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

Version 12: April 2021

Document History/Version Control

Document	**SVHA Board Approval Date**
SVHA Group Model By-Laws (Version 1)	2 February 2012
SVHA Group Model By-Laws (Version 2)	5 April 2012
SVHA Group Model By-Laws (Version 3)	2 August 2012
SVHA Group Model By-Laws (Version 4)	29 October 2012
SVHA Group Model By-Laws (Version 5)	1 August 2013
SVHA Group Model By-Laws (Version 6)	12 December 2013
SVHA Group Model By-Laws (Version 7)	1 October 2014
SVHA Group Model By-Laws (Version 8)	4 August 2016
SVHA Group Model By-Laws (Version 10)	6 June 2019
SVHA Group Model By-Laws (Version 12)	15 April 2021

Facility Schedule History/Version Control

Document	**Date**
St Vincent's Hospital Melbourne Schedules (Version 1)	5 April 2012
St Vincent's Hospital Melbourne Schedules (Version 2)	12th December 2013
St Vincent's Hospital Melbourne Schedules (Version 3)	30th July 2015
St Vincent's Hospital Melbourne Schedules (Version 4)	23rd May 2019
St Vincent's Hospital Melbourne Schedules (Version 5)	23rd July 2021

TABLE OF CONTENTS

FOREWORD

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

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

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

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

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

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

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

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

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

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

PREAMBLE

The By-Laws mandate the Accreditation, Credentialing, Re-accreditation and process for defining and amending the Scope of Clinical Practice for Medical Practitioners, Dental Practitioners and other categories of approved health practitioner providing services to patients at the Facility.

The purpose of this process is to assess the training, experience, competence, judgement, professional capabilities and knowledge, fitness and character of a Medical Practitioner, Dental Practitioner and other categories of approved health practitioner who holds Accreditation or seeks Accreditation at a Facility.

Relevantly, there is the ability to amend, impose conditions, suspend or terminate Scope of Clinical Practice or Accreditation based upon the grounds set out in the By-Laws.

Credentialing and defining the Scope of Clinical Practice are governance responsibilities of the Facility Chief Executive Officer and may be delegated as appropriate. Accreditation, Credentialing, Re-accreditation and the process for defining and amending Scope of Clinical Practice is a non-punitive process, with the paramount consideration being the safety, quality and experience of patients.

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

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

SVHA VISION, MISSION, VALUES AND CARE STATEMENTS

Mission

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

Vision

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

Values

Compassion

Justice

Integrity

Excellence

Care

Our care is:

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

1. BY-LAWS

1.1 Application of By-Laws

This document sets out the By-Laws that apply to all Facilities determined by the Board. SVHA requires that the By-Laws are read in their entirety by an applicant as part of the Accreditation and Re-accreditation process, as well as at any time amendments are made to the By-Laws, given that the By-Laws require strict adherence by Accredited Practitioners. A failure to read the By-Laws and any amendments will not be considered a reasonable excuse for non-compliance.

1.2 Inconsistencies with legislation

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

2. INTERPRETATION

2.1 Paramount considerations

(a) Accreditation, Credentialing, Re-accreditation, the process for defining and amending the Scope of Clinical Practice and action that may be taken pursuant to these By-Laws are key elements of the clinical governance framework within SVHA.

(b) Safety, quality and experience with respect to patients involves a mutual commitment from SVHA, its staff and Accredited Practitioners. It is the expectation of SVHA that all involved in the care of patients will work towards this mutual commitment; and

(c) In making decisions with respect to these By-Laws and taking actions pursuant to these By-Laws, the safety, quality and experience of patients will be the paramount considerations.

2.2 Definitions

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

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

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

(b) any specified Conditions;

(c) the Code of Conduct;

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

(e) these By-Laws.

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

Accredited Practitioner means a Medical Practitioner or Dental Practitioner authorised to treat patients at the Facility in accordance with a specified Accreditation Classification and Scope of Clinical Practice, or such other category of health practitioner approved by the FCEO.

Act means all relevant legislation applicable to and governing:

(a) the Facility and its operation;

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

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

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

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

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

Behavioural Standards means the 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 SVHA, Board members of SVHA, executive of SVHA, 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), SVHA Vision, Mission, Values and Care Statements, and the Catholic Health Code of Ethical Standards..

Board means the Board of Directors of SVHA.

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

(a) all clinical risks are being appropriately managed;

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

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

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

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

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

(a) the SVHA Group CEO;

(b) the Divisional CEO (DCEO);

(c) the Facility CEO (FCEO);

(d) the Regional CEO (FCEO).

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

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

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

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

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

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

Condition means as applicable with respect to an Accredited Practitioner:

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

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

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

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

Credentialing means the formal process used to match the skills, experience and qualifications to the role and responsibilities of the position. This will include actions to verify and assess the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees/awards/fellowships/certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, current registration and status, indemnity insurance, and other skills/attributes (for example training and experience in leadership, research, education, communication and teamwork) for the purpose of forming a view about their Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services within specific Facility environments. Credentialing involves obtaining evidence contained in

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

Credentials means the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees/awards/fellowships/certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, current registration and status, indemnity insurance, and other skills/attributes (for example training and experience in leadership, research, education, communication and teamwork) that contribute to the Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services at the Facility. This may include (where applicable and relevant) history of and current status with respect to clinical practice and outcomes during period previous of Accreditation, disciplinary actions, By-Law actions, compensation claims, complaints and concerns – clinical and behavioural, professional registration and Professional Indemnity Insurance.

Current Fitness means the current fitness required of an Accredited Practitioner to carry out the Scope of Clinical Practice sought or currently held, including with the confidence of peers and the Facility, having regard to any relevant physical or mental impairment, disability, condition or disorder (including due to alcohol, drugs or other substances) which detrimentally affects or there is a reasonably held concern (in the FCEO's opinion) that it may detrimentally affect the person's capacity to provide health services at the expected level of safety and quality having regard to the Scope of Clinical Practice sought or currently held.

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

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

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

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

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

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

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

(a) the CEO of the Public Hospitals Division;

(b) the CEO of the Private Hospitals Division; and

(c) the CEO of the Aged Care Division.

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

Facility CEO (FCEO) means the following chief executive officer or general manager positions which report to a DCEO or Regional Chief Executive Officer (RCEO):

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

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

(c) Chief Executive Officer of St Vincent's Private Hospital Fitzroy

(d) Chief Executive Officer of St Vincent's Private Hospital East Melbourne and Kew;

(e) Chief Executive Officer of St Vincent's Private Hospital Werribee;

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

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

(h) Chief Executive Officer of St Vincent's Private Hospital Griffith;

(i) Chief Executive Officer of St Vincent's Private Hospital Northside;

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

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

Locum Tenens means a person not currently an Accredited Practitioner who is nominated by an Accredited Practitioner to provide services to his or her patients during a period of absence from the Facility.

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

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

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

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

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

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

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

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

Organisational Capabilities means the 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, staffing (including qualifications and skill-mix), facilities, equipment, technology and support services required and by reference to the Facility's private health licence (where applicable), clinical service capacity, clinical services plan and clinical services 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 (including additional operating theatre utilisation), in order to provide a balanced mix of safe, high quality health care services that meet the Facility, consumer and community needs and aspirations. Organisational Need will be determined by, but not limited to, allocation of limited resources, clinical service capacity, funding, clinical services, strategic, business and operational plans of SVHA and the Facility and the clinical services capability framework.

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

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

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

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

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

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

Regional CEO (RCEO) means the CEO of two or more hospitals as defined on a geographic basis. Any function of a Facility CEO (FCEO) as defined in these By-Laws may also be carried out by an RCEO where applicable.

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

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

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

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

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

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

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

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

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

(a) SVHA

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

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

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

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

Urgent Appointment means an appointment of an Accredited Practitioner in urgent circumstances limited to a specific patient or episode of care.

2.3 General Interpretation

(a) Rules for Interpreting these By-Laws

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

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

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

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

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

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

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

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

(b) Titles

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

(c) Quorum

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

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

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

(d) Resolutions without meetings

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

(e) Meeting by electronic means

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

(f) Voting

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

(g) Delegation

Where these By-Laws confers a function or responsibility on the SVHA Group CEO, SVHA Group Chief Medical Officer, DCEO or FCEO, that function or

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

(h) Compensation

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

3. PRIVACY AND CONFIDENTIALITY

3.1 Privacy

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

3.2 Accredited Practitioners

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

(a) business information concerning SVHA or the Facility;

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

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

(d) personal, sensitive, health or identifying information relating to other Accredited Practitioners or staff of SVHA; and

(e) information obtained as result of participation in quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services of the Accredited Practitioner, other Accredited Practitioners, the Facility and SVHA.

