ST VINCENT'S HEALTH AUSTRALIA LIMITED
GROUP MODEL BY-LAWS

Version 8: 4th August 2016

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FOREWORD

1. All references to By-Laws in these By-Laws means the SVHA Group Model By-Laws.

2. This document sets out the By-Laws that are used by the Board to determine the clinical governance requirements with respect to Accredited Practitioners.

3. All references to Facility or Facilities in these By-Laws is a facility or facilities of SVHA.

4. These By-Laws apply to all public and private Facilities of SVHA. Specific provisions may be applicable to only one of these two groups.

5. These By-Laws must be read in conjunction with the Clinical Credentialing and Scope of Practice Policy and all other relevant SVHA policies adopted by the Board.

6. The Board has the sole authority to make and amend these By-Laws.

7. Where a Facility has legislative obligations or operational procedures which are different or additional to these By-Laws, these will be set out in Schedule 1.

8. For the composition of Committees, membership constitution, method of selection of appointees, term of Appointment, review of Scope of Clinical Practice, frequency of meeting and quorum of Committees refer to the Terms of Reference for each Facility in Schedule 2.

9. The composition of each Committee will reflect the Facility's organisational requirements.

10. Where the Facility Chief Executive Officer has delegated his or her authority to a Delegated Authority in respect of any power under a particular By-Law, a reference to the Facility Chief Executive Officer in that By-Law will also include that Delegated Authority. Schedule 1 sets out the specific delegations for the Facility.

PREAMBLE

The By-Laws mandate the Accreditation, Credentialing, Re-accreditation and process for defining and amending the Scope of Clinical Practice for Medical Practitioners and Dental Practitioners (both as a result of a review by the FCEO or at the request of a Medical Practitioner), providing services to patients at the Facility. The purpose of this process is to assess the training, experience, competence, judgement, professional capabilities and knowledge, fitness and character of a Medical Practitioner or Dental Practitioner who holds Accreditation or seeks Accreditation at a Facility. Relevantly, there is the ability to amend, suspend or terminate a Medical Practitioner's or Dental Practitioner's Scope of Clinical Practice in the interest of patient safety, the needs of the Facility or if the Accredited Practitioner displays conduct inconsistent with the Facility's mission, vision or values. Credentialing and defining the Scope of Clinical Practice are governance responsibilities of the Facility Chief Executive Officer and may be delegated as appropriate. The Credentialing, Re-accreditation and the process for defining and amending Scope of Clinical Practice is a non-punitive process. These processes must be fair, transparent and legally robust.

As a group of Catholic public, private and aged care facilities, SVHA reflects in its policies and practices the ethical and moral teachings of the Catholic Church. Those who accept Appointment as a Facility's Accredited Practitioner agree to respect and observe those principles embodied in the following:

- SVHA's Mission, Vision and Values
- SVHA Code of Conduct
- Ethical Framework of Mary Aikenhead Ministries
- Codes of Ethical Standards for Catholic Health and Aged Care Services in Australia
- These By-Laws
- Applicable SVHA and Facility policies and procedures
- Applicable State and Commonwealth policies and legislative requirements
- Codes of Conduct articulated by relevant registration authorities

SVHA VISION, MISSION, VALUES AND CARE STATEMENTS

Mission

As a Catholic health and aged care service we bring bring God's love to those in need through the healing ministry of Jesus. We are especially committed to people who are poor and vulnerable.

Vision

We lead through research driven, excellent and compassionate health and aged care.

Values

Compassion

Justice

Integrity

Excellence

Creed

We believe in the dignity of people because each one is created in God's image. We are committed to justice and compassionate care for all.

Care

Our care is

- Provided in an environment underpinned by Mission and Values.
- Holistic and centred on the needs of each patient and resident.
- High quality, safe and continuously improved to ensure best practice.
- Innovative and informed by current research using contemporary techniques and technology.
- Delivered by a team of dedicated, appropriately qualified people who are supported in a continuing development of their skills and knowledge, and
- Provided with a commitment to a respect of life according to the Gospel.

1. BY-LAWS

1.1 By-Laws apply to Facilities

This document sets out the By-Laws that apply to all Facilities at which the Board has determined they will apply.

1.2 Inconsistencies with legislation

Where there is any inconsistency between these By-Laws and any legislative requirements or mandatory directives pursuant to legislation applicable to a Facility, to the extent of such inconsistency the legislative requirement or mandatory directive will prevail and apply to that particular Facility.

2. INTERPRETATION

2.1 Definitions

In these By-Laws, unless the context otherwise requires:

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

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

(b) any specified Conditions;

(c) the Code of Conduct;

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

(e) these By-Laws.

Accreditation Classification means one or more of the designated classifications of an Accredited Practitioner as set out in Schedule 1 in respect of the Facility to which Accreditation has been granted.

Accredited Practitioner means a Medical Practitioner or Dental Practitioner authorised to treat patients at the Facility in accordance with a specified Accreditation Classification and Scope of Clinical Practice.

Act means all relevant legislation applicable to and governing:

(a) the Facility and its operation;

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

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

AHPRA means the Australian Health Practitioner Regulation Agency established under the *Health Practitioner Regulation National Law Act* 2009 *(*as in force in each State and Territory) which came into effect on 1 July 2010.

Application Form means the form approved by the Facility from time to time for use by a Medical Practitioner or Dental Practitioner to apply for Accreditation at the Facility.

Appointment means the employment or engagement of an Accredited Practitioner to provide services within the Facility according to any Conditions defined by general law and supplemented by a Contract of Employment or Contract of Engagement, or howsoever named by the Facility.

Board means the Board of Directors of SVHA.

Board Quality and Safety Committee means a committee established by the Board to ensure systems are in place and are being monitored for the purposes of providing information to the Board so that the Board can assess and determine whether in respect of SVHA Group Entities and Facilities:

(a) all clinical risks are being appropriately managed;

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

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

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

Catholic Health Code of Ethical Standards means the *Code of Ethical Standards for Catholic Health and Aged Care Services in Australia*, published by Catholic Health Australia from time to time.

(a) Chief Executive Officer means either or all of the following as applicable and specified at any time within these By-laws:

(b) the SVHA Group CEO;

(c) the Divisional CEO (DCEO)

(d) the Facility CEO (FCEO).

Code of Conduct means the relevant code of conduct of the SVHA Group Entity or the Facility.

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

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

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

(c) appeals in accordance with these By-Laws

Condition means as applicable with respect to an Accredited Practitioner:

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

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

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

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

Credentialing means the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of an Accredited Practitioner for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific Facility environments. Credentialing involves obtaining evidence contained in verified documents to delineate the theoretical range of services which an Accredited Practitioner is competent to perform.

Credentials means the qualifications, professional training, clinical experience, current registration and status, indemnity insurance, training and experience in leadership, research, education, communication and teamwork that contribute to the competence, performance and professional suitability to provide safe, high quality health care services at the Facility.

Current Fitness means the current fitness required of an Accredited Practitioner to carry out the Scope of Clinical Practice sought or currently held. An individual does not have current fitness if that person suffers from any physical or mental impairment, disability, condition or disorder which detrimentally affects, or is likely (in the FCEO's reasonable opinion) to detrimentally affect the individual's physical or mental capacity to practise medicine or dentistry and carry out the Scope of Clinical Practice sought or currently held.

Dental Practitioner means a person registered as a dentist by the Dental Board of Australia governed by the AHPRA pursuant to the *Health Practitioner Regulation National Law Act* 2009 as in force in each State and Territory.

Designated Authority means designated authority of the FCEO which may include another senior position title of the Facility.

Division means the relevant division of SVHA as applicable being either:

(a) the Division of Public Hospitals which comprises all of the SVHA public Hospital Facilities;

(b) the Division of Private Hospitals which comprises all of the SVHA private Hospital Facilities;

(c) the Division of Aged Care and Shared Services which comprises all the aged care Facilities.

Divisional CEO (DCEO) means the chief executive officer of the relevant Division of SVHA being either:

(a) the CEO of the Public Hospitals Division;

(b) the CEO of the Private Hospitals Division;

(c) the CEO of the Aged Care and Shared Services Division.

Facility means hospital, aged care facility or day procedure centre conducted by a SVHA Group Entity and in which health services and aged care are provided.

Facility CEO (FCEO) means the following chief executive officer and general manager positions which report to a DCEO:

(a) Chief Executive Officer of St Vincent's Hospital Melbourne;

(b) Chief Executive Officer of St Vincent's Health Network Sydney;

(c) Chief Executive Officer of St Vincent's Private Hospital Melbourne (including Kew, East Melbourne & Fitzroy);

(d) Chief Executive Officer of St Vincent's Private Hospital Sydney;

(e) Chief Executive Officer of Mater Hospital North Sydney;

(f) Chief Executive Officer of Holy Spirit Northside Private Hospital;

(g) Chief Executive Officer of St Vincent's Private Hospital Brisbane;

(h) Chief Executive Officer of St Vincent's Private Hospital Toowoomba.

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

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

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

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

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

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

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

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

Organisational Capabilities means the Facility's ability to provide facilities, services and clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions.

Organisational Need means the extent to which the Facility elects to provide a specific clinical service, procedure or other intervention in order to provide a balanced

mix of safe, high quality health care services that meet patient and community need and expectation. This will include consideration of the strategic, operational and business plans, goals and objectives of the organisation.

Professional Indemnity Insurance means the insurance of an Accredited Practitioner taken out in accordance with By-Law 9.4.

Professional Misconduct has the same meaning prescribed to that term in the *Health Practitioner Regulation National Law Act* 2009 as in force in each State and Territory.

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

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

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

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

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

Surgical Assistant means an individual who assists an Accredited Practitioner in the private Facilities' operating theatres.

SVHA means St Vincent's Health Australia Limited ACN 073 503 536.

SVHA Group CEO means the chief executive officer of SVHA as appointed by the Board.

