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

Version 14: 15 May 2025

Document History/Version Control

Document	SVHA Board Approval Date
SVHA Group Model By-Laws (Version 1)	2 February 2012
SVHA Group Model By-Laws (Version 2)	5 April 2012
SVHA Group Model By-Laws (Version 3)	2 August 2012
SVHA Group Model By-Laws (Version 4)	29 October 2012
SVHA Group Model By-Laws (Version 5)	1 August 2013
SVHA Group Model By-Laws (Version 6)	12 December 2013
SVHA Group Model By-Laws (Version 7)	1 October 2014
SVHA Group Model By-Laws (Version 8)	4 August 2016
SVHA Group Model By-Laws (Version 10)	6 June 2019
SVHA Group Model By-Laws (Version 11)	3 December 2020
SVHA Group Model By-Laws (Version 12)	15 April 2021
SVHA Group Model By-Laws (Version 13)	30 November 2022
SVHA Group Model By-Laws (Version 14)	15 May 2025

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FOREWORD

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

2. All references to By-Laws means the SVHA Group Model By-Laws and all references to Facility or Facilities in these By-Laws is a facility or facilities of SVHA.

3. These By-Laws apply to all public and private Facilities of SVHA. Specific provisions may be applicable to only one of these two groups. Where a Facility has legislative obligations or operational procedures which are different or additional to these By-Laws, these will be set out in Schedule 1.

4. These By-Laws must be read in conjunction with the Clinical Credentialing and Scope of Practice Policy and all other relevant SVHA policies adopted by the Board. The terms of the By-Laws will prevail to the extent of any inconsistencies.

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

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

7. The composition of each Committee will reflect the Facility's organisational requirements and where relevant the reasons for the composition of the Committee.

8. Where the Facility Chief Executive Officer has delegated his or her authority to a Delegated Authority in respect of any power under a particular By-Law, a reference to the Facility Chief Executive Officer in that By-Law will also include that Delegated Authority.

PREAMBLE

All Medical Practitioners, Dental Practitioners and other categories of approved registered health practitioners are required to hold a current Appointment to practise clinically at one or more SVHA Facilities or services and must comply with the By-Laws.

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

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

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

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

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

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

SVHA VISION, MISSION, VALUES AND CARE STATEMENTS

Mission

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

Vision

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

Values

Compassion

Justice

Integrity

Excellence

Care

Our care is:

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

1. BY-LAWS

1.1. Application of By-Laws

This document sets out the By-Laws that apply to all Facilities and services determined by the Board. All Applicants agree that they read and accepted the By-Laws in its entirety as part of their Accreditation and Re-accreditation. All Accredited Practitioners agree to strictly adhere to the By-Laws including any amendments made from time to time. A failure to read the By-Laws and any amendments will not be considered a reasonable excuse for non-compliance.

1.2. Extended application of By-Laws

The By-Laws also apply to an Accredited Practitioner providing care, providing services and their conduct in the following circumstances:

(a) from premises owned, leased, sub-leased or licensed on a sessional basis from SVHA or a Facility (including associated corporate entities);

(b) at consulting rooms or space that is rented, leased or subject to some other arrangements with SVHA or a Facility (including associated corporate entities);

(c) at consulting rooms or other spaces that may be privately owned or subject to arrangements with an entity not owned or operated by SVHA or a Facility (including associated corporate entities), with application of the By-Laws limited to care being provided at that time to a SVHA or Facility patient; and

(d) Behavioural Standards extend to the Accredited Practitioner's conduct at off-site premises event or premises with a connection to SVHA or the Facility or where SVHA or Facility staff are attending in a social or professional capacity.

1.3. Inconsistencies with legislation

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

2. INTERPRETATION

2.1. Paramount considerations

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

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

(c) In making decisions with respect to these By-Laws and taking actions pursuant to these By-Laws, the health, safety, quality of care provided and experience of patients and our obligations under any Act will be the paramount considerations.

