# HEALTHE CARE GROUP PTY LTD

# HOSPITAL BY-LAWS

**Commercial in confidence**

**For Implementation from 10 February 2025 (version 7)**

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# FOREWARD

1. This document sets out the By-Laws that are to be adopted by Healthe Care Group Pty Ltd (**Healthe Care or HC Group**) and its subsidiaries.

2. The By-Laws are to be used by the HC Group Board (the "**Board**") and the HC Group subsidiaries to determine the clinical governance and all other requirements with respect to Accredited Practitioners.

3. These By-Laws apply to all Facilities of HC Group.

4. The By-Laws are supplemented by a suite of terms of reference, forms, policies, procedures, protocols and other supporting documents. These form part of the By-Laws and require compliance in the same way as if they were included in the By-Laws.

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

6. Where the Facility Chief Executive Officer (FCEO) has delegated their authority to a Delegated Authority in respect of any power under a particular By-Law, a reference to the FCEO in that By-Law will also include that Delegated Authority.

## 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 certain Allied Health Professionals providing services at a Facility.

Credentialing and defining the Scope of Clinical Practice are governance responsibilities of the FCEO and may be delegated as appropriate.

As a group of private, acute care, psychiatric, rehabilitation, day surgery facilities, Group's policies and practices reflect and are consistent with the expectation of the communities within which HC Group's Facilities are located. Those who obtain Accreditation as an Accredited Practitioner at one or more Facilities agree to respect and observe those principles embodied in the following (as amended from time to time):

1. HC Group's Mission, Vision and Values
2. HC Group's Code of Conduct
3. These By-Laws
4. Applicable HC Group and Facility policies, annexures and procedures
5. Applicable State and Commonwealth policies and legislative requirements
6. Codes of Conduct articulated by relevant registration authorities.

## OVERVIEW

### About Healthe Care

Healthe Care is a privately owned private hospital operator. The group currently operates Facilities across Australia and continues to grow and seek new opportunities in other jurisdictions.

Healthe Care manages its Facilities through a combination of two key factors: the implementation of a disciplined corporate framework driven by a 'hands on' executive team; and the creation of strong local management teams at each Facility who are empowered to take ownership over localised operational issues.

Healthe Care recognises the great importance of developing trusting relationships with staff and of partnering with its doctors, dentists and other allied health professionals. These By-Laws are an important part of building and ensuring the continuation of a long and trusting relationship that will help achieve Healthe Care's goal of becoming the health care provider of choice for doctors, dentists, allied health professionals, patients, staff and key stakeholders in Australia.

## VISION, MISSION, VALUES AND CARE STATEMENTS

### Vision

Care is our passion. People are our business. Excellence is our standard. Growth is our ambition.

### Mission

To improve and sustain people's health.

### Values

Healthe Care's core values are:

1. Best Practice
2. Best Experience
3. Respect
4. It's Personal
5. Positive Energy

### Care Statement

1. Healthe Care fundamentally believes at its Facilities it is **"Real People, Extraordinary Care".**

2. Healthe Care's objectives are therefore strongly allied to ensuring that their patients, their families and carers receive the best possible care while at a Healthe Care Facility and that patients receive:
   - High quality medical care;
   - In a safe caring environment;
   - That is efficient and effective.

3. The mission, vision and core values should be used to guide the application of the By-Laws.

### Care

Our care is

- Provided in an environment underpinned by HC Group's Mission and Values.
- Holistic and centered on the needs of each patient, inclusive of their family/carer.
- 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.
- Value-based and focused on achieving best patient outcomes.

# 1. BY-LAWS

## 1.1 Key Matters Relating to the By-Laws and Accredited Practitioners

a) Day to day managerial responsibility of Healthe Care Facilities is delegated by the Board to the FCEO. The By-Laws provide direction from the Board to the FCEO in relation to exercise of certain aspects of their managerial responsibility. One such direction is that, in making decisions and acting pursuant to these By-Laws, including the weighing of factors, the quality of health care, the safety of patients, and the safety and wellbeing of Healthe Care staff will be the paramount considerations.

b) The quality of health care and the safety of patients is central to the services provided by Healthe Care Facilities. This involves a mutual commitment from Healthe Care Facilities, its clinical workforce and Accredited Practitioners.

c) Health care in Australia is subject to numerous legislation and standards. The By-Laws assist in compliance with certain aspects of this regulation.

d) Medical, dental and certain allied health care at Healthe Care Facilities is provided by Accredited Practitioners who have been granted access to the Facility and the use of its resources. The By-Laws define the relationship between Healthe Care and its Accredited Practitioners, entitlements arising from Accreditation, entitlements that do not arise from Accreditation and conditions that must be accepted by an Accredited Practitioner as a consequence of accepting Accreditation. The By-Laws support the clinical governance framework for Medical Practitioners, Dental Practitioners and Allied Health Professionals who are appointed and provide services to patients of Healthe Care Facilities through what is known as a Credentialing process. If successful, this will result in the grant of Accreditation with an approved Scope of Clinical Practice.

e) All Medical Practitioners, Dental Practitioners and certain Allied Health Professionals are required to hold a current Accreditation at a Facility in order to provide services, to include a defined Scope of Clinical Practice for each Facility at which they are Accredited, and will be assessed against the Credentialing requirements, Organisational Capabilities and Organisational Need of the particular Facility.

f) Accredited Practitioners must comply with the By-Laws.

g) Healthe Care aims to maintain a high standard of patient care and to continuously improve the safety and quality of its services. The By-Laws and associated documents are aimed at maintenance and improvements in safety and quality.

h) There is no right entitling a Medical Practitioner, Dental Practitioner or Allied Health Professionals to be appointed at a Facility, to maintain Accreditation at a Facility, or to receive Re-Accreditation at a Facility. There are benefits in being appointed at a Facility. In addition, there are terms, conditions and obligations attaching to Accreditation. Non-compliance with any of the terms, conditions and obligations may trigger a review process, a Re-Accreditation not being offered, and/or imposition of special conditions, suspension of Accreditation or termination of Accreditation.

i) In considering the relationship between Healthe Care, the Facility and an Accredited Practitioner; these By-Laws do not of themselves:

   i. create a contractual or employment relationship, or any implied contractual terms, with the Accredited Practitioner; or

   ii. confer on an Accredited Practitioner any legally enforceable right or create in any Accredited Practitioner any legitimate expectation in relation to any matter or thing referred to in the By-Laws.

j) The following principles and requirements apply to and form the basis of the relationship between Healthe Care, the Facility and an Accredited Practitioner:

   i. These By-Laws will take effect and supersede any previous published version. Unless determined otherwise by the Board in the circumstances of a particular case, the By-Laws will be operational and effective regardless of when an issue or circumstance arose (for example, action may be taken under the current By-Laws for matters that occurred at a time previous to the date that the By-Laws were in place);

   ii. The granting of Accreditation affords the Accredited Practitioner the ability to provide services at the Facility, within an approved Scope of Clinical Practice, which at all times will be subject to the terms and conditions of the By-Laws and any associated terms of approval of the Accreditation;

   iii. Conferral of Accreditation results in a conditional non-contractual license to enter the Facility and provide services, in accordance with the terms of approval given. It provides the Accredited Practitioner with an ability on each occasion to make a request for access to the Facility for the treatment and care of a patient, within the limits of the Accredited Practitioner's Scope of Clinical Practice, and to utilise the Facility and its resources for that purpose. This will at all times be subject to the provisions of the By-Laws, Facility and Healthe Care policies, resource limitations, Organisational Need and Organisational Capabilities;

      Note: 'Conditional license' means the permission granted on a non-exclusive basis by a Facility to an Accredited Practitioner, who is carrying out their own independent practice, to attend the premises of the Facility, to utilise appropriate resources of the Facility, and to provide services to patients of the Facility, subject at all times to the terms and conditions set out in the By-Laws and the approval of Accreditation. This permission may be withdrawn in accordance with the By-Laws.

   iv. The decision to grant access to the Facility or particular resources for the treatment and care of a patient is on each occasion within the sole discretion of the FCEO, with there being no appeal pursuant to these By-Laws from such a decision;

   v. Accreditation does not give an Accredited Practitioner any right or entitlement to, or guarantee of, admission, any level of availability of bed access, allocation of operating / procedure session time, allocation of any patient or entitlement to any roster, with these decisions within the sole discretion of the FCEO, and there being no appeal pursuant to these By-Laws from such a decision;

   vi. The FCEO retains a right of refusal for a particular admission, treatment, use of resources or particular patient, and also with respect to the Accredited Practitioner's attendance at the premises of Facility, with there being no appeal pursuant to these By-Laws from such a decision;

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

k) A condition of granting and accepting Accreditation, and of ongoing Accreditation, is that the Accredited Practitioner understands and agrees that:

i. The nature of the relationship is as set out above in By-Law 1.1;

ii. These By-Laws (including any other documents referenced in the By-Laws) are the full extent of processes and procedures available to them with respect to all matters relating to and impacting upon Accreditation;

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

iv. The By-Laws apply from the time of granting of Accreditation, regardless of whether they were read by the Accredited Practitioner;

v. Amendments to the By-Laws apply from the time of approval by the Board, regardless of whether they were read by the Accredited Practitioner; and

vi. While Healthe Care and the Facility (including decision-makers of Healthe Care and the Facility) will generally conduct themselves in accordance with these By-Laws, there are no legal consequences for not doing so.

l) Where an obligation is placed upon an individual under these By-Laws and the individual is an employee of Healthe Care or the Facility, then by virtue of the terms of employment that obligation may be satisfied under the terms of employment of that individual (for example, requirements relating to indemnification and insurance).

### 1.2 By-Laws apply to Facilities.

This document sets out the By-Laws that apply to all Facilities at which the Board has determined they will apply, including services and care of a patient:

a) of a Facility;

b) at premises of the Facility;

c) to or from a Facility;

d) to or from a health service managed by Healthe Care or the Facility; or

e) on behalf of a service provider that provides services to Healthe Care or the Facility.

### 1.3 Inconsistencies with legislation

Where there is any inconsistency between these By-Laws and any Act applicable to a Facility, to the extent of such inconsistency the Act will prevail and apply to that particular Facility.

### 1.4 Modification of By-Laws

a) From time to time the By-Laws may be modified by the Board.

b) Unless otherwise specified by the Board, changes take effect from the date the change is approved by the Board and such changes shall apply to all Accredited Practitioners from that date.

c) If the modified By-Laws are to have retrospective effect, this must be specifically stated by the Board, as well as the time that the modifications shall take retrospective effect. The modified By-Laws apply to all Accredited Practitioners, including those Accredited Practitioners accredited prior to the modification of the By-Laws.

d) The Board or Group CEO or HC Group EGMCG (or delegate) may approve terms of reference, policies, procedures and audit tools that are created pursuant to these By-Laws or to provide greater detail and guidance in relation to implementation of aspects of these By-Laws. These may include but are not limited to Accreditation, Credentialing and Organisational Capabilities and the further criteria and requirements will be incorporated as criteria and requirements of these By-Laws.

