Friendly Society Private Hospital
Leading Healthcare for the Wide Bay

FRIENDLY SOCIETY PRIVATE HOSPITAL

Health Practitioner By-Laws

Effective Date
03 February
2026

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1. Preface

The Friendly Society Private Hospital is a not-for-profit organisation and part of the Bundaberg Friendly Society Medical Institute Limited. The Hospital has been an integral part of the Bundaberg community since 1946.

The Board of Directors of the Bundaberg Friendly Society Medical Institute Limited are responsible for the overall stewardship, strategic direction, governance and performance of the Friendly Society Private Hospital.

The Board has approved these By-laws for the health care professionals and the delegations as detailed within these By-laws.

2. Mission & Values

Vision

To be the Hospital of Choice for Friendly, Quality Health Care

Values

The following four CORE values communicate essential principles which drive our organisation to meet our mission.

Collaboration
We work together, recognising the contributions of everyone, to build a supportive workplace that produce the best health outcomes.

Openness
We are inquisitive and seek to understand new perspectives to learn, grow and continuously improve. We communicate transparently, prioritising honesty and open communication to build a safe and inclusive workplace that values diverse experiences.

Respect
We value one another and recognise that everyone has talents, ideas and skills to contribute. We are considerate and listen to understand.

Empowerment
We are trusted and enabled to take ownership of our work and goals, made decisions and contribute our unique talents and ideas to advance the Friendlies and ourselves as individuals.

These values should be used to guide the application of the By-laws.

Part A – Definitions and introduction

3. Definitions and interpretation

3.1 Definitions

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

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

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

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

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

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

Allied Health Privileges means the entitlement to provide treatment and care to Patients as an Allied Health Professional within the areas approved by the CEO in accordance with these By-laws.

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

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

Board means the Board of Directors of the Facility.

By-laws means these By-laws.

Chief Executive Officer (CEO) means the person appointed to the position of CEO, or equivalent position by whatever name, of the Facility or any person acting, or delegated to act, in that position.

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

Code of Conduct means the relevant code of conduct in place at the Facility relating to conduct and behaviour, however named.

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

Credentialling means, in respect of a person who applies for Accreditation or Re-Accreditation, is the formal process used to match the skills, experience and qualifications to the roles and responsibilities of that position. This will include actions to verify and assess the applicant's Credentials, including the identity (to the required level of identity assessment that may be specified in the relevant policy and procedure), education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees / awards / fellowships / certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, and other skills/attributes (for example in leadership, research, education, communication, teamwork), for the purpose of forming a view about the applicant's Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care to the standard required by the Facility and with respect to the Scope of Practice sought.

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

Current Fitness is the current fitness required of an Accredited Practitioner to carry out the Scope of Practice sought or currently held. Subject to compliance with relevant legislative requirements, a person is not to be considered as having Current Fitness if that person suffers from a physical or mental impairment, restriction, limitation, disability, condition, disorder or deterioration (including due to alcohol or drugs) which detrimentally affects, is likely to detrimentally affect or presents a reasonable risk of impacting on the person's capacity to provide health services at the expected level of safety and quality.

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

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

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

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

Facility means the Friendly Society Private Hospital (**FSPH**) located at 19-23 Bingera Street, Bundaberg QLD 4670, owned and operated by the Bundaberg Friendly Society Medical Institute Limited

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

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

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

New Clinical Service means clinical services, treatments, procedures, techniques, instruments, therapeutic drugs / medicines, therapeutic goods, medical devices, technology, products or other interventions that are being introduced by an Accredited Practitioner into the organisational setting of the Facility for the first time, or if currently used by the Accredited Practitioner are planned to be used in a different way or for something other than its registered or approved purpose. Further, the definition extends to a technology proposed to be used by an Accredited Practitioner directly or indirectly in the care of a Patient (including as a communication tool or that will use / store/ transmit Patient health information, images or data), that is introduced into the organisational setting of the Facility for the first time, or if currently used by the Accredited Practitioner is planned to be used in a different way or for something other than its registered or approved purpose, which is not currently the subject of a Facility policy for use. Such technologies include but are not limited to mobile devices, mobile health apps, analytical, decision-making and support tools.

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

Organisational Need means the extent to which the Facility considers it necessary to provide a specific clinical service, procedure or other intervention, or elects to provide additional resources to support expansion of an existing clinical service, procedure or other intervention, to provide a balanced mix of safe, high quality health care services that meet Facility, consumer and community needs and aspirations. Organisational Need may be determined by factors including, but not limited to, the allocation of limited resources, funding, the strategic direction of the Facility, clinical services plans, business and operational plans and any applicable clinical service capability framework.

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

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

Professional Conduct means behaving in a way that promotes professional and personal integrity that is consistent with relevant Codes of Conduct and supports the Facility's approach to meeting Behavioural Standards.

Re-Accreditation means the process provided in these By-laws by which a person who already holds Accreditation may apply for and be considered for Accreditation.

Scope of Practice means the extent of an individual Accredited Practitioner's permitted Clinical Practice within the Facility based on the individual's Credentials, Competence, Performance, Current Fitness and professional suitability, and as aligned to Organisational Capability and Organisational Need. Scope of Practice may also be

referred to as delineation of clinical privileges and is subject to a formal approval by the Facility.

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

Suspension means a temporary pause of an Accredited Practitioner's Accreditation imposed pursuant to By-Law 12.1, during which the Accredited Practitioner cannot attend the Facility premises (unless specific permission is provided by the CEO), cannot undertake Clinical Practice, cannot exercise Scope of Practice, cannot provide services at the Facility and cannot be involved in the care of Facility Patients (including a restriction on providing instructions or supervision to others).

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

Termination means the conclusion of an Accredited Practitioner's Accreditation at the Facility imposed pursuant to By-Law 12.2, the consequence of which is that the Accredited Practitioner is no longer an Accredited Practitioner, cannot attend Facility premises for Patient care, cannot undertake Clinical Practice, cannot exercise Scope of Practice, cannot provide services at the Facility and cannot be involved in the care of Facility Patients (including a restriction on providing instructions or supervision to others).

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

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

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

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

3.2 Interpretation

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

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

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

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

3.3 Meetings

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

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

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

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

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

Resolutions may be adopted by means of a circular resolution.

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

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

4. Introduction

4.1 Purpose of this document

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

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

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

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

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

Part B – Terms and conditions of Accreditation

5. Compliance Obligations of Accredited Practitioners

5.1 Professional and Compliance obligations

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon the following requirements:

(a) Complying with the entirety of the requirements set out in the By-laws at all times.

Any non-compliance with the By-laws may be grounds for Suspension, Termination and/or imposition of conditions.