2.2. Definitions

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

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

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

(b) any specified Conditions;

(c) the Code of Conduct;

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

(e) these By-Laws.

Accreditation Classification means one or more of the designated classifications of an Accredited Practitioner in place at the particular Facility and/or as set out in the relevant policy of the Facility to which Accreditation has been granted and/or as set out in Schedule 1.

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

Act means all relevant legislation applicable to and governing:

(a) the Facility and its operation;

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

(c) the health services provided by, and the conduct of, the Accredited Practitioner including but not limited to the private health facilities legislation and regulations (however named) in place in the particular State or Territory where the Facility is located.

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

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

Applicant means any registered health practitioner who wishes to apply for Accreditation, Re-accreditation or an amendment of Scope of Clinical Practice at the Facility.

Appointment means the authorisation of an Accredited Practitioner to provide services within the Facility according to the By-Laws and any Conditions defined by law which, for any practitioner who is an employee, may be supplemented by a contract of employment. The Appointment is a conditional non-contractual licence to enter the Facility and provide services, and does not of itself create any contractual relationship between an Accredited Practitioner and a Facility or SVHA, including that it does not of itself create any contract of employment.

Behavioural Standards means the standard of conduct and behaviour expected of an Accredited Practitioner arising from personal interactions, communication and other forms of interaction with other Accredited Practitioners, employees of SVHA, Board members of SVHA, executive of SVHA, third party service providers, patients, family members of patients and others. The minimum standard required of Accredited Practitioners in order to achieve the Behavioural Standards is compliance with the Code of Conduct, the expectations set out in the relevant National Health Practitioner Board's code of conduct including the Good Medical Practice: A Code of Conduct for Doctors in Australia (as applicable), SVHA Vision, Mission, Values and Care Statements, and the Catholic Health Code of Ethical Standards.

Board means the Board of Directors of SVHA.

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

(a) all clinical risks are being appropriately managed.

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

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

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

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

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

(a) the SVHA Group CEO

(b) the Divisional CEO (DCEO)

(c) the Facility CEO (FCEO)

(d) the Regional CEO (FCEO)

Code of Conduct means the SVHA Code of Conduct applicable from time to time.

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

(a) Appointment and Credentialing;

(b) Defining the Scope of Clinical Practice;

(c) Review of Accreditation or Clinical Scope of Practice; and

(d) Appeals.

Competence means, in respect of a person who applies for Accreditation or Re-accreditation, or holds current Accreditation, that the person is assessed to have the required knowledge, skills, training, decision-making ability, judgement, insight and

interpersonal communication necessary for the Scope of Clinical Practice and has the demonstrated ability to provide health services at an expected level of safety and quality.

Condition means as applicable with respect to an Accredited Practitioner:

(a) any condition imposed by a Regulatory Authority including the relevant National Health Practitioner Board established under the National Law; or

(b) any condition imposed pursuant to these By-laws.

Credentialing means the process used to verify the Credentials of a clinician to determine their ability to provide safe, high quality health care services within a specific health care setting and role.

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

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

Dental Practitioner means a person registered as a dentist by the Dental Board of Australia assisted by AHPRA pursuant to the National Law.

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

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

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

(b) the Division of St Vincent’s Public Hospital which comprises all of the SVHA Public Hospital Facilities;

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

(d) the Division of Virtual and At Home Services.

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

(a) the CEO of the Private Hospitals Division;

(b) the CEO of the St Vincent's Sydney Hospital Network;

(c) the CEO of the St Vincent's Hospital Melbourne;

(d) the CEO of the Aged Care Division;

(e) the CEO of Virtual and At Home Services.

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

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

(a) Chief Executive Officer of St Vincent's Private Hospitals NSW;

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

(c) Chief Executive Officer of St Vincent's Private Hospitals Victoria

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

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

(f) National Director of Virtual and At Home Services.