3.3 Committees

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

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

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

3.4 What confidentiality means

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

3.5 When confidentiality can be breached

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

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

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

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

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

(e) where disclosure is required in order to perform a requirement of these By-Laws or in accordance with a function of the Facility or SVHA.

3.6 Privacy and confidentiality obligations continue

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

3.7 Information sharing

Subject to By-Law 9.2, the Facility will be entitled to disclose an Accredited Practitioner's confidential information (including personal information and sensitive information as those terms are defined in the *Privacy Act 1988* (Cth)) in relation to their appointment, conduct and any other matters related to these By-laws to other SVHA Group Entities and to any College that the Accredited Practitioner is a member of.

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

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

3.8 Mandatory notification of Notifiable Conduct

Notwithstanding By-Laws 3.1 to 3.8, all registered health practitioners acting in a management role with SVHA must comply with their responsibilities under the National Law in regard to mandatory notification of Notifiable Conduct by another practitioner or a student undertaking clinical training where they have formed a

reasonable belief that a health practitioner has behaved in a way that constitutes Notifiable Conduct in relation to the practise of their profession or suffers from an impairment that may place the public at substantial risk of harm.

4. BOARD POWERS AND TRANSITIONAL ARRANGEMENTS

4.1 Board powers

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

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

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

4.2 Transitional arrangements

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

5. COMMITTEES

5.1 Power to establish Committees

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

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

5.2 Terms of Reference for Committees

Schedule 2 provides the Terms of Reference for Committees.

5.3 Indemnification

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

(a) acted in good faith;

(b) acted in accordance with the terms of reference;

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

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

5.4 Statutory immunity for Committees

(a) An SVHA Group Entity may in specific circumstances seek and be granted declarations under jurisdictional legislation in respect of a Committee at a Facility where the Committee's emphasis is on the quality assurance or review of clinical practice or clinical competence. Such a declaration may,

amongst other things, afford statutory immunity or qualified privilege or similar for members of that Committee in the course of carrying out specific aspects of the role and function of that Committee.

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

5.5 Committee access to the SVHA Board

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

6. DISCLOSURE OF INTEREST OF MEMBERS OF COMMITTEES

6.1 Disclosure of interest

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

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

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

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

6.2 Nature of disclosure

Disclosure by a person at a meeting that the person:

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

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

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

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

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

6.3 Chairperson to notify Facility Chief Executive Officer

The chairperson of the relevant Committee will:

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

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

6.4 Record of disclosure

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

6.5 Determination to effect of matter disclosed

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

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

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

7. CLINICAL REVIEW COMMITTEES

7.1 Objectives

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

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

(b) support clinicians to take part in clinical review of their own practice;

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

(d) providing a forum for Accredited Practitioners to meet and discuss relevant clinical and administrative matters, including a forum to discuss evidence-based care and the latest developments; and

(e) providing a forum to consider and discuss strategies to improve the cultural awareness and cultural competency of Accredited Practitioners to meet the needs of its community, including Aboriginal and Torres Strait Islander patients.

7.2 Functions

The functions of the clinical review Committee or Committees, howsoever named, are to include between them:

(a) review of clinical indicators and where appropriate provide feedback;

(b) monitor variations in individual and speciality practice against expected outcomes;

(c) review Performance against external measures;

(d) review mortality and morbidity reports and statistics, providing feedback and making recommendations where appropriate;

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

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

(g) assisting to develop, implement and review policies and protocols in clinical areas;

(h) review specific cases identified as an outcome of the reviews undertaken in By-Law 7.2(a) and provide feedback and recommendations to individual Accredited Practitioners relating to Performance, variations in practice, health outcomes, clinical improvement and more broadly to all relevant Accredited Practitioners relating to general clinical improvement and best practice;

(i) assisting Accredited Practitioners within clinical specialities with information about relevant best practice guidelines, clinical advances, clinical improvements, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice, and to support Accredited Practitioners within the clinical specialty to use best available evidence, including relevant Clinical Care Standards developed by the Australian Commission on Safety and Quality in Health Care;

(j) provide relevant information about unwarranted clinical variation to Facility staff with responsibility for risk, safety and quality so that it may be incorporated into Facility and SVHA risk management systems and processes;

(k) notify the FCEO of any identified clinical issues and risks at the Facility or with respect to individual Accredited Practitioners;

(l) as requested, liaise with and provide relevant information to the Board Quality and Safety Committee; and

(m) make recommendations based upon information and clinical variation to inform the FCEO and Facility with respect to improvements in safety and quality systems.

7.3 Meetings of clinical review Committee or Committees

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

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

7.4 Minutes and reporting

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

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

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

7.5 Mandatory attendance

(a) It is a Condition of Accreditation that:

(i) all Accredited Practitioners must attend and participate in a minimum of 50 percent of the Formal Meetings of the clinical review Committee or Committees, howsoever named; and

(ii) where a specific case involving an Accredited Practitioner's patient has been listed for review, the Accredited Practitioner must present details about the specific case and actively engage in discussion with other attendees.

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

8. APPOINTMENT OF ACCREDITED PRACTITIONERS

8.1 Application Form

Any Medical Practitioner or Dental Practitioner who wishes to apply for Accreditation, Re-accreditation or an amendment of Scope of Clinical Practice at the Facility (the **Applicant**) must obtain from the Facility an Application Form (and any related material, including a copy of these By-Laws) and must read the By-Laws and complete the Application Form in its entirety and submit to the FCEO. If an electronic process for lodgement of applications is in place at the Facility, then this must be utilised.

8.2 Applications for Appointment

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

(a) The FCEO will consider the application in the context of its completeness, the applicant's Credentials, Organisational Need, Organisational Capabilities, and otherwise satisfying the requirements of the By-Laws, and may make any inquiries, consultation, request verification of information or documents, and request permission to contact third parties, that is relevant to that consideration as he or she thinks fit. Following this consideration, the FCEO may determine to discontinue with the application process or give further consideration to the process as outlined at By-Law 8.2(b) – (p) below.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(p) On receiving notice of Appointment, the applicant must indicate his or her acceptance in writing of the SVHA and Facility By-Laws, policies and procedures SVHA's Visions, Mission, Values and Care Statements.

8.3 **Recency of Practice**

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

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

(c) The FCEO may at any time make inquiry regarding concerns raised regarding an Accredited Practitioner's Recency of Practice where patient health and safety could be compromised. Inquiry and or investigation will take the form outlined in By-Law 13.1.

8.4 **Period of Appointment**

(a) Unless otherwise determined by the FCEO, Appointments to positions as Accredited Practitioners are made in accordance with the requirements of the Facility and a periodic cycle determined by the FCEO and will be for a period of three (3) years to a maximum of five (5) years. The period will be determined by and within the complete discretion of the FCEO in line with State and Territory requirements. The date of Appointment being on the date the FCEO approves the Appointment.

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

(c) The period approved of between three to five years for the purpose of these By-Laws will begin and conclude in accordance with the sequence customary at the Facility.

8.5 **Nature of appointment**

(a) 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 processes or procedures will be incorporated or implied, other than processes and procedures that have been explicitly set out in these By-Laws or apply by reason of a public sector appointment or regulation.

(b) 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 and SVHA will generally conduct themselves in accordance with these By-Laws and there are no consequences for not doing so, other than by reason of a public sector appointment or regulation.

8.6 **Provisional Appointment**

(a) The FCEO may, in his or her complete discretion, decide to approve a provisional period of Appointment for up to one (1) year before an applicant proceeds to complete Accreditation, to be referred to as a provisional Appointment. If this occurs, the terms and conditions of the provisional Appointment will be within the complete discretion of the FCEO. Within one (1) month prior to the end of the provisional Appointment, a review will be undertaken by the FCEO. Should the provisional review outcome not support the granting of continued Accreditation, this outcome will be notified in writing by the FCEO and there will be no appeal available pursuant to these By-Laws with respect to this unsuccessful outcome.