As an alternative to Suspension, Termination or imposition of conditions, the CEO or delegate may decide that the circumstances require a different approach. This may involve agreement with the Accredited Practitioner on actions to take or failing agreement a direction will be given by the CEO or delegate to the Accredited Practitioner. If the agreement or direction is not complied with, this will be a breach of the By-laws and the CEO or delegate may decide to suspend or terminate Accreditation based upon breach of the agreement or direction.

(b) Complying with all policies, procedures, processes, guidelines, work instructions, clinical pathways, forms and clinical systems of the Facility.

(c) Complying with all relevant legislation, regulations and directions (however named or described).

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

(d) Complying with all requirements regarding infection or disease prevention and control, and requirements relating to vaccination (including vaccination status and undergoing vaccination).

(e) Assisting the Facility to comply with any Commonwealth or State mandated service capability frameworks, licensing requirements or minimum standards applying to the Facility.

(f) Maintaining registration with AHPRA, the Medical Board of Australia (MBA) or Dental Board of Australia (DBA) that is sufficient for the Scope of Practice granted.

(g) Maintaining adequate professional indemnity insurance to the satisfaction of the Facility.

(h) Providing evidence annually, or at other times upon request, of adequate professional indemnity insurance and registration with AHPRA, and all other relevant licences or registration requirements for the Scope of Practice granted.

If further information is requested in relation to insurance or registration, the Accredited Practitioner will assist to obtain that information, or provide written permission for the Facility to obtain that information directly.

(i) Ensuring that all activities undertaken in any consulting rooms on Facility premises or that are associated with the Facility are compliant with relevant By-laws, policies, protocols and the Values.

(j) Providing evidence annually (or upon request) of currency of compliance with continuing professional development requirements of the relevant College.

If requested, the Accredited Practitioner will provide further information on continuing professional development activities.

(k) Providing in a timely manner such information and documentation as required by the Facility to assess suitability for ongoing Accreditation and to practice.

(l) Not charging excessive fees which fall outside what is considered reasonable by peers of the relevant discipline or the CEO .

For the avoidance of doubt, and without limiting the generality of this By-law, the Board and CEO considers the raising of fees by an Accredited Practitioner which are in all the circumstances manifestly excessive, without reasonable excuse, to be contrary to generally accepted standards of ethics and Professional Conduct.

In addition to any other mechanisms to manage this issue available pursuant to these By-laws, the CEO may require the Accredited Practitioner to justify and provide evidence that the fees are not excessive. If the Accredited Practitioner fails to do so without reasonable excuse to the satisfaction of the CEO or delegate, this may be regarded as a failure to adhere to standards of ethical and Professional Conduct as required by these By-laws.

(m) Not treating at the Facility a member of the Accredited Practitioner's immediate family.

(n) Not facilitating, engaging, or using the services of a Medical or Health Practitioner or any other person at the Facility who does not hold Accreditation.

5.2 Operational obligations

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon compliance with the following requirements:

(a) Efficient use of resources, including facilities, theatres and support services.

(b) Adhering to all expectations and requirements relating to established specialty craft or peer groups applicable to that Accredited Practitioner (including attendance at meetings and active participation in required activities), unless exempted by the CEO.

(c) Maintaining a sufficient level of clinical activity to enable the CEO to be satisfied that:

(i) the Accredited Practitioner’s knowledge and skills are current; and

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

Note: The level of clinical activity or volume may be specified in written communication to the Accredited Practitioner.

Note: The activity of an Accredited Practitioner will be reviewed at Re-Accreditation and may be reviewed at any time during their Accreditation.

(d) Contributing to the growth and development of the Facility through actions or activities as reasonably requested from time to time.

(e) Not representing or purporting to communicate on behalf of the Facility, in any circumstances, including through engagement with media or social media, or through the use of Facility letterhead, use of Facility

registered trademarks or use of the name “Friendly Society Private Hospital” in business names (registered or unregistered), unless with the express written permission of the CEO .

5.3 Education and Training obligations

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon compliance with the following requirements:

(a) Contributing to the education, training and supervision of students, junior Medical Practitioners and other appointed health practitioners as required from time to time. This may include:

(i) facilitating the availability of Patients for clinical teaching (subject to Patient consent);

(ii) supporting tutorials and bed-side teaching.

(b) Providing in a timely manner such information and documentation as required by the Facility to remain compliant with legislative and regulatory requirements and to meet Organisational Needs.

(c) Remaining compliant with mandatory training as determined by the CEO and in respect to the National Safety and Quality Health Service Standards.

5.4 Research obligations

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon compliance with the following requirements:

(a) No research will be undertaken without the prior approval of the CEO and the Human Research Ethics Committee (where required), following submission of an application by the Accredited Practitioner in the required form and with all required information.

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

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

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

(e) Research conduct will occur in accordance with Facility policies, standard operating procedures and research governance requirements, with any breach or potential breach, including arising from the possibility of a research integrity matter or misconduct, to be immediately reported to the CEO.

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

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

5.5 New Clinical Service obligations

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon compliance with the following requirements:

(a) Accredited Practitioners proposing to introduce, provide or use a New Clinical Service will provide the CEO with supportive evidence to the satisfaction of the CEO.

(b) Supportive evidence referred to in (a) above will depend on the specific circumstances, and will be compliant with any policy and procedures of the Facility.

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

(d) Before treating patients with respect to a New Clinical Service:

  (i) written approval of the CEO must be obtained;

  (ii) what is proposed must fall within the Accredited Practitioner's Scope of Practice or an amendment to Scope of Practice must firstly be approved;

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

  (iv) if there is a risk to the Facility, then confirmation must be received that the insurance arrangements of the Accredited Practitioner will extend insurance coverage.

(e) The Accredited Practitioner must provide evidence of adequate professional indemnity insurance (where appropriate) to cover their own potential liability, and if requested, evidence that Medicare and private health funds will adequately fund the New Clinical Service.

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

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

(h) The Accredited Practitioner must update the CEO or delegate on the outcomes and benefits of implementation of the New Clinical Service as reasonably requested by the CEO.

(i) Following consideration of the reported outcomes and benefits referred to in (h) above, the CEO may withdraw approval for the continuation of the New Clinical Service, or may impose restrictions, with there being no right of appeal from this decision.

5.6 Conduct and Behavioural obligations

Accreditation of an Accredited Practitioner shall be conditional upon the practitioner maintaining a high standard of Professional Conduct and behaviour, and the Accredited Practitioner must at all times conduct themselves and behave at all times in accordance with:

(a) Standards of ethical and Professional Conduct outlined in the Good Medical Practice: A Code of Conduct for Doctors in Australia, published by the Medical Board of Australia;

(b) Standards of ethical and Professional Conduct outlined in specialty college standards and guidelines (however described) applicable to that Accredited Practitioner;

(c) the Values;

(d) Facility Codes of Conduct, policies, protocols and guidelines;

(e) The Behavioural Standards (as defined in these By-laws);

(f) Applicable laws relating to conduct and behaviour; and

(g) Specific requests and directions made with regard to conduct and behaviour.