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

Medical Practitioner means a person registered as a medical practitioner by the Medical Board of Australia assisted by AHPRA pursuant to the National Law.

Medical Proctor means a registered medical practitioner who acts only as a monitor to evaluate the technical and clinical competency of an Accredited Practitioner. A medical proctor does not directly provide patient care, has no clinician-patient relationship with the patient being treated, and does not receive a fee from the patient.

National Health Practitioner Board means the Regulatory Authority established under the National Law.

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, treatments, procedures, techniques, instruments, therapeutic drugs / medicines, therapeutic goods, medical devices, technology, products or other interventions:

(a) that are being introduced by an Accredited Practitioner into the Facility for the first time;

(b) if currently used by the Accredited Practitioner are planned to be used in a different way, for something other than its registered, listed or approved purpose, or significantly altered from that previously approved;

(c) which would be considered by a reasonable body of medical opinion to be significantly different from existing clinical practice; and

includes

(d) 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; and

(e) technology proposed to be used by an Accredited Practitioner directly or indirectly in the care of a patient (including as a communication tool or that will use / store / transmit patient health information, images or data), that is introduced into the organisational setting of the Facility for the first time, or if currently used by the Accredited Practitioner is planned to be used in a different way or for something other than its registered, listed or approved purpose. Such technologies include but are not limited to mobile devices, mobile health apps, analytical, decision-making and support tools and artificial intelligence.

Notifiable Conduct means conduct as defined in the National Law in relation to a registered health practitioner, and currently means the practitioner has:

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

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

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

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

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

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

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

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

Professional Misconduct has the same meaning prescribed to that term in the National Law.

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

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

Recency of practice means the minimum hours overall and with respect to specific areas of clinical practice or surgeries/procedures required to maintain competence to maintain professional skills and knowledge.

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

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

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

Scope of Clinical Practice means the scope of an Accredited Practitioner's clinical practice within a Facility which is decided after Credentialling. The scope of practice is determined by delineating the extent of an Accredited Practitioner's clinical practice within a particular Facility based on the individual's Credentials, Competence, Performance, Current Fitness, professional suitability and the Organisational Need and Organisational Capabilities of the Facility to support the Accredited Practitioner's Scope of Clinical Practice.

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

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

Suspension means a temporary pause of an Accredited Practitioner's Appointment under By-Law 14, during which the Accredited Practitioner cannot attend the Facility (unless specific permission is granted by the FCEO acting in their sole discretion), cannot undertake clinical practice, cannot exercise their Scope of Clinical Practice, cannot provide services at the Facility and cannot be involved in the care of Facility patients (including a restriction on providing instructions or supervision to others).

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

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

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

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

(a) SVHA;

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

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

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

Termination means the conclusion of an Accredited Practitioner's Appointment under By-Law 15, the consequence of which is that the Accredited Practitioner is no longer an Accredited Practitioner, cannot attend the Facility premises for patient care, cannot undertake clinical practice, cannot exercise Scope of Clinical Practice, cannot provide services at the Facility and cannot be involved in the care of Facility patients (including a restriction on providing instructions or supervision to others).

Unprofessional Conduct or Unsatisfactory Professional Conduct has the same meaning prescribed to those terms in the National Law.

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

2.3. General Interpretation

(a) Rules for Interpreting these By-Laws

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

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

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

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

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

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

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

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

(b) Titles

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

(c) Quorum

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

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

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

(d) Resolutions without meetings

A decision may be made by a Committee or group established pursuant to these By-Laws (except that established by By-Law 18) without a meeting if a consent in writing, including electronic means, setting forth such a decision is signed by all the Committee or group members, as the case may be.