8.7 **Temporary Appointment**

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

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

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

(d) Accreditation granted under this By-Law 8.7 will remain in force for a period of up to 90 days from the date of determination by the FCEO, with the period of Temporary Appointment in the complete discretion of the FCEO. Any extension is at the discretion of the FCEO, will be no longer than an additional 90 days and must be approved in writing by the FCEO.

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

(f) Temporary Appointment will automatically cease upon expiry of its term or at such other times as the FCEO decides.

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

8.8 **Urgent Appointments**

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

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

(i) Confirm registration with AHPRA; and

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

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

(d) Accreditation granted under By-Law 8.8 applies only to the specific patient or episode of care for which the accreditation is sought

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

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

(g) There will be no right of appeal pursuant to these By-Laws from decisions relating to the granting, termination or cessation of Urgent Appointments.

8.9 **Locum tenens**

(a) If an Accredited Practitioner nominates a Locum Tenens to provide services to his or her patients during a period of absence from the Facility and the nominee is not currently an Accredited Practitioner, the nominee must receive approval from the FCEO for Accreditation.

(b) Accreditation of a Locum Tenens may be made through the process for Temporary Appointment.

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

8.10 **On-Call arrangements**

(a) Although the FCEO may require participation by an Accredited Practitioner in on-call arrangements, an Accredited Practitioner has no entitlement to request participation in or remain in on-call arrangements.

(b) Removal (including temporary removal) from on-call arrangements may be made at the discretion of the FCEO or delegated head of the relevant speciality.

(c) There is no appeal available pursuant to these By-Laws with respect to decisions relating to on-call arrangements.

8.11 **Accreditation of other health practitioners**

(a) The FCEO may establish an Accreditation process at the Facility with respect to all or some categories of allied health professional or nurse practitioner.

(b) Prior to the Accreditation of an allied health professional or nurse practitioner, the FCEO will ensure appropriate registration and professional indemnity insurance arrangements.

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

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

8.12 **Third party providers**

(a) If certain services are delivered by a third party provider, such as medical imaging or pathology, the FCEO may require Medical Practitioners or other categories of health practitioner delivering the services on behalf of the third party provider to firstly be granted Accreditation pursuant to these By-Laws or alternatively may require the third party provider to undertake its own Accreditation process.

(b) Despite paragraph (a) above, Accreditation pursuant to these By-Laws is required for procedural and interventional Medical Practitioners and other categories of health practitioners performing procedural and interventional clinical services at the Facility.

(c) If a contract with a third party provider is terminated, the Accreditation of any Medical Practitioner or other categories of health practitioner delivering the services on behalf of the third party provider will also immediately terminate and there will be no appeal permitted pursuant to these By-Laws.

8.13 **Options with respect to ongoing and conclusion of Accreditation**

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

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

8.14 **Monitoring of Accreditation**

(a) The Facility will implement processes to monitor and audit Accreditation processes and compliance with approved Scope of Clinical Practice.

(b) Accredited Practitioners must comply with and provide all information necessary to assist the Facility with monitoring and audit pursuant to this By-Law.

(c) The Facility will implement processes to monitor and improve the effectiveness of Credentialing and Accreditation processes.

9. TERMS AND CONDITIONS OF APPOINTMENT OF ACCREDITED PRACTITIONERS

9.1 Compliance with By-Laws

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

9.2 General terms and conditions

Accredited Practitioners must:

(a) comply with rules, policies and procedures of SVHA and the Facility;

(b) strictly adhere to their authorised Scope of Clinical Practice;

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

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

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

(f) comply with, act in accordance with and achieve at a minimum the Behavioural Standards, which includes but is not limited to the Code of Conduct and the Catholic Health Code of Ethical Standards;

(g) consent to the sharing of information relating to their conduct within SVHA and to any College that they are a member of, but only to the extent necessary to obtain appropriate expert advice and provided the Facility has in place an agreement with the relevant College which includes terms and conditions applicable to sharing of information of Accredited Practitioners;

(h) not engage in any conduct that may be perceived as a reprisal against another person for making a report or supplying information relating to the Behavioural Standards Programs in place across SVHA;

(i) where applicable, provide appropriate professional mentorship and support to maintain the health and well-being of junior medical staff including active supervision for junior medical doctors in training whether in accredited or non-accredited positions;

(j) observe all requests made by the Facility with regard to his or her conduct in the Facility and with regard to the provision of services within the Facility and, upon request, meet with and discuss with the FCEO any matters arising out of these By-Laws;

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

(l) adhere to general Conditions of clinical practice applicable at the Facility;

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

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

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

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

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

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

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

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

9.3 **Responsibility for patients**

Accredited Practitioners must:

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

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

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

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

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

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

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

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

(i) provide adequate instructions and clinical handover to Facility staff and other Accredited Practitioners to enable them to understand what care the Accredited Practitioner requires to be delivered to his or her patients, appropriately supervising the care that is provided by the Facility staff and other Accredited Practitioners. If a patient is transferred to an intensive or critical care unit of the Facility, the Accredited Practitioner will maintain responsibility for matters relating to the surgery, procedure or anaesthetic (as the case may be);

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

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

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

(m) attend in person upon patients admitted or required to be treated by the Accredited Practitioner as frequently as is required by the clinical circumstances. Absent special circumstances, an Accredited Practitioner will review a patient in person within 24 hours of the patient being admitted under that Accredited Practitioner or within a shorter timeframe if clinically appropriate or requested by staff of the Facility. Prior to the initial attendance, the Accredited Practitioner will provide adequate written instructions for the management of the patient. Absent special circumstances as noted in the medical record, an Accredited Practitioner will thereafter review the patient

within clinically appropriate timeframes. If Accredited Practitioners are unable to provide this level of care personally, they will secure the agreement of another Accredited Practitioner to do so and notify this to staff of the Facility;

(n) upon request by staff of the Facility, attend in person upon patients under their care for the purposes of the proper care and treatment of those patients;

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

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

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

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

(s) ensure that patients are not discharged without review by and written approval of the Accredited Practitioner, complying with the discharge policy of the Facility. The Accredited Practitioner must ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the patient, patient's carer, referring practitioner, general practitioner and/or other treating practitioners.

9.4 **All admissions subject to approval**

(a) The ability of an Accredited Practitioner to admit a patient to the Facility will, at all times, be subject to approval of the FCEO and within the sole discretion of the FCEO;

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

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

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

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

(e) The decision of the FCEO with respect to the matters set out in By-Law 9.4 is final and there is no right of appeal pursuant to these By-Laws.

9.5 **Right to request discharge or transfer of patient**

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

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

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

9.6 **Safety and quality**

Accredited Practitioners must:

(a) familiarise themselves with, support and strictly adhere to Facility policies and procedures with respect to patient deterioration;

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

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

(c) 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 Facility time;

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

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

(f) comply with and assist the Facility to comply with programs or standards of State or Commonwealth health departments, statutory bodies or safety and quality organisations, including but not limited to the National Safety and Quality Health Service Standards and Clinical Care Standards of the Australian Commission on Safety and Quality in Health Care;

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

(h) meaningfully participate in clinical review and peer review Committee meetings, including review of clinical data and outcomes and respond to requests for information regarding statistical outliers, adverse events and

cases flagged in incidents, clinical indicator or key performance indicator reporting;

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

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

9.7 Professional Indemnity Insurance

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

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

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

(c) that is in an amount and on terms and conditions acceptable to the Facility; and

(d) that is with an insurance company acceptable to the Facility.

9.8 Annual disclosure

Accredited Practitioners must furnish annually to the Facility evidence of:

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

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

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

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

9.9 Continuous disclosure

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

(a) Credentials;

(b) Scope of Clinical Practice;

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

(d) Professional Indemnity Insurance status;

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

(f) Matters requiring notification or notified pursuant to By-Law 9.10.

9.10 **Advice of material issues**

Without limiting By-Law 9.9, Accredited Practitioners must advise the FCEO in writing as soon as possible but at least within two (2) business days if any of the following matters occur or come to the attention of the Accredited Practitioner:

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

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

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

(d) the initiation or conclusion of any process, inquiry, investigation or proceedings by any external body, including, but not restricted to, other health facilities, regulatory authorities, relevant registration boards, relevant colleges, polices, coroner, tribunal, court, complaints body or private health fund involving the Accredited Practitioner, irrespective of whether this relates to a patient of the Facility;

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

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

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

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

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

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

(k) matters regarded as Reportable Conduct; and

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

9.11 **Medical records**

Accredited Practitioners must:

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

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

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

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

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

(B) full and informed written patient consent;

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

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

(E) therapeutic orders;

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

(G) observations of the patient's progress;

(H) notes of any special problems or complications;

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

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

(K) any additional information required to meet contractual health fund obligations.

(b) complete an operation, procedure or anaesthetic report (as the case may be) that shall include a detailed account of the findings at surgery, the surgical technique undertaken, anaesthetic used, complications and post-operative orders, and the full name of any Surgical Assistant, anaesthetist and other

Medical Practitioner present. Operation reports shall be written or dictated as soon as is practicable and the report signed by the attending Accredited Practitioner and made part of the patient's Facility medical record;

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

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

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

(f) ensure that complications, incidents, variations and deviations from standard clinical pathways and expectations are recorded in the Facility medical record;

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

(h) cooperate and assist the Facility to comply with any audits relating to documents and associated requests for clarification of information recorded;

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

(j) medical records must not be removed from the facility without prior arrangement or approval.

9.12 **Continuing education**

Accredited Practitioners must:

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

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

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

9.13 **Clinical activity and utilisation**

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

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

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

(c) Facility resources are being appropriately managed and utilised to maximum potential;

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

(e) Facility resources are being appropriately managed and utilised to maximum potential including as a minimum either:

(i) 30 surgical procedures or

(ii) 30 patient admissions.

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

9.14 **Participation in Committees**

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

(b) In addition to the requirement under By-Law 9.14(a), Accredited Practitioners must meet all reasonable requests to participate in, and contribute actively to, Committees established to co-ordinate and direct the various functions of the Facility.

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

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

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

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

9.15 **Emergency/disaster planning**

Accredited Practitioners must:

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

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

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

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

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

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

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

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

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

(iv) will not engage in Reportable Conduct;

(c) The Accredited Practitioner must inform SVHA immediately if he or she is unable to give the undertakings set out in By-Law 9.14(b).

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

9.17 **Teaching and supervision**

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

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

(b) consent being given by the patient.

9.18 **Notifiable Conduct and mandatory reporting**

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

9.19 **Notice of leave**

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

(a) notify the FCEO in writing, at least four weeks in advance of holidays, and

(b) provide the name of a backup Accredited Practitioner during the Accredited Practitioner's absence.

10. TRANSFER OF ACCREDITATION STATUS BETWEEN FACILITIES

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

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

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

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

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

11. SURGICAL ASSISTANTS

11.1 **Use of Surgical Assistants**

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

(b) Accredited Practitioners are responsible for the conduct of and must directly supervise Surgical Assistants whilst assisting with procedures in the Facility.

11.2 **Accreditation**

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

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

11.3 **Term of Appointment**

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

11.4 **Appointments discretionary**

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

11.5 **Terms and conditions**

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

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

(b) agree to the requirements and undertakings set out in By-Law 9.14.

11.6 **No admitting or patient management rights**

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

11.7 **Amending Scope of Clinical Practice**

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

11.8 **Appeal**

No right of appeal will exist in respect of decisions made relating to Accreditation of a Surgical Assistant.

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

12.1 **Notice to Accredited Practitioner**

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

12.2 **Apply for Re-accreditation**

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

12.3 **Amendments**

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

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

(b) at any other time.

12.4 **Process**

Subject to SVHA or the relevant SVHA Group Entity policy or as otherwise determined by the FCEO for a specific application, the processes for Re-accreditation and/or amending the Scope of Clinical Practice of Accredited Practitioners under this By-Law 12 will otherwise be the same as for an initial Accreditation pursuant to By-Law 8.

12.5 **Review**

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

13. INQUIRY ARISING FROM CONCERNS, ALLEGATIONS OR COMPLAINTS

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

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

(a) non-compliance with the By-Laws;

(b) non-compliance with Scope of Clinical Practice;

(c) potential ground for suspension or termination of Accreditation;

(d) patient health or safety could be compromised;

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

(f) concerns may arise with respect to Competence, Performance or Current Fitness;

(g) incompatibility with Organisational Capabilities or Organisational Need;

(h) clinical conduct that falls below the standard as determined by the clinician's peers or management;

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

(j) the reputation of the Facility, a SVHA Group Entity or SVHA could be threatened or brought into disrepute;

(k) the potential loss or breach of the Facility's accreditation or licence, including associated terms or conditions;

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

(m) non-compliance with the Behavioural Standards;

(n) the interests of a patient, staff, another Accredited Practitioner or someone engaged in or at the Facility could be impacted or affected adversely; or

(o) a law may be contravened.

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

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

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

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

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

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

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

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

13.3 **Action by Facility Chief Executive Officer**

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

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

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

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

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

13.4 **Committee to assess issue of concern**

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

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

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

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

13.5 Notifiable Conduct and mandatory reporting in relation to any investigation

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

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

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

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

14. REVIEW OF ACCREDITATION OR SCOPE OF CLINICAL PRACTICE

14.1 Surveillance of AHPRA registration database

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

14.2 Grounds for review

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

(a) non-compliance with the By-Laws;

(b) non-compliance with Scope of Clinical Practice;

(c) potential ground for suspension or termination of Accreditation;

(d) patient health or safety could be compromised;

(e) concerns may arise with respect to Competence, Performance or Current Fitness;

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

(g) incompatibility with Organisational Capabilities or Organisational Need;

(h) loss of confidence in the Accredited Practitioner;

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

(j) the reputation of the Facility, a SVHA Group Entity or SVHA could be threatened or brought into disrepute;

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

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

(m) non-compliance with the Behavioural Standards;

(n) the interests of a patient, staff, another Accredited Practitioner or someone engaged in or at the Facility could be affected adversely; or

(o) a law may be contravened.

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

(a) The FCEO may, at any time, initiate an internal review to examine a ground or grounds set out in By-Law 14.2 and following such review the FCEO will make a decision concerning the continuation, amendment, suspension or termination of Accreditation.

(b) An internal review will be undertaken by a person or persons or Committee that is internal to SVHA.

(c) The FCEO will make a final determination in relation to the matter, subject to the provisions of By-Law 19.2.

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

(a) The FCEO may, at any time, initiate an external review to examine a ground or grounds set out in By-Law 14.2 and following such review the FCEO will make a decision concerning the continuation, amendment, suspension or termination of Accreditation.

(b) An external review will be undertaken by a person or persons that is external to SVHA.

(c) The FCEO will make a final determination in relation to the matter, subject to the provisions of By-Law 19.2 (appeals).

14.5 **Notice to Accredited Practitioners**

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

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

(c) The FCEO will decide on all procedural matters with respect to the review, which may include a determination on:

(i) terms of reference, process and reviewers;

(ii) opportunity for submissions, oral and/or written;

(iii) timeframes;

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

(v) format for review findings; and

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

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

(e) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO that the review is being undertaken under either By-Law 14.3 or 14.4.

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

Following a review under By-Law 14.3 or 14.4 the FCEO will consider the review findings and make a decision, which will include a determination whether or not to continue (including with conditions), amend, suspend or terminate Accreditation in accordance with the provisions set out in these By-Laws and, in the event a decision is make to continue with conditions this may include a decision that the Accredited Practitioner will:

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

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

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

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

14.7 **Notice of outcome of the review**

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

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

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

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

(b) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO of any mandatory reporting made under By-Law 14.8.

14.9 Interrelationship with By-Law 13

(a) For the avoidance of any doubt, the FCEO is not required to comply with By-Law 13 before proceeding with a review pursuant to By-Law 14.

15. SUSPENSION

15.1 Grounds for Suspension

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

(a) it is in the interests of patient care or safety;

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

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

(d) professional registration has been suspended in whole or in part;

(e) professional registration has been amended, conditions imposed or undertakings agreed;

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

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

(h) the Accredited Practitioner has breached any Conditions of Accreditation;

(i) the Accredited Practitioner has breached the By-Laws;

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

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

(l) based upon information notified pursuant to By-Laws 9.7 or 9.8;

(m) a failure to notify or provide continuous disclosure of a matter required pursuant to By-Laws 9.7 or 9.8;

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

(o) the Accredited practitioner has been found to have made a false declaration or provided inaccurate information to the Facility either through omission of important information or inclusion of false, incomplete or inaccurate information (regardless of whether this is intentional or not);

(p) based upon the outcome of a review carried out pursuant to By-Law 14;

(q) based upon an ongoing criminal investigation or conviction; or

(r) there are other issues or unresolved concerns (including with respect to an ongoing or completed investigation that is internal or external to SVHA) in respect of the Accredited Practitioner that the FCEO considers is a ground for suspension.

15.2 **Suspension framework**

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

(b) Prior to making the decision to impose a suspension, the FCEO will ordinarily consult with the SVHA Group Chief Medical Officer and DCEO, however it is recognised that in the interests of patient safety on occasion this may not be possible.

(c) A ground for suspension may relate to matters external to the Facility or SVHA.

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

(e) 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.

15.3 **Notification of suspension decision**

(a) The FCEO will notify the Accredited Practitioner of:

(i) the fact of the suspension;

(ii) the period of suspension;

(iii) the reasons for the suspension;

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

(v) if the FCEO considers it appropriate in the circumstances, any actions that must be performed for the suspension to be lifted and the timeframe for the actions to occur; and

(vi) the right of appeal (if available).

(b) As an alternative to an immediate suspension, the FCEO may elect to deliver a show cause notice to the Accredited Practitioner advising of:

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

(d) the grounds upon which suspension may occur;

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

(f) 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;

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

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

15.4 **Suspension effective immediately**

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

(b) Suspension is ended either by terminating Accreditation or lifting the suspension.

15.5 **Alternative arrangements for patients**

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

15.6 **Appeal rights**

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

15.7 **Notification to Board**

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

15.8 **Notifiable Conduct and Mandatory Reporting**

(a) The FCEO must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation*

National Law Act 2009*,* (including in relation to any suspension of Accreditation of an Accredited Practitioner under By-law 15, as enforced in each State and Territory*.*

(b) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO of any mandatory reporting made under By-Law 15.8.

15.9 **Interrelationship with By-Laws 13 and 14**

(c) For the avoidance of any doubt, the FCEO is not required to comply with By-Laws 13 or 14 before proceeding with action pursuant to By-Law 15.

16. TERMINATION OF ACCREDITATION

16.1 **Immediate termination**

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

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

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

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

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

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

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

16.2 **Unprofessional Conduct**

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

16.3 **Termination when not immediate**

In the event of a decision to terminate Accreditation, an Accredited Practitioner in accordance with any of the items below, the FCEO may, in considering circumstances that may impact on patient safety, agree to a limited period of time for

the termination to take affect enabling the Accredited Practitioner to continue to manage inpatients within the facility.

(a) based upon any of the matters in By-Law 15.1 and it is considered by the FCEO that suspension is an insufficient response in the circumstances;

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

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

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

(e) the Accreditation or Scope of Clinical Practice is no longer supported by the Organisational Need or Organisational Capabilities of the Facility;

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

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

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

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

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

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

16.4 **Termination framework**

(a) Prior to making the decision to terminate Accreditation, the FCEO will ordinarily consult with the SVHA Group Chief Medical Officer and DCEO, however it is recognised that in the interests of patient safety, on occasion this may not be possible.

(b) A ground for termination may relate to matters external to the Facility or SVHA.

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

By-Law 16. The support person is not to participate in the process. Should the support person be a lawyer that same person must not act as a legal representative for the Accredited Practitioner.

(d) 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.

16.5 **Notification of termination decision**

(a) The FCEO will notify the Accredited Practitioner of:

(i) the fact of the termination;

(ii) the reasons for the termination;

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

(iv) the right of appeal (if available).

(b) As an alternative to an immediate termination, the FCEO may elect to deliver a show cause notice to the Accredited Practitioner advising of:

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

(d) the grounds upon which termination may occur;

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

(f) 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

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

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

16.6 **Notification to Board**

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

16.7 **Appeal rights**

(a) No right of appeal will exist in respect of immediate termination of Accreditation pursuant to By-Laws 16.1 and 16.2.

(b) For a termination of Accreditation pursuant to By-Law 16.3, the Accredited Practitioner shall have the rights of appeal established by these By-Laws.

16.8 **Immediate Termination at each Facility**

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

16.9 **Notifiable Conduct and Mandatory Reporting**

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

(b) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO of any mandatory reporting made under By-Law 16.8.

16.10 **Interrelationship with By-Laws 13 and 14**

(c) For the avoidance of any doubt, the FCEO is not required to comply with By-Laws 13 or 14 before proceeding with action pursuant to By-Law 16.

17. IMPOSITION OF CONDITIONS

17.1 **Imposing Conditions in lieu of suspension or termination**

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

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

(c) The FCEO will notify the Accredited Practitioner in writing of:

(i) the conditions imposed;

(ii) the reasons for it;

(iii) the consequences if the conditions are breached;

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

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

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

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

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

(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 protective process primarily for the purpose of staff and patient safety and quality of patient care, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

17.2 Notification of conditions

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

17.3 Notification to Board

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

17.4 Notifiable Conduct and Mandatory Reporting

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

(b) The FCEO must advise the SVHA Group Chief Medical Officer and DCEO of any mandatory reporting made under By-Law 17.

18. APPEAL RIGHTS

18.1 No appeal rights against refusal of initial or probationary Appointment

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

18.2 Appeal rights generally

Except where these By-Laws state otherwise, a Medical Practitioner or Dental Practitioner who has Accreditation in respect of the Facility and whose Accreditation

is amended, made conditional, suspended, terminated, not renewed or conditionally renewed by the Facility, will have the rights of appeal set out in By-Law 19.

18.3 Concurrent appeal rights

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

19. APPEAL PROCEDURE

19.1 Appeal must be lodged in fourteen days

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

(b) Upon receipt of a notice of appeal, the FCEO will forward the notice of appeal to the DCEO.

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

19.2 Relevant Committee established to hear appeal

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

(a) a nominee of the DCEO or the SVHA Group Chief Medical Officer, who may be an Accredited Practitioner, who must be independent of the decision under appeal and who will be the chairperson of the appeals Committee;

(b) a nominee of the FCEO, who may be an Accredited Practitioner, and who must be independent of the decision under appeal; and

(c) any other member or members who bring specific expertise to the decision under appeal, with at least one member preferably but not necessarily practising in the same area of practice or speciality of the appellant, as determined by the DCEO, who must be independent of the decision under appeal and who may be an Accredited Practitioner. The DCEO in his or her complete discretion may invite the appellant to make suggestions or comments with respect to the proposed additional members of the appeals Committee, but is not bound to follow the suggestions or comments.

19.3 Commissioning and Commencement

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

(b) The DCEO will prepare terms of reference and submit relevant material to the chairperson of the appeals Committee.

19.4 **Procedure for appeal**

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

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

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

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

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

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

(g) Neither the appellant nor any party will have any legal representation at any meeting of the appeals Committee. The appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the appeals Committee, as the appeal is intended to be conducted through direct communication between the appellant and appeals Committee.

(h) The appellant and FCEO are not entitled to be present during deliberations of the appeals Committee.

19.5 **Recommendation of appeals Committee**

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

(b) The recommendation of the appeals Committee may be made by a majority of the members of the appeals Committee and, if an even number, the Chairperson has the deciding vote.

(c) The DCEO will provide a copy of the written recommendation of the appeals Committee to the Board, SVHA Chief Medical Officer, FCEO and appellant.

(d) The Board will consider the recommendation of the appeals Committee, and any information or documents before the appeals Committee that the Board may require, and the Board will make a decision regarding the appeal.

(e) The decision of the Board will be notified in writing to the DCEO, SVHA Chief Medical Officer, FCEO and appellant.

(f) Any actions required arising from the decision of the Board, including notifications that may be required internally and externally, will be the responsibility of the FCEO.

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

20. RESEARCH

20.1 Approval of research

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

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

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

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

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

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

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

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

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

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

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

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

20.2 Withdrawal or disapproval of research

The FCEO may decide not to approve, or withdraw permission for, or place Conditions upon, the conduct or continuation of research involving treatment of human subjects at the Facility if in his or her opinion the research:

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

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

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

(d) is inconsistent with good professional practice; and

There is no appeal available pursuant to these By-Laws from the decision of the FCEO or with respect to the approval of the HREC.

21. EXPERIMENTAL OR INNOVATIVE TREATMENT OR TECHNIQUES

21.1 Approval of experimental treatment or techniques

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

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

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

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

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

21.2 Approval by the FCEO

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

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

(c) There is no appeal available pursuant to these By-Laws from the decision of the FCEO.

21.3 Ethical issues and human subjects

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

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

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

21.4 New Clinical Services, Procedures or Other Interventions

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

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

(c) The relevant Committee will advise the FCEO:

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

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

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

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

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

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

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

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

(iv) if applicable in the circumstances, evidence will be provided that private health funds will adequately fund; and

(v) notify the relevant Committee; and

(vi) there is no appeal available pursuant to these By-Laws from the decision of the FCEO.

22. MANAGEMENT OF EMERGENCIES

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

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

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

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

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

23. REPUTATION OF THE FACILITY

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

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

23.2 Accredited Practitioner to cease upon notice from the FCEO

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

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

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

decision. The FCEO may, in its absolute discretion, affirm or vary the decision of the scope of clinical practice Committee.

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

24. DISPUTES

24.1 Committees

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

25. REVISION OF BY-LAWS

(a) The Board may from time to time, make, amend, suspend or rescind any By-Law.

(b) The Board will initiative a review of these By-Laws not less than every five years.

26. FACILITY SCHEDULES

See following pages

This page is intentionally blank

ST VINCENT'S HOSPITAL MELBOURNE

SCHEDULES

Schedule 1

Amendments to the Model By-Laws for St Vincent's Hospital (Melbourne) Limited

Part A – Supplementary and amending By-Laws

1. By-Law 2. 1 Definitions is **amended** by:

(a) amending the definition of *Accreditation Classification* as follows:

Accreditation Classification means one or more of the following designated classifications of an Accredited Practitioner in respect of the Facility to which Accreditation has been granted:

(a) Dental Practitioner;

(b) Fellow;

(c) Fractional Specialist Medical Practitioner;

(d) Full Time Specialist Medical Practitioner;

(e) General Medical Practitioner;

(f) Honorary Medical Officer;

(g) Hospital Medical Officer;

(h) Medical Officer

(i) Registrar and

(j) Visiting Medical Practitioner.

A **Medical Observer** is not an Accredited Practitioner**.** A Medical Observer is a Medical Practitioner who seeks to develop familiarity with a particular procedure, process or modes of care at St Vincent's Hospital (Melbourne) Limited (St Vincent's (Melbourne)). Medical Observers are appointed under the supervision or direction of a specific member of the Senior Medical Staff and the medical staff of his or her unit. Such appointments are on an unpaid basis and do not constitute employment for any purpose. A Medical Observer enters into an Agreement with the Facility and does not have an individual Scope of Clinical Practice. (See *St Vincent's (Melbourne) Medical Observer Policy*)

A **Visiting Independent Medical Practitioner** (VIMP) is a Medical Practitioner who is not employed by St Vincent's (Melbourne), who attends to or treats a patient at the patient's request and/or at the request of St Vincent's (Melbourne). Examples include:

a) A private General Practitioner (or his/her locum) of a residential aged care client;

b) An independent anaesthetist who attends an acute aged care psychiatric unit to participate in ECT (Electroconvulsive Therapy); and

c) An independent specialist invited by a St Vincent's (Melbourne) Accredited Practitioner to undertake a consultation on a patient.

A VIMP is not provided formal Accreditation under these By-Laws however St Vincent's (Melbourne) policy requires that medical registration be verified and a relevant scope of clinical practice be approved by the Medical Advisory Committee.

Facility by deleting the definition and **replacing** it with:

Facility *means any hospital, aged care facility or day procedure centre, health service in a correctional setting or any other premise at which St Vincent's (Melbourne) provides health services including but not limited to:*

- *St Vincent's Hospital, Melbourne, Fitzroy Campus*
- *St George's Health Service and Berengarra, Kew*
- *Prague House, Kew*
- *Caritas Christi Hospice, Kew*
- *St Vincent's Hospital on the Park, East Melbourne*

(b) adding the following new definitions:

Fellow means a Medical Practitioner who is undertaking specialist training or who has recently completed specialist training or who is otherwise designated as a "Fellow" by St Vincent's (Melbourne).

Fractional Specialist means a Specialist Medical Practitioner who is engaged to work on a fractional basis of 35 hours or less per week.

Full-Time Specialist means a Specialist Medical Practitioner who is engaged to work on a full time basis**.**

General Practitioner means a registered medical practitioner who is qualified and competent for general practice in Australia.

Honorary Medical Officers means a Medical Officer who is given an appointment to an unpaid position with a defined Scope of Clinical Practice in clinical practice, teaching or research.

Hospital Medical Officer means a doctor with three or less years of experience and who is not performing the duties of a Medical Officer or a Registrar

Medical Officer means a doctor with three (3) or more completed years of experience and who is not performing the duties of a Registrar

Registrar means a doctor who is appointed to an accredited specialist training position or who holds a position designated as such by the hospital.

(c) **Visiting Independent Medical Practitioner** means a Medical Practitioner, who may be a General Practitioner or is otherwise contracted by the Hospital to deliver medical services, who is given an Honorary Appointment and has a defined Scope of Clinical Practice to visit and attend to their patients or a group of patients as part of a specific program of St. Vincent's Melbourne.

(d) Deleting the definition "**Surgical Assistant**".

2. **By-Law 7.1 Objectives** is **amended** by deleting section (a) and in sub section (c) deleting the words **"and administrative"**

3. **By-Law 7.5 Mandatory attendance** is **amended** by:

Sub section (a) is deleted and **replaced** with

(a) It is a condition of Accreditation that:

(i) All Accredited Practitioners must attend and participate in at least one specialty review committee meeting annually; and,

(ii)

4. **By-Law 11 Surgical Assistants** is **amended** by deleting sections 11.1 to 11.8 and **replacing** it with:

"This By-Law 11 does not apply to St Vincent's (Melbourne).

5. **By-Law 22.4 New Clinical Services, Procedures or Other Interventions** is **amended** as follows:

1. In (a) by **replacing** "Chief Executive Officer" with ***"Medical Advisory Committee"***

2. In (b) by **replacing** "Scope of Clinical Practice" with ***"Medical Advisory"***

SCHEDULE 2

Committees - Terms of Reference
Part A: Medical Advisory Committee
Part B: Mortality and Clinical Review Committee

SCHEDULE 2, PART A: MEDICAL ADVISORY COMMITTEE

1. GOVERNING BODY

St Vincent's Health Australia Limited

2. ENTITY/FACILITY

This Committee is established for all facilities of St Vincent's Hospital (Melbourne) Limited including but not limited to:

(a) St Vincent's Hospital, Melbourne, Fitzroy Campus

(b) St Vincent's on the Park, East Melbourne

(c) St George's Health Service and Berengarra, Kew

(d) Prague House, Kew

(e) Caritas Christi Hospice, Kew

3. AUTHORITY TO ESTABLISH COMMITTEE

The Hospital Chief Executive Officer (HCEO) is responsible for the overall governance of St Vincent's Hospital (Melbourne) Limited. To ensure effective governance in an efficient manner the HCEO will establish committees to undertake various governance functions of the HCEO in relation to the appointments of up to 12 months, credentialing, definition of scope of clinical practice and approval of new interventions and techniques and to report to the HCEO on committee work.

4. DEFINITIONS

By-Law means the St Vincent's Health Australia Limited Group Model By-Laws as amended for St Vincent's (Melbourne) in accordance with Schedule 1.

HCEO means the CEO of St Vincent's (Melbourne).

St Vincent's (Melbourne) means St Vincent's Hospital (Melbourne) Limited and all its operated facilities.

SVHA means St Vincent's Health Australia Limited

SVHM means St Vincent's Hospital (Melbourne) Limited

5. NAME OF COMMITTEE

Medical Advisory Committee

6. PURPOSE OF COMMITTEE

The purpose of the Medical Advisory Committee is to:

(a) Protect, promote and maintain health and safety of the public by ensuring proper standards in the practice of medicine at St Vincent's (Melbourne)

(b) Act as the St Vincent's (Melbourne) Scope of Practice Committee for medical practitioners

(c) Provide advice in relation to clinical services, procedures or other interventions to ensure these are delivered by competent clinicians, in an environment that supports safety and high quality care

(d) Promote efficient and effective clinical processes

(e) Ensure compliance with all applicable internal and external policy and procedures and legislation

(f) Approve, Monitor and review the safety and efficacy and safe introduction of new clinical services, procedures and other interventions and clinical devices

(g) Consider and where appropriate approve applications for sabbatical leave from Senior Medical Staff

(h) Oversee the processes for performance management and performance appraisal of Senior Medical Staff

(i) Provide advice on significant professional and clinical leadership issues affecting senior medical staff including Senior Medical Staff establishment (new positions, recruitment and succession planning)

7. ROLE AND FUNCTION

(a) Short Term Appointments

  (i) Ensure verification of training, qualifications, experience and registration status prior to appointment of Hospital Medical Officers, Fellows and Senior Medical Officer for 12 months or less

  (ii) Consider the recommendation of the Executive Director of Medical Services, Aged and Community Care or the Executive Director of Surgery and Surgical Services in relation to appointment of Hospital Medical Officers, Fellows and Senior Medical Officer for 12 months or less.

(b) Advice on clinical services

Provide advice in relation to clinical services, procedures or other interventions to ensure these are delivered by competent clinicians, in an environment that supports safety and high quality care.

(c) Safe Introduction of New Interventions and Treatments

Monitor, review and approve the safety and efficacy of new clinical services, procedures and other interventions and clinical devices.

(d) Senior Medical Staff

(i) Consider and where appropriate approve applications for sabbatical leave from senior medical staff.

(ii) Oversee the processes for performance management and performance appraisal of senior medical staff.

(iii) Provide advice on significant professional and clinical leadership issues affecting senior medical staff including Senior Medical Staff establishment (new positions, recruitment and succession planning).

(e) Credentialing and Recredentialing

In performing all functions including credentialing and recredentialing ensure adherence to:

(i) Mission and values of SVHA

(ii) The By Laws

(iii) Victorian Department of Health and Human Services (DHHS) Policy and Guidelines and Ministerial Directives

(iv) Human resource management policies and procedures of SVHA and St Vincent's (Melbourne) including SVHA Clinical Credentialing and Defining Scope of Practice Policy and SVHM Safe Introduction of New Interventions and Treatments Policy

(v) Principles of equal employment opportunity, merit, natural justice and procedural fairness and prevention of discrimination

(vi) All applicable legislation

8. COMPOSITION

The Committee has 12 members:

(a) HCEO

(b) SVHM Chief Medical Officer (Chair)

(c) Executive Director Integrated Care

(d) Executive Director Acute Services

(e) Chair of the SVHM Senior Medical Staff Association

(f) Chair of the SVHM Division of Medicine

(g) Chair of the SVHM Division of Surgery

(h) A Director of Pathology

(i) Director of Anaesthesia

(j) Executive Director of People and Corporate Services

Other persons may attend a meeting or meetings at the request of the Chair or the SVHM Chief Executive Officer.

9. APPOINTMENTS

(a) Appointment of chair

The Chair will be the Chief Medical Officer.

(b) Appointment of committee secretary

The Director of People and Corporate Services will ensure that secretariat services are provided to the Committee including a Committee Secretary and/or Minute Taker.

(c) Appointment of members

Members will be appointed by the HCEO.

10. TERM OF OFFICE

(a) Members hold office for the term of their appointment to the role or until the HCEO determines that their appointment has concluded.

(b) Occasional vacancies will be filled by the HCEO in consultation with the Chair as they arise.

11. TRAINING OF MEMBERS

Initial and ongoing training of members will be provided by the HCEO or delegate.

12. MEETINGS

(a) Frequency

The Committee will meet monthly on dates and at times determined by the Chairperson.

(b) Form of Meeting

(i) The Committee may meet in person or by electronic means in accordance with By Law 2.2 (e).

(ii) The Committee may choose to pass a resolution without a meeting in accordance with By Law 2.2 (a) (d).

(c) Notice of meetings

The Committee will receive notice of meeting at least five (5) working days prior to the meeting.

(d) Committee papers

Papers will be circulated with the Notice of Meeting at least five (5) working days prior to the meeting.

(e) Quorum

Quorum for the meeting is 5 members.

(f) Voting

Voting will be on a simple majority basis. Each member present at the meeting will have one vote and in the event of a tied vote the Chair will have the casting vote. There will be no proxy vote.

(g) Minutes

Formal Minutes will be taken at each meeting and after approval from the Chair, draft minutes will be distributed to members as soon as practicable after the meeting. Draft Minutes will also be distributed with the papers for the following meeting and considered for adoption.

13. DECLARATION OF CONFLICT OF INTEREST

The provisions of By-Law 6 apply to the requirement and process for disclosures of interests of members of the Committee.

14. SUB-COMMITTEES

(a) The Committee may establish such sub committees as it considers necessary including sub committees to act as part of a selection panel in relation to appointments.

(b) A Committee member may not sit on a selection panel for a candidate for whom she or he has provided a reference or has offered to act as referee without the express permission of the HCEO or delegate.

15. ASSESSMENT OF COMMITTEE PERFORMANCE

The Committee will assess its performance biannually and will participate in other assessment of its performance as required by the HCEO from time to time. The Committee may make recommendations to improve the Committee's performance to the HCEO.

16. REPORTING ARRANGEMENTS

The Committee formally reports to HCEO.

17. REVIEW OF TERMS OF REFERENCE

These Terms of reference will be reviewed annually at the first meeting for each calendar year annually and the Committee may make recommendations through the Chair to the HCEO to suggest improvements or amendments to the Terms of Reference.

SCHEDULE 2, PART B: MORTALITY AND CLINICAL REVIEW COMMITTEE

1. GOVERNING BODY

St Vincent's Health Australia Limited

2. ENTITY/FACILITY

This Committee is established for all facilities of St Vincent's Hospital (Melbourne) Limited including but not limited to

(a) St Vincent's Hospital, Melbourne, Fitzroy Campus

(b) St Vincent's on the Park, East Melbourne

(c) St George's Health Service, Kew

(d) Prague House, Kew

(e) Caritas Christi Hospice, Kew

3. AUTHORITY TO ESTABLISH COMMITTEE

The Hospital Chief Executive Officer (HCEO) is responsible for the overall governance of St Vincent's Hospital (Melbourne) Limited. To ensure effective governance in an efficient manner the HCEO will establish committees to undertake various governance functions of the HCEO in relation to quality and safety of clinical practices and the clinical competence of those providing those services.

4. DEFINITIONS

By-Laws means the St Vincent's Health Australia Limited Group Model By-Laws as amended for St Vincent's (Melbourne) in accordance with Schedule 1.

HCEO means the Chief Executive Officer of St Vincent's (Melbourne).

St Vincent's (Melbourne) means St Vincent's Hospital (Melbourne) Limited and all its operated facilities.

SVHA means St Vincent's Health Australia Limited

SVHM means St Vincent's Hospital (Melbourne) Limited

5. NAME OF COMMITTEE

Mortality and Clinical Review Committee

6. PURPOSE OF COMMITTEE

The purpose of the Mortality and Clinical Review Committee is to:

(a) Protect, promote and maintain health and safety of the public by ensuring proper standards in the practice of medicine at St Vincent's (Melbourne);

(b) Assess and evaluate the quality of health services provided by St Vincent's (Melbourne) in any and all of its facilities;

(c) Review clinical practices or clinical competence of persons providing those services;

(d) Provide an additional independent review to that conducted by the relevant Senior Clinician and treating clinical team of patient mortality and significant non-fatal adverse clinical events within St Vincent's (episodes); and

(e) To act in the public interest by providing a forum in which learnings, opportunities for improvement, strategies for preventing recurrence of system errors and minimising the risk of harm to patients can be identified.

7. ROLE AND FUNCTION

(a) A member of the MCRC who is designated by the MCRC will regularly screen the medical records of the Hospital for Episodes.

(b) Where there is an identified potential quality of care issue in an Episode a summary will be forwarded to the MCRC for detailed review and discussion.

(c) The MCRC will also review all 'reportable' deaths as prescribed by the regulations of the Coroners Act 1985 (amended 1999). Accordingly, the following Hospital deaths will be reviewed:

  (i) a death that appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from accident or injury;

  (ii) a death that occurs during a medical procedure or following a medical procedure, was causally related to the procedure, and was not to be reasonably expected;

  (iii) a death that will not result in a Certificate of Cause of Death being signed;

  (iv) a death that occurred in custody or care;

  (v) a death that relates to a person of unknown identity;

  (vi) a death that relates to a patient within the meaning of the Mental Health Act 1986.

(d) The SVHM Executive, SVHM Clinical Quality and Safety Committee and/or the SVHM Audit and Risk Committee may from time to time, refer an Episode to the

MCRC for investigation and reporting. These will include the sentinel adverse events defined from time to time by the Victorian Department of Health and Human Services (DHHS).

(e) The MCRC will regularly review mortality trends and compare these with best practice outcomes. The equation used to calculate this rate is: Mortality rate = (the number of deaths / number of occupied bed days) x 1000. Any significant variation will be examined and reported with appropriate recommendations aimed at correction.

(f) The MCRC will review the data sent from the Victorian Surgical Consultative Council Surgical Outcomes Information Initiative (SOII) and report to Heads of Units where no variance has occurred.

(g) MCRC will review the data sent from the Victorian Surgical Consultative Council Surgical Outcomes Information Initiative (SOII) and initiate an investigation where a variance has occurred with the relevant Head of Unit and Surgeons and report back to the committee the outcome of the investigation.

(h) Following MCRC review, cases requiring further clarification will be referred to a relevant sub-committee for investigation, review or response.

(i) Wherever possible, the MCRC will facilitate quality improvement processes (e.g. new procedures, policies, education programs) to reduce the risk of harm to patients. This may involve establishment of working parties on specific issues that arise.

(j) The MCRC will receive reports from its sub-committees and ensure that appropriate action has been taken in respect of matters raised by those sub-committees.

(k) The MCRC will review clinical practices or clinical competence of persons providing clinical services, as required under Section 139(2)(b) of the Health Services Act. A meeting of the MCRC to consider clinical practices or clinical competence will not be properly constituted unless the chair of the senior medical staff (or nominee) is in attendance.

(l) To ensure that all hospital staff are aware that the MCRC will receive on a confidential basis any issues of concern about clinical competence of a practitioner, the MCRC will establish a mechanism for such notification, which appropriately protects the informant.

(m) Where it is difficult to distinguish whether an activity would constitute quality assurance or research the MCRC can refer items to the Human Research and Ethics Committee for review. This may be required if an investigation has the potential for infringing basic ethical principles.

8. AUTHORITY AND REPORTING

(a) Through the HCEO, the MCRC will provide de-identified material representing the learnings to the SVHA Board and SVHA Group Clinical Quality and Risk Committee. Those reports may include recommendations relating to:

(i) Patient care and clinical procedures whether or not as a result of investigation or Episodes;

(ii) Changes to clinical and other procedures;

(iii) Appropriate discipline, counselling and education of staff involved in episodes.

(b) De-identified material representing the learnings will also be provided to the St Vincent's Executive Clinical Quality and Safety Committee.

(c) De identified material representing the learnings will be provided to Heads of Units.

(d) The MCRC is authorised to:

(i) seek any information it requires from any employee; and all employees are directed to co-operate with any lawful request made by the MCRC; and external parties;

(ii) obtain outside legal or other independent professional advice;

(iii) ensure the attendance of external parties with relevant experience and expertise.

9. COMPOSITION

(a) The Committee will be comprised of those persons holding the offices listed in Appendix 1 and such other senior hospital and medical staff, non-medical staff and others with appropriate skills and expertise as the HCEO may subsequently from time to time appoint.

(b) If there is an item of business to be transacted at a meeting of the MCRC that is determined by the Chair on reasonable grounds to specifically relate to one or more groups of the various medical disciplines within the Hospital, then the Chair may require representatives from those groups or with an interest in that Episode to attend that meeting.

(c) The MCRC shall keep a register of the names of the members and any alteration in the membership from time to time.

10. APPOINTMENTS

(a) Appointment of chair

The Chair will be the SVHM Chief Medical Officer.

(b) Appointment of committee secretary

The Chief Medical Officer will ensure that secretariat services are provided to the Committee including a Committee Secretary and/or Minute Taker.

(c) Appointment of members

Members will be appointed by the HCEO.

11. TERM OF OFFICE

(a) Subject to Clauses 10(b) and (c) the person holding the office stipulated in Appendix 1 and Appendix 2 will be the member. If that person ceases to hold that office that person shall immediately cease to be a member of the MCRC and the successor to that office will, on that person's commencement of that office, become the member of the MCRC.

(b) Notwithstanding Clause 10(a) the HCEO has the power to remove a member of the MCRC without assigning a reason for such removal.

(c) Other than those members holding office by virtue of their office within the Hospital, members appointed by the HCEO will serve for a period of two years but may be reappointed. The cycle is linked to the December meeting. Casual vacancies, when they arise, will be filled by the HCEO.

12. TRAINING OF MEMBERS

Initial and ongoing training of members will be provided by the SVHM Chief Medical Officer or her nominee.

13. MEETINGS

(a) Frequency

The MCRC shall meet a minimum of eight times per year, the HCEO or CMO may convene a meeting of the MCRC whenever he or she considers it necessary.

(b) Form of Meeting

The Committee may meet in person or by electronic means in accordance with By Law 2.2 (e).

(c) Notice of meetings

A Notice of Meeting will be provided at least five (5) working days prior to the meeting.

(d) Committee papers

Papers will be circulated with the Notice of Meeting at least five (5) working days prior to the meeting.

(e) Quorum

Quorum for the meeting is 5 members from those listed in Appendix 1.

(f) Voting

Voting will be on a simple majority basis. Each member present at the meeting will have one vote and in the event of a tied vote the Chair will have the casting vote. There will be no proxy vote.

(g) Minutes

(i) Formal Minutes will be taken at each meeting.

14. DECLARATION OF CONFLICT OF INTEREST

The provisions of By-Law 6 apply to the requirement and process for disclosures of interests of members of the Committee.

15. SUB-COMMITTEES

The Committee may establish such sub committees as it considers necessary to fulfil its purpose and functions.

16. ASSESSMENT OF COMMITTEE PERFORMANCE

The Committee will participate in assessment of its performance as required by the HCEO from time to time. The Committee may make recommendations to improve the Committee's performance to the HCEO through the SVHM Chief Medical Officer.

17. REPORTING ARRANGEMENTS

The Committee formally reports to HCEO St Vincent's (Melbourne).

18. REVIEW OF TERMS OF REFERENCE

These Terms of reference will be reviewed annually at the first meeting for each calendar year and the Committee may make recommendations through the Chair to the SVHM Chief Executive Officer to suggest improvements or amendments to the Terms of Reference.

See also Appendix 1 and Appendix 2

APPENDIX 1: MORTALITY & CLINICAL REVIEW COMMITTEE MEMBERS

LIST OF CORE MEMBERS

SVHM Hospital Chief Executive Officer
Chief Medical Officer (Chair)
Chief Nursing Officer
Corporate Counsel
Executive Director of Integrated Services
Executive Director of Acute Services
Chair of Senior Medical Staff
Clinical Risk Manager
Director of Medical Education and Stimulation
General Manager Quality & Risk
Medical Case Reviewer
Manager of Nursing Education
Head of Surgery

LIST OF OCCASIONAL MEMBERS

Senior Anaesthesia Registrar
Consultant of Anaesthetist
Anatomical Pathologist
Cardiothoracic Surgeon
Consultant Cardiologist
Medical Director Correctional Health
Cardiothoracic Surgeon
Quality Coordinator for Mental Health
Respiratory and Sleep Medicine Physician
Director of Emergency Medicine
Intensive Care Representative
Haematology Representative
Colorectal Surgeon

Consultant Dermatologist
Specialist in Medical Imaging
Addiction Medicine Specialist
Emergency Medicine Physician
Consultant Endocrinologist
ENT Surgeon
Director ENT/Head and Neck Surgery
Consultant Gastroenterologist
Head of General Medicine
Head of Geriatric Medicine
Consultant Geriatrician
Upper GI/Hepatobiliary Surgeon
Consultant Haematologist
Director of Clinical Immunology
Consultant Clinical Immunologist
Infectious Diseases Physician
Consultant Critical Care Physician
Consultant Psychiatrist
Manager, Mental Health Service
Senior Nurse, Mental Health Service
Team Manager, Mental Health Service
Director Mental Health Services
Professor/Director of Psychiatry of Old Age
Medical Microbiologist
Consultant Nephrologist
Director of Nursing SGHS
Director of Nursing, Fitzroy
Consultant Neurosurgeon
Consultant Neurologist
Consultant Oncologist
Orthopaedic Surgeon
Palliative Care Physician
Plastic Surgeon

Consultant Radiologist
Director of Rehabilitation
Rehabilitation Consultant
Consultant, Rheumatologist
Stroke Physician
General Surgeon
Consultant Urologist
Vascular Surgeon
Fellow in Medical Administration

LIST of ADDITIONAL CEO APPONTED MEMBERS

NIL	