Note: While standards of Professional Conduct and behaviour may be specified in a Facility Code of Conduct, policy, protocol or guideline, the process to manage non-compliance for an Accredited Practitioner is set out in these By-laws.

Note: If a ***first and final written warning*** has been given (noting that there is no requirement to do so before taking action pursuant to the By-laws), and further non-compliance with Professional Conduct and behaviour requirements occurs, the action taken pursuant to these By-laws will likely be significant and unless specific circumstances exist more likely will result in Termination of Accreditation.

5.7 Notifications and Continuous Disclosure obligations

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon compliance with the following requirements:

Notification Obligations

(a) Notifying the CEO immediately, and following up with written confirmation within 2 days, should:

(i) the Accredited Practitioner be made aware of a notification, complaint, investigation or process that has been commenced in relation to the Accredited Practitioner or in relation to the Accredited Practitioner's provision of patient care or research conduct. This notification obligation extends to a notification, complaint, investigation or process commenced by the Accredited Practitioner's registration board, AHPRA, Office of Health Ombudsman, disciplinary body, Police, Coroner (excluding reportable deaths where the Coroner is able to advise that a cause of death certificate will be issued and no further action is to be taken by the Coroner), a health complaint body, or another statutory authority, State or Government agency or any other relevant body/organisation. The notification obligation is irrespective of whether this relates to a Patient of the Facility or conduct at the Facility;

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

(iii) they are involved in a serious incident at a Facility or service operated by the Facility;

(iv) there be a serious clinical incident involving a Patient under the care of the Accredited Practitioner at a Facility or service operated by the Facility;

(v) the Accredited Practitioner receive a written complaint from a Patient of the Facility or person lodging a complaint on behalf of the Patient;

(vi) the Accredited Practitioner has been served with a compensation claim (including a pre-proceeding notification) in relation to a Patient of the Facility;

(vii) The Accredited Practitioner receive communication from a private health insurance fund, Medicare or Professional Services Review in relation to concerns or an investigation relating to services provided to a Patient of the Facility;

(viii) any finding (including but not limited to criticism or adverse comment about the care or services provided or research undertaken by the Accredited Practitioner) be made in relation to or against the Accredited Practitioner by a civil court, the Accredited Practitioner's registration board, AHPRA, disciplinary body, Coroner, a health complaints body including the Office of Health Ombudsman, or another statutory authority, State or Government agency, or any other relevant body/organisation. The notification obligation is irrespective of whether this relates to a Patient of the Facility or conduct at the Facility;

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

(x) the Accredited Practitioner's accreditation with a professional college as a supervisor and/or membership of a professional association be denied/withdrawn/restricted/made conditional in circumstances relevant for their Accreditation;

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

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

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

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

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

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

(xvii) the Accredited Practitioner make a mandatory notification to AHPRA in relation to another Accredited Practitioner of the Facility;

(xviii) there be, or arise, any matters which have a material bearing upon their Credentials, Scope of Practice, or ability to deliver health care services to Patients safely;

(xix) they develop or become aware of an actual, potential, or perceived conflict of interest with the Facility, be it financial, commercial, legal, or professional; or

(xx) there arise any other matter or circumstance that has or may be reasonably expected to have a material bearing upon their eligibility to be appointed under these By-laws.

Continuous Disclosure Obligations

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

(i) any of the matters notified or that ought to have been notified in paragraph 5.7(a) above;

(ii) the Accreditation of the Accredited Practitioner;

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

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

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

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

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

(viii) the reputation of the Facility; or

(ix) subject to restrictions relating to or impacting upon legal professional privilege or statutory obligations off confidentiality, the commencement, progress and outcome of compensation claims, coronial investigations or inquests, police investigations, patient complaints (where the Accredited Practitioner seeks professional advice or notifies an insurer), health complaints body complaints or investigations including by the Office of Health Ombudsman, or other inquiries involving Patients of the Accredited Practitioner that were treated at the Facility or another health care organisation where accreditation or appointment is held.

5.8 Confidentiality obligations

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon compliance with the following requirements:

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

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

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

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

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

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

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

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

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

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

(ii) where disclosure is required by law;

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

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

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

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

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

(e) The confidentiality requirements continue with full force and effect after the Accredited Practitioner ceases to hold Accreditation.

(f) Accredited Practitioners acknowledge that in order for the Facility to properly function, effective communication is required, including between the Board, CEO , Facility Executive, Committees of the Facility, staff of the Facility and other Accredited Practitioners. Accredited Practitioners acknowledge and consent to communication between these persons and entities of information, including their own personal information that may otherwise be restricted by the *Privacy Act*. The acknowledgment and consent is given on the proviso that the information will be dealt with in accordance with obligations pursuant to the *Privacy Act* and only for proper purposes and functions.

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

(h) Confidentiality requirements prohibit the recipient of the confidential information from using it, copying it, disclosing it, or reproducing it to disclose to another person or to be made available to the wider public.

(i) Confidentiality requirements continue with full force even after the Accredited Practitioner ceases to hold Accreditation at the Facility.

6. Clinical Governance, Safety, Quality and Clinical Obligations

6.1 Clinical Governance, Safety and Quality obligations of Accredited Practitioners

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon compliance with the following requirements and expectations:

(a) Actively assisting the Facility to comply with clinical governance requirements, safety and quality initiatives, performance objectives, policies, procedures and frameworks.

Note: This includes but is not limited to hand hygiene, infection prevention and control, medication prescribing, safety in surgery, clinical handover, prescribing blood and blood products, recognising and responding to clinical deterioration, and speaking up for safety.

(b) Actively assisting the Facility to comply with accreditation standards or other requirements applying to the Facility and contractual requirements imposed upon the Facility relating to safety, quality, adverse events, preventable events and never events.

Note: This includes those standards and requirements of the Australian Commission on Safety and Quality in Health Care, Departments of Health (Commonwealth and State), private health insurers and public health funders.

(c) Complying with all Facility requirements that are in place to optimise patient outcomes.

Note: This includes quality standards developed by the Facility itself and external standards, for example but not limited to, the National Safety and Quality in Health Care Standards and Clinical Care Standards established by the Australian Commission on Safety and Quality in Health Care.

Note: Accredited Practitioners will comply with and take all reasonable actions to facilitate their implementation including, but not limited to: the use of any defined clinical guidelines; adherence to any Facility clinical governance framework as established from time to time; and participating in education and training as required by the Facility from time to time.