## 2. INTERPRETATION

### 2.1 Definitions

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

- **ACCREDITATION** means the formal process provided for in these By-Laws by which a Medical Practitioner, Dental Practitioner or certain Allied Health Professional is permitted in writing by the FCEO to provide services at the Facility, following an assessment of Credentials and having satisfied the Credentialing and Scope of Clinical Practice requirements in these By-Laws. This includes meeting requirements of Organisational Capabilities and Organisational Need. The process serves to verify and assess the qualifications, experience, professional standing and other relevant professional attributes 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 a specific Facility. This incorporates an acceptance in writing by such person, to deliver medical, surgical, dental or other health services to patients at the Facility in accordance with:

  a) the specified Accreditation Classification (where applicable);
  b) Scope of Clinical Practice;
  c) any specified Conditions;
  d) the Code of Conduct;
  e) the policies and procedures at the Facility; and
  f) these By-Laws.

- **ACCREDITATION AND CREDENTIALING COMMITTEE** means the committee established for each Facility by the relevant HC Group Entity for the purpose, inter alia, of considering:

  (a) applications for Accreditation or Re-Accreditation by Medical Practitioners, Dental Practitioners or Allied Health Professionals, including assessment of Credentials and satisfaction of the Credentialing requirements in these By-Laws;

  (b) the Organisational Needs and Organisational Capabilities of the Facility, including New Clinical Services, Procedures or other Inventions; and

  (c) Scope of Clinical Practice for Accredited Practitioners and Accredited Professionals.

- **ACCREDITATION CLASSIFICATION** means one or more of the designated classifications of an Accredited Practitioner approved by the FCEO, which may include Allied Health Professional, Consultant Emeritus, Contracted Career Medical Officer, Dental Practitioner, Employed Career Medical Officer, Fellow, General Practitioner (GP), Midwife,

Midwife Group Practice Midwife, Nurse Practitioner, Other Practitioner, Perioperative Nurse Surgical Assistant, Registrar, Registered Nurse (employed by Visiting Medical Officer), Registered Nurse (working in a specialist area), Specialist Practitioner, Surgical Assistant or such other classification approved by the FCEO.

- **ACCREDITED PRACTITIONER** means a Medical Practitioner or Dental Practitioner who has Accreditation at a Facility in accordance with the By-Laws, with a specified Accreditation Classification and Scope of Clinical Practice. Accreditation as an Accredited Practitioner under these By-Laws is a prerequisite to provide services at the Facility.

- **ACCREDITATION PERIOD** means the duration of Accreditation specified in a notification of Accreditation.

- **ACCREDITED PROFESSIONAL** means an Allied Health Professional who has Accreditation at a Facility in accordance with these By-Laws.

- **ACT** means all relevant legislation applicable to and governing:

  a) the Facility and its operation, including the private health facilities legislation of the applicable State or Territory;

  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).

- **ALLIED HEALTH PROFESSIONAL** means specialist nurses and Surgical Assistants/technicians, chiropractors, dieticians, independent midwives, occupational therapists, pharmacists, physiotherapists, podiatrists, psychologists, speech pathologists, social workers, rehabilitation counsellors or other categories of allied health professionals as determined by the Board.

- **APPLICATION FORM** means the form approved by the Facility from time to time for use by a Medical Practitioner, Dental Practitioner or Allied Health Professional to apply for Accreditation at a Facility.

- **BEHAVIOURAL STANDARDS** means standards of conduct and behaviour expected of an Accredited Practitioner or Professional arising from personal interactions, communication and other forms of interaction with other Accredited Practitioners / Professionals, clinical workforce of the Facility, Board, executive of Healthe Care and the Facility, third party service providers, patients, family members of patients and others. The minimum standard required to meet the behavioral standards includes compliance with the requirements set out in the Code of Conduct and the expectations set out in the Good Medical Practice: A Code of Conduct for Doctors in Australia (as applicable).

- **BOARD** means the Board of Directors of Healthe Care.

- **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 so that the Board can assess and determine whether in respect of HC Group and its 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** mean these By-Laws, including any Schedules, as amended from time to time.

- **CHIEF EXECUTIVE OFFICER (CEO)** means the CEO of Acute Services or Specialty Services

- **CLINICAL PRACTICE** means the professional activity undertaken by Accredited Practitioners or Professionals for the purposes of investigating patient symptoms and preventing and/or managing illness, together with associated professional activities related to clinical care.

- **CODE OF CONDUCT** means the relevant code of conduct of the HC Group Entity or the Facility.

- **COMMITTEE** means a committee or sub-committee established by the Facility in accordance with these By-Laws including but not limited to perform the following functions:

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

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

  c) Appeals in accordance with these By-Laws;

  d) Patient care and clinical outcomes; and

  e) Clinical services

- **COMPETENCE (INCLUDING COMPETENTLY)** means that the person is assessed to have the required knowledge, skills, training, decision-making ability, judgment, insight and interpersonal communication necessary for the Scope of Clinical Practice for which the person has applied (or been granted) 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 or an Accredited Professional**:**

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

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

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

- **CONTRACTED CAREER MEDICAL OFFICER** means a Medical Practitioner who is contracted to the Facility and is engaged pursuant to a contract who may consult and treat patients under the supervision of a Specialist Practitioner but may not admit patients to the hospital.

- **CREDENTIALING** means in respect of an applicant for Accreditation or Re-Accreditation, is the formal process used to match the skills, experience and qualifications to the roles and responsibilities of that position. This will include actions to verify and assess the applicant's Credentials, including the identity (to the required level of identity specified in any relevant policy and procedure, which will be a minimum 100 points), education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees / awards / fellowships / certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, and other skills/attributes (for example in leadership, research, education, communication, teamwork), good standing, declaration of relevant matters and issues, for the purpose of forming a view about the applicant's Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care to the standard required by the Facility and with respect to the Scope of Clinical Practice

- **CREDENTIALS** in respect of an applicant for Accreditation or Re-Accreditation, is the identity (to the required level of identity specified in any relevant policy and procedure, which will be a minimum 100 points of verification), 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, other skills/attributes (for example in leadership, research, education, communication, teamwork), good standing, and declaration of relevant matters and issues, that contribute to the person's Competence, Performance, Current Fitness and professional suitability to provide safe, high quality healthcare. The applicant's history of and current status with respect to Clinical Practice and outcomes at the Facility during prior periods of Accreditation, disciplinary actions, Professional Conduct, By-Law actions, compensation claims, complaints and concerns – clinical and behavioural, professional registration and appropriate professional indemnity insurance arrangements are relevant to credentials.

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

- **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.

- **DELEGATED AUTHORITY** means delegated authority of the FCEO, which may include another senior position title of the Facility.

- **EMPLOYED CAREER MEDICAL OFFICER** means a Medical Practitioner who is an employee of the Facility and is engaged pursuant to a contract of employment who may consult and treat patients under the supervision of a Specialist Practitioner but may not admit patients to the hospital.

- **FACILITY (or HOSPITAL)** means a hospital or day procedure centre conducted by a HC Group Entity.

- **FACILITY CEO (FCEO)** means the chief executive officer of a Facility however titled.

- **FELLOW** means a Medical Practitioner who has completed their specialist training and

who is yet to commence full time private practice or salaried specialist appointment. Fellows may be sponsored by an individual Visiting Medical Officer, Specialist Medical Group, Facility or University and may be contracted to undertake research, training or further postgraduate studies under the supervision of their sponsor or sponsor's appointed representative. Fellows may only be appointed to assist under the direction of an Accredited Specialist Practitioner who is supervising the Fellow for the treatment of their patients. Fellows may also assist an Accredited Specialist Practitioner with operations or procedures performed in the operating room, procedure room or laboratory. Fellows shall not have admitting direct rights to the Facility and shall not be eligible to vote or stand for office of any committee or group established under these By-Laws.

- **GENERAL PRACTITIONER in a metropolitan hospital** means a Medical Practitioner registered with the Medical Board of Australia and recognised as holding specialist qualification in the field of general practice. General Practitioners shall not have direct admitting rights to the Facility but may consult and treat patients who are under the care of Specialist Practitioners with admitting rights.

- **GENERAL PRACTITIONER in a rural hospital** means a Medical Practitioner who has been recognised as a General Practitioner for the purposes of the Health Insurance Act 1973 (Commonwealth), who is registered as such by the relevant registration body and who may admit patients to a Facility.

- **GROUP CEO** means the Chief Executive Officer / Managing Director of HC Group Pty Ltd.

- **HC GROUP and HEALTHE CARE** mean Healthe Care Group Pty Ltd and its subsidiaries.

- **HC GROUP EXECUTIVE GENERAL MANAGER CLINICAL GOVERNANCE (EGMCG)** means the Executive General Manager Clinical Governance, Safety and Quality

- **HC GROUP GROUP ENTITY** means a subsidiary of HC GROUP.

- **HEALTH DEPARTMENT** means the Department of Government with the responsibility for health in the State or Territory in which a Facility is located.

- **MAC** means the **Medical Advisory Committee** constituted by an HC GROUP Entity for a Facility for the purpose of advising the relevant HC GROUP Entity (in its capacity as licensee of the Facility) on the Accreditation and Re-Accreditation of Medical Practitioners, Dental Practitioners and Allied Health Professionals at the Facility and various other matters relating to the safety and quality of services at the Facility as defined in the relevant State and Territory private health facility legislation

- **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** means clinical services, procedures, technology or other interventions, including the use of prostheses and implantable devices or diagnostic procedures, that are considered by a reasonable body of medical opinion to be significantly different from existing clinical practice. It includes a procedure that has not been performed at the Facility, as well as variations to an existing procedure or treatment where a new device or item of equipment is introduced.

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

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

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

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

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

- **NURSE PRACTITIONER** means a Registered Nurse who is registered as a nurse practitioner by the relevant registration body and who is educated to function autonomously and collaboratively in an advanced and expanded clinical nursing role.

- **ORGANISATIONAL CAPABILITIES** means the Facility's ability to provide facilities, services and clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational capabilities will be determined by consideration of, but not limited to, the availability, limitations and/or restrictions of the services, clinical workforce (including qualifications and skill-mix), facilities, equipment, technology and support services required, as well as licensing requirements and service capability limitations / restrictions.

- **ORGANISATIONAL NEED** means the extent to which the Facility considers it necessary to provide a specific clinical service, procedure or other intervention, or elects to provide additional resources to support expansion of an existing clinical service, procedure or other intervention, to provide a balanced mix of safe, high quality health care services that meet the Facility, consumer and community needs and aspirations. Organisational need may be determined by factors including, but not limited to, the allocation of limited resources, available operating theatre lists, necessity for additional specialists in a particular specialty area, lack of need for additional specialists in a particular specialty area, funding, the strategic direction of Healthe Care and the Facility, clinical services plans, business and operational plans and any applicable clinical service capability framework.

- **OTHER PRACTITIONER** means health practitioners seeking Accreditation not falling into other Accreditation Categories including visiting complimentary or natural therapy providers.

- **PERFORMANCE** means the extent to which an Accredited Practitioner / Professional provides health care services Competently and in a manner which is consistent with known good Clinical Practice and Professional Conduct expectations at the Facility.

- **PERIOPERATIVE NURSE SURGICAL ASSISTANT** means a Registered Nurse who has undertaken an advanced practice nursing role as the first assistant in surgery.

- **PROFESSIONAL CONDUCT** means behaving in a way that promotes professional and personal integrity that is consistent with relevant behaviour policies and codes of conduct and supports the approach to meeting Behavioural Standards.

- **PROFESSIONAL INDEMNITY INSURANCE** means the insurance of an Accredited Practitioner or Accredited Professional and further referred to in By-Law 9.4.

