical specialty provided at the Hospital. In determining the preferred approach, the Credentialing Committee should consider the processes provided in the National Standard for Credentialing and Defining the Scope of Practice to ensure that decision-making regarding the approach taken by the facility occurs in a consistent and transparent manner.

When defining the scope of practice for each medical practitioner or allied health professional, the Credentialing Committee should:

a. Review the clinical services, procedures or other interventions which have been requested for inclusion in scope of practice and consider whether:

i. A responsible body of medical opinion deems the relevant clinical services, procedures or other interventions to be beneficial to patients;

ii. In the event that the clinical services, procedures or other interventions are not so recognised by a responsible body of medical opinion, they have been reviewed by the ethics committee of Mater Health and their introduction has been deemed to be acceptable in the circumstances (with or without conditions); and

iii. In the event that the clinical services, procedures or other interventions are new to the facility, they are being introduced in compliance with the facility and Mater Health policies for the introduction of new clinical services.

b. Review and consider the relevance to the specific circumstances in which the scope of practice is requested by reference to:

i. Policies or guidelines published by the professional colleges, associations and societies;

ii. Requirements of the professional colleges, associations and societies for current trainees to gain experience in the requested Scope of Practice;

iii. Credible or peer-reviewed publications relating to competence and performance (including the relationship between volume and quality) in the requested scope of practice; and

iv. Organisational capability and organisational need to provide the scope of practice sought.

c. Consider the volume of the relevant activity undertaken by the medical practitioner over the past 12 months and the implications regarding the medical practitioner's ongoing competence and performance.

d. Review available sources of objective data relevant to the medical practitioner's competence and performance including any available registry data and consider;

e. Review current references and ensure that they confirm the medical practitioner's adequacy of clinical knowledge, technical skill, judgement, experience, competence and performance in each of the specific areas within the scope of practice sought.

f. Review referees' comments on the medical practitioner's communication skills and teamwork ability insofar as these are likely to contribute to clinical performance.

g. Review referees' comments on overall professional performance.

h. Consider the specific Hospital circumstances in which the clinical services, procedures or other interventions will be provided.

i. Following deliberations on all of the relevant information, make a recommendation to the Regional Executive Director / Executive Officer / Director of Medical Services by the MAC whether to approve, approve with conditions or reject the application.

j. The Credentialing Committee shall ensure appropriate documentation relating to deliberations.

k. The Credentialing Committee shall monitor corrective and preventative actions relating to the committee and effectiveness of actions implemented for improving performance.

Key performance indicators (KPI)

KPI	Target
Committee review all initial accreditation applications and provides feedback and recommendations to the General Manager	100% per year
Committee review all renewal of accreditation applications and provides feedback and recommendations to the General Manager	100% per year
Committee review all requests for amendment of scope of practice applications and provides feedback and recommendations to the General Manager	100% per year
Review and approve all Temporary and/or Emergency accreditation applications	100% per year
Committee review all initial accreditation applications and provides feedback and recommendations to the General Manager	100% per year

Review and evaluation

a. Annual review of Terms of Reference (March)

b. Annual review of By-Laws

17.3 Annexure C: Practice Improvement Meeting (PIMs) Terms of Reference

Purpose

To contribute to improved clinical quality and patient safety through:

a. Critical analysis by a multidisciplinary group of clinicians of the circumstances surrounding the outcomes of care. These outcomes will include selected deaths, serious morbidity and significant aspects of regular clinical practice;

b. Making recommendations which focus on measures that can prevent similar incidents or adverse outcomes, or for improving the processes of care provided to this group of patients. Recommendations will avoid apportioning blame to individuals;

c. Initiating action on these recommendations and overseeing the implementation of these actions; and

d. Reporting on implementation of these actions to the Facility Patient Safety and Quality.

Committee

In particular, the committee will review or provide the opportunity to review:

a. All deaths associated with a health care intervention and which are not an expected manifestation of the disease process;

b. Individual or aggregate data regarding adverse outcomes or clinical events which are agreed by the committee as providing useful insight into the quality of care provided;

c. Statistical indicators of the department's performance against agreed benchmarks;

d. Clinical incidents notified;

e. Patient feedback notified;

f. Open Disclosure cases involving major adverse events;

g. The committee will consider whether any issue raised needs to be recorded and maintained on a Facility or Departmental Risk Register Membership;

h. All senior medical staff appointed to the Department;

i. All junior medical staff appointed or allocated on rotation to the Department;

j. Nursing and midwifery staff associated with the Department's dedicated wards;

k. Allied health and pharmacy staff dedicated to the Department's activity; and

l. Clinicians from other Departments with which there is frequent interaction.

Meeting operating procedures

a. The meeting will occur monthly to three monthly (depending on volume of cases and prioritisation);

b. The schedule of meetings will be published well in advance;

c. The meeting will elect a Chairperson. This election will be ratified by the Department Head;

d. The office of Chairperson will be reviewed annually but may be extended;

e. An agenda will be circulated in advance of the meeting;

f. Actions notes will be kept and circulated to members after the meeting;

g. The Chairperson will conduct the meeting to ensure that it focuses on health care service improvement and not on individual blame; and

h. Performance issues identified are referred to performance management processes in accordance with Managing Complaints and Concerns about Clinicians.

Adapted from NSW Health, Guidelines for Conducting and Reporting Morbidity and Mortality/Clinical Review Meetings, September 2020.

18. Documents related to these By-laws

External documents

1.	*Privacy Act (Cth)*
2.	Australian Health Practitioner Regulation Agency
3.	Good Medical Practice: A Code of Conduct for Doctors in Australia
4.	*Civil Liability Act (QLD)*
5.	National Statement on Ethical Conduct in Human Research 2007
6.	Code of Ethical Standards for Catholic Health and Aged Care Services in Australia

19. Document controls

19.1 Document revision history

Version	Release date	Description	Risk-rated Review date
5	25 Jun 2020	Version 5 published on the Mater Document Centre	June 2023
6	02 July 2021	Version 6 published on the Mater Policy and Procedure Library	July 2024

19.2 Document review and approval

Name Person/committee	**Position** If applicable	**Function** Owner/author/review/approve
Peter Steer	Mater Group CEO	Document owner
Key reviewers: State Health Executive Committee; Credentialing Committee		Review
Mater Board		Authorise

19.3 Keyword indexing

Keywords:	By-Laws, health practitioner, medical practitioner, accreditation, credentialing,