SVHA Chief Medical Officer means the chief medical officer of SVHA as appointed by the SVHA Group CEO.

SVHA Group Entity means all of the entities which operate the facilities which make up SVHA and the Divisions including:

(a) SVHA

(b) a related body corporate (as that term is defined in the *Corporations Act* 2001 (Cth)) of SVHA;

(c) the Congregation of the Religious Sisters of Charity trading as St Vincent's Private Hospital Sydney; and

(a) The Holy Spirit Northside Private Hospital Limited.

Temporary Appointment means an appointment of an Accredited Practitioner for a specified period of less than 90 days, unless otherwise determined by the FCEO.

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

2.2 **General Interpretation**

(a) Rules for Interpreting these By-Laws

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

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

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

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

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

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

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

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

(b) Titles

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

(c) Quorum

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

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

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

(d) Resolutions without meetings

A decision may be made by a Committee or group established pursuant to these By-Laws (except that established by By-Law 19) without a meeting if a consent in writing, including electronic means, setting forth such a decision is signed by all the Committee or group members, as the case may be.

(e) Meeting by electronic means

A Committee or group established pursuant to these By-Laws (except that established by By-Law 19) may hold any meeting by electronic means whereby participants can be heard and can hear but are not necessarily in the same place. The requirements of these By-Laws will nonetheless apply to such a meeting.

(f) Voting

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

(g) Delegation

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

(h) Compensation

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

3. PRIVACY AND CONFIDENTIALITY

3.1 Privacy

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

3.2 Accredited Practitioners

Subject to By-Law 3.1, every Accredited Practitioner must keep confidential the following information:

(a) business information concerning SVHA or the Facility;

(b) information concerning the insurance arrangements of SVHA or the Facility where applicable;

(c) personal, sensitive or health information concerning any patient, clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services.

3.3 **Committees**

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

(a) the proceedings for the Accreditation including designation of Scope of Clinical Practice of the Accredited Practitioner; and

(b) the proceedings for any change to Scope of Clinical Practice of the Accredited Practitioner.

3.4 **What confidentiality means**

The confidentiality requirements of By-Laws 3.1, 3.2 and 3.3 prohibit the recipient of the confidential information from using or disclosing it for any unauthorised purpose, copying it, reproducing it or making it public.

3.5 **When confidentiality can be breached**

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

(a) where disclosure is required or specifically authorised by law;

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

(c) where disclosure is required by a regulatory body in connection with the Accredited Practitioner;

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

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

3.6 **Privacy and confidentiality obligations continue**

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

3.7 **SVHA Group**

The Facility will be entitled to disclose an Accredited Practitioner's confidential information (including personal information and sensitive information as those terms are defined in the *Privacy Act 1988* (Cth)) in relation to their appointment or any other matters related to these By-laws to other SVHA Group Entities.

3.8 **Mandatory notification of Notifiable Conduct**

Notwithstanding By-Laws 3.1 to 3.7, all registered practitioners acting in a management role with SVHA must comply with their responsibilities under the National Law in regard to mandatory notification of Notifiable Conduct by another practitioner or a student undertaking clinical training where they have formed a reasonable belief that a health practitioner has behaved in a way that constitutes

Notifiable Conduct in relation to the practise of their profession or suffers from an impairment that may place the public at substantial risk of harm.

4. BOARD POWERS AND TRANSITIONAL ARRANGEMENTS

4.1 Board powers

(a) The Board is empowered to make By-Laws, rules, regulations and policies for the operation of the Facility as it may deem necessary from time to time.

(b) Unless otherwise specified, changes take effect from the time of the resolution by the Board.

(c) Any changes under By-Law 4.1(b) take effect from the date the change is approved by the Board and apply to all Accredited Practitioners from that date.

4.2 Transitional arrangements

Accreditation under previous By-Laws is maintained under any new By-Laws approved by the Board.

5. COMMITTEES

5.1 Power to establish Committees

(a) The FCEO may establish any Committees for the Facility.

(b) Subject to these By-Laws and any Act, the FCEO can determine the membership, powers, authorities and responsibilities that are delegated to a Committee and the administrative rules by which each Committee is to operate.

5.2 Terms of Reference for Committees

Schedule 2 provides the Terms of Reference for Committees.

5.3 Indemnification

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

(a) acted in good faith;

(b) acted in accordance with their delegated authority; and

(c) acted in accordance with any Act governing their conduct.

5.4 Statutory immunity for Committees

(a) An SVHA Group Entity may in specific circumstances seek and be granted declarations under jurisdictional legislation in respect of a Committee at a Facility where the Committee's emphasis is on the quality assurance or review of clinical practice or clinical competence. Such a declaration may, amongst other things, afford statutory immunity or qualified privilege or similar for members of that Committee in the course of carrying out specific aspects of the role and function of that Committee.

(b) If an SVHA Group Entity has sought and been granted declarations as set out under By-Law 5.4(a) in respect of any Committee of any Facility, the terms and conditions of Statutory Immunity of a Committee of the Facility are set out in Schedule 1.

5.5 Committee access to the SVHA Board

The SVHA Board Quality and Safety Committee will have a standing agenda item for state-based Medical Credentialing Committees to discuss and escalate issues of a complex credentialing nature to the full SVHA Board.

6. DISCLOSURE OF INTEREST OF MEMBERS OF COMMITTEES

6.1 Disclosure of interest

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

(a) in a matter that has been considered, or is about to be considered, at a meeting, such a member or person must not, subject to By-Law 6.5, participate in the relevant discussion or resolution; or

(b) in a matter being considered or a decision being made by the Facility,

and must as soon as possible after the relevant facts have come to the person's knowledge, disclose the nature of the interest at the meeting.

6.2 Nature of disclosure

Disclosure by a person at a meeting that the person:

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

(b) is a partner, or is in the employment, of a specified person;

(c) is a family relative or personal partner, of a specified person; or

(d) has some other specified interest relating to a specified company or other body or a specified person,

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

6.3 Chairperson to notify Facility Chief Executive Officer

The chairperson of the relevant Committee will:

(a) notify the FCEO of any disclosure made under this By-Law; and

(b) record the disclosure in the minutes of the relevant Committee.

6.4 Record of disclosure

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

6.5 Determination to effect of matter disclosed

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

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

Subject to By-Law 6.2, the fact that a member of any Committee, is a member of a particular clinical discipline will not be regarded as a direct or indirect material personal interest, if that person participates in the Appointment process, the process to consider amendment of the Scope of Clinical Practice, or the suspension or termination of an Accredited Practitioner in the same discipline.

7. CLINICAL REVIEW COMMITTEES

7.1 Objectives

A Facility or group of SVHA Facilities will have a clinical review Committee or Committees, howsoever named, which will have the following objectives:

(a) assessment and evaluation of quality of health services including the review of clinical practices or clinical competence of persons providing those services;

(b) reviewing clinical outcomes to identify system or individual practices that impact on patient outcomes; and

(c) providing a forum for Accredited Practitioners to meet and discuss relevant clinical and administrative matters.

7.2 Functions

The clinical review and quality functions of the clinical review Committee or Committees, howsoever named, are to:

(a) review clinical indicators;

(b) review mortality and morbidity reports and make recommendations where appropriate;

(c) encourage participation in quality projects to improve patient outcomes;

(d) review adverse event trends related to clinical practice and where appropriate make recommendations;

(e) review specific cases identified as an outcome of the reviews undertaken in By-Law 7.2(a) – (d); and

(f) notify the FCEO of any identified clinical issues and risks at the Facility.

7.3 Meetings of clinical review Committee or Committees

(a) The clinical review Committee or Committees, howsoever named, must meet at least twice per year for formal quality, morbidity and mortality review meetings (**Formal Meetings**) or as otherwise required by the FCEO.

(b) A specialty review Committee or Committees, howsoever named, must meet at least twice per year and may meet at other times.

7.4 Minutes and reporting

(a) The chairperson, or his or her delegate for this purpose, must record minutes of the Formal Meetings of the clinical review committee or committees, howsoever named.

(b) Minutes recorded at Formal Meetings must be distributed to the members of the clinical review Committee or Committees, howsoever named, in a timely manner.

(c) All minutes and actions arising from the Formal Meetings are to be forwarded to the peak quality and safety Committee (howsoever named) of the Facility as determined by the FCEO.

7.5 Mandatory attendance

(a) It is a Condition of Accreditation that:

(i) all Accredited Practitioners must attend and participate in at least one Formal Meeting of the clinical review Committee or Committees, howsoever named, annually; and

(ii) where a specific case involving an Accredited Practitioner's patient has been listed for review, the Accredited Practitioner must attend the meeting and/or provide a written report.

(b) The FCEO may, on demonstration of extenuating circumstances, waive the Condition of Appointment in By-Law 7.5(a). Any condition in By-law 7.5(a) may only be waived where the FCEO has been provided with satisfactory explanation and evidence of the relevant extenuating circumstances and has waived the relevant Condition in By-law 7.5.(a) in writing.

8. APPOINTMENT OF ACCREDITED PRACTITIONERS

8.1 Application Form

Any Medical Practitioner or Dental Practitioner who wishes to apply for Accreditation, Re-accreditation or an increase in Scope of Clinical Practice at the Facility must obtain from the Facility an Application Form (and any related material, including a copy of these By-Laws) and must complete and submit the Application Form to the FCEO.

8.2 Applications for Appointment

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

(a) The FCEO will consider the application in the context of the Organisational Need and Organisational Capabilities of the Facility and may make any inquiries or consultation relevant to that consideration as he or she thinks fit. Following this consideration, the FCEO may determine to discontinue with the application process or give further consideration to the process as outlined at By-Law 8.2(b) – (n) below.

(b) The FCEO (after receiving advice from the appointments Committee) may define particular additional categories and types of Scope of Clinical Practice or limit the Scope of Clinical Practice granted, as the individual circumstances may require.