- **PROFESSIONAL MISCONDUCT** has the same meaning prescribed to that term and the

term “Unsatisfactory Professional Conduct” in the *Health Practitioner Regulation National Law Act* 2009 or associated Act as in force in each State and Territory and includes (but is not limited to):

a) unprofessional conduct by the practitioner that amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and

b) more than one instance of unprofessional conduct that, when considered together, amounts to conduct that is substantially below the standard reasonably expected of a registered health practitioner of an equivalent level of training or experience; and

(c) conduct of the practitioner, whether occurring in connection with the practice of the health practitioner's profession or not, that is inconsistent with the practitioner being a fit and proper person to hold registration in the profession.

- **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.

- **RE-ACCREDITATION** means the process provided in these By-Laws by which a person who currently holds Accreditation may apply for and be considered for another period of Accreditation following conclusion of the previous term of Accreditation. If an applicant previously held Accreditation, but does not currently hold Accreditation, the applicant will be regarded as a new applicant and the application will not be regarded as Re-Accreditation.

- **REGISTERED NURSE (employed by Visiting Medical Officer)** means a Registered Nurse visiting the Facility and employed by a Visiting Medical Officer.

- **REGISTERED NURSE (working in a specialist area)** means a Registered Nurse visiting the Facility and working in a specialist area.

- **REGISTRAR** means a Medical Practitioner who holds a registrar position at a teaching hospital or is in a College recognised “registrar” training position at the Facility to have the Accreditation status of registrar. Registrars may only be appointed to assist with the treatment of patients under the care of a Specialist Practitioner who is supervising the Registrar. Registrars shall not have admitting rights to the Facility and shall not be eligible to vote or stand for office of any committee or group established under these By-Laws.

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

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

- **SCOPE OF CLINICAL PRACTICE** means the extent of an individual Accredited Practitioner’s or Professional's permitted Clinical Practice within the Facility, that is assessed and documented in writing, based on the individual’s Credentials, Competence, Performance, Current Fitness, professional suitability, Organisational Capabilities and Organisational Need.

- **SPECIALIST PRACTITIONER** means an Accredited Practitioner who is:
  a) recognised as a specialist for the purposes of the Health Insurance Act 1973 (Cth); and

  b) is appointed by the Board in the category of Specialist Practitioner

- **STAFF SPECIALIST** means a Specialist Practitioner appointed to and employed by or seconded to the Facility.

- **SURGICAL ASSISTANT** means a health professional who assists under the direct supervision of a Specialist Practitioner in the pre-operative assessment, operating theatre and immediate post-operative care but is unable to initiate or change treatment orders or patient management.

- **TEMPORARY APPOINTMENT** means an appointment of an Accredited Practitioner (or Accredited Professional) for a specified limited period.

- **UNPROFESSIONAL CONDUCT OR UNSATISFACTORY PROFESSIONAL CONDUCT** has the same meaning prescribed to those terms in the *Health Practitioner Regulation National Law Act* 2009 as in force in each State and Territory.

## 2.2 General Information

***Rules for Interpreting these By-Laws***

a) 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.

   viii. A reference to “Accredited Practitioner” in these By-Laws includes “Accredited Professional”, as the context requires.

b) *Titles*

   i. 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*

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

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

b. 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*

i. 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*

i. 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

i. 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

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

h) Compensation

i. 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

a) Accredited Practitioners will comply with, assist the Facility to comply with, and not do anything to bring Healthe Care or the Facility in breach of, obligations relating to:

- the *Privacy Act 1988* (Cth);
- the Australian Privacy Principles established by the *Privacy Act 1988* (Cth);
- the various State and Territory statutes and regulations relating to privacy and

confidentiality of information (or equivalent laws if the Facility is located in another jurisdiction);
- common law duties of confidentiality; and
- relevant Healthe Care and Facility policies;

including but not limited to privacy and confidentiality of personal, sensitive, health, financial and identifying information.

In compliance with these obligations, Accredited Practitioners must ensure appropriate privacy, confidentiality, notification and consent measures are in place and working effectively for this information, including with respect to security, storage, handling, access to systems and data, sharing and communication of information. This will include having in place within their own practice adequate policies, systems and education regarding prevention of inappropriate practice, protection of information, preservation of practice data and business continuity if inappropriate or unauthorised access occurs.

### 3.2 Accredited Practitioners

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

a) business information concerning HC Group, HC Group Entity or the Facility;

b) information concerning the insurance arrangements of HC Group, HC Group Entity or the Facility where applicable;

c) personal, sensitive, health, financial and identifying information concerning a patient of Healthe Care or the Facility;

d) clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services and any employee, Accredited Practitioner or contractor of HC Group or a HC Group Entity;

e) the particulars of these By-laws.

### 3.3 Committees

a) 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 confidentiality and privacy of the following information:

i. the application for the Accreditation including designation of Scope of Clinical Practice of the Accredited Practitioner;

ii. the application for or consideration of any change to Scope of Clinical Practice of the Accredited Practitioner; and

iii. clinical practice, quality assurance, peer review activities.

### 3.4 What confidentiality means

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

### 3.5 When confidentiality can be breached

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

i. where disclosure is required or specifically authorised by law;

ii. where use and/or disclosure of personal information is consistent with By-Law 3.1;

iii. where disclosure is required by a Regulatory Authority in connection with the Accredited Practitioner;

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

v. where disclosure will not breach By-Law 3.1 and is required in order to perform a requirement of these By-Laws or is required to provide clinical care to the patient.

### 3.6 Privacy and confidentiality obligations continue

a) 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 HC Group Entity

a) 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 Accreditation or any other matters related to these By-Laws to other HC Group Entities.

### 3.8 Notification of Data Breaches and Notifiable Conduct

a) If a breach of any of the obligations set out above occurs, including through inadvertence or a third-party security breach, then the Accredited Practitioner must immediately notify the FCEO, comply with data breach laws, actively assist to resolve the breach and make appropriate notifications to impacted individuals.

b) Notwithstanding By-Laws 3.1 to 3.7, all Accredited Practitioners acting in a management role with HC Group 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 practice 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 4.1b) 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

a) Accreditation under previous By-Laws is maintained under any new or updated By-Laws approved by the Board.

## 5. COMMITTEES

### 5.1 Power to establish Committees

a) The HC Group Board, Board of each HC Group Entity and FCEO may establish any Committees deemed necessary to comply with any Act, for the effective and compliant conduct of the Facility or as otherwise set out in these By-Laws.

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

### 5.2 Terms of Reference for Committees

a) The composition of Committees, membership constitution, method of selection of appointees, term of appointment, frequency of meetings, quorum and any other procedural requirements will be set the Terms of Reference for each Facility as approved by the FCEO and which are taken to form part of these By-Laws once approved.

b) Composition of each Committee will reflect the Facility's organisational requirements, Organisational Capabilities and Organisational Need for the clinical services provided.

### 5.3 Indemnification

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

i. acted in good faith;

ii. acted in accordance with their delegated authority; and

iii. acted in accordance with any Act governing their conduct;

b) Indemnity will not be granted if the FCEO determines that person has:

i. failed to comply with the By-Laws;

ii. failed to comply with the terms of reference of the Committee;

iii. failed to adhere to a direction of the FCEO;

iv. failed to perform his or her responsibilities or functions in good faith;

v. engaged in any illegal, criminal, fraudulent, dishonest, malicious or reckless act or omission; or

vi. engaged in anti-competitive conduct.

c) Any legal costs or expenses are to be approved in advance by the Facility, through a lawyer or law firm appointed or approved by the Facility, and on terms approved by the Facility.

### 5.4 Statutory immunity for Committees

a) An HC 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 HC Group Entity has sought and been granted declarations as set out under By-Law 5.4a) in respect of any Committee of any Facility, the terms and conditions of Statutory Immunity of a Committee of the Facility will be incorporated into the Terms of Reference of that Committee.

## 6. DISCLOSURE OF INTEREST OF MEMBERS OF COMMITTEES

### 6.1 Disclosure of interest

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

i. 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

ii. 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, and such a member or person must not, subject to By-Law 6.5, participate further in the relevant discussion or resolution.

### 6.2 Nature of disclosure

a) Disclosure by a person at a meeting that the person:

i. is a member, or is in the employment, of a specified company or other body;

ii. is a partner, or is in the employment, of a specified person;

iii. is a family relative or personal partner, of a specified person; or

iv. 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

a) The Chairperson of the relevant Committee will:

i. notify the FCEO of any disclosure made under this By-Law; and

ii. record the disclosure in the minutes of the relevant Committee.

### 6.4 Record of disclosure

a) 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

a) 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

a) 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 Accreditation 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. ACCREDITATION AND CREDENTIALING, MEDICAL ADVISORY, PATIENT CARE REVIEW COMMITTEES

### 7.1 Objectives

A Facility or group of HC Group Facilities will have the following Committees (and any other Committees required by law or as deemed necessary by Healthe Care and each HC Group Entity):

a) **Accreditation and Credentialing Committee**, howsoever named, which will have written terms of reference and include the following objectives:

i. considering an application for Accreditation or Re-Accreditation; and

ii. providing a recommendation on an application for Accreditation or Re-Accreditation, including Scope of Clinical Practice.

b) **Medical Advisory Committee**, which will have written terms of reference and include the following objectives:

i. provide advice and recommendations to the FCEO;

ii. form an Accreditation and Credentialing Committee to provide recommendations to the FCEO to consider when making a decision on an Application for Accreditation or Re-Accreditation, including a recommendation relating to Scope of Clinical Practice;

iii. providing assistance, where necessary, to the Accreditation and Credentialing Committee and the FCEO regarding Accreditation and Re-Accreditation applications and disputes, complaints and conditions associated therewith;

iv. advise the FCEO on clinical and related issues placed before it, including policies and procedures, with a view to best-practice clinical governance and improvement of patient quality and safety;

v. inform and advise the FCEO in relation to services to meet the health needs of the community;

vi. continually assessing the capacity of the Facility to provide safe, patient-centred and appropriate health services to patients of the Facility, including policies, procedures and protocols related to these matters;

vii. optimising the delivery of patient care, based on both research and current best practice, including to actively encourage and advance continuous quality improvement and other activities aimed at better patient care;

viii. establishing and maintaining mechanisms to continually evaluate, monitor and improve clinical care and patient safety across the Facility services and for each specialty (or assisting the Facility with its systems and processes relating to these matters), and subsequently ensuring those mechanisms are operational and either directly or through sub-committees carrying out monitoring of the outcomes from these mechanisms. Some of these objectives may be carried out by the Patient Care Review Committee;

ix. establishing and maintaining a mechanism for formally reviewing clinical outcomes (specific cases, overall statistics and variations), incidents (including SAC1, sentinel events), adverse outcomes of Accredited Practitioners (including by a peer review process), Competence of Accredited Practitioners and Performance of Accredited Practitioners (or assisting the Facility with any of its systems and processes relating to each of these matters), and subsequently ensuring those mechanisms are operational and either directly or through sub-committees monitoring of the outcomes from these mechanisms. Some of these objectives may be carried out by the Patient Care Review Committee;

x. advising on specific Accredited Practitioner, medical or patient care issues raised by the FCEO or an Accredited Practitioner

xi. advising on proposals for research and clinical trials to be performed at the Facility in accordance with these By-Laws;

xii. advising on New Clinical Services, Procedures and Other Inventions in accordance with these By-Laws;

xiii. advising the FCEO on medical workforce issues and medical requirements of the Facility;

xiv. advising the FCEO on efficient and equitable use of Facility resources, including to actively encourage and advance the efficient and better use of resources;

xv. acting in compliance with the *Health Practitioner Regulation National Law*, including with respect to voluntary and mandatory notifications;

xvi. advising the FCEO actual or potential breaches of any Act or standards of clinical service;

xvii. seeking and responding to feedback from Accredited Practitioners regarding the performance of the Medical Advisory Committee and sub-committees;

xviii. represent the collective views of the Accredited Practitioners at the Facility, including by providing the forum to liaise between the FCEO and the Accredited Practitioners;

xix. plan and manage a continuing education program for Accredited Practitioners;

xx. advise the FCEO about recommendations for external referral and notification of matters relating to clinical safety and quality of care;

xxi. keep adequate agendas, minutes and documentation about the above matters, including the reasons for and/or evidence upon which decisions or recommendations are made, with the agenda and minutes (including decisions and recommendations) to be provided to the FCEO;

xxii. provide a periodic report to the FCEO on activities and to provide a report on a specific matter or issue where requested by the FCEO;

xxiii. provide a report or notification direct to the Board or where required by regulation to an external regulatory body such as the Department of Health on any matter of significant concern unable to be resolved, despite reasonable efforts, directly with the FCEO, and to provide notification to the FCEO about the fact of the report or notification.