(e) Meeting by electronic means

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

(f) Voting

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

(g) Delegation

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

(h) Compensation

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

3. Privacy and confidentiality

3.1. Privacy

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

3.2. Accredited Practitioners

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

(a) business information concerning SVHA or the Facility;

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

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

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

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

3.3. Committees

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

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

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

3.4. What confidentiality means

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

3.5. When confidentiality can be breached

The confidentiality requirements of By-Law 3 do not apply in the following circumstances: where disclosure is required or specifically authorised by law;

(a) where disclosure is required by a Regulatory Authority in connection with the Accredited Practitioner;

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

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

3.6. Privacy and confidentiality obligations continue

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

3.7. Information sharing

(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)) with respect to any matters related to these By-laws internally within the Facility, to other SVHA Group Entities, any Regulatory Authority and College that the Accredited Practitioner is a member.

(b) As part of the application process for Accreditation or following approval of Accreditation, the Accredited Practitioner y consent to SVHA collecting, holding, accessing, using and disclosing personal information, sensitive information and confidential information relating to the Accredited Practitioner, the application

process, Accreditation, these By-Laws, a breach of the Behavioural Standard and/or the conduct of the Accredited Practitioner.

(c) Given that it is a mandatory requirement that the terms of the By-Laws and any amendments will be read and accepted in full, this By-Law will be taken as sufficient notice to the Accredited Practitioner pursuant to the Privacy Act 1988 (Cth).

3.8. Mandatory notification of Notifiable Conduct

Notwithstanding By-Laws 3.1 to 3.7, all registered health practitioners acting in a management role with SVHA must comply with their responsibilities under the National Law in regard to mandatory notification of Notifiable Conduct of another registered health practitioner or a student undertaking clinical training.

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 date of the resolution by the Board and apply to all Accredited Practitioners from that date.

4.2. Transitional arrangements

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

5. Committees

5.1. Power to establish Committees

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

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

5.2. Terms of Reference for Committees

The Terms of Reference for Committees will be reviewed annually as determined by the FCEO.

5.3. Indemnification

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

(c) acted in good faith;

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

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

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

5.4. Statutory immunity for Committees

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

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

5.5. Committee access to the SVHA Board

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

6. DISCLOSURE OF INTEREST OF MEMBERS OF COMMITTEES

6.1. Disclosure of interest

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

(a) in a matter that has been considered, or is about to be considered, at a meeting; or

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

such a member or person must not, subject to By-Law 6.5, participate in the relevant discussion or resolution and must as soon as possible after the relevant facts have come to the person's knowledge, disclose the nature of the interest at the meeting.

6.2. Nature of disclosure

Disclosure by a person at a meeting that the person:

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

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

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

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

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

6.3. Chairperson to notify Facility Chief Executive Officer

The chairperson of the relevant Committee will:

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

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

6.4. Record of disclosure

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

6.5. Determination to effect of matter disclosed

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

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

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

7. CLINICAL REVIEW COMMITTEES

7.1. Objectives

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

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

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

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

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

(e) providing a forum to consider and discuss strategies to improve the cultural awareness and cultural competency of Accredited Practitioners to meet the needs of its community, including the provision of culturally safe and respectful health care that is responsive to Aboriginal and Torres Strait Islander (Peoples) patients.

7.2. Functions

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

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

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

(c) review Performance against external measures;

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

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

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

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

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

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

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

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

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

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

7.3. Meetings of clinical review Committee or Committees

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

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

7.4. Minutes and reporting

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

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

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

7.5. Mandatory attendance

(a) It is a Condition of Accreditation that:

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

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

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

8. APPOINTMENT OF ACCREDITED PRACTITIONERS

8.1. Application Form

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

8.2. Applications for Appointment

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

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

Note: If an Applicant has previously had an application for Accreditation rejected or Accreditation has been terminated pursuant to these By-Laws, a further application for Appointment will be treated as a new application for Accreditation rather than an application for Re-Accreditation. Unless a longer period has previously been specified, an application cannot be made within 12 months since notification of the unsuccessful application or the date of termination of Accreditation.

(b) An application fee may be levied on Applicants. The FCEO will determine if the application fee is to be levied on the Applicant and the amount of the fee. This must be paid before the application may progress. The Application Form will contain details of the application fee if applicable.