(c) Any delineation of approved Scope of Clinical Practice for the Applicant must be specifically defined on the appointment letter. Approval is granted by the FCEO.

(d) An application fee, as determined by the Facility from time to time, may be levied on applicants. The FCEO will determine if the application fee is to be levied on the Applicant. The Application Form will contain details of the application fee if applicable.

(e) The FCEO may contact up to three referees nominated by the Applicant, but receive no less than 2, to request written references and must also check the Applicant's qualifications, Professional Indemnity Insurance and Credentials (including verifying registration and current entitlement to practice). Referees must include a current supervisor at the facility or a supervisor not at the same facility but currently practicing in the same specialty as the potential appointee.

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

(g) If a referee declines to provide a written reference, the FCEO must record that fact. The FCEO may contact the Applicant and request that the Applicant nominate another referee.

(h) The FCEO may ask for advice on the application from the head of the division(s) or department(s) of the Facility most relevant to the application (where applicable).

(i) The application, with all relevant material obtained or identified under paragraphs (a) to (h), will then be considered by the appointments Committee or such equivalent Committee, and an assessment made by that Committee of the Current Fitness, Credentials, character and ability of the applicant to cooperate with management and staff at the Facility.

(j) The appointments Committee (or such other Committee as the FCEO considers appropriate) will make a recommendation to the scope of clinical practice Committee or such equivalent Committee, as to the Accreditation sought by the applicant.

(k) The scope of clinical practice Committee or such equivalent Committee, will then consider the recommendation of the appointments Committee or such equivalent Committee, and make an assessment of the Current Fitness, Credentials, character and ability to cooperate with management and staff at the Facility and will make a recommendation to the FCEO as to the Accreditation sought by the applicant.

(l) The FCEO will make a final determination on the application and will have complete discretion to approve or disapprove each application for Accreditation or Re-accreditation after following the provisions set out in By-Laws 8.2(a) to 8.2(k) (where applicable).

(m) The FCEO must notify each applicant in writing of his or her decision.

(n) On receiving notice of Appointment, the applicant will indicate his or her acceptance in writing of the Facility By-Laws, rules, regulations and also SVHA's Visions, Mission, Values and Care Statements.

8.3 **Temporary Appointment**

(a) The FCEO may approve Temporary Appointments and may grant Accreditation to such temporarily appointed Medical Practitioners or Dental Practitioners.

(b) In considering whether to approve the Temporary Appointment of a Medical Practitioner or Dental Practitioner, the FCEO may consult with the chairperson of the appointments Committee and/or the head of the division or department most relevant to the applicant's speciality.

(c) An individual seeking Temporary Appointment must submit an Application Form to the FCEO along with all required supporting documentation.

(d) Accreditation granted under this By-Law 8.3 will remain in force for a period of up to 90 days from the date of determination by the FCEO. This period can be extended at the discretion of the FCEO but the total period cannot exceed 12 months. Any extension must be approved in writing by the FCEO.

(e) Should any Medical Practitioner or Dental Practitioner granted Temporary Appointment wish to obtain Accreditation under this By-Law 8.3, that Medical Practitioner or Dental Practitioner must lodge the Application Form and supporting material with the FCEO at which time the process in By-Law 8.2 will be applied.

(f) Provisional appointment may be granted by the FCEO, after review.

(g) There will be no right of appeal in respect of the termination or suspension of a Medical Practitioner or Dental Practitioner holding a Temporary Appointment.

8.4 **Urgent Appointments**

(a) The FCEO or delegate may approve Urgent Appointments and may grant Accreditation to such urgently appointed Medical Practitioners or Dental Practitioners

(b) In considering whether to approve an Urgent Appointment the FCEO must at a minimum:

(i) Confirm registration with AHPRA

(c) (ii) Obtain a verbal reference from one other Accredited Practitioner at the facility; from a practitioner not at the same facility but currently practicing in the same specialty as the potential appointee; or from the Director of Medical Services / Chief Medical Officer at the applicants place of appointment

(d) An individual seeking or granted Urgent appointment must provide evidence of Professional Indemnity insurance within 24 hours of appointment

(e) Accreditation granted under By-Law 8.4 applies only to the specific patient or episode of care for which the accreditation is sought

(f) The FCEO will advise the Accredited Practitioner in writing of the completion of the Urgent Appointment

(g) Provision of Urgent Appointment does not grant the Accredited Practitioner the right to Temporary Accreditation

(h) There will be no right of appeal in respect to the termination of a Medical Practitioner or Dental Practitioner holding an Urgent Appointment.

8.5 Appointments made periodically

(a) Unless otherwise determined by the FCEO, Appointments to positions as Accredited Practitioners are made in accordance with the requirements of the Facility and a periodic cycle determined by the FCEO and will be for a period of:

(i) one year;

(ii) two years;

(iii) three years;

(iv) four years; or

(v) five years,

which period will be determined by the FCEO. The date of Appointment being on the date the FCEO approves the Appointment.

(b) Where Accreditation is granted and it coincides with the commencement of any periodic cycle referred to in By-Law 8.5(a), the Accreditation will be for the specified period. Where Accreditation is granted after a periodic cycle has commenced, Accreditation will be for the unexpired portion of that specified period.

(c) The periods of up to one year, two years, three years, four years or five years for the purpose of these By-Laws will begin and conclude in accordance with the sequence customary at the Facility.

9. TERMS AND CONDITIONS OF APPOINTMENT OF ACCREDITED PRACTITIONERS

9.1 Conditions applicable to all Accredited Practitioner Appointments

An Appointment as an Accredited Practitioner is conditional on the Accredited Practitioner complying with all matters and Conditions set out in this By-Law 9.

9.2 General

Accredited Practitioners must:

(a) comply with their authorised Scope of Clinical Practice;

(b) comply with the Code of Conduct and the Catholic Health Code of Ethical Standards;

(c) comply with the provisions of the Act, all applicable legislation and general law;

(d) comply with their responsibilities under the National Law in regard to mandatory notification of notifiable conduct by another practitioner or a

student undertaking clinical training where the Accredited Practitioner has formed a reasonable belief that a health practitioner has behaved in a way that constitutes notifiable conduct in relation to the practice of their profession or suffers from an impairment that may place the public at substantial risk of harm.

(e) comply with these By-Laws, rules and policies and procedures of the Facility;

(f) maintain their professional registration with AHPRA and furnish annually to the Facility when requested to do so, evidence of registration and advise the FCEO immediately of any material changes to the conditions or status of their professional registration (including suspension or termination);

(g) attend patients subject to the limits of any Conditions imposed by the FCEO;

(h) if theatre sessions have been requested by the Accredited Practitioner and allocated, then the Accredited Practitioner must effectively utilise the theatre sessions;

(i) observe all requests made by the Facility with regard to his or her conduct in the Facility and with regard to the provision of services within the Facility;

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

(k) adhere to general Conditions of clinical practice applicable at the Facility, including compliance with the accreditation standards of the National Safety and Quality Health Service Standards 2011 or such other accreditation body nominated by the Facility;

(l) observe the rules and practices of the Facility in relation to the admission, discharge and accommodation of patients;

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

(n) participate in clinical review Committee meetings, including review of clinical data and outcomes and respond to requests for information regarding statistical outliers, adverse events and cases flagged in incidents, clinical indicator or key performance indicator reporting;

(o) participate in formal on-call arrangements as required by the Facility;

(p) seek relevant approvals from the relevant Committee and, where applicable, the relevant research and ethics Committee in regard to any research, experimental or innovative treatments, including any new or revised technology (see By-Laws 20 and 21);

(q) not aid or facilitate the provision of medical or dental care to patients at the Facility by Medical Practitioners or Dental Practitioners who are not Accredited Practitioners;

(r) not purport to represent any SVHA Group Entity or SVHA in any circumstances, including the use of the letterhead of the Facility, SVHA Group Entity or SVHA, unless with the express written permission of the FCEO;

(s) subject to the requirement of relevant laws, keep confidential details of all information which comes to his or her knowledge concerning patients, clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services; and

(t) co-operate with and participate in any clinical quality assurance, quality improvement or risk management process, project or activities as required by the Facility and these By-Laws.

9.3 **Responsibility for patients**

Accredited Practitioners must:

(a) Obtain full and informed written patient consent prior to a procedure being performed;

(b) not admit a patient to the Facility unless a suitable or appropriate bed is available to accommodate that patient;

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

(d) observe the rules and requirements applicable in the Facility with respect to the admission of patients;

(e) accept full responsibility for his or her patients from admission until discharge, or until the care of the patient is transferred to another Accredited Practitioner;

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

(g) work with and as part of the multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care for Accredited Practitioners' patients;

(h) provide adequate instructions to Facility staff and other Accredited Practitioners to enable them to understand what care the Accredited Practitioner requires to be delivered to his or her patients and appropriately supervising the care that is provided by the Facility staff and other Accredited Practitioners;

(i) note the details of a transfer of care to another Accredited Practitioner on the patient's Facility medical record and communicating the transfer to the Nurse Unit Manager or other responsible nurse staff member;

(j) attend his or her patients properly, and with the utmost care and attention, after taking into account the requirements of the Facility and Scope of Clinical Practice granted to the Accredited Practitioner;

(k) visit patients with reasonable frequency having regard to each patient's clinical condition and needs;

(l) upon request by staff of the Facility, attending to patients under their care for the purposes of the proper care and treatment of those patients;

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

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

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

(p) comply with all infection control procedures of the Facility including appropriate hand hygiene; and

(q) take into account the policies of the Facility when exercising judgement regarding the length of stay of patients at the Facility and the need for ongoing hospitalisation of patients.

9.4 **Professional Indemnity Insurance**

Accredited Practitioners who are not otherwise fully indemnified by the Facility must maintain a level of professional indemnity insurance (including run off/tail insurance where appropriate) consistent with requirements of the relevant Regulatory Authority:

(a) which covers all potential liability of the Accredited Practitioner in respect of the Facility and patients;

(b) which appropriately reflects and covers the Accredited Practitioner’s Scope of Clinical Practice and activities performed at the Facility; and

(c) that is on terms and conditions acceptable to the Facility.