c) **Patient Care Review Committee** (**PCR Committee**), which will have written terms of reference and operate in accordance with By-Laws 7.2 to 7.5

### 7.2 Patient Care Review Committee Function

a) The clinical review and quality functions of the PCR Committee is to:

i. review clinical indicators;

ii. review mortality and morbidity reports and make recommendations where appropriate;

iii. encourage participation in quality projects to improve patient outcomes;

iv. review adverse event trends related to clinical practice and where appropriate make recommendations;

v. review specific cases referred; and

vi. notify the FCEO of any identified clinical issues and risks at the Facility.

### 7.3 Meetings of PCR Committee

a) The PCR Committee must meet at least four times 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 their delegate for this purpose, must record minutes of the Formal Meetings of the PCR Committee.

b) Minutes recorded at Formal Meetings must be distributed to the members of the PCR Committee in a timely manner.

c) All minutes and actions arising from the Formal Meetings are to be forwarded to the FCEO and the peak Quality and Safety Committee (MAC) of the Facility.

### 7.5 Mandatory attendance

a) It is a Condition of Accreditation that:

i. all Accredited Practitioners should attempt to attend and participate in at least one Meeting of the PCR Committee and/or relevant Departmental meetings, howsoever named, annually; and

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

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

## 8. APPOINTMENT OF ACCREDITED PRACTITIONERS

### 8.1 Principles

The following principles should be considered and guide the making of decisions in the Credentialing and Accreditation process:

a) The FCEO is the ultimate decision-maker with respect to each application for Accreditation and Re-Accreditation, including Scope of Clinical Practice, and the FCEO may take all matters that the FCEO considers relevant into account when making a decision;

b) In making recommendations to the FCEO in relation to an application for Accreditation or Re-Accreditation, the key considerations are Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care to the standard required by the Facility and with respect to the Scope of Clinical Practice sought (noting that the requirements for each are set out in more detail in the definition section of the By-Laws);

c) Credentialing and Accreditation are organisational governance responsibilities that are conducted with the primary objective of maintaining and improving the safety and quality of health care services;

d) Processes of Credentialing and Accreditation are complemented by registration requirements and individual professional responsibilities that protect the community;

e) Effective processes of Credentialing and Accreditation benefit patients, communities, health care organisations and health care professionals;

f) Credentialing and Accreditation are essential components of a broader system of organisational management of relationships with health care professionals;

g) Credentialing and Accreditation and any reviews should be a non-punitive process, with the objective of maintaining and improving the safety and quality of health care services.

## 8.2 Application On-Line Form

a) Any Medical Practitioner, Dental Practitioner, Allied Health Professional, or other Health Practitioner who is entitled and wishes to apply for Accreditation, Re-Accreditation or an increase in Scope of Clinical Practice at the Facility must contact the FCEO to be invited to complete the HC Group e-credentialing system on-line Application Form and obtain any related material, including a copy of these By-Laws.

b) In order to proceed further, the on-line Application Form must be completed in full, and all required documents uploaded and submitted through the HC Group's e-credentialing system to the FCEO.

c) An application for Re-Accreditation must be submitted within the specified timeframe before expiry of the current period of Accreditation, which unless specified otherwise will be no less than 3 months prior to expiry of the current period of Accreditation. If this timeframe is not met, the FCEO may decide not to accept the application or may decide that the application will be treated in the same way as a new application for Accreditation, meaning that the process and entitlements available for an applicant for Re-Accreditation pursuant to the By-Laws will not apply (including that an appeal pursuant to these By-Laws is not available in relation to an unsuccessful application).

## 8.3 Applications for Accreditation

A duly completed Application Form will be considered in accordance with the following process and any supplementary policies and procedures that may be in place at the Facility:

a) The FCEO will consider the Application Form and associated documentation in the context of the Organisational Need and Organisational Capabilities of the Facility and may make any inquiries or consultation relevant to that consideration as he or she thinks fit. Following this consideration:

   i. For a new application for Accreditation, the FCEO may determine to discontinue with the application process in the sole discretion of the FCEO or to allow the application to proceed through the process as outlined from By-Law 8.3b) onwards. The FCEO may liaise with the Accreditation and Credentialing Committee in relation to this stage of enquiry. There is no appeal available pursuant to these By-Laws from a decision to discontinue, no reasons are required to be given, and in this case a further application may not be submitted within a 12-month period from the decision to discontinue;

   ii. For an application for Re-Accreditation, the FCEO may reject an application if out of time, incomplete or otherwise non-compliant with the By-Laws, but otherwise will refer the application through the process as outlined from By-Law 8.3b) onwards. However, if an Accredited Practitioner has not exercised Accreditation or utilised the Facility for a continuous period of 6 months leading up to the application, without good reason that is communicated and accepted by the FCEO, or at a level or frequency as otherwise specified to the Accredited Practitioner by the FCEO, the FCEO may reject the application and there is no appeal available pursuant to these By-Laws from this decision of the FCEO.

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

c) The FCEO (or their delegate) may request to meet with the applicant and may contact up to three referees nominated by the applicant. For an application to proceed further, the FCEO must **receive no less than 2 references (written or verbal)** and must also check the applicant's qualifications, Professional Indemnity Insurance and Credentials (including verifying identity, registration, and current entitlement to practice). One referee must be currently practicing in the same specialty as the applicant and have recent knowledge of the applicant.

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

e) 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.

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

g) For applications the FCEO considers should proceed further, in accordance with By-Law 8.3a) above, the FCEO will refer the application and all additional relevant material and information gathered during the process of enquiry to the MAC.

h) The MAC via the Accreditation and Credentialing Committee will undertake the formal Credentialing process to match the skills, experience and qualifications to the roles and responsibilities of the applied position and Scope of Clinical Practice sought, including actions to verify and assess the applicant's Credentials and to form a review about the applicant's Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care to the standard required by the Facility and with respect to the Scope of Clinical Practice sought.

i) For an application for Re-Accreditation, the MAC via the Accreditation and Credentialing Committee, will additionally consider any history of non-compliance with the By-Laws, the applicant's history of and current status with respect to Clinical Practice and outcomes at the Facility during prior periods of Accreditation, Professional Conduct, disciplinary actions, By-Law actions, compensation claims, and complaints / concerns (clinical and behaviour).

j) The MAC via the Accreditation and Credentialing Committee will make recommendations to the FCEO relating to the application in accordance with (h) and (i) above, including Scope of Clinical Practice and any Conditions to be applied to the Accreditation.

k) The recommendations in (j) above will then be considered by the FCEO prior to making a final determination as to Accreditation, Scope of Clinical Practice, Accreditation Period, and any Conditions to be applied to the Accreditation.

l) The FCEO will make a final determination on the application and will have complete discretion to approve or reject each application for Accreditation or Re-accreditation after following the provisions set out above (where applicable), including with respect to consideration of Organisational Capabilities and Organisational Need, as well as any other matters that the FCEO considers relevant.

m) The FCEO must notify the applicant in writing of the decision, including the Scope of Clinical Practice, Accreditation Period, and any Conditions.

n) The Accreditation Period must not exceed five (5) years or otherwise must adhere to requirements of the particular State or Territory *(Note: The State of Victoria mandates no more than three (3) years Accreditation)*. There is no automatic entitlement to the full period of possible Accreditation and shorter periods may be considered appropriate in the circumstances.

o) On receiving the notice of approved Accreditation, the applicant will indicate their acceptance in writing of the Facility By-Laws, rules, regulations and also HC Group's Visions, Mission, Values and Care Statements.

p) An Accredited Practitioner is Accredited only for the Accreditation Period and ceases to be an Accredited Practitioner on the last day of the Accreditation Period unless there is a successful application for Re-Accreditation or Temporary Appointment has been granted. In addition, an Accreditation Practitioner may conclude Accreditation earlier than the expiry of the Accreditation Period through resignation with appropriate notice.

q) If the FCEO decides to reject an application for Accreditation, there is no appeal available pursuant to these By-Laws and no reasons are required to be given.

r) If the CEO decides to reject an application for Re-Accreditation, other than for a reason specified in (a)(ii) above, there is an appeal available pursuant to these By-Laws.

## 8.4 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.

## 8.5 Temporary Appointment (including Locum Appointment)

a) The FCEO may, in their complete discretion, approve Temporary Appointments and may grant Accreditation to such temporarily appointed Medical Practitioners, Dental Practitioners, Allied Health Professional or Other Health Practitioner.

b) An individual seeking Temporary Appointment must submit via the HC Group's e-credentialing system on-line Application Form to the FCEO and upload in the HC Group's e-credentialing system all required supporting documentation.

c) In considering whether to approve the Temporary Appointment of a Medical Practitioner, Dental Practitioner or Allied Health Professional, the FCEO must consult with the head of the division or department most relevant to the applicant's specialty and in addition be satisfied as to the following:

   i. verification has occurred that the applicant is registered with AHPRA in the specialty appropriate for the Scope of Practice sought;

ii. the applicant will agree to continuously observe the By-Laws, current policies and procedures of the Facility;

iii. the Facility has the facilities to support the applicant's proposed treatment of any patient;

iv. the Facility is able to provide appropriate staff, resources and support to the applicant's treatment of any patient;

v. any treatment of a patient by the applicant will comply with the Facility's licence and is within its service capability;

vi. the applicant has provided requested referee details and the reference checks are to the satisfaction of the FCEO and are relevant to the Scope of Clinical Practice sought;

vii. the applicant has provided sufficient verification of identity to a minimum of 100 points; and

viii. that applicant has provided sufficient evidence of appropriate Professional Indemnity Insurance.

d) Accreditation granted under this By-Law 8.5 will remain in force for a period of up to 60 days from the date of determination by the FCEO. This period can be extended at the discretion of the FCEO by a further 30 days. Any extension must be approved in writing by the FCEO. Any further extension requires approval of the HC Group CEO or EGMCG (or delegate).

e) The FCEO will notify the applicant in writing of the decision.

f) There will be no right of appeal in respect of a decision to decline, suspend or terminate a Temporary Appointment.

## 8.6 Urgent Accreditation

a) In accordance with this By-Law 8.6, the FCEO or delegate may approve, in the complete discretion of the FCEO, urgent Accreditation to Medical Practitioners, Dental Practitioners or Allied Health Professionals (**Urgent Accreditation**).