(d) Participating and actively engaging in review of their own Clinical Practice (peer review) focused on safety, quality, reducing unwarranted variation and meeting expected standards of Patient care. This includes:

(i) Attendance at all M&M meetings where the Accredited Practitioner's cases / care / clinical services are being reviewed, and if the Accredited Practitioner is unable to attend then notification is to be provided in advance to the Chair of the meeting and the Accredited Practitioner is required to attend the next scheduled meeting;

(ii) Attendance at a minimum of 50% of MAC and M&M meetings scheduled by the Facility in each calendar year, unless attendance below this threshold has been approved in writing by the CEO;

(iii) Active participation in discussion and responding to questions about the Accredited Practitioner's cases / care / clinical services under review, including in a manner and in a language so that all involved in the meeting can understand what is being discussed; and

(iv) Provision of all relevant information and documentation about the Accredited Practitioner's cases / care / clinical services under review.

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

Note: Non-compliance with these requirements is considered serious and may result in action being taken pursuant to these By-Laws or may be a factor considered in deciding not to grant Re-Accreditation.

(e) Engaging with representatives of the Facility to monitor variation in the Accredited Practitioner's practice and performance against expected health outcomes, to receive feedback on variation in practice and health outcomes, to review performance against external measures, to engage in any review or audit of that Accredited Practitioner's practice and to inform improvements in safety and quality systems.

(f) Not engaging in any conduct that may be perceived, regardless of the intention of the Accredited Practitioner, as a reprisal against another person for making a report or supplying information relating to issues of safety, quality or behaviour of the Accredited Practitioner or about a Patient of the Accredited Practitioner (including as part of any speaking up for safety initiative in place at the Facility).

Note: If this occurs, it will be regarded as a breach of the Behavioural Standards.

(g) Complying and fully cooperating with any Facility review of incidents, complications, adverse events (including as set out in lists prepared by private health insurers/health funds and public health funders) and complaints management (including in relation to the Accredited Practitioner's patients) in accordance with the Facility's policy and procedures and where required by the CEO .

(h) Assisting with and actively participating in Facility incident management, investigation and reviews (including root cause analysis, system reviews, or as required by health funders) and open disclosure processes, or any other requirement of the Facility relating to review of Patient care and outcomes.

(i) Participating in risk management activities and programs as reasonably required by the Facility, including the implementation of risk management strategies and recommendations arising from system reviews and root cause analysis.

(j) Providing requested information and assistance in circumstances where the Facility requires information and assistance from the Accredited Practitioner to fully investigate a clinical incident, Patient outcome or any other event.

Note: This includes the provision of reports and any copies of relevant documentation or correspondence.

(k) Providing requested information and assistance to permit the Facility to comply with, or respond to a legal request or direction or contractual obligation.

Note: This includes pursuant to a court order, from a health complaint's body including the Office of Health Ombudsman, AHPRA, Coroner, Police, State Health Department its agencies or departments, State Private Health Regulatory/Licensing Units, Commonwealth Government and its agencies or departments, or private health insurers/health funds.

(l) Providing requested information and assistance in circumstances where the Facility is undertaking investigation into the conduct of research within the Facility or where there is another relevant organisation or regulatory body undertaking a research investigation.

(m) Assisting the Facility with its functions and objectives, and personally engaging in continuous education, reflection and improvement, through membership of and active participation in committees, clinical specialty and peer review groups. The functions, objectives and engagement will include:

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

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

(iii) supporting Accreditation activities;

(iv) clinical oversight;

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

(vi) audit of outcome and processes of care; and/or

(vii) supporting safety and quality initiatives and programs of the Facility, the Australian Commission on Safety and Quality in Health Care (including clinical care standards), State Health Department its agencies or departments.

6.2 Clinical obligations

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon compliance with the following requirements:

(a) Admitting and/or treating Patients only within the Scope of Practice granted, including any terms or conditions attached to the approval of Accreditation.

Note: Accredited Practitioners will seek approval through the applicable By-law process for any variation to approved Scope of Practice.

(b) Not providing services, care or treatment outside of the defined service capability of the Facility.

(c) Providing clinical care based upon best available evidence and/or standards of care that are well recognised by peers and in accordance with recognised professional and ethical standards.

(d) Accredited Practitioners who admit Patients to the Facility or who provide care to admitted Patients of the Facility, will be at all times responsible for the care of the Patient and must ensure that they are available to treat and care for those Patients at all times. This includes attendance on site to see their Patients and being contactable and available by telephone to Facility staff and other Accredited Practitioners within a clinically acceptable period of time.

(e) If an Accredited Practitioner is unable or unavailable, for whatever reason, to provide continuity of care for a Patient, including pursuant to the requirements in (d) above, the Accredited Practitioner must have adequate clinical cover in place when absent or on leave, must ensure appropriate back-up is in place and must notify the Facility administration of the name of an alternative Accredited Practitioner to whom the care of the Patient or Patients has been delegated (with sufficient Scope of Practice) and over what period of time. Arrangements must be communicated and documented in the way prescribed by the Facility.

(f) Reviewing and attending in person upon all Patients admitted by them:

(i) as frequently as is required by the clinical circumstances of those Patients and as would be regarded as clinically appropriate in the circumstances;

(ii) as reasonably requested by Facility staff;

(iii) as reasonably requested by another Accredited Practitioner; or

(iv) as reasonably requested by a Patient or family member of a Patient.

(g) Absent special circumstances or where circumstances as set out in By-law 6.2(f) require an earlier review and attendance, an Accredited Practitioner:

(i) will initially review a Patient in person within 24 hours of the Patient being admitted under the Accredited Practitioner. Prior to the initial attendance, the Accredited Practitioner will provide adequate written instructions to Facility staff for management of the Patient;

(ii) will thereafter be available to review the Patient in person on a daily basis until discharge; and

(iii) will secure the agreement of another Accredited Practitioner (including through locum or on-call arrangements) and notify the Facility of this arrangement, if the Accredited Practitioner is unable to personally provide the above level of care

(h) Accepting if Facility staff caring for a Patient are unable to contact the Accredited Practitioner or on-call/locum cover within what the Facility staff considers to be a clinically acceptable period of time, that Facility staff may escalate and utilise alternative arrangements available through the Facility.

(i) Prior to taking a period of leave, notifying the CEO , ensuring adequate clinical cover is in place (with an Accredited Practitioner who has sufficient Scope of Practice), ensuring that adequate handover has occurred and where possible avoiding undertaking major surgery or procedures in circumstances where post-procedure care is to be transferred to locum cover or an on-call Accredited Practitioner.