9.5 **Annual disclosure**

Accredited Practitioners must furnish annually to the Facility evidence of:

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

(b) medical/dental registration (as applicable); and

(c) continuous registration with the relevant specialist college or professional body

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

9.6 **Continuous disclosure**

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

(a) Credentials;

(b) Scope of Clinical Practice;

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

(d) any adverse outcomes or complications in relation to the Accredited Practitioner's patient or patients (current or former) of the Facility;

(e) Professional Indemnity Insurance status; and

(f) Registration with the relevant professional registration board, including any Conditions or limitations placed on such registration.

9.7 **Advice of material issues**

Without limiting By-Law 9.6, Accredited Practitioners must advise the FCEO in writing as soon as possible but at least within 14 days if any of the following matters occur and come to the attention of the Accredited Practitioner:

(a) an adverse finding (formal or informal, current or former) made against him or her by any registration, disciplinary, investigative or professional body;

(b) his or her professional registration being revoked, suspended or amended (including the imposition of any Conditions);

(c) the initiation of any process, inquiry or investigation by the relevant board or coroner or tribunal (or equivalent body in any other jurisdiction, as applicable) or a health care complaints body (howsoever described) involving the Accredited Practitioner or the initiation of a legal process relevant to the medical practice which impacts or arises from their practice of medicine;

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

(e) his or her Appointment to Accreditation at, or Scope of Clinical Practice at, any other facility, hospital or day procedure centre is altered in any way other than at the request of the Accredited Practitioner;

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

(g) any claim, or any circumstance which may give rise to a claim, in respect of the management of a patient of that Accredited Practitioner in the Facility (including all relevant details); or

(h) he or she being charged with, or convicted of, any indictable offence or under any laws that regulate the provision of health care or health insurance.

9.8 **Medical records**

Accredited Practitioners must:

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

(i) in compliance with the Act and any applicable codes or guidelines published by AHPRA;

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

(iii) in a way which enables the SVHA Group Entity operating the Facility to collect revenue in a timely manner and any other data reasonably required in respect of a Facility, including as a minimum:

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

(B) full and informed written patient consent;

(C) completing admission forms authorised by the Facility within 24 hours of admission;

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

(E) therapeutic orders;

(F) particulars of all procedures, including pathology and radiology reports;

(G) observations of the patient's progress;

(H) notes of any special problems or complications;

(I) discharge notes, completed discharge summary and documentation of requirements and arrangements for follow-up; and

(J) each attendance upon the patient with the entries dated, timed, signed and specifying the designation of the practitioner

(b) complete an operation report that shall include a detailed account of the findings at surgery, the surgical technique undertaken, complications and post-operative orders, and the full name of any Surgical Assistant, anaesthetist and other Medical Practitioner present. Operation reports shall be written or dictated as soon as is practicable and the report signed by the attending Accredited Practitioner and made part of the patient’s Facility medical record;

(c) ensure the provision of CMBS Item Numbers and prompt notification to the Facility of any subsequent change or addition to the Item Numbers;

(d) where orders are given by telephone to a registered nurse (who will read back those orders to the Accredited Practitioner for confirmation), enter those orders in the medical record within twenty-four hours;

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

(f) take all reasonable steps to ensure that, following the discharge of each patient, the Facility's medical record is completed within a reasonable time after the patient's discharge; and

(g) acknowledge and agree that medical records of patients of the Facility are owned by the relevant SVHA Group Entity operating the Facility.

9.9 **Continuing education**

Accredited Practitioners must:

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

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

(c) co-operate and participate in appropriate quality improvement activities, including satisfying the mandatory attendance and participation requirements of By-Law 7.5(a).

9.10 **Clinical activity**

Accredited Practitioners must maintain a sufficient level of clinical activity in the Facility to enable the FCEO, acting reasonably, to be satisfied that:

(a) the Accredited Practitioner's knowledge and skills are current;

(b) the Accredited Practitioner is familiar with the operational policy, procedures and practices of the Facility; and

(c) the Accredited Practitioner is able to contribute actively and meaningfully to the division or department relevant to his or her Scope of Clinical Practice and to the Committees.

9.11 **Participation in Committees**

(a) Accredited Practitioners must participate in the clinical review Committee or Committees, howsoever named, in accordance with By-Law 7.5(a) unless otherwise excused under By-Law 7.5(b).

(b) In addition to the requirement under By-Law 9.11(a), Accredited Practitioners must meet all reasonable requests to participate in, and contribute actively to, Committees established to co-ordinate and direct the various functions of the Facility.

(c) Without limiting By-Law 9.11(a), the FCEO may require any Accredited Practitioner to nominate him or herself to act as a member of a Committee. Before doing so, the FCEO must have regard to:

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

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

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

9.12 **Emergency/disaster planning**

Accredited Practitioners must:

(a) be aware of their role in relation to emergency and disaster planning;

(b) be familiar with the Facility's safety and security policies and procedures; and

(c) participate in emergency drills and exercises which may be conducted at the Facility.

9.13 **Working with children checks/criminal record checks**

(a) The Appointment of Accredited Practitioners is conditional on the person satisfactorily completing any forms that SVHA may require for the purpose of fulfilling SVHA's obligations under applicable child protection legislation.

(b) The Accredited Practitioner must undertake to SVHA that he or she is not a Prohibited Person, and:

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

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

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

(iv) will not engage in Reportable Conduct;

(c) The Accredited Practitioner must inform SVHA immediately if he or she is unable to give the undertakings set out in By-Law 9.13(b).

(d) Accredited Practitioners must provide authority to the Facility to conduct a criminal history check with the appropriate authorities in any jurisdiction at any time.

9.14 **Teaching and supervision**

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

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

(b) consent being given by the patient.

9.15 Notifiable Conduct and mandatory reporting

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

9.16 Notice of leave

Where Accreditation has been granted in respect of the Facility, an Accredited Practitioner must use their best endeavours to notify the FCEO in writing, at least four weeks in advance of holidays, so that the FCEO may make appropriate arrangements during the Accredited Practitioner's absence.

10. TRANSFER OF ACCREDITATION STATUS BETWEEN FACILITIES

(a) An Accredited Practitioner who is Accredited at a specified Facility may apply in writing to the FCEO of another SVHA Facility for the Accreditation to be extended to that Facility.

(b) Applications and accompanying documentation from the original Facility in which the Accreditation was approved will be submitted to the appointments Committee or such other Committee as the facility determines, of the new Facility for endorsement prior to the approval by the FCEO.

(c) Transferral of Accreditation status is not automatic, and the decision makers involved must still satisfy themselves as to the training, experience, competence, judgement, professional capabilities and knowledge, Current Fitness, Credentials, character of the applicant, Organisational Need and Organisational Capabilities.

(d) A transferral of Accreditation status can only be on the basis of the same or lesser Scope of Clinical Practice held at the original Facility (including category, type and level of Accreditation and delineation of Scope of Clinical Practice), otherwise an application must be made for an initial Accreditation.

(e) There will be no right of appeal in respect of the decision not to transfer Accreditation status between the Facilities.

11. SURGICAL ASSISTANTS

11.1 Use of Surgical Assistants

(a) Accredited Practitioners must utilise as Surgical Assistants only those Surgical Assistants whose bona fides and Credentials have been verified and approved and who have been Accredited by the FCEO in accordance with these By-Laws.

(b) Accredited Practitioners are responsible for the conduct of Surgical Assistants whilst performing procedures in the Facility.

11.2 **Accreditation**

(a) The FCEO may grant Accreditation to a Surgical Assistant after reviewing a completed Application Form and having satisfied him or herself as to the Credentials, judgement, Current Fitness and character of the Surgical Assistant.

(b) The FCEO may require the Surgical Assistant to attend an interview and/or nominate referees who can attest to those matters on which the FCEO must be satisfied under By-Law 11.2(a).

11.3 **Term of Appointment**

All Appointments made pursuant to this By-Law 11 will be made for periods determined by the FCEO.

11.4 **Appointments discretionary**

All Appointments made pursuant to this By-Law 11 are discretionary. The FCEO may terminate or suspend the Accreditation of a Surgical Assistant at any time.

11.5 **Terms and conditions**

All Surgical Assistants granted Accreditation under this By-Law 11 will:

(a) comply with the requirements and Conditions for Accreditation as set out in these By-Laws, to the fullest extent applicable to the Surgical Assistant; and

(b) agree to the requirements and undertakings set out in By-Law 9.13.

11.6 **No admitting or patient management rights**

No Surgical Assistant granted Accreditation under this By-Law 11 will be entitled to admit patients into the Facility or make decisions regarding their clinical management.

11.7 **Amending Scope of Clinical Practice**

No Surgical Assistant granted Accreditation under this By-Law 11 will be entitled to amend his or her Scope of Clinical Practice.

11.8 **Appeal**

No right of appeal will exist in respect of the termination of the Accreditation of a Surgical Assistant.

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

12.1 **Notice to Accredited Practitioner**

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

12.2 **Apply for Re-accreditation**

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

12.3 **Amendments**

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

(a) at the same time as making an application for Re-accreditation; or

(b) at any other time.

12.4 **Process**

(a) The FCEO will forward applications for Re-accreditation and/or amendments to Scope of Clinical Practice, together with all other relevant information, to the relevant Committee for review and consideration.

(b) Subject to SVHA or the relevant SVHA Group Entity policy, the processes for Re-accreditation and/or amending the Scope of Clinical Practice of Accredited Practitioners under this By-Law 12 will:

(i) include an assessment and review of the Accredited Practitioner's performance, Current Fitness, Credentials, character and ability to cooperate with management and staff at the Facility; and

(ii) be otherwise the same as for an initial Accreditation, save that By-Law 18.1 will not apply to Re-accreditation or amendments to Scope of Clinical Practice.