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

i. confirm registration with AHPRA or relevant Regulatory Authority and consider any antecedents identified, including conditions or complaints

ii. confirm appropriate Professional Indemnity Insurance;

iii. obtain a verbal reference from one other Accredited Practitioner at the Facility or 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 at the Applicant's place of current Accreditation;

iv. minimum 100 points verification of identity through inspection of relevant documents (e.g. birth certificate, passport, driver's license with photograph) as adopted by the Australian Government and identified in the 100 points of identification guide.

c) An individual seeking or granted Urgent Accreditation must provide evidence of Professional Indemnity insurance within 24 hours of being granted Urgent Accreditation.

d) Urgent Accreditation granted under this By-Law 8.6 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 Accreditation.

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

g) There will be no right of appeal in respect of a decision to decline, suspend or terminate an Urgent Appointment.

### 8.7 Appointments of Directorships

a) Appointments of Directorships including a Medical Director and or Director of Psychiatry and or any other directorships are appointed at the discretion of the FCEO.

b) Appointments of Directorships can change at any time and are rotational with a maximum duration of three (3) years.

c) The FCEO has complete authority to withdraw an appointed Directorship at any time. There will be no appeal against such a decision.

## 9. TERMS AND CONDITIONS OF ACCREDITATION

### 9.1 Conditions applicable to all Accredited Practitioners

a) Approval and Continuation of Accreditation is conditional on the Accredited Practitioner complying with all terms and Conditions set out in this By-Law 9.

### 9.2 General

Accredited Practitioners must:

a) comply with their approved Scope of Clinical Practice;

b) comply with the Code of Conduct, Behavioural Standards, laws, any directions given and Facility policies in relation to standards of behaviour and conduct (Note: The standard of conduct and behaviour may be set out in a code or policy, however the process to manage conduct or behaviour of an Accredited Practitioner is as set out in these By-Laws);

c) treat fairly and with respect all Accredited Practitioners, patients, families of patients, carers of patients, staff and other people working at, engaged or attending the Facility, and must not abuse, assault, bully, harass or intimidate any person;

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

e) take all necessary steps to ensure a safe workplace, in compliance with relevant workplace and occupational health and safety laws;

f) comply with their responsibilities under the National Law, including mandatory reporting of Notifiable Conduct;

g) comply with these By-Laws;

h) comply with the rules, policies and procedures of Healthe Care and the Facility;

i) maintain professional registration with AHPRA (and/or other relevant Regulatory Authority) and furnish annually to the Facility or 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;

j) effectively utilise any allocated theatre or procedural sessions;

k) comply with and assist the Facility to comply with specific requirements of private health insurers and take all necessary steps to allow the Facility to collect revenue in a timely manner from appropriate sources for the care provided;

l) 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;

m) participate, when requested by the FCEO, in 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;

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

o) seek relevant approvals from the FCEO and relevant Committee and, where applicable, the relevant Research and Ethics Committee in regard to any research, experimental or innovative treatments, including any New Clinical Services, Procedures or Other Inventions (see By-Laws 20 and 21);

p) not aid or facilitate the provision of medical, dental or other health care to patients at the Facility by Medical Practitioners, Dental Practitioners or Allied Health Professionals who are not Accredited Practitioners;

q) not purport to represent any HC Group Entity or Healthe Care or the Facility in any circumstances, including the use of the letterhead, unless with the express written permission of the FCEO;

r) understand and actively assist the Facility to comply with accreditation standards or other requirements applying to the Facility, including those of the Australian Commission on Safety and Quality in Health Care (e.g. the National Safety and Quality Health Service Standards), Department of Health (Commonwealth or State), private health insurers and public patient funders;

s) understand and actively assist the Facility to comply with clinical governance requirements, incident reporting, vaccination/immunisation requirements, safety and quality initiatives, internal reviews, external reviews and other requirements that are in place to optimise patient outcomes, safety, quality and experience;

t) co-operate with, actively participate in and/or provide necessary information for any clinical quality assurance, quality improvement, incident management, reviews and risk management process, project or activities as required by the Facility and these By-Laws, including assisting in and providing information with respect to adverse events and system reviews, including but not limited to Root Cause Analysis (RCA) and Serious Adverse Patient Safety Events (SAPSE);

u) participate and actively engage in review of their own Clinical Practice, including peer review, audits and monitoring of variation;

v) provide requested information and assistance in circumstances where the Facility requires information and assistance to fully investigate a patient incident or outcome or respond to a statutory complaint or investigative body;

w) provide requested information or assistance to permit the Facility comply with, or respond to, a legal request or direction or contractual obligation;

x) where reasonable to do so, participate in open disclosure and duty of candour discussions with patients and families of patients and ensure regular follow up with patients following procedures and/or completion of services to ensure the best possible patient outcome and experience.

### 9.3 Care and responsibility for patients

Accredited Practitioners must:

a) personally obtain full and informed written patient or substitute decision-maker consent prior to treatment and/or a procedure and/or anaesthetic being performed;

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) seek consent for the presence of any other person in the operating theatre or in treatment not directly required for the delivery of care, for example an observer or student;

d) not admit a patient to the Facility unless a suitable or appropriate bed and staffing is available to accommodate that patient;

e) admit to the Facility only those patients who, in the opinion of the FCEO, can be properly managed in the Facility, including in accordance with the approved clinical services capability attached to the Facility license (Note: the FCEO may notify Accredited Practitioners from time to time of any categories of patients who are considered inappropriate for admission to the Facility);

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

g) accept full responsibility for their patients from admission until discharge, or until the care of the patient is transferred to another Accredited Practitioner;

h) be available for contact at all times when that Accredited Practitioner has a patient admitted to the Facility, or must nominate another Accredited Practitioner with equivalent Accreditation / Scope of Clinical Practice to continue the care of their patient during their absence (such nomination to be notified to the Facility in writing);

i) 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;

j) prior to or on admission of a patient to the Facility, provide adequate written instructions for the initial management of their patient on admission;

k) absent special circumstances, review a patient in person within 24 hours of the patient being admitted under that Accredited Practitioner or within a shorter timeframe if clinically necessary or requested by staff of the Facility. Thereafter the Accredited Practitioner will review the patient within clinically appropriate timeframes;

l) if the Accredited Practitioner is unable to continue to provide care for a patient at any time during the period of the patient's admission at the Facility, immediately notify the FCEO and other relevant Facility staff and ensure that the patient's care is handed over to another Accredited Practitioner;

m) work with and as part of the multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care and outcome for Accredited Practitioners' patients, including post treatment follow up care and communication;

n) provide adequate supervision and/or instructions to Facility staff and other Accredited Practitioners to enable them to understand what care the Accredited Practitioner requires to be delivered to their patients and appropriately supervising the care that is provided by the Facility staff and other Accredited Practitioners;

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

p) attend their 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;

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

r) 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;

s) carry out procedures, give advice and recommend treatment within the generally accepted areas of practice applicable to the Accreditation Classification of the Accredited Practitioner and to their Accreditation;

t) 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;

u) comply with all infection control procedures of the Facility including appropriate hand hygiene, appropriate use of Personal, Protective Equipment (PPE) and as advised by the commonwealth and state public health departments during a declared epidemic or pandemic event;

v) understand Facility polices and processes, and ensure compliance, relating to safety and quality, including pre-procedure checks, procedure matching, correct site, time out, end of procedure checks, surgical safety, speaking up for safety and deterioration;

w) facilitate appropriate and timely discharge, including to 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;

x) 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;

y) not treat a member of their immediate family or anyone with whom they have a close personal relationship without the written approval of the FCEO (which may be given or withheld at the FCEO's absolute discretion).

### 9.4 Professional Indemnity Insurance

Accredited Practitioners must maintain a level of Professional Indemnity Insurance (including run

off/tail insurance where appropriate) consistent with requirements of the relevant Regulatory Authority, and which:

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

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

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

### 9.5 Annual disclosure

Accredited Practitioners must furnish annually to the Facility evidence of:

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

b) medical/dental/allied health and other health practitioner registration (as applicable);

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

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

### 9.6 Continuous disclosure

Each Accredited Practitioner must keep the FCEO continuously informed of matters which have a material bearing upon their Accreditation, Credentials and Scope of Clinical Practice, including but not limited to;

a) ability to deliver health care services to patients safely and in accordance with their authorised Scope of Clinical Practice;

b) Current Fitness;

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

d) Professional Indemnity Insurance status and the ability to resolve a medical malpractice claim;

e) registration with the relevant professional registration board, including any conditions or limitations placed on such registration;

f) compliance with all relevant laws and any codes, policies, methods of best practice, directions or notices made or issued by a Regulatory Authority;

g) reputation of the Accredited Practitioner;

h) reputation of Healthe Care or the Facility; and

i) any of the matters in By-Law 9.7.

### 9.7 Advice of material issues

Without limiting By-Law 9.6, Accredited Practitioners must advise the FCEO in writing as soon as possible but at least within two (2) days if any of the following occurs:

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

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

c) the Accredited Practitioner is involved in a serious incident at a Facility or service operated by the Facility;

d) there is a serious clinical incident involving a patient under the care of the Accredited Practitioner at a Facility or service operated by the Facility;

e) there is a workplace or occupational health and safety issue or incident at a Facility or service operated by the Facility;

f) the Accredited Practitioner receives a written complaint from a patient of the Facility or person lodging a complaint on behalf of the patient;

g) the Accredited Practitioner is served with court proceedings making a compensation claim in relation to a patient of the Facility;

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

i) billing restrictions are replaced upon the Accredited Practitioner by Medicare or Professional Services Review;

j) any finding (including but not limited to criticism or adverse comment about the care or services provided or research undertaken by the Accredited Practitioner) is made in relation to or against the Accredited Practitioner by a civil court, the Accredited Practitioner's registration board, AHPRA, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency, or any other relevant body/organization. This includes but is not limited to Professional Misconduct, Unsatisfactory Professional Conduct or Unsatisfactory Professional Performance;

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

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

m) the Accredited Practitioner is subject to any complaint and/or investigation relating to research conduct or a clinical trial, including a breach of research ethics, protocols or procedures;

n) the Accredited Practitioner's professional indemnity insurance is made conditional, reduced or not renewed, or should limitations be placed on insurance or professional indemnity coverage, or should the insurance taken up occur through the universal cover obligation (sometimes referred to as insurer of last resort obligation);

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

p) any physical or mental condition / impairment or substance abuse problem or deterioration occur that could affect the Accredited Practitioner's ability to safely practise, or that would require any special assistance to enable him or her to practise safely and competently;

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

r) the Accredited Practitioner believes that patient care or safety is being compromised or at risk, or may potentially be compromised or at risk, by another Accredited Practitioner of the Facility;

s) the Accredited Practitioner makes a mandatory notification to AHPRA in relation to another Accredited Practitioner of the Facility;

t) there arises any matters which have a material bearing upon their Credentials, Scope of Clinical Practice, or ability to deliver health care services to patients safely;

u) the Accredited Practitioner's authority under a law of a state or territory to administer, obtain, possess, prescribe, sell, supply or use a scheduled medicine or class of medicine is cancelled or restricted;

v) the Accredited Practitioner develops or become aware of an actual, potential, or perceived conflict of interest with Healthe Care or the Facility, be it financial, commercial, legal, or professional; or

w) there arises any other matter or circumstance that has or may be reasonably expected to have a material bearing upon their eligibility to be Accredited or retain Accreditation under these By-Laws.