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

(d) Referees must include at least one current supervisor or professional colleague in the same speciality at the Facility if the Applicant is currently appointed at the Facility. If the Applicant is not currently appointed at the Facility, the referees must include at least one supervisor, head of department / speciality or health service CEO. Referees must not be personally related to the Applicant and any financial relationship with Referees must be disclosed in advance by the Applicant.

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

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

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

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

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

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

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

(l) The FCEO (after receiving the recommendation from the appointments Committee) will make a final determination on the application and will have complete discretion to seek further information before making a decision to approve or reject each application for Accreditation or Re-accreditation, and to make a decision with respect to the Scope of Clinical Practice.

(m) The FCEO must notify each applicant in writing of his or her decision, and if the application is approved then the delineation of approved Scope of Clinical Practice is to be specifically defined in the Appointment letter.

(n) On receiving the notice of Appointment, the applicant must indicate his or her acceptance in writing which will be taken to include the applicant's acceptance and agreement to comply with the SVHA and Facility By-Laws, policies and procedures SVHA's Visions, Mission, Values and Care Statements.

8.3. Recency of Practice

(a) To practise competently and safely, an Accredited Practitioner must have Recency of 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 about an Accredited Practitioner's Recency of Practice

8.4. Period of Appointment

(a) The period of Appointment will be determined by the FCEO, which for Facilities located in New South Wales and Queensland will be for a minimum period of three

(3) years and up to a maximum period of five (5) years, and for Facilities located in Victoria will be for a maximum period up to three (3) years, in line with State and Territory requirements. The date of Appointment is the date of the FCEO approval of the Appointment and will be set out in the Appointment letter.

(b) Despite By-Law 8.4(a), for a new applicant for Appointment, the FCEO may determine in his or her complete discretion that the period of Appointment will be for a lesser period of time in accordance with By-Law 8.6(a).

8.5. Nature of appointment

(a) It is a condition of accepting Accreditation, and of ongoing Accreditation, that the Accredited Practitioner understands and agrees that these By-Laws are the full extent of processes and procedures available to the Accredited Practitioner with respect to all matters relating to and impacting upon Accreditation, and no additional processes or procedures will be incorporated or implied, other than processes and procedures that have been explicitly set out in these By-Laws or apply by reason of a public sector appointment or regulation.

(b) Accredited Practitioners acknowledge and agree as a condition of the granting of, and ongoing Accreditation, that the granting of Accreditation establishes only that the Accredited Practitioner is a person able to provide services at the Facility, as well as the obligations and expectations with respect to the Accredited Practitioner while providing services for the period of Accreditation, the granting of Accreditation creates no rights or legitimate expectation with respect to access to the Facility or its resources, and while representatives of the Facility and SVHA will generally conduct themselves in accordance with these By-Laws - there are no consequences for not doing so, other than by reason of a public sector appointment or regulation.

8.6. Provisional Appointment

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

8.7. Temporary Appointment

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

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

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

(d) Temporary Appointment may include a 'Medical Proctor' who is a Medical Practitioner attending to provide mentoring and guidance to an Accredited Practitioner,

(e) Accreditation granted under this By-Law 8.7 will remain in force for a period of up to 90 days from the date of determination by the FCEO, with the period of Temporary Appointment in the complete discretion of the FCEO. Any extension is at the discretion of the FCEO, and other than in exceptional circumstances as determined

by the FCEO will be no longer than an additional 90 days and must be approved in writing by the FCEO.

(f) Should any Medical Practitioner or Dental Practitioner granted Temporary Appointment wish to obtain Accreditation, the process in By-Law 8.2 will be followed.