12.5 **Review**

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

13. INVESTIGATIONS OF CONCERNS, ALLEGATIONS OR COMPLAINTS

13.1 **Facility Chief Executive Officer may make investigations**

The FCEO may make inquiries regarding a concern raised, allegation or complaint against an Accredited Practitioner if the FCEO considers that any of the following consequences may occur:

(a) patient health or safety could be compromised;

(b) the efficient operation of the Facility could be hindered;

(c) the reputation of the Facility, an SVHA Group Entity or SVHA could be threatened;

(d) the potential loss of the Facility's accreditation or licence;

(e) the imposition of any conditions on the Facility's licence;

(f) the interests of a patient or someone engaged in or at the Facility could be affected adversely; or

(g) a law has been, or may be, contravened.

13.2 **Notice to Accredited Practitioners and procedural matters**

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

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

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

(ii) a requirement for a witness to be present at the time the Accredited Practitioner is advised and the designation of that witness, for example a senior manager at the Facility or the chairperson of a Committee where a Committee has been involved in the concern or issue to be raised with the Accredited Practitioner;

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

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

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

13.3 **Review by Facility Chief Executive Officer**

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

(a) the FCEO may decide to take no further action;

(b) if in the opinion of the FCEO the matter can be dealt with appropriately by reviewing the Accredited Practitioner's Scope of Clinical Practice, the FCEO must request a review of the Accredited Practitioner's Scope of Clinical Practice in accordance with By-Law 14;

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

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

13.4 **Committee to assess issue of concern**

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

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

(b) may invite the Accredited Practitioner to meet with the relevant Committee in person; and

(c) must provide the FCEO with its written conclusions and/or opinions in a timely manner and supported by reasons.

13.5 **Notifiable Conduct and mandatory reporting in relation to any investigation**

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

(b) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO of any mandatory reporting made under By-Law 13.5(a).

(c) The Group Chief Medical Officer must advise other SVHA facilities where the Accredited Practitioner is accredited of the notification.

(d) The Accredited Practitioner must notify other facilities where they hold accreditation of the notification.

14. REVIEW OF SCOPE OF CLINICAL PRACTICE IN LIGHT OF INVESTIGATIONS OF CONCERNS, ALLEGATIONS OR COMPLAINTS

14.1 **Surveillance of AHPRA registration database**

The FCEO will conduct periodic and active surveillance of the AHPRA registration database to ensure currency of registration and accuracy of any Conditions imposed.

14.2 **Facility Chief Executive Officer initiated internal review**

The FCEO may, at any time, direct the appointments Committee to conduct an internal review of the Accreditation previously granted to an Accredited Practitioner including an assessment if necessary of Current Fitness and Credentials of the Accredited Practitioner and following such review, the appointments Committee will make a recommendation to the FCEO, through the scope of clinical practice Committee concerning the continuation, amendment, suspension or revocation of Accreditation. The FCEO will make a final determination in relation to the matter, subject to the provisions of By-Law 19.2.

14.3 **Facility Chief Executive Officer initiated external review**

The FCEO may, at any time, direct the appointments Committee to convene to request and monitor an independent review of the Accreditation previously granted to an Accredited Practitioner including an assessment if necessary of Current Fitness and Credentials of the Accredited Practitioner and following such review, a recommendation to the appointments Committee may be made concerning the continuation, amendment, suspension or revocation of Accreditation. Such a review process will result in a recommendation to the FCEO who will make a final determination in relation to the matter, subject to the provisions of By-Law 19.2.

14.4 **Notice to Accredited Practitioners**

(a) The FCEO will advise the Accredited Practitioner in respect of whom a review is being conducted under either By-Law 14.1 or 14.2 of the commencement and substance of the review and the extent to which the Accredited Practitioner may participate in the review and that the Accredited

Practitioner will be provided with an opportunity to respond at the conclusion of the review.

(b) The FCEO will decide on all procedural matters relevant to advising the Accredited Practitioner under By-Law 14.3(a) which may include a determination on:

(i) how the review in respect of the Accredited Practitioners will be dealt with under these By-Laws;

(ii) a requirement for a witness to be present at the time the Accredited Practitioner is advised and the designation of that witness;

(iii) the extent and nature of any relevant records or documents to be provided or produced in connection with the review; and

(iv) any appropriate timeframes and format of response by the Accredited Practitioner.

(c) The Accredited Practitioner will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 14. The support person is not to participate in the process. Should the support person be a lawyer that same person must not act as a legal representative for the Accredited Practitioner.

(d) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO that the review is being undertaken under either By-Law 14.2 or 14.3.

14.5 **Action the Facility Chief Executive Officer may take following review**

Following a review under By-Law 14.2or 14.3 the FCEO may direct that the Accredited Practitioner:

(a) relinquish his or her Appointment at the Facility;

(b) cease performing surgical, anaesthetic or dental procedures or perform only defined procedures;

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

(d) practise a restricted range of medical, surgical, anaesthetic or dental procedures; or

(e) not admit or manage patients unless in consultation with another Accredited Practitioner qualified in the same field of practice,

or may apply additional Conditions to the Accredited Practitioner's Appointment.

14.6 **Notice of outcome of the review**

The FCEO must give written notice to the Accredited Practitioner where the FCEO wishes to exercise his or her rights under this By-Law 14.

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

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

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

(b) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO of any mandatory reporting made under By-Law 14 (including in relation to any action taken in relation to the Accreditation of an Accredited Practitioner under By-law 14.5).

15. SUSPENSION

15.1 **Suspension of Accredited Practitioners or the imposition of conditions by Facility Chief Executive Officer**

The FCEO may, following consultation with the relevant Committee (and/or such other persons as the FCEO considers appropriate) and the SVHA Group Chief Medical Officer and DCEO, and ensuring that any decisions made are consistent with any Condition imposed by the relevant regulatory authority:

(a) suspend all or any portion of an Accredited Practitioner's Accreditation, including the right to use the operating theatre and, if necessary, his or her Appointment; or

(b) impose Conditions on the Appointment of an Accredited Practitioner,

whenever the FCEO considers:

(c) it is in the interests of patient care and safety in the Facility;

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

(e) the behaviour or conduct of the Accredited Practitioner is such that it is unduly hindering the efficient operation of the Facility at any time;

(f) the Accredited Practitioner has breached any Conditions of Accreditation, including Conditions imposed by these By-Laws.

(g) the behaviour or conduct of the Accredited Practitioner is bringing the Facility into disrepute or otherwise damaging the reputation of the Facility;

(h) the behaviour or conduct of the Accredited Practitioner is inconsistent with the Code of Conduct, the Facility's mission statement or the Codes of Ethical Standards for Catholic Health and Aged Care Services in Australia;

(i) the Accredited Practitioner has not provided satisfactory evidence on demand of his or her professional qualifications, current registration as a Medical Practitioner or Dental Practitioner or sufficient and current Professional Indemnity Insurance;

(j) the practitioner has been found to have made a false declaration to the Facility either through omission of important information or inclusion of false information; or

(k) there are other unresolved issues in respect of the Accredited Practitioner that the FCEO considers is a ground for suspension.

15.2 **Notification of suspension decision and reasons**

(a) The FCEO must:

(i) notify the Accredited Practitioner of the decision to suspend and conditions and timeframes which will apply to reinstatement and must give reasons; and

(ii) invite a written response from the Accredited Practitioner within a timely manner of the FCEO's notification.

(b) The Accredited Practitioner will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 15. The support person is not to participate in the process. Should the support person be a lawyer that same person must not act as a legal representative for the Accredited Practitioner.

15.3 **Suspension effective immediately**

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

15.4 **Alternative arrangements for patients**

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

15.5 **Appeal rights**

Unless otherwise provided in these By-Laws, the affected Accredited Practitioner will have the rights of appeal established by these By-Laws.

15.6 **Notification to Board**

The FCEO will notify the SVHA Group Chief Medical Officer and DCEO of any suspension of Accreditation of an Accredited Practitioner. The SVHA Group Chief Medical Officer will notify the SVHA Group CEO who will notify the Board of any suspension of Accreditation of an Accredited Practitioner.

15.7 **Notifiable Conduct and Mandatory Reporting**

(a) The FCEO must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009*,* (including in relation to any suspension of Accreditation of an Accredited Practitioner under By-law 15), as enforced in each State and Territory*.*

(b) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO of any mandatory reporting made under By-Law 15.7(a).

16. TERMINATION OF ACCREDITATION

16.1 Immediate termination

Accreditation of Accredited Practitioners will be terminated immediately by the FCEO, and in consultation with the SVHA Group Chief Medical Officer and DCEO, if:

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

(b) the Accredited Practitioner ceases to be registered in the relevant profession, specialty and jurisdiction for which Accreditation has been issued;

(c) the Accredited Practitioner is convicted of an offence involving sex or violence or any offence in relation to the Accredited Practitioner's practice as a Medical Practitioner or Dental Practitioner;

(d) the Accredited Practitioner fails, refuses or is unable to comply with the requirements and undertakings set out in By-Law 9.13, or is dishonest in respect of the undertakings given in By-Law 9.13(b);

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

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

16.2 Unprofessional Conduct

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

16.3 Termination on incapacity

An Accredited Practitioner’s Appointment may be terminated if, in the reasonable opinion of the FCEO, an Accredited Practitioner becomes incapable of performing his or her duties for a continuous period of six months or for a cumulative period of six months in any 12 month period.