### 9.8 Medical records

Accredited Practitioners must:

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

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

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

iii. which includes as a minimum:

1. pre-admission notes or a letter on the patient's condition and plan of management, including notifying the Facility of significant co-morbidities;
2. full and informed written patient consent;
3. completing admission forms authorised by the Facility within 24 hours of admission;
4. 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;
5. therapeutic orders;
6. particulars of all procedures, including pathology and radiology reports;
7. observations of the patient's progress;
8. notes of any special problems or complications;
9. discharge notes, completed discharge summary and documentation of requirements and arrangements for follow-up; and
10. each attendance upon the patient with the entries dated, timed, signed and specifying the designation of the practitioner.

b) complete an Operation Report and Anaesthetic Report that shall include a detailed account of the findings at surgery, the surgical technique undertaken, complications and post-operative orders, and the full name of any Surgical Assistant, Anaesthetist and other Medical Practitioner present;

c) ensure that 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;

d) ensure the provision of accurate CMBS Item Numbers and prompt notification to the Facility of any subsequent change (which includes alerting to the incorrect provision of a CMBS Item Number) or addition to the Item Numbers;

e) record all data required to meet health fund obligations, collect revenue and allow compilation of health care statistics, and is sufficient to allow clinical coding to occur;

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

g) comply with all legal requirements and standards in relation to the prescription, administration, discard and safeguarding of medication, and properly documenting all drug orders correctly and legibly in the medication chart of the Facility medical record;

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

i) 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;

j) be responsive to any organisation review and feedback about documentation;

k) utilise any electronic medical record or e-health technology that may be in place; and

l) acknowledge and agree that medical records of patients of the Facility are owned by and copyright vests in the relevant HC Group Entity operating the Facility.

## 9.9 Continuing education

Accredited Practitioners must:

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

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

c) co-operate and participate in appropriate quality improvement activities, including satisfying the mandatory attendance and participation requirements set out in these By-Laws.

## 9.10 Clinical activity

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

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

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

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

## 9.11 Participation in Committees

a) Accredited Practitioners must participate in the Departmental meetings howsoever named, in accordance with By-Law 7.5a) unless otherwise excused under By-Law 7.5b).

b) In addition to the requirement under By-Law 9.11a), 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 9.11a), the FCEO may require any Accredited Practitioner to nominate him or herself to act as a member of a Committee. Before doing so, the FCEO must have regard to:

   i. the Accredited Practitioner's current, or recent historical contribution to Committee or Committees at the Facility (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).

## 9.12 Emergency/disaster planning

Accredited Practitioners must:

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

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

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

### 9.13 Pandemic Preparedness and Response

Declared pandemics pose unprecedented challenges to the health system and wider community in Australia. Preparing for and responding to pandemic viruses is a whole-of-Healthe Care responsibility. Accredited Practitioners must:

a) be aware of their role in response to the Facility's, commonwealth and state governments' public health department directives;

b) be familiar with the Facility's pandemic preparedness and response plans, infection prevention and control policies and processes in compliance with commonwealth and state governments' public health departments directives and Healthe Care's external provider of infection prevention and control consultants;

c) comply with the Facility's policies and procedures developed in response to a declared pandemic including ensuring that the correct category of surgery/procedure is assigned, best practice guidance regarding hand hygiene, respiratory / cough etiquette, use of PPE and social distancing developed from commonwealth and state governments' public health departments, chief medical/health officers and Healthe Care's external provider of Infection Prevention and Control Consultants.

### 9.14 Working with children checks/criminal record checks

a) The Appointment of Accredited Practitioners is conditional on the person satisfactorily completing any forms that HC Group and/or the relevant HC Group Entity may require for the purpose of fulfilling HC Group's and the relevant HC Group Entities' obligations under applicable child protection legislation.

b) The Accredited Practitioner must undertake to HC Group and the relevant HC Group Entity 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 HC Group immediately if he or she is unable to give the undertakings set out in By-Law 9.14b).

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.

### 9.15 Teaching and supervision

a) 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:

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

ii. consent being given by the patient.

### 9.16 Notifiable Conduct and mandatory reporting

a) 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.

### 9.17 Evidence Based Clinical Practice

a) Healthe Care and the Facility require the use of evidence based Clinical Practice at Facilities and require Accredited Practitioners to provide clinical care based upon best available evidence and/or standards of care that are well recognised by peers and in accordance with recognised professional and ethical standards.

b) Further to a), the national clinical guidelines developed collaboratively by organisations such as the National Health and Medical Research Council, the Australian Commission on Safety and Quality in Health Care and a College, professional association or other clinical professional organisation, represent the current clinical best practice for many areas of medicine, and should whenever possible and practicable, be consulted for guidance to support informed clinical decision-making and the development of pathways of care that yield optimal clinical outcomes.

### 9.18 Notice of leave

a) Where Accreditation has been granted in respect of the Facility, an Accredited Practitioner must use their best endeavours to notify the FCEO in writing, at least four weeks in advance of planned leave and make appropriate arrangements for another Accredited Practitioner to take over the care and treatment of their patients during the Accredited Practitioner's absence.

### 9.19 Notice of Resignation

a) An Accredited Practitioner who wishes to resign their Accreditation status shall forward a written resignation to the FCEO, giving 14 days' notice.

## 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 HC Group 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 FCEO of the new Facility and to the MAC via the Accreditation and Credentialing Committee of the new Facility for consideration.

c) Transfer of Accreditation status is not automatic, and the decision makers involved must still satisfy themselves as to Credentials, including Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care to the standard

required by the Facility and with respect to the Scope of Clinical Practice sought, as aligned to Organisational Need and Organisational Capabilities of the new Facility.

d) A transfer 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) The FCEO of the new Facility will advise of the decision, and if transfer of Accreditation is accepted, will advise of the Scope of Clinical Practice, Accreditation Period and any Conditions with respect to the new Facility.

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

## 11. SURGICAL ASSISTANTS

### 11.1 Use of Surgical Assistants

a) Accredited Practitioners must utilise as Surgical Assistants only those Surgical Assistants whose 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 directly supervising and for the conduct of Surgical Assistants whilst performing procedures in the Facility and must not delegate performance of substantive aspects of the procedure to Surgical Assistants.

### 11.2 Accreditation

a) The FCEO may grant Accreditation to a Surgical Assistant after reviewing a completed Application Form (completed as per HC Group's e-credentialing system) and having satisfied themself as to Credentials, including Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care to the standard required by the Facility and with respect to the Scope of Clinical Practice sought, as aligned to Organisational Need and Organisational Capabilities.

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 11.2a).

c) The FCEO will not grant temporary Surgical Assistant privileges at short notice (presenting on the particular day to assist) unless the FCEO is satisfied under By-Laws 11.2a).

### 11.3 Term of Appointment

a) All Appointments made pursuant to this By-Law 11 will be made for periods determined by the FCEO, with the maximum period being 3 years for VIC and maximum of 5 years for other States and Territories.

### 11.4 Appointments discretionary

a) All Appointments made pursuant to this By-Law 11 are discretionary. The FCEO may cancel 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) Limit performance of duties to providing assistance to the Accredited Practitioner performing the procedure and must not perform substantive aspects of the procedure, subject to an exception that in cases of emergency all reasonable and appropriate measures may be required in the best interests of the patient.

### 11.6 No admitting or patient management rights

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

### 11.7 Amending Scope of Clinical Practice

a) No Surgical Assistant granted Accreditation under this By-Law 11 will be entitled to amend their Scope of Clinical Practice.

### 11.8 Appeal

a) No right of appeal will exist in respect of an application for Accreditation of a Surgical Assistant, the termination of the Accreditation of a Surgical Assistant or any other decision made in relation to a Surgical Assistant.

### 11.9 Indemnity

In the event that a Surgical Assistant is Accredited by the FCEO pursuant to this By-Law 11 at the nomination of an Accredited Practitioner, the Accredited Practitioner engaging the Surgical Assistant shall bear all liability in relation to any act or omission of the Accredited Surgical Assistant while on or in the Facility and the Accredited Practitioner shall ensure that their Professional Indemnity Insurance covers any claim, loss or damage suffered or incurred as a direct result of the Accredited Surgical Assistant's act or omission while working or present at or in the Facility and shall ensure that the Accredited Surgical Assistant is covered by Worker Compensation Insurance. The Accredited Practitioner will, if requested by the FCEO, sign a release and indemnity deed in a form substantially the same as this By-Law prior to the Accredited Surgical Assistant being permitted access to the Facility.

## 12. REQUESTS TO VARY SCOPE OF CLINICAL PRACTICE

### 12.1 Variation

a) An Accredited Practitioner may make an application to the FCEO to vary their Scope of Clinical Practice at any time, and this must occur prior to an Accredited Practitioner performing services outside of currently approved Scope of Clinical Practice or when introducing New Clinical Services, Procedures or Other Interventions.

### 12.2 Process

a) The FCEO will forward applications for variation to Scope of Clinical Practice, together with all other relevant information, to the Accreditation and Credentialing Committee for review and consideration before decision by the FCEO.

b) The process for variation of Scope of Clinical Practice is the same as an application for Re-Accreditation, save that the FCEO may elect to waive the requirement and make a decision without proceeding through this process if the proposed variation is limited to a reduction in Scope of Clinical Practice.

## 13. INVESTIGATIONS OF CONCERNS, ALLEGATIONS OR COMPLAINTS

### 13.1 Facility Chief Executive Officer may monitor and undertake audits

The FCEO may monitor and undertake audits of the Accredited Practitioner's compliance with their obligations set out in the By-Laws, including compliance with relevant standards and Scope of Clinical Practice. If any concerns arise from the monitoring/audit process the FCEO may decide to make investigations pursuant to By-Law 13.2.

### 13.2 Facility Chief Executive Officer may make investigations

The FCEO may investigate pursuant to this By-Law a concern raised, allegation or complaint against an Accredited Practitioner, including in circumstances where the concern raised, or allegation or complaint made has or may result in:

a) patient health or safety could be compromised;

b) the efficient operation of the Facility being threatened or interrupted;

c) the reputation of the Facility, a HC Group Entity or HC Group could be threatened;

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

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

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

g) a law has been, or may be, contravened; or

h) staff welfare or safety could be compromised.

### 13.3 Notice to Accredited Practitioner and procedural matters

a) The FCEO will advise the Accredited Practitioner in respect of whom the concern, allegation or complaint has been made and 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 under By-Law 13.3a), which may include a determination on:

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

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

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

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

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

### 13.4 Review by Facility Chief Executive Officer

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

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

b) if in the opinion of the FCEO the matter requires formal review of the Accredited Practitioner's Accreditation and/or Scope of Clinical Practice, the FCEO will initiative a review in accordance with By-Law 14, or alternatively the FCEO may proceed direct to action pursuant to By-Laws 15-17;

c) the FCEO may impose an interim suspension or 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 or until the outcome of a review in accordance with By-Law 14. There will be no right of appeal with respect to imposition of an interim suspension or conditions.

Note: In is not a requirement to proceed through By-Law 13 before initiating a review pursuant to By-Law 14 or taking action pursuant to By-Laws 15-17, and as such, those processes may be initiated independently without an investigation pursuant to By-Law 13.

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

a) The FCEO 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.

b) The FCEO must advise the HC Group CEO and EGMCG a of any mandatory reporting made.

c) The National Risk and Compliance Manager must advise other HC Group Entities and 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 AND SCOPE OF CLINICAL PRACTICE

### 14.1 Facility Chief Executive Officer initiated internal review

a) The FCEO may, at any time, direct the Accreditation and Credentialing Committee or other appropriate individuals who are internal to Healthe Care, as determined by the FCEO, to conduct a review of the Accreditation and/or Scope of Clinical Practice previously granted

to an Accredited Practitioner, or with respect to any matter where concerns have been identified or allegations made that the FCEO has determined requires a review.

b) The FCEO will determine, before appointing an internal reviewer(s), that they are not biased and do not have a conflict of interest or perceived conflict of interest (with the fact of holding employment with or Accreditation at Healthe Care or the Facility an insufficient basis to establish bias or conflict of interest or perceived conflict of interest).

c) The internal reviewer(s) is required to provide a report on the findings of the review in accordance with the terms of reference to the FCEO.

### 14.2 Facility Chief Executive Officer initiated external review

a) The FCEO may, at any time, commission an external review with appropriate reviewer(s) external to Healthe Care, as determined by the FCEO, to conduct a review of the Accreditation and/or Scope of Clinical Practice previously granted to an Accredited Practitioner, or with respect to any matter where concerns have been identified or allegations made that the FCEO has determined requires a review.

b) The FCEO will determine, before appointing an external reviewer(s), that they are not biased and do not have a conflict of interest or perceived conflict of interest.

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

### 14.3 Notice to Accredited Practitioners

a) The FCEO will advise the Accredited Practitioner in respect of whom a review is being conducted under either By-Law 14.1 or 14.2 of the commencement and substance of the review, the extent to which the Accredited Practitioner may participate in the review and that the Accredited Practitioner will be provided with an opportunity to respond during the review.

b) The FCEO will decide on all procedural matters, including:

i. how the review will be dealt with under these By-Laws;

ii. the extent and nature of any relevant records or documents to be provided or produced in connection with the review; and

iii. any appropriate timeframes and format of response by the Accredited Practitioner.

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

d) The FCEO may impose an interim suspension or Conditions on the Accreditation of the Accredited Practitioner until such time as the FCEO has made a decision in relation to the review. There will be no right of appeal with respect to imposition of an interim suspension or conditions.

e) The FCEO must advise the HC Group CEO and EGMCG (or delegate) that the review is being undertaken under either By-Law 14.1 or 14.2 and whether an interim suspension or Conditions have been imposed.

### 14.4 Action the Facility Chief Executive Officer may take following review

Following a review report under By-Law 14.1 or 14.2 the FCEO will determine, in accordance with the By-Laws, what (if any) action will be taken regarding the Accredited Practitioner's Accreditation and Scope of Clinical Practice. This may include but is no limited to unchanged Accreditation, termination of Accreditation, acceptance of an undertaking, accreditation with special Conditions or suspension of Accreditation.

### 14.5 Notice of outcome of the review

a) The FCEO must give written notice to the Accredited Practitioner of the outcome of the review, including reasons, and the right of appeal (if any) from a decision made.

b) The FCEO must notify the HC Group CEO and EGMCG (or delegate) of the outcome of any review undertaken under By-Law 14.

### 14.6 Notifiable Conduct and mandatory reporting in relation to review of scope of clinical practice

a) The FCEO must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009.

b) The FCEO must advise the HC Group CEO and EGMCG (or delegate) of any mandatory reporting made under By-Law 14.

### 14.7 Not Contingent

The FCEO's right to proceed with review(s) in accordance with this By-Law 14 is not contingent on the FCEO having first carried out any review in accordance with By-Law 13, and the FCEO is not required to proceed with a review in accordance with this By-Law 14 before initiating action pursuant to By-Laws 15-17.

## 15. SUSPENSION OF ACCREDITATION

### 15.1 Suspension of Accredited Practitioners by Facility Chief Executive Officer

The FCEO may, and where possible following consultation with the MAC Chair, HC Group CEO and EGMCG (or delegate), suspend an Accredited Practitioner's Accreditation (in whole or in part), if the FCEO believes that:

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

b) it is in the interests of staff or Accredited Practitioner welfare or safety or workplace health and safety;

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

d) the Accredited Practitioner has breached any Conditions of Accreditation, including Conditions imposed by these By-Laws;

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

f) the behaviour or conduct of the Accredited Practitioner is inconsistent with the Behavioural Standards, the Code of Conduct or the Facility's mission or values statements;

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

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

i) serious and unresolved allegations have been made in relation to the Accredited Practitioner (this may be related to a patient or patients of another Facility or a facility not operated by Healthe Care, including if these are the subject of review by an external agency including a registration board, disciplinary body, Coroner, complaints commission or another health service);

j) the Accredited Practitioner has failed to observe any of the terms and conditions of Accreditation;

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

l) the Accreditation, has been suspended, terminated, restricted or made conditional by another health care organisation;

m) the Accredited Practitioner is the subject of a criminal investigation about a serious matter (for example a drug related matter, or an allegation of a crime against a person such as a sex or violence offence) which, if established, could affect their ability to exercise their Scope of Clinical Practice safely and competently and with the confidence of the Facility and the broader community;

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

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

p) an Internal Review or External Review has been initiated pursuant to these By-laws and the FCEO considers that an interim suspension is appropriate pending the outcome of the review; or

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

### 15.2 Notification of suspension decision and reasons

The FCEO:

a) Will notify the Accredited Practitioner of the decision to suspend, period of suspension, reasons for suspension, if applicable and appropriate in the circumstances any action to be performed for the suspension to be lifted and the right of appeal (noting there is no appeal from a decision for interim suspension);

b) If the FCEO considers applicable and appropriate in the circumstances, invite a written response from the Accredited Practitioner within a timely manner of the FCEO's notification, including a response why the Accredited Practitioner may consider the suspension should be lifted.

### 15.3 Suspension effective immediately and no right to claim

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

b) Suspension is ended either by lifting the suspension or termination of Accreditation.

c) It is a condition of Accreditation that the Accredited Practitioner acknowledges and agrees that suspension of their Accreditation is a safety and protective process and thus shall not, in any circumstances, give rise to any right on behalf of the Accredited Practitioner to claim compensation from the Facility, Healthe Care or a HC Group Entity (including for economic loss or reputational damage) and the Accredited Practitioner further agrees that this By-Law provision may be relied upon as an absolute bar to any proceedings.

### 15.4 Alternative arrangements for patients

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

### 15.5 Appeal rights

a) Unless otherwise provided in these By-Laws, the affected Accredited Practitioner will have the rights of appeal established by these By-Laws (other than from an interim suspension).

### 15.6 Notification to Board

a) The FCEO will notify the HC Group CEO and EGMCG (or delegate) of any suspension of Accreditation of an Accredited Practitioner. The HC Group CEO or EGMCG (or delegate) will notify the Board of any suspension of Accreditation of an Accredited Practitioner.

b) The HC Group CEO or EGMCG (or delegate) will notify other Healthe Care Facilities of the outcome, and absent special circumstances as determined and documented by the FCEO at those other Facilities, suspension of Accreditation will automatically apply at those other Healthe Care Facilities.

### 15.7 Notifiable Conduct and Mandatory Reporting

a) The FCEO must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009.

b) The FCEO must advise the HC Group CEO and EGMCG (or delegate) of any mandatory reporting made under By-Law 15.7a).

### 15.8 Alternative to Suspension

As an alternative to an immediate suspension, the FCEO may elect to deliver a Show Cause Notice to the Accredited Practitioner advising of:

a) the facts and circumstances forming the basis for possible suspension;

b) the grounds under the By-laws upon which suspension may occur;

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

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

e) a timeframe in which a response is required from the Accredited Practitioner to the show cause notice:

f) Following receipt of the response the FCEO will determine whether the Accreditation will be suspended. If suspension is to occur, notification will be sent in accordance with the notification requirements of this By-Law. Otherwise, the Accredited Practitioner will be advised that suspension will not occur at this stage; 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 in the future.

## 16. TERMINATION OF ACCREDITATION

### 16.1 Immediate termination

Accreditation shall be immediately terminated by the FCEO and, where considered reasonable and appropriate in the circumstances, in consultation with the HC Group CEO and EGMCG (or delegate), if, the following has occurred or based on the information available to the FCEO at that time it appears the following has occurred:

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

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

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

d) the Accredited Practitioner fails, refuses or is unable to comply with the requirements and undertakings set out in By-Law 9.14, or is dishonest in respect of the undertakings given in By-Law 9.14;

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

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

g) A contract of employment or to provide services is terminated or ends and is not renewed (and the Accredited Practitioner does not hold Accreditation unrelated to the services provided under this contract); or

h) 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 their Professional Indemnity Insurance has been cancelled, lapsed or does not cover their Scope of Clinical Practice).

### 16.2 Termination when not immediate

Accreditation of an Accredited Practitioner may be terminated by the FCEO having, where considered reasonable and appropriate in the circumstances following consultation with the HC Group CEO and EGMCG (or delegate), if the following occurred, or if it appears based upon the formation available to the FCEO that the following has occurred:

a) the Accredited Practitioner fails to observe the terms and Conditions of their Accreditation or fails to abide by these By-Laws or the Facility's policies and procedures;

b) if the Accredited Practitioner is found guilty of Professional Misconduct or Unprofessional Conduct by any inquiry, investigation or hearing by any disciplinary body or professional standards organisation.

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

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

e) to do so would be in the interests of staff or Accredited Practitioner welfare or safety;

f) the Accredited Practitioner's registration is subject to conditions which are inconsistent with their continuing to be appointed as an Accredited Practitioner;

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

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

i) the conduct or continuing Accreditation of the Accredited Practitioner compromises the efficient operation or the interests of the Facility, HC Group Entity or HC Group;

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

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

l) the Accredited Practitioner has appealed the suspension of their Accreditation and the decision to suspend is upheld;

m) based upon a finalised Internal or External Review;

n) the Accredited Practitioner is convicted of an offence which affects his or her ability to practice, is considered inconsistent with the expectations of an Accredited Practitioner at the Facility, or which relates to fraudulent or dishonest conduct;

o) there are grounds for suspension pursuant to By-Law 15.1 but in the circumstances it is considered by the FCEO that suspension is an insufficient response; or

p) there are other issues or concerns that are considered to be a ground for termination.

### 16.3 Notifications

a) The FCEO will notify the Accredited Practitioner of the decision to terminate, reasons for termination and the right of appeal (if any);

b) The FCEO will notify the HC Group CEO and EGMCG (or delegate) of any termination of Accreditation of an Accredited Practitioner. The HC Group CEO and EGMCG will together coordinate notification to the Board of any termination of Accreditation of an Accredited Practitioner.

### 16.4 No appeal rights where immediate termination

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

b) A right of appeal exists in respect of termination pursuant to By-Law 16.2;

c) If termination of Accreditation occurs, an individual is precluded from applying for Accreditation at any Healthe Care Facility for a period of 2 years form the date of termination of Accreditation, unless a lesser period is approved by the HC Group CEO and EGMCG (or delegate). The fact and circumstances of termination of Accreditation may be taken into account in a future application and may be the sole determining factor in not granting Accreditation.