(j) Locum cover must be approved in accordance with these By-laws and the Accredited Practitioner must ensure that the locum carries sufficient Scope of Practice for the care required, that the locum's contact details are made available to the Facility staff and all relevant persons are aware of the locum cover and the dates of locum cover.

(k) Participating in agreed formal on-call and roster arrangements as required by the Facility.

Note: The Facility will determine the requirements for on-call and rosters, taking into account Patient safety, continuity of care, anticipated service demand, Organisational Capability, Organisational Need and private hospital licensing requirements.

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

(m) Accredited Practitioners transferring Patients to other health care providers will take all reasonable steps to ensure that the Patient is transferred safely and that the arrangements to support the Patient's care during transfer and at the time of arrival to the other provider have been established with the relevant clinical teams involved (transferring and receiving teams).

(n) Accredited Practitioners accepting care of Patients transferred from other hospitals or locations will take all reasonable steps to ensure that the Patient is transferred safely and that arrangements to support the Patient's care have been established in advance.

(o) Accredited Practitioners must familiarise themselves with, support and strictly adhere to Facility policies and procedures with respect to patient deterioration.

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

(q) Ensuring that any changes to contact details are notified promptly to the CEO and will ensure this is

recorded in any other document prescribed by the Facility for documenting and communicating such changes.

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

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

(t) Accredited Practitioners (including their on-call and locum cover) must at all times be aware of the importance of effective communication with other members of the health care team, referring doctors, the Facility executive, Patients and the Patient's family/carers or next of kin. Accredited Practitioners must at all times ensure appropriate, timely communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.

(u) Accredited Practitioners must provide adequate supervision to more junior practitioners involved in care (including when assisting in surgery or involved in ward care). The frequency and extent of supervision will depend on the level of experience of the more junior practitioner and the complexity of Patient care required. The Accredited Practitioner retains ultimate responsibility for Patient care regardless of whether more junior practitioners are involved.

(v) Accredited Practitioners will comply with the following requirements for surgery:

(i) The Facility has the right to allocate theatre and procedural suite access and time as it sees fit and retains the right to re-allocate theatre/procedural suite sessions depending upon its needs and expectations;

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

(iii) Accredited Practitioners are only permitted to utilise surgical assistants who are appointed pursuant to the By-laws;

(iv) Accredited Practitioners accept complete responsibility for, and must directly supervise, surgical assistants who assist the Accredited Practitioner with surgical and other procedures;

(v) Accredited Practitioners must give consideration to their own potential fatigue and that of other staff involved in the provision of Patient care, when making Patient bookings and in utilising operating theatre and procedural time. This includes the total number of Patients, number of consecutive working days, total hours worked in a day, total hours worked over the preceding days and external commitments;

(vi) Absent an unexpected occurrence or emergency on a particular day, for elective surgery to commence beyond the specified after-hours elective surgery start time for the particular Facility,

this requires the written approval of the CEO ;

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

(w) Accredited Practitioners must facilitate appropriate and timely discharge of their Patients to promote efficient and effective use of the Facility's resources. Patients will be discharged only with the written approval of the Accredited Practitioner, who shall comply with the discharge policy of the Facility and complete all relevant discharge documentation (including medication, discharge plan and instructions, with copies to be included in the Facility medical record). It is the responsibility of the Accredited Practitioner to ensure that all information reasonably necessary to ensure continuity of care after discharge is provided to the referring practitioner, general practitioner and/or other treating practitioner.

6.3 Treatment and Financial Consent obligations

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon compliance with the following requirements:

(a) Accredited Practitioners must provide and obtain fully informed consent for treatment from the Patient or their legal guardian or substitute decision maker (except where it is not practical in cases of emergency, see paragraph (b) below). This will occur in accordance with accepted medical and legal standards (including professional college guidelines, the Good Medical Practice: A Code of Conduct for Doctors in Australia and applicable legislation) and in accordance with the policy and procedures of the Facility.

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

(c) For the avoidance of any doubt, the requirements for fully informed consent applies to anaesthetic consent.

(d) The consent will be evidenced in writing, will be signed by the Accredited Practitioner and the Patient or their legal guardian or substitute decision maker and will be compliant with the current policy and procedures of the Facility.

(e) Fully informed consent will be obtained directly by the Accredited Practitioner under whom the Patient is admitted or treated.

Note: The consent process will ordinarily include an explanation of the Patient's condition and prognosis, treatment and alternatives, inform the Patient of material risks associated with treatment and alternatives, following which consent to the treatment will be obtained.

Note: The Accredited Practitioner will take all reasonable steps to ensure that the Patient has the appropriate level of understanding regarding the treatment as part of the process of obtaining fully informed consent, as well as responding to questions raised by the Patient.

(f) The consent process must satisfy the Facility's requirements from time to time as set out in its policy and procedures, including full completion of the Facility consent form.

Note: The legal requirement for an Accredited Practitioner to obtain fully informed consent and written evidence of this will ordinarily require the Accredited Practitioner to utilise that Accredited Practitioner's own consent documentation in addition to completion of the Facility consent form.

(g) Unless in exceptional circumstances approved by the CEO , admissions will not be accepted or surgery/procedures will not proceed until complete compliance with Facility consent processes and documentation has occurred.

Note: Non-compliance includes, but is not limited to, provision of incomplete documentation, unsigned documentation, incomplete signed documentation, or if there is not a match between the documentation that has been supplied and the information obtained from the Patient.

(h) If, following completion of the surgery/procedure, it has been identified that there is not a complete match between the surgery/procedure actually performed and that which was planned or that which was documented as intended to be performed, this will be immediately notified by the Accredited Practitioner to the CEO , regardless of whether notification of the discrepancy has also been made by Facility staff. The Accredited Practitioner will provide all necessary and requested assistance to resolve the discrepancy or address the issue that has occurred.

Note: Notification will occur not only if there is an apparent divergence between what was planned and that performed, but if additional surgeries/procedures appear to have been performed or if planned surgeries/procedures appear not to have been performed.

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

Note: This requirement extends to the disclosure of anticipated costs provided by other Accredited Practitioners or health service providers as much as it is practicable and feasible.

Note: This requirement extends to the disclosure of anaesthetic and surgical assistant fees.

Note: The Facility may in its discretion require evidence that full financial disclosure and consent has occurred in any particular case.

Note: This requirement does not apply if the Patient is an eligible public patient (or other category of patient) funded through an arrangement with the State or the Commonwealth and no payment is to be made by the Patient.