16.4 Termination when not immediate

Accreditation of an Accredited Practitioner may be terminated by the FCEO, in consultation with the SVHA Group Chief Medical Officer and DCEO, by giving the Accredited Practitioner 1 month written notice if:

(a) the Accredited Practitioner fails to observe the terms and Conditions of his or her Accreditation or fails to abide by these By-Laws or the Facility’s policies and procedures and fails to rectify the breach;

(b) the Accredited Practitioner, after due hearing, is considered by the FCEO to have engaged in Professional Misconduct and/or Unprofessional Conduct;

(c) the Accredited Practitioner is not considered by the FCEO as having Current Fitness;

(d) to do so would be in the interests of patient care or safety or in the interests of staff welfare or safety;

(e) the Accredited Practitioner's registration is subject to conditions which are inconsistent with his or her continuing to be appointed as an Accredited Practitioner;

(f) the Accreditation is no longer supported by the Organisational Need or Organisational Capabilities of the Facility;

(g) the Facility ceases to provide support services required within the Scope of Clinical Practice of the Accredited Practitioner;

(h) the conduct or continuing Accreditation of the Accredited Practitioner compromises the efficient operation or the interests of the Facility, SVHA Group Entity or SVHA;

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

(j) the Accredited Practitioner does not, without prior approved leave, provide services at the Facility for a period of twelve months;

(k) the Accredited Practitioner ceases to hold, in the FCEO's opinion, current and adequate Professional Indemnity Insurance; or

(l) the Accredited Practitioner has applied for a review of the suspension of his or her Accreditation under By-Law 15.5 and on review the decision to suspend is upheld.

16.5 **Notification to Board**

The FCEO will notify the SVHA Group Chief Medical Officer and the DCEO of any termination of Accreditation of an Accredited Practitioner. The SVHA Group Chief Medical Officer will notify the SVHA Group CEO who will together coordinate notification to the Board of any termination of Accreditation of an Accredited Practitioner.

16.6 **No appeal rights where immediate termination**

No right of appeal will exist in respect of immediate termination pursuant to By-Law 16.1.

16.7 **Immediate Termination at each Facility**

The immediate termination of Accreditation of an Accredited Practitioner pursuant to By-Law 16.1 at one Facility will cause the automatic termination of Accreditation at any other Facility operated or conducted by an SVHA Group Entity.

16.8 **Notifiable Conduct and Mandatory Reporting**

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

(b) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO of any mandatory reporting made under By-Law 16.8(a) (including in relation to any termination of Accreditation of an Accredited Practitioner under By-law 16).

17. IMPOSITION OF CONDITIONS

17.1 Imposing Conditions in lieu of suspension or termination

(a) In lieu of the suspension of the Scope of Clinical Practice or termination of Accreditation of an Accredited Practitioner, and ensuring that any decisions made are consistent with any Condition imposed by the relevant Regulatory Authority, the FCEO may elect to impose Conditions on the Accreditation or Scope of Clinical Practice of an Accredited Practitioner.

(b) The imposition of Conditions may be recommended by the appointments Committee or scope of clinical practice Committee, but is at the ultimate discretion of the FCEO.

(c) The FCEO must notify the Accredited Practitioner in writing of the imposition of Conditions, the reasons for it, the consequences if the Conditions are breached, invite a written response and advise of the right of appeal, the appeal process and the timeframe for an appeal.

(d) If the Conditions are breached, then suspension of Scope of Clinical Practice or termination of Accreditation of an Accredited Practitioner may occur.

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

(f) The appeal procedure contained in these By-Laws will apply to an imposition of conditions under By-law 17.

17.2 Notification of conditions

Following expiration of the appeal period, the decision to impose Conditions under these By-laws will be notified to other SVHA Facilities where Scope of Clinical Practices are held by that Accredited Practitioner, as well as notification whether an appeal has been lodged, and that other Facility may elect to ask the Accredited Practitioner to show cause why the imposition of Conditions or other action should not occur at that Facility.

17.3 Notification to Board

The FCEO will notify the SVHA Group Chief Medical Officer and the DCEO of any imposition of Conditions on the Accreditation of an Accredited Practitioner. The SVHA Group Chief Medical Officer will advise the SVHA Group CEO who will notify the Board of any imposition of Conditions on an Accredited Practitioner.

17.4 Notifiable Conduct and Mandatory Reporting

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

relation to the imposition of Conditions on the Accreditation or Scope of Clinical Practice of an Accredited Practitioner) under By-law 17.

(b) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO of any mandatory reporting made under By-Law 17.4(a).

18. APPEAL RIGHTS

18.1 No appeal rights against refusal of initial Appointment

There will be no right of appeal against a decision not to make an initial Appointment except in a public Facility and governed by relevant State legislation and/or policy.

18.2 Appeal rights generally

Except where these By-Laws state otherwise (see By-Laws 8.3(g), 11.8, 16.6, 18.1 and 23.3(b)) a Medical Practitioner or Dental Practitioner who has Accreditation in respect of the Facility and whose Accreditation is amended, made conditional, suspended, terminated, not renewed or conditionally renewed by the Facility, will have the rights of appeal set out in By-Law 19.

18.3 Concurrent appeal rights

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

19. APPEAL PROCEDURE

19.1 Appeal must be lodged in fourteen days

An Accredited Practitioner will have 14 days from the date of notification of a decision to amend, make conditional, suspend, terminate, not renew or conditionally renew his or her Appointment to lodge an appeal against the decision. Such an appeal must be in writing and be lodged with the FCEO.

19.2 Relevant Committee established to hear appeal

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

(a) the SVHA Group Chief Medical Officer;

(b) a member of the Board or a nominee of the Board who may be the DCEO;

(c) a Medical Practitioner or Dental Practitioner nominee (as appropriate) of the scope of clinical practice Committee (preferably, but not necessarily, practising in the same area of practice or speciality as the appellant); and

(d) a nominee of the appropriate professional college of the appellant.

19.3 **FCEO**

If the decision being appealed and reviewed by the appeals Committee was made:

(a) by the FCEO personally, then the FCEO must not be a member of the appeals Committee hearing the relevant appeal; or

(b) by a Designated Authority, then that Designated Authority must not be a member of the appeals Committee hearing the relevant appeal.

19.4 **Chairperson**

The chairperson of the appeals Committee will be a member of the Board or the SVHA Group Chief Medical Officer or a nominee of the Board.

19.5 **One vote per member**

(a) Each member of the Appeals Committee will have one vote; and

(b) if there is an equality of votes the chairperson shall have a casting vote in addition to a deliberative vote.

19.6 **Notice**

The appellant will be provided with appropriate notice by the appeals Committee and will have the opportunity to make a submission to the appeals Committee.

19.7 **Submissions**

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

19.8 **No legal representation**

Neither the appellant nor any party will have any legal representation at any meeting of the appeals Committee. The appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the appeals Committee.

19.9 **Chairperson determines procedure of the appeals Committee**

The chairperson of the appeals Committee will determine any question of procedure for the appeals Committee provided that it complies with the conventions of natural justice.

19.10 **Final determination of the Appeals process**

The appeals Committee will make a written recommendation to the Board, which will consider the recommendation and the processes leading to the appeals Committee's recommendation. The Board will then make a determination regarding the appeal. The determination of the Board will be final and binding.

20. RESEARCH

20.1 Approval of research

Clinical research by an Accredited Practitioner in or at the Facility may only commence if:

(a) it is to be carried out by, or under the supervision of an Accredited Practitioner within his or her field of clinical accreditation, and with appropriate research experience, as a co-investigator;

(b) the proposed clinical research is consistent with the National Health & Medical Research Council (NHMRC) Statement on Ethical Conduct in Human Research (2007) and any relevant jurisdictional legislation or guidelines;

(c) an application to carry out the proposed research is submitted using the appropriate forms – National Ethics Application Form (NEAF) or specific jurisdictional forms to facilitate the Facility's Human Research Ethics Committee (HREC);

(d) the HREC is constituted according to the NHMRC Statement on Ethical Conduct in Human Research (2007);

(e) the FCEO may delegate the facilitation of the HREC and associated research governance requirements to an appropriately qualified manager and Director of Research;

(f) clinical research may only commence after written approval from the HREC and FCEO and after all ethical and governance issues have been approved;

(g) in accordance with the NHMRC Statement on Ethical Conduct in Human Research (2007) the HREC may delegate to an appropriate subcommittee the approval for 'low risk' and 'quality assurance' studies;

(h) all clinical research will be conducted in accordance with approvals or Conditions recommended by the HREC;

(i) each Facility will ensure the appropriate insurance cover for the clinical research is in place;

(j) all clinical research must comply with relevant legislative provisions, standards and guidelines including but not limited to guardianship legislation, radiation, safety precautions and any other jurisdictional specific matters; and

(k) a fee, as determined by the Facility from time to time, may be levied for consideration of commercial research projects

20.2 Withdrawal or disapproval of research

The FCEO may withdraw permission for, or place Conditions upon, the conduct or continuation of research involving treatment of human subjects at the Facility if in his or her opinion the research:

(a) cannot be conducted by the Accredited Practitioner and/or supported by the Facility at an appropriate standard of safety and quality;

(b) is outside the authorised Scope of Clinical Practice of the Accredited Practitioner;

(c) is likely to result in damage to the reputation of the Facility or SVHA Group Entity or SVHA; or

(d) is inconsistent with good professional practice.

21. EXPERIMENTAL OR INNOVATIVE TREATMENT OR TECHNIQUES

21.1 Approval of experimental treatment or techniques

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

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

(b) the experimental or innovative treatment or technique is consistent with the Code of Conduct and with the Codes of Ethical Standards for Catholic Health and Aged Care Services in Australia;

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

(d) where appropriate, the Accredited Practitioner complies with the relevant provisions of guardianship legislation including but not limited to obtaining any necessary approvals of the relevant guardianship authority.

21.2 Approval by the FCEO

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

(b) The FCEO must have regard to Facility policy regarding the circumstances where formal review and approval of experimental or innovative treatments or techniques are required.

21.3 Ethical issues and human subjects

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

(a) the treatment or technique has been referred to and approved by the relevant ethics Committee; and

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

21.4 New Clinical Services, Procedures or Other Interventions

(a) An Accredited Practitioner who proposes to perform a New Clinical Service, Procedure or Other Intervention at the Facility must apply in writing to the FCEO for approval.

(b) The FCEO must refer the application to the relevant Committee which will advise on the safety, efficacy and role of the New Clinical Service, Procedure or Other Intervention in the context of the Facility's Organisational Need and Organisational Capabilities.

(c) The relevant Committee will advise the FCEO:

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

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

(d) The FCEO may seek additional advice about the financial, operational or clinical implications of the introduction of the New Clinical Service, Procedure or Other Intervention.

(e) The FCEO may refuse permission for the introduction of a New Clinical Service, Procedure or Other Intervention.

(f) Before approving the introduction of a New Clinical Service, Procedure or Other Intervention the FCEO must:

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

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

(iii) be satisfied that the appropriate indemnity and/or insurance arrangements are in place; and

(iv) notify the relevant Committee.

22. MANAGEMENT OF EMERGENCIES

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

(a) the available Accredited Practitioner may make appropriate arrangements for referrals for the purposes of urgent or necessary consultations or treatment and will inform the FCEO of such arrangements;

(b) the FCEO will, as soon as possible, notify the Accredited Practitioner under whose care the patient was admitted of the circumstances, of the condition of the patient and of the actions taken;

(c) the available Accredited Practitioner will advise the Accredited Practitioner under whose care the patient was admitted of the action taken;

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

23. REPUTATION OF THE FACILITY

23.1 FCEO may require cessation of certain types of procedures, advice or treatment

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

23.2 Accredited Practitioner to cease upon notice from the FCEO

On being notified by the FCEO of a requirement under By-Law 23.1, the Accredited Practitioner will immediately cease to carry out such procedures, give such advice, or recommend such treatment.

23.3 Scope of clinical practice Committee to make recommendation to the FCEO

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

(b) There is no right of appeal against a decision of the FCEO under this By-Law 23.

24. ADMISSION AND REMOVAL OR TRANSFER OF PATIENTS

24.1 All admissions subject to approval

The right of the Accredited Practitioner to admit a patient to the Facility will, at all times, be subject to approval of such admission by the FCEO. The FCEO will be entitled to refuse permission for the admission of any patient without giving a reason.

24.2 Right to request discharge or transfer of patient

(a) The right of the Accredited Practitioner to admit a patient to the Facility will, at all times, be subject to the right of the FCEO to require the removal or transfer of a patient.

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

24.3 **Facility may do all things necessary to arrange removal**

Should the Accredited Practitioner fail to make such arrangements when requested under By-Law 24.2, or fail to make adequate arrangements, the FCEO will be entitled to do all such necessary acts and things to arrange for the removal or transfer of the patient.

25. DISPUTES

25.1 **By-Laws**

Any dispute or difference which may arise as to the meaning or interpretation of these By-Laws will be determined by the SVHA Group Chief Medical Officer in consultation with the SVHA Group General Manager Corporate Governance.

25.2 **Committees**

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

26. REVISION OF BY-LAWS

(a) The Board may from time to time, following approval and recommendation from the Board Quality and Safety Committee review these By-Laws and may make, amend, suspend or rescind any By-Law.

(b) The Board must review these By-Laws not less than every five years.

27. FACILITY SCHEDULES

See following pages

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Schedule 1

Supplementary and amending By-Laws

1. For the purposes of the definition **Accreditation Classification in By-Law 2.1**, the following are the designated classifications:

   (a) Consultant Emeritus;

   (b) General Practitioner (GP);

   (c) Registrar; and

   (d) Specialist Practitioner.

2. **By-Law 2.1 Definitions** is amended by adding in the following new definitions:

   (a) **Consultant Emeritus** means a Medical Practitioner or Dental Practitioner who is recognised by the Facility as having provided distinguished service to the Facility and who has retired from active practice or is otherwise a member of the medical or dental profession of outstanding merit or extraordinary accomplishment.

   (b) **Fellow** means a Medical Practitioner who has completed their specialist training and who is yet to commence full time private practice or salaried specialist appointment. Fellows may be sponsored by an individual Visiting Medical Officer, Specialist Medical Group, Facility or University and may be contracted to undertake research, training or further postgraduate studies under the supervision of their sponsor or sponsor's appointed representative.

   Fellows may only be appointed to assist under the direction of an Accredited Specialist Practitioner who is supervising the Fellow for the treatment of their patients. Fellows may also assist an Accredited Specialist Practitioner with operations or procedures performed in the Operating Room, Procedure Room or Laboratory. Fellows shall not have admitting direct rights to the Facility and shall not be eligible to vote or stand for office of any committee or group established under these By-laws.

   (c) **General Practitioner means** a medical practitioner registered with the Medical Board of Australia and recognised as holding specialist qualification in the field of general practice. General practitioners shall not have direct admitting rights to the facility.

   (d) **Registrar** means a Medical Practitioner who holds a registrar position at a teaching hospital in New South Wales or is in an accredited training position at a non-teaching or private hospital. Registrars may only be appointed to assist with the treatment of patients under the care of a Specialist Practitioner who is supervising the Registrar. Registrars shall not have admitting rights to the Facility and shall not be eligible to vote or stand for office of any committee or group established under these By-laws.

(e) **Specialist Practitioner** means an Accredited Practitioner who is:

(i) recognised as a specialist for the purposes of the Health Insurance Act 1973 (Cth); and

(ii) is appointed by the Board in the category of Specialist Practitioner

3. **By-Law 2.2 General Interpretation** is amended by:

Act means the *Private Hospitals and Day Procedure Centres Act 1988 (*NSW) and on commencement, the *Private Health Facilities Act 2007* (NSW)

Schedule 2

Committees - Terms of Reference

1. **Name of committee**
   Medical Advisory Committee

2. **Governing body**
   St Vincent's Health Australia Limited

3. **Facility**
   Mater Hospital

4. **Authority to establish committee**
   The Facility Chief Executive Officer (FCEO) is responsible for the overall governance of the Mater Hospital. To ensure effective governance in an efficient manner the FCEO will establish committees to undertake various governance functions of the FCEO in relation to the appointment, credentialing and definition of scope of clinical practice and to report to the FCEO on committee work.

5. **Purpose of committee**
   This is the senior advisory committee on clinical matters to the Facility and provides representation to the FCEO on behalf of Accredited Practitioners to ensure optimal standards of patient care and adequate communication between Accredited Practitioners and the FCEO to ensure safe and high quality provision of care for patients.

6. **Role and functions**
   The Medical Advisory Committee is an advisory to the FCEO and shall:

   (a) adhere to the Mission and Values of SVHA

   (b) act in an advisory role to the FCEO and the Hospital Executive

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

   (d) establish appropriate sub-committees, receive and, where necessary, act upon their reports

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

   (f) provide a means whereby Accredited Practitioners can advise the Facility of appropriate policies regarding the clinical organisation of the Facility

   (g) contribute to the development of continuing education programs and promote undergraduate and post-graduate medical education and research

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

   (i) endeavour to ensure that the delivery of patient care in the Facility is maintained at an optimal level based on current best clinical practice and research

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

(k) consider the recommendations of the Appointments and Credentialing Committee in relation to applications for appointment as Accredited Practitioners, amendments and or termination of Scope of Clinical Practice in accordance with these By-Laws

(l) at the direction of the FCEO, establish a sub-committee to enquire into any question that may arise with respect to the Current Fitness of an Accredited Practitioner to maintain that Accreditation and, having considered the report of that sub-committee, make a recommendation to the FCEO with regard to any action that might be taken

(m) review any research or experimental or innovative treatment or techniques and make a recommendation on any necessary amendment of the scope of clinical practice of an Accredited Practitioner

(n) pursuant to Private Health Facilities Act 2007 No 9 (NSW), provide advice to the Director-General of NSW Health in relation to any persistent failure by the Facility to act on the advice of the MAC on matters for which the MAC has responsibility

7. Composition

Membership of the Medical Advisory Committee will be at least 5 representatives from the specialty or craft groups, plus the FCEO, Medical Director, Director of Clinical Operations and Director(s) of Nursing. The FCEO or Medical Director, maintains the discretion to appoint members to the Medical Advisory Committee.

8. Meetings

(a) **Frequency**

The Committee shall meet at least four (4) times per year, however may meet more frequently.

(b) **Notice of meetings**

The Committee secretary will provide a minimum of two week's notice of the next meeting.

(c) **Committee papers**

Minutes shall be distributed to all members of the Medical Advisory Committee prior to the next meeting.

(d) **Quorum**

A quorum for the meeting is 50% plus one of the Committee membership

(e) **Declaration of conflict of interest**

Members of the Medical Advisory Committee are expected to comply with item 6 of the SVHA By-Laws. Members will be invited to declare any conflict of interest at the beginning of each meeting.

(f) **Voting**

Where a vote is required, the Committee will comply with item 2.2(f) of the SVHA By-Laws. Voting will be on a majority basis and only by those in attendance at the meeting. There will be no proxy votes.

(g) **Minutes**

(a) Minutes of all meetings of the Medical Advisory Committee shall be recorded by the FCEO or delegate

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

(c) No business shall be considered at a meeting of the Medical Advisory Committee until the minutes of the previous meeting have been confirmed or otherwise disposed of

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

9. Term of office

Members of the Medical Advisory Committee will be appointed for a term of two years. The FCEO may, at his or her discretion, determine to extend the members' term of appointment on whatever conditions the FCEO believes appropriate.

10. Appointments

(a) **Appointment of chair/co-chair**

The Chairperson of the Medical Advisory Committee shall be elected for a term of two years from amongst the Accredited Practitioner members of the Committee.

(b) **Appointment of committee secretary**

The Secretariat will be nominated by the FCEO.

11. Training of members

The FCEO or delegate will be responsible for training Medical Advisory Committee members to the credentialing process and their responsibilities.

12. Establishment of sub-committees

Each Medical Advisory Committee will have a minimum of two sub-committees. These include:

(a) One Credentials Committee

(b) One Clinical Review Committee

Other sub-committees may include:

(c) Infection control

(d) Operating room & anaesthetic advisory committees

(e) Drug & therapeutics

(f) Medical education

(g) “Ad hoc” committees as required from time to time.

13. Assessment of committee performance

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

14. Reporting arrangements

The committee formally reports to the FCEO.

15. Review of Terms of Reference

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

SCHEDULE 2

Committees - Terms of Reference

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

2. **Governing body**
   St Vincent's Health Australia Limited

3. **Facility**
   Mater Hospital

4. **Authority to establish committee**
   The FCEO is responsible for the overall governance of Mater Hospital. To ensure effective governance in an efficient manner the FCEO will establish committees to undertake various governance functions of the FCEO in relation to the appointment, credentialing and definition of scope of clinical practice and to report to the FCEO on committee work.

5. **Purpose of committee**
   The purpose of this Committee is to review and make recommendations to the Medical Advisory Committee on formal applications for the granting of Scope of Clinical Practice in line with legislative requirements and SVHA policy at Mater Hospital.

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

   6.1. adhere to the mission and values of St Vincent's Health Australia

   6.2. ensure that applicants are appropriately qualified for appointment or re-appointment as Accredited Practitioners consistent with the terms and conditions set out in the SVHA Model By-Laws

   6.3. consider applications and determine the scope of clinical practice and make recommendations thereon to the Medical Advisory Committee in accordance with the Hospital's By-Laws

   6.4. consider applications by an Accredited Practitioner for the amendment of his or her Scope of Clinical Practice and following due consideration make a recommendation to the Medical Advisory Committee as to the amendments sought

   6.5. review any new or amended use of technology or procedures to treat patients including assessing the infrastructure of the Facility and other matters which are relevant, and make a recommendation on the amendment of the scope of clinical practice of an Accredited Practitioner to the Medical Advisory Committee.

7. **Composition**
   The membership of the Medical Credentialing Committee shall consist of at least five (5) members:
   - Chairman of the Medical Advisory Committee
   - Medical Director (where applicable)
   - Accredited Practitioners from Divisions / Departments of the Facility as determined by the FCEO and on the advice of the Medical Advisory Committee

- The FCEO (ex-officio)
- The Director of Nursing (ex-officio)

Other members may be co-opted as the Committee deems necessary.

The committee may co-opt the services of any other person should it consider this necessary. That person shall not have voting rights at any meeting of the Appointment and Credentialing Committee.

8. Meetings

8.1. Frequency

Ordinary meetings of the Appointments and Credentialing Committee shall not be held less than four times per year. Additional meetings, including special meetings, will be held as is deemed necessary to review formal applications for visiting privileges of Accredited Practitioners.

8.2. Notice of meetings

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

8.3. Committee papers

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

8.4. Quorum

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

8.5. Declaration of conflict of interest

Members of the Appointments and Credentialing Committee are expected to comply with item 6 of the SVHA By-Laws. Members will be invited to declare any conflict of interest at the beginning of each meeting.

8.6. Voting

Where a vote is required, the Committee will comply with item 2.2(f) of the SVHA By-Laws. Voting will be on a majority basis and only by those in attendance at the meeting. There will be no proxy votes.

8.7. Minutes

The Appointment and Credentialing Committee, as a sub-committee of the Medical Advisory Committee, will report and make recommendations to the Medical Advisory Committee in respect of the appointment and re-appointment of Accredited Practitioners

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

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

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

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

9. Term of office

The term of office of members will be for two years or the Accredited Practitioner members' term on the Medical Advisory Committee.

10. Appointments

10.1. **Appointment of chair / co-chair**

The Chairperson of the Appointment and Credentialing Committee shall be elected for a term of two years from the Accredited Practitioner members of the committee

10.2. **Appointment of committee secretary**

The Secretariat will be nominated by the FCEO

10.3. **Appointment of members**

The Accredited Members of the Appointment and Credentialing Committee shall be drawn from the Medical Advisory Committee or at the invitation of the FCEO

11. Training of members

The FCEO or delegate will be responsible for training Appointments and Credentialing Committee members to the credentialing process and their responsibilities.

12. Assessment of committee performance

Committee performance will be assessed regularly through review of meeting minutes by the Medical Advisory Committee and annually through formal review by the Medical Advisory Committee.

13. Reporting arrangements

The committee formally reports to the Medical Advisory Committee.

14. Review of Terms of Reference

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

Schedule 2

Committees - Terms of Reference

1. **Name of committee**
   Patient Care Review Committee / Clinical Review Committee (or however named)

2. **Governing body**
   St Vincent's Health Australia Limited

3. **Facility**
   Mater Hospital.

4. **Authority to establish committee**
   The FCEO is responsible for the overall governance of Mater Hospital. To ensure effective governance in an efficient manner the FCEO will establish committees to undertake various governance functions of the FCEO in relation to clinical review and clinical quality improvement.

5. **Purpose of committee**
   The purpose of the Committee is to provide oversight of clinical governance for the specialty or service area of the Facility and maintain ongoing review of clinical activities and thus effect continual improvements to ensure safe and high quality provision of care for patients. Functions include:

   5.1. Support the organisation's safety and quality culture

   5.2. Advise on structures and processes to ensure appropriate standards of patient care are met

6. **Role and functions**
   The duties of the Patient Care Review Committee / Clinical Review Committee are to:

   6.1. Adhere to the mission and values of St Vincent's Health Australia

   6.2. Ensure formal programs of clinical review, including monitoring and evaluation of clinical outcomes with the use of clinical indicators and other benchmarking data is undertaken as recommended by the Australian Commission on Safety and Quality in Health Care (ACSQHC) National Safety and Quality Health Service Standards and SVHA policy.

   6.3. Promote clinical review in all areas of clinical practice including the monitoring of patient care, morbidity and mortality through review of deaths and relevant complications arising from patient care within the Facility

   6.4. Review all SAC 1 incidents to ensure appropriate investigation and action has been undertaken, including management of issues of related to professional or individual competence

   6.5. Recommend and / or review any Root Cause Analyses / investigation conducted by the hospital as a result of a serious adverse event

   6.6. Monitor and review any cases referred to the Coroner

6.7. Monitor and evaluate the incidence of complications according to disease and operations classification data and identify and report on any particular evident trends which may require further action

6.8. Ensure strong links with other hospital committees within the organisation to enable sharing of information and presentation to enable implementation of organisational wide risk management strategies

6.9. To recommend action to be taken where problems or opportunities relating to improvement of patient care are identified.

6.10. To evaluate the effectiveness of actions taken and provide feedback to Accredited Practitioners and other stakeholders on results of activities through education and other programs.

7. Composition

The membership of the Clinical Review Committee shall consist of Accredited Practitioners, Facility staff, including members of the Quality and Risk team, and Facility Executive. The Committee may co-opt the services of any other person at its discretion.

8. Meetings

8.1. **Frequency**

The Committee shall meet at least four (4) times per year.

8.2. **Notice of meetings**

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

8.3. **Committee papers**

Committee papers will be distributed at least 7 days before the scheduled meeting.

8.4. **Quorum**

A quorum will consist of at least 50% of members including two (2) Accredited Practitioners.

8.5. **Declaration of conflict of interest**

Members of the Clinical Review Committee are expected to comply with item 6 of the SVHA By-Laws. Members will be invited to declare any conflict of interest at the beginning of each meeting.

8.6. **Voting**

Where a vote is required, the Committee will comply with item 2.2(f) of the SVHA By-Laws. Voting will be on a majority basis and only by those in attendance at the meeting. There will be no proxy votes.

8.7. **Minutes**

The Patient Care Review Committee / Clinical Review Committee (or however named), as a sub-committee of the Medical Advisory Committee, will report and make recommendations to the Medical Advisory Committee

8.7.1. Minutes of all meetings of the Patient Care Review Committee / Clinical Review Committee (or however named) shall be recorded by the Minute Secretary

8.7.2. Minutes shall be distributed to all those entitled to attend meetings of the Patient Care Review Committee / Clinical Review Committee (or however named) within fourteen days of each meeting

8.7.3. No business shall be considered at a meeting of the Patient Care Review Committee / Clinical Review Committee (or however named) until the minutes of the previous meeting have been confirmed or otherwise disposed of. No discussion of the minutes shall be permitted except as to their accuracy

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

9. Term of office

Members of the Patient Care Review Committee / Clinical Review Committee (or however named) will be for two years. The Chairperson may, in his or her discretion, determine to extend the members' term of appointment on whatever conditions are deemed appropriate.

10. Appointments

10.1. **Appointment of chair/co-chair**

The Chairperson of the Patient Care Review Committee / Clinical Review Committee (or however named) will be elected from one of the Accredited Practitioners on the committee. The term of the appointment will be for two years

10.2. **Appointment of committee secretary**

The Secretariat will be nominated by the FCEO

10.3. **Appointment of members**

Appointment of Accredited Practitioner members will be by invitation

11. Training of members

The FCEO or delegate will be responsible for training Appointments and Credentialing Committee members to the credentialing process and their responsibilities.

12. Establishment of sub-committees

The Patient Care Review Committee / Clinical Review Committee (or however named) may establish, suspend or disband any ad hoc or standing sub-committee as required to review and evaluate specific aspect of patient care and hospital services.

Each sub-committee will report to the Patient Care Review Committee / Clinical Review Committee (or however named). Recommendations made by the sub-committees will be reviewed by the Patient Care Review Committee / Clinical Review Committee (or however named) at their next meeting

13. Assessment of committee performance

Committee performance will be assessed regularly through review of meeting minutes by the Medical Advisory Committee and annually through formal review by the Medical Advisory Committee.

14. Reporting arrangements

The Patient Care Review Committee / Clinical Review Committee (or however named), as a sub-committee of the Medical Advisory Committee, will report and make recommendations to the Medical Advisory Committee

15. Review of Terms of Reference

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