### 16.5 Immediate Termination at each Facility and no right to claim

a) The termination of Accreditation of an Accredited Practitioner at one Facility will cause the automatic termination of Accreditation at any other Facility operated or conducted by an HC Group Entity;

b) It is a condition of Accreditation that the Accredited Practitioner acknowledges and agrees that termination of their Accreditation is a safety and protective process and thus shall not, in any circumstances, give rise to any right on behalf of the Accredited Practitioner to claim compensation from the Facility, Healthe Care or a HC Group Entity (including for economic loss or reputational damage) and the Accredited Practitioner further agrees that this By-Law provision may be relied upon as an absolute bar to any proceedings in relation thereto.

### 16.6 Notifiable Conduct and Mandatory Reporting

a) The FCEO must comply with their obligations of mandatory reporting of notifiable conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009.

b) The FCEO must advise the HC Group CEO and EGMCG (or delegate) of any mandatory reporting.

### 16.7 Alternative to Termination

As an alternative to proceeding immediately to the process of termination of Accreditation, the FCEO may elect to deliver a show cause notice to the Accredited Practitioner advising of:

a) the facts and circumstances forming the basis for possible termination;

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

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

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

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

f) Following receipt of the response the FCEO will determine whether the Accreditation will be terminated. If termination is to occur notification will be sent in accordance with the notification requirements of this By-Law. Otherwise, the Accredited Practitioner will be advised that termination will not occur at this stage; 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 in the future.

## 17. IMPOSITION OF CONDITIONS AND OTHER ACTIONS IN LIEU OF SUSPENSION OR TERMINATION OF ACCREDITATION

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

a) At the conclusion of or pending the finalisation of an internal review or external review, or in lieu of the suspension or termination of Accreditation, the FCEO may elect to impose Conditions on the Accreditation or Scope of Clinical Practice of an Accredited Practitioner.

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

c) If the Conditions are breached, then suspension or termination of Accreditation of an Accredited Practitioner may occur, as determined by the FCEO.

d) 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.

e) The appeal procedure contained in these By-Laws will apply to an imposition of Conditions under By-Law 17, other than no appeal is available with respect to imposition of Conditions on an interim basis pending finalisation of an internal review or external review.

f) It is a condition of Accreditation that the Accredited Practitioner acknowledges and agrees that imposition of Conditions upon their Accreditation is a safety and protective process and thus shall not, in any circumstances, give rise to any right on behalf of the Accredited Practitioner to claim compensation from the Facility, Healthe Care or a HC Group Entity (including for economic loss or reputational damage) and the Accredited Practitioner further agrees that this By-Law provision may be relied upon as an absolute bar to any proceedings in relation thereto.

### 17.2 Notification of conditions

a) The decision to impose Conditions under these By-Laws will be notified to other HC Group 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

a) The FCEO will notify the HC Group CEO and EGMCG (or delegate) of any imposition of Conditions on the Accreditation of an Accredited Practitioner. The HC Group CEO or EGMCG will notify the Board of any imposition of Conditions on an Accredited Practitioner.

### 17.4 Notifiable Conduct and Mandatory Reporting

The FCEO must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009.

b) The FCEO must advise the HC Group CEO and EGMCG (or delegate) of any mandatory reporting made under By-Law 17.4a).

### 17.5 Other Potential Action

In lieu of suspension of Accreditation, termination of Accreditation or imposition of Conditions, and in the complete discretion of the FCEO, the FCEO may firstly elect one of the following options:

a) Informal Counselling, to discuss the issue of concern and attempt to agree on an outcome or outcomes arising from that discussion;

b) Formal warning, which may be a first and final warning, such that if similar concerns arise in the future, then the FCEO will no longer have the option of counselling or a warning, and must consider an undertaking, imposition of Conditions, suspension of Accreditation or termination of Accreditation; or

c) Undertaking, which is a written agreement by an Accredited Practitioner to do or not to do something, which will be set out in writing the agreement reached, be dated, have a timeframe for which it will apply, a date for review, acknowledgement of the consequences if breached and be signed by the Accredited Practitioner.

## 18. APPEAL RIGHTS

### 18.1 No appeal rights

a) The By-Laws must specifically provide a right of appeal from a decision, otherwise no appeal rights exist pursuant to the procedure set out in this By-Law 18.

b) For the avoidance of any doubt, there shall be no right of appeal by an Applicant against a decision not to grant an initial Accreditation as an Accredited Practitioner to the Facility, from any terms or conditions that may be attached to an approval of an initial Accreditation as an Accredited Practitioner at the Facility or from interim decisions.

c) The By-Laws have specifically indicated no appeal from decisions made pursuant to By-Law 1.1(j)(iv)-(vi), 8.2c), 8.3a)i), 8.3(a(ii), 8.3g), 8.3r), 8.5f), 8.6g), 8.7c), 10(f), 11.8, 13.4c), 14.3d), 16.6a), 17.1e), 20.2, 21.2 and 23.3.

### 18.2 Appeal rights generally

a) An Accredited Practitioner who currently holds Accreditation 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 unless they have been specifically excluded (for example an interim decision), including but not limited to appeals being provided for pursuant to By-Laws 15.5a), 16.6b), 17.1e).

### 18.3 Concurrent appeal rights

a) 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 lodge an appeal against the decision, otherwise any entitlement to appeal is lost.

b) Such an appeal must be in writing and be lodged with and received by the FCEO.

### 19.2 Relevant Committee established to hear appeal

An Appeals Committee will be established by the HC Group CEO and EGMCG (or delegate), which must as a minimum include:

a) the HC Group CEO, or delegate;

b) the HC Group EGMCG, or delegate; and

c) If a clinical or treatment related matter, a person of the same specialty as the Appellant.

### 19.3 Bias or Conflict of Interest

Before accepting the appointment, the nominees will confirm that they do not have a known bias or conflict of interest or perceived conflict of interest with the Appellant. It will not be sufficient to establish bias, conflict of interest or perceived conflict of interest that the individual is an employee or Accredited Practitioner of Healthe Care or the Facility.

### 19.4 Chairperson

a) The chairperson of the Appeals Committee will be the HC Group CEO and EGMCG (or delegate).

### 19.5 One vote per member

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

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

### 19.6 Notice and Process

a) The Appellant will be provided with a notice by the Appeals Committee.

b) The initial notice will advise the members of the Appeal Committee, the process to be adopted, the documents to be provided and make a request for a written submission within a specified timeframe.

c) A further notice will advise the date for oral hearing before the Appeal Committee.

d) The Appellant will have the opportunity to make an oral submission to the Appeals Committee at the oral hearing.

e) Matters of procedure will be determined by the Chairperson of the Appeals Committee, and as this is not a court process, the appeal will proceed with as little formality as possible.

### 19.7 No legal representation

a) Neither the Appellant nor any party will have any legal representation at any meeting or hearing of the Appeals Committee.

b) The Appellant is entitled to be accompanied by a support person, who may be a lawyer, but that support person is not entitled to address the Appeals Committee.

### 19.8 Final determination of the Appeals process

a) The appeal is confined to the evidence that was before the FCEO at the time of making the decision and will be decided on the basis whether it was reasonably open for the FCEO to have made that decision.

b) The Appeals Committee will make a written recommendation to the Board, including reasons, in accordance with the requirements of By-Law 19.8(a).

c) The Board will consider the written recommendation, but is not bound by it, and the Board will then make a final and binding determination regarding the appeal.

### 19.9 No Stay

a) Lodgement of an appeal will not stay the decision under appeal, and it may be actioned accordingly.

## 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 their field of clinical Accreditation, and with appropriate research experience, as a co-investigator;

b) the proposed clinical research is consistent with the National Health & Medical Research Council (NHMRC) Statement on Ethical Conduct in Human Research (2023) 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;

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, after all ethical and governance issues have been approved and evidence of insurance is in place;

g) in accordance with the NHMRC Statement on Ethical Conduct in Human Research 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 (refer to Healthe Care's Clinical Trials and Research Policy (2.14);

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 has the complete discussion to not approve research and there is no appeal from such a decision.

The FCEO may also withdraw permission for, or place Conditions upon, the conduct or continuation of research involving treatment of human subjects at the Facility if in their 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 HC Group Entity or HC Group; or

d) is inconsistent with good professional practice.

There is no appeal from the decision to withdraw permission or place conditions.

# 21. NEW CLINICAL SERVICES, PROCEDURES, OR OTHER INTERVENTIONS

## 21.1 Approval process

New Clinical, Services, Procedures, or Other Interventions, or anything else that would be regarded as 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) it is consistent with the Code of Conduct, the Codes of Ethical Standards and any other relevant policy of Healthe Care;

c) if involving clinical research, By-Law 20 is complied with;

d) the requirements of By-Law 21.2 are complied with (if applicable);

e) The FCEO is satisfied that all necessary information has been provided, has consulted with relevant persons within Healthe Care or the Facility, and that appropriate insurance cover (including from Healthe Care's insurer and the Accredited Practitioner's insurer or there is alternative acceptable insurance in place), and funding is in place;

f) 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;

g) formal written approval is provided by the FCEO, including with any terms and conditions; and

h) The applicant agrees to the terms and conditions of approval.

## 21.2 Process for 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 regulatory, 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 and there is no appeal from such decision.

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

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

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

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

iv. notify the relevant Committee.

## 22. MANAGEMENT OF EMERGENCIES

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

In such cases, the following provisions will apply:

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

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

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

a) The FCEO may, from time to time, on the basis of ethical 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

a) 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 FCEO will refer the matter to the Accreditation and Credentialing Committee for consideration and discussion. The 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 Committee.

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

## 24. ADMISSION AND REMOVAL OR TRANSFER OF PATIENTS

### 24.1 All admissions subject to approval

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

### 24.2 Right to request discharge or transfer of patient

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

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

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

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

## 25. DISPUTES

### 25.1 By-Laws

a) Any dispute or difference which may arise as to the meaning or interpretation of these By-Laws will be determined by the EGMCG in consultation with the CEO Acute Services or Specialty Services.

### 25.2 Committees

a) 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, the HC Group CEO or EGMCG (or delegate).

## 26. REVISION OF BY-LAWS

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

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

## 27. SERVICE PROVIDERS

If a Facility enters into a contract for the provision of clinical services (such as medical imaging or pathology or allied health services) by a third-party contractor to the patients of the Facility, the contract may:

a) provide that only health professionals who have been Accredited pursuant to these By-Laws to treat patients at the Facility may provide the clinical services; or

b) require the third-party contractor to ensure that:

i. The Credentials, professional registration and professional indemnity insurance status of the health professionals who provide the contracted services are strictly verified by the third-party contractor and are consistent with the contractual requirements, and that evidence of Credentials, professional registration and professional indemnity insurance status is provided to the FCEO; and

ii. the health professionals who provide the services do so only within the Scope of Clinical Practice or under the Accreditation Classification or conditions of Accreditation specified in the contract as generally applicable to all health professionals providing the services, unless they have been accredited specifically by the Facility as Accredited Practitioners with a modified Scope of Clinical Practice/Accreditation Classification/conditions of Accreditation;

however, regardless of any contractual arrangements, all procedural and interventional radiologists or pathologists must be Accredited by the Facility as Accredited Practitioners pursuant to these By-Laws in order to treat patients at the Facility.

The FCEO has complete authority to withdraw authority for any health professional to provide all or some of the contracted services to patients of the Facility. There will be no appeal against such a decision.

The Accreditation of any health professional who provides services on behalf of a third-party contractor to the patients of the Facility will terminate with the contract under which those services are provided. There will be no appeal against the termination of an Accreditation under this Rule.