6.4 Documentation obligations

Accreditation of an Accredited Practitioner, and maintaining ongoing Accreditation, shall be conditional upon compliance with the following requirements:

(a) Maintaining full, accurate, informative, legible and contemporaneous records (inclusive of pathology, radiology, other investigative reports and discharge summaries). This requirement applies to each attendance upon the Patient, procedures, orders, instructions and consent. The entries will be dated, time and signed and contained in the Facility Patient record. The entries must be sufficient to allow any person involved in care, at any point in time, to understand the Accredited Practitioner's instructions, orders and treatment plan. The records will comply with Good Medical Practice: A Code of Conduct for Doctors in Australia, the Facility policy requirements, legislative requirements, State based standards, standards set for hospitals accreditation and health fund obligations.

(b) Access to and use of Facility Patient records is compliant with privacy and confidentiality obligations owed to the Patient. Arising from this, Accredited Practitioners may only access and if necessary, obtain a copy of Facility Patient records to facilitate the on-going care of the Patient. In addition, to comply with privacy

and confidentiality obligations set out in the By-laws and in accordance with legal obligations, if access to or copies of Facility Patient records is sought for a purpose other than ongoing care of the Patient, the Accredited Practitioner will ensure that they obtain the written consent of the Patient and the Facility.

(c) Acting at all times on the basis of, and accept that, ownership and copyright of entries contained in the Facility Patient records vests in the Facility.

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

(e) Ensuring an anaesthetic report is completed (where an anaesthetic is administered to a Patient), including documentation of the pre-anaesthetic evaluation, fully informed anaesthetic consent, post-anaesthetic evaluation, complications and post anaesthetic orders.

(f) Ensuring, in a timely manner, that a discharge summary is completed (compliant with any Facility policy and procedures) that includes all relevant information reasonably required by the referring practitioner, general practitioner or other treating practitioner for continuity and ongoing care of the Patient.

(g) Being responsive to any organisational review and feedback about clinical documentation of the Accredited Practitioner, including where this is to facilitate improved written communication and capture of clinical assessment, interventions and patient outcomes for clinical coding.

(h) Utilising any electronic medical record and ehealth technology (including prescribing) that may be in place.

(i) If technology is being utilised to facilitate communication by the Accredited Practitioner between the health care team or with Patients, ensuring that:

(i) the technology is managed in accordance with any applicable Facility policy and procedure, including any required approval before use of the technology or category of technology;

(ii) privacy and confidentiality obligations of the Patient are strictly adhered to (including pursuant to the *Privacy Act* (Cth)) ; and

(iii) the communication is additionally documented in a timely and comprehensive way in the Facility Patient record.

(j) Recording all data required by the Facility to meet health fund obligations, collect revenue and allow compilation of health care statistics, and that is sufficient to allow clinical coding to occur. Medical record entries must be recorded in accordance with the requirements of this By-law, at the time of or shortly after the attendance or episode of care, and all other data required by the Facility to meet health fund obligations, collect revenue and allow compilation of health care statistics, and that is sufficient to allow clinical coding to occur, must be recorded within 7 days.

(k) Ensuring that all Pharmaceutical Benefits Scheme prescription requirements and financial certificates are completed in accordance with Facility policy and procedures and regulatory requirements.

(l) Responding in a timely manner to queries, requests for information and completion of documentation relating to the matters set out in this By-law.

6.5 Complaints Management obligations

The CEO , upon receipt of a complaint from a complainant (including a Patient, former Patient, family member of a Patient, family member of a former Patient, staff member, another Accredited Practitioner, person providing or involved in services at the Facility or through a regulatory body), or upon receipt of

information pursuant to the notification and disclosure obligations in these By-laws, may elect to manage the complaint in the first instance pursuant to this By-law and in accordance with the relevant Facility complaints policy/protocol.

Note: In compliance with this By-law, the Accredited Practitioner will provide all necessary information and assistance, participate in direct discussions with any of the persons referred to above and will assist with complaint resolution, as requested by the CEO .

Part C – Accreditation of Medical Practitioners

7. Credentialling and Scope of Practice

7.1 Eligibility for Accreditation as Medical Practitioners

Accreditation as Medical Practitioners will only be granted if Medical Practitioners demonstrate adequate Credentials to the satisfaction and within the complete discretion of the Facility, meet requirements of Organisational Capability and Organisational Need as determined by the Facility, satisfy all requirements of the By-laws, are prepared to comply with the By-laws and the Facility policies, and provide written acknowledgment of such preparedness to comply with the By-laws and the Facility policies.

7.2 Entitlement to treat Patients at the Facility

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

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

(c) A Medical Practitioner's use of the facilities for the treatment and care of Patients is limited to the Scope of Practice granted by the CEO and subject to the conditions upon which the Scope of Practice is granted, resource limitations, and Organisational Need and Organisational Capability.

(d) Accredited Practitioners acknowledge and accept that admission or treatment of a particular Patient is subject always to bed availability, and the availability or adequacy of nursing or allied health staff or facilities given the treatment or clinical care proposed for the Patient.

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

The CEO will determine, in the sole discretion of the CEO , the outcome of applications for Accreditation as Medical Practitioners and defined Scope of Practice for each applicant.

In making any determination, the CEO will make independent and informed decisions and in so doing will have regard to the matters set out in these By-laws and will have regard to the recommendations of the Medical Advisory Committee.

The CEO may, at his/her discretion, consider other matters as relevant to the application when making his/her determination.

7.4 Medical Advisory Committee

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

The MAC members, including the chairperson, will be appointed by the Board for such period as determined by the Board and may be removed at any time from membership of the committee by the Board.

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

In the absence of a Credentialling Committee, the role will be performed by the MAC. If there is a requirement for a separate Credentialling Committee to consider and make recommendations relating to Credentialling, but the role is performed by the MAC, the terms of reference for the Credentialling Committee will include a process that provides for closing the MAC meeting and reconvening it as a Credentialling Committee meeting, including recording of separate minutes.

In addition to the terms of reference established for the MAC or Credentialling Committee, the Committees must be constituted according to and the members of the Committees must conduct themselves in accordance with any legislative obligations, including standards that have mandatory application to the Facility and Committee members. For example, the obligations imposed pursuant to the Private Health Facilities Act (QLD).

The CEO , Director of Nursing and Chair of the Board will be entitled to attend meetings of the MAC as ex-officio members, such that they will not have an entitlement to vote in relation to decisions or recommendations of the MAC and Credentialling Committee.

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

8. The process for Accreditation and Re-Accreditation

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

(a) Applications for Initial Accreditation (defined for the purposes of these By-laws to mean where the applicant does not currently hold Accreditation at the Facility) and Re-Accreditation (where the applicant currently holds Accreditation at the Facility) as Medical Practitioners must be made in writing on the prescribed form. All questions on the prescribed form must be fully completed and all required information and documents supplied before an application will be considered. Applications should be forwarded to the CEO at least six weeks prior to the Medical Practitioner seeking to commence at the Facility or such shorter time permitted by to the Facility due to Organisational Need or patient needs. Temporary Accreditation or Emergency Accreditation will be considered at the discretion of the CEO .