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

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

8.8. Urgent Appointments

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

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

  (i) Confirm the applicant's registration status with AHPRA; and

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

(c) An individual seeking or granted Urgent Appointment must provide evidence of Professional Indemnity insurance within 24 hours of appointment and in any event before commencing any work at the Facility

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

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

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

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

8.9. Locum tenens

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

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

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

8.10. On-Call arrangements

(a) Although the FCEO may require participation of an Accredited Practitioner in on-call arrangements, an Accredited Practitioner has no entitlement to request participation in or remain in on-call arrangements or to decide the manner in which those on-call arrangements will be administered.

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

(c) Accredited Practitioners who are involved in administering a roster connected to provision of the services to the Facility or its Accredited Practitioners will not do so in a way that is anti-competitive, and will work with the intention that the roster arrangement is to facilitate patient access to services of the Facility.

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

8.11. Accreditation of other health practitioners

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

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

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

(d) There is no right of appeal pursuant to these By-Laws with respect to decisions made regarding Accreditation (including decisions not to grant), Re-Accreditation (including decisions not to grant), Scope of Clinical Practice and conclusion of Accreditation with respect to the Applicant.

8.12. Third party providers

(a) If certain services are delivered by a third party provider, such as medical imaging, pathology or a State /Territory operated public health service, the FCEO may require Medical Practitioners or other categories of registered health practitioners delivering the services on behalf of the third party provider to firstly seek and be granted Accreditation pursuant to these By-Laws or alternatively may require the third party provider to undertake its own Accreditation process and provide evidence of this.

(b) Despite paragraph (a) above, Accreditation pursuant to these By-Laws is required for health practitioners intending to provide procedural or interventional clinical services at the Facility.

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

8.13. Options with respect to ongoing and conclusion of Accreditation

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

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

(c) An Accredited Practitioner who intends to cease treating patients indefinitely will notify this intention to the FCEO and following consultation with the FCEO, the Appointment will be taken to be withdrawn on the date notified by the FCEO.

8.14. Monitoring of Accreditation

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

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

9. TERMS AND CONDITIONS OF APPOINTMENT OF ACCREDITED PRACTITIONERS

9.1. Compliance with By-Laws

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

9.2. General terms and conditions

Accredited Practitioners must:

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

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

(c) comply and assist SVHA and the Facility to comply with the Act, all applicable legislation and general law including the National Safety and Quality Health Service Standards and the Aged Care Quality Standards established under the relevant Act;

(d) comply with the National Law in regard to mandatory notification of Notifiable Conduct of another practitioner or a student undertaking clinical training at the Facility and notify the FCEO of any such notification;

(e) maintain their professional registration with the relevant National Health Practitioner Boards and AHPRA, furnish evidence of registration to the Facility and when requested to do so and advise the FCEO immediately of any material changes to the conditions or status of their professional registration (including suspension, cancellation, reprimands, cautions or the imposition of conditions);

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

(g) not engage in any conduct that may be perceived as a reprisal against another person for making a report or supplying information relating to the Behavioural Standards Programs in place across SVHA or for making a report or supplying information relating to issues of safety or quality with respect to the Accredited Practitioner;

(h) comply with all requirements (whether imposed externally or by the Facility) regarding infection or disease prevention and control, including requirements relating to vaccination;

(i) consent to the sharing of information relating to their Competence, behaviour and conduct within SVHA and to any Regulatory Authority and College that they are a member;

(j) where applicable, provide appropriate professional mentorship and support to maintain the health and well-being of junior medical staff, and provide active

supervision for junior medical practitioners in training whether in accredited or non-accredited positions;

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

(l) adhere to accepted ethics and standards of practice, including as applicable the standards, guidelines, ethical codes and codes issued by the National Health Practitioner Boards and professional organisations including the Australian Medical Association, Australian Dental Association, professional Colleges as issued from time to time in relation to his or her colleagues, Facility employees and patients;

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

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

(o) participate in on-call arrangements as required by the Facility, including provision of sufficient after-hours and weekend support, with the extent of support by a particular Accredited Practitioner and the manner of that support (including whether that is provision in advance of available dates/periods or inclusion in a roster) will be determined by the FCEO taking into account considerations as determined relevant by the FCEO (which may include patient safety, continuity of care, anticipated service demand, Organisational Capability, Organisational Need, private hospital licensing requirements, extent of service provision by individual Accredited Practitioners and individual circumstances of Accredited Practitioners);