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

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

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

8.2 Consideration by the Medical Advisory Committee

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

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

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

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

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

(i) initiate an Internal Review;

(ii) initiate an External Review;

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

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

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

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

8.3 Consideration of applications for Initial Accreditation by the CEO

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

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

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

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

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

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

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

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

(f) The CEO will forward a letter to the Medical Practitioner advising the Medical Practitioner whether the application has been approved or rejected. No reasons are required to be provided if an application is rejected. If the application has been approved, the letter will also contain details of the Scope of Practice granted.

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

8.4 Initial Accreditation tenure

(a) Initial Accreditation as a Medical Practitioner at the Facility may, at the election of the CEO , be for a ***probationary period of one year***, or in circumstances where Initial Accreditation is granted without a probationary period, the CEO may grant an ***Initial Accreditation period of up to five years***

(b) Prior to the end of any probationary period established pursuant to By-law 8.4(a), a review of the Medical Practitioner's level of Competence, Current Fitness, Performance, compatibility with Organisational Capability and Organisational Need, and confidence in the Medical Practitioner will be undertaken by the CEO . The CEO will seek assistance with the review from the relevant Medical Advisory Committee or Speciality Committee where established. The CEO may initiate the review at any time during the probationary period where concerns arise about Performance, Competence, Current Fitness of, or confidence in the Medical Practitioner, or there is an identified Professional Conduct or behavioural concern.

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

(i) a review conducted by the CEO at the end of the probationary period, or

(ii) a review conducted by the CEO at any time during the probationary period,

causes the CEO to consider:

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

(iv) the probationary period should be terminated, or

(v) the probationary period should not be extended, or

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

the Medical Practitioner will be:

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

(viii) be given an opportunity to provide a submission (oral and/or written as determined by the CEO).

(d) Should the Medical Practitioner have an acceptable probationary Accreditation review outcome, or in circumstances where Initial Accreditation is granted without a probationary period, the CEO may grant an Accreditation period of up to five years on receipt of a signed declaration from the Medical Practitioner describing any specific changes, if any, to the initial information provided and ongoing compliance with all requirements as per the By-laws.

(e) Should the probationary Accreditation review outcome be unacceptable to the CEO,they may, in consultation with the Medical Advisory Committee:

(i) amend the Scope of Practice granted; or

(ii) decide that Accreditation will not be granted.

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

8.5 Re-Accreditation

(a) Any Medical Practitioner wishing to be Re-Accredited must send a completed application form to the CEO at least three months prior to the expiration date of the Medical Practitioner's current term of Accreditation.

(b) The CEO and Medical Advisory Committee will deal with applications for Re-Accreditation in the same manner in which they are required to deal with applications for Initial Accreditation as Medical Practitioners. The considerations in deciding the application will extend to the applicant's history of and current status with respect to Clinical Practice and outcomes at the Facility during prior periods of Accreditation, disciplinary actions, By-Law actions, By-Law compliance including engagement with clinical governance, safety, quality and clinical requirements of the Facility (eg peer review), compensation claims, complaints and concerns – clinical and behavioural, professional registration and appropriate indemnity insurance.

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

8.6 Re-Accreditation tenure

Granting of Re-Accreditation and Scope of Practice will be for a term of up to five years, as determined by the CEO .

8.7 Nature of Accreditation of Visiting Medical Practitioners

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

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

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

(d) Accredited Practitioners acknowledge and agree as a condition of the granting of, and ongoing Accreditation, that the granting of Accreditation establishes only that the Accredited Practitioner is a

person able to provide services at the Facility, as well as the obligations and expectations with respect to the Accredited Practitioner while providing services for the period of Accreditation, the granting of Accreditation creates no rights or legitimate expectation with respect to access to the Facility or its resources, and while representatives of the Facility will generally conduct themselves in accordance with these By-laws they are not legally bound to do so and there are no legal consequences for the Facility and its representatives in not doing so;

(e) Conferral of Accreditation results only in a conditional non-contractual licence to enter the Facility and provide services, in accordance with the terms of approval given. It provides the Accredited Practitioner with an ability on each occasion to make a request for access to the Facility for the treatment and care of a Patient, within the limits of the Accredited Practitioner's Scope of Practice, and to utilise the Facility and resources for that purpose, subject always to the provisions of the By-laws, Facility policies, resource limitations, and in accordance with Organisational Need and Organisational Capability at the time of the request for access.

Note: 'Conditional licence' is a legal term that in this context means the permission granted by the Facility to an Accredited Practitioner on a non-exclusive basis to attend the premises of the Facility, to utilise appropriate resources of the Facility, and to provide services to Patients of Facility, subject at all times to the terms and conditions set out in the By-laws and Accreditation. This permission may be withdrawn by the Facility.

9. Extraordinary Accreditation

9.1 Temporary Accreditation

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

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

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

(d) The period of Temporary Accreditation shall be determined by the CEO , which will be for a period of no longer than three (3) months. In exceptional circumstances as determined by the CEO , one further extension of no longer than three (3) months may be granted.

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

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

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

(h) Temporary Accreditation will not be used for Medical Practitioners based outside of Bundaberg who travel

in periodically for Patient care. Standard Accreditation processes set out in By-Laws 8.1 to 8.7 will apply.

9.2 Emergency Accreditation

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

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

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

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

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

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

(v) verification will be undertaken by the CEO and will be fully documented.

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

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

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

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

9.3 Locum Tenens

Locums (defined to mean a Medical Practitioner not currently holding Accreditation at the Facility and who is temporarily fulfilling the Patient care responsibilities of a Visiting Medical Practitioner) must be approved by the CEO before they are permitted to arrange the admission of and/or to treat Patients on behalf of Visiting Medical Practitioners.

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

Accredited Medical Practitioners are expected to notify the Facility, in advance of a holiday relief or expected absence, that a locum intends admitting Patients during their absence.

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

10. Variation of Accreditation or Scope of Practice

10.1 Medical Practitioner may request amendment of Accreditation or Scope of Practice

(a) An Accredited Medical Practitioner may apply for an amendment or variation of their existing Scope of Practice or any term or condition of their Accreditation, other than in relation to the general terms and

conditions applying to all Accredited Practitioners as provided in these By-laws.

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

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

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

11. Review of Accreditation or Scope of Practice

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

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

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

(ii) the rights, interests, health or safety of a Patient, staff, student or someone engaged in or at the Facility has been, or could potentially be, adversely affected or could be infringed upon, or a workplace health and safety concern has arisen;

(iii) behaviour, including in relation to non-compliance with the Behavioural Standards;

(iv) Competence;

(v) Current Fitness;

(vi) Performance;

(vii) compatibility with Organisational Capability and Organisational Need;

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

(ix) confidence held in the Medical Practitioner;

(x) compliance / non-compliance with these By-laws;

(xi) compliance / non-compliance with Facility policy / procedure / protocol;

(xii) a possible ground for Suspension or Termination of Accreditation may have occurred;

(xiii) the efficient operation of the Facility could be threatened or disrupted;

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

(xv) the potential to bring the Facility into disrepute;

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

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

(b) The CEO will determine whether the process to be followed is an;

(i) Internal Review; or

(ii) External Review.

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

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

(e) The CEO must make a determination whether to impose an interim suspension or conditions upon the Accreditation of the Medical Practitioner pending the outcome of the review and, if imposed, there is no right of appeal from this interim decision pursuant to the By-laws.

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

11.2 Internal Review of Accreditation and Scope of Practice

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

(b) The terms of reference, process, and reviewers will be as determined by the CEO . The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral as determined by the CEO . The opportunity for submissions, as determined by the CEO , is the extent of natural justice and fairness considerations that will be applied to this Facility process. Provision of documentation and the terms of provision of documentation will be at the complete discretion of the CEO .

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

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

(e) Following consideration of the report, the CEO is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate a Medical Practitioner’s Accreditation in accordance with these By-laws.

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

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

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

11.3 External Review of Accreditation and Scope of Practice

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

(b) An External Review will be undertaken by a person(s) external to the Facility and of the Accredited Medical Practitioner in question and such person(s) will be nominated by the CEO at his/her discretion.

(c) The terms of reference, process, and reviewers will be as determined by the CEO . The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral as determined by the CEO . The opportunity for submissions, as determined by the CEO , is the extent of natural justice and fairness considerations that will be applied to this Facility process. Provision of documentation and the terms of provision of documentation will be at the complete discretion of the CEO .

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

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

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

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

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

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

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

12.1 Suspension of Accreditation

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

(i) it is in the interests of Patient care or safety;

(ii) the continuance of the current Scope of Practice, or performance of particular aspects of Patient treatment or care, raises a reasonable concern about the safety and quality of treatment or care to be provided by the Medical Practitioner;

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

(iv) it is in the interests of staff, or other Accredited Practitioner, welfare or safety;

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

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

(vii) the Medical Practitioner has failed to comply with the By-Laws, including the terms and conditions of Accreditation, or has failed to comply with policies or procedures of the Facility;

(viii) the Medical Practitioner has not adequately engaged with clinical governance, safety, quality and clinical requirements of the Facility, including but not limited to peer review;

(ix) the behaviour or conduct is in breach or apparent breach of the Behavioural Standards, a direction or undertaking, the By-Laws, Code of Conduct or policies regarding behaviour or conduct, is not consistent with the Medical Board of Australian Good Medical Practice: A Code of Conduct for Doctors in Australia or is not consistent with the relevant code of the Medical Practitioner's College;

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

(xi) the behaviour or conduct is bringing, or may bring, the Facility into disrepute or is compromising the interests of the Facility generally,

(xii) the behaviour or conduct appears to be not consistent with the Values;

(xiii) the behaviour or conduct is notifiable or notified to AHPRA or the Office of Health Ombudsman;

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

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

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

(xvii) the Medical Practitioner's professional indemnity insurance is withdrawn, amended, limited or conditions imposed, in a way that is not considered acceptable to the Facility;

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

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

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

(xxi) the Accredited Practitioner is subject to allegations or findings of dishonesty, fraud, bribery or corruption;

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

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

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

(xxv) an Internal Review or External Review has been initiated pursuant to these By-laws and the CEO considers that an interim suspension is appropriate pending the outcome of the review. A lower threshold of satisfaction is permitted with respect to the criteria for interim suspension given the review is not completed and the paramount consideration will be Patient safety; or

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

(b) The CEO shall notify the Medical Practitioner of:

(i) the fact of the suspension;

(ii) the period of suspension;

(iii) the reasons for the suspension;

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

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

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

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

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

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

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

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

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

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

Ordinarily suspension will be suspension of Accreditation in its entirety, however the CEO may determine for a particular case that the suspension will be a specified part of the Scope of Practice previously granted and these By-laws in relation to suspension will apply to the specified part of the Scope of Practice that is suspended.

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

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

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

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

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

12.2 Termination of Accreditation

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

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

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

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

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

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

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

(ii) based upon a finalised Internal Review or External Review pursuant to these By-laws and termination of Accreditation is considered appropriate in the circumstances;

(iii) conditions have been imposed by the Medical Practitioner's registration board or AHPRA and the CEO is unable or unwilling to accommodate the conditions imposed;

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

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

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

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

(viii) the Medical Practitioner has engaged in actions that would be considered Notifiable Conduct as defined in the *Health Practitioner Regulation National Law Act 2009* or its predecessor Acts;

(ix) the Medical Practitioner is convicted of a sex offence, violence offence or any offence which affects the his/her practice as a Medical Practitioner, or which relates to fraudulent and/or dishonest conduct;

(x) it is determined that the Medical Practitioner does not have the appropriate Current Fitness to retain the Scope of Practice granted or the Facility does not have confidence in the continued Accreditation of the Medical Practitioner. This could include failure to notify actions taken against them by another hospital or health service; and/or

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

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

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

(i) the fact of the termination;

(ii) the reasons for the termination;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(k) As a separate right and despite anything set out above in By-law 12.2, the CEO may terminate the Accreditation of an Accredited Practitioner without being required to provide reasons, by ordinarily providing no less than three (3) months written notice, or such other shorter or longer period as the CEO considers reasonable in the circumstances. There will be no right of appeal pursuant to these By-laws from such a decision of the CEO .

12.3 Imposition of conditions

(a) At the conclusion of or pending finalisation of a review, or in lieu of a Suspension, or in lieu of a Termination, the CEO may elect to impose conditions on the Accreditation or Scope of Practice.

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

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

(d) If the conditions are breached, then Suspension or Termination of Accreditation may occur, as determined by the CEO .

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

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

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

12.4 Resignation and expiry of Accreditation

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

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

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

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

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

13. Appeal rights and procedure

13.1 Rights of appeal against decisions affecting Accreditation

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

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

13.2 Appeal process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Part D – Accreditation of Dentists

14. Accreditation and Scope of Practice of Dentists

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

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

Part E– Accreditation of Visiting Allied Health Professionals

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

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

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

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

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

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

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

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

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

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

17. Audit and Compliance

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

The audit process will include identification of opportunities for quality improvement in the Credentialling and Accreditation processes that will be reported to the Board by the CEO.