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

(q) provide all reasonable and necessary assistance upon request by the Facility in order to comply with or respond to requests, enquiries or investigations, including a legal request or information requests from external agencies; and

(r) not purport to represent or communicate on behalf of any SVHA Group Entity or SVHA, including through the use of letterhead of the Facility, SVHA Group Entity or SVHA (other than its appropriate use in routine clinical care), unless with the express written permission of the FCEO.

9.3. Responsibility for patients

Accredited Practitioners must:

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

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

(c) admit to the Facility only those patients who satisfy applicable requirements of the Facility relating to admission, where there is a suitable or appropriate bed available and whose treatment and needs can be accommodated by the Organisational Capability and appropriately managed in the Facility (the FCEO may notify

Accredited Practitioners of any categories of patients who are considered inappropriate for admission to the Facility and otherwise each admission is subject to the ultimate approval of the FCEO in accordance with By-Law 9.4);

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

(e) accept full responsibility for his or her patients from admission until discharge, or until the care of the patient is formally transferred to another Accredited Practitioner. Transfer of care to another Accredited Practitioner will be recorded in the patient's Facility medical record and communicated to the Nurse Unit Manager or other responsible nurse staff member;

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

(g) attend upon patients in a timely manner and with the utmost care and attention, using their best endeavours to attend promptly, including in person, after being requested to do so by Facility staff, another Accredited Practitioner, by a patient or family member of a patient, or being available by telephone in a timely manner to assist Facility staff in relation to the Accredited Practitioner's patients;

(h) attend in person upon patients admitted or required to be treated by the Accredited Practitioner as frequently as is required by the clinical circumstances. Absent special circumstances, an Accredited Practitioner will review a patient in person within 24 hours of the patient being admitted under that Accredited Practitioner or within a shorter timeframe if clinically appropriate or requested by staff of the Facility. Prior to the initial attendance, the Accredited Practitioner will provide adequate written instructions for the management of the patient. Absent special circumstances as noted in the medical record, an Accredited Practitioner will thereafter review the patient within clinically appropriate timeframes. If Accredited Practitioners are unable to provide this level of care personally, they will secure the agreement of another Accredited Practitioner to do so and notify this to staff of the Facility;

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

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

(k) 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;

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

(m) be willing, in an emergency or upon request by the FCEO (or another person authorised by the FCEO for this purpose), and where reasonably available, to assist Facility staff and other Accredited Practitioners;;

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

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

9.4. All admissions subject to approval

(a) The ability of an Accredited Practitioner to admit a patient to the Facility will, at all times, be subject to approval of and within the sole discretion of the FCEO, without the requirement to provide a reason;

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

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

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

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

9.5. Right to request discharge or transfer of patient

(a) The ability of an Accredited Practitioner to admit a patient to the Facility will, at all times, be subject to the right of the FCEO to require the discharge 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 discharge or transfer of the patient. The Accredited Practitioner will be required to make all necessary arrangements for the discharge or transfer of the patient, including notifying the relatives of the patient and, where necessary, arranging the admission of the patient to another hospital or aged care facility.

(c) Should the Accredited Practitioner fail to make such arrangements when requested under By-Law 9.5, or fail to make adequate arrangements, the FCEO will be entitled to make the necessary arrangements for discharge or transfer.

9.6. Safety and quality

Accredited Practitioners must:

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

(b) familiarise themselves with and strictly adhere to Facility policies and procedures with respect to surgical safety, including pre-procedure checks, leading time out, end of procedure checks, allowing Facility staff sufficient time to comply with these

requirements, respecting and appropriately responding to concerns for safety relating to any of these matters;

(c) familiarise themselves with and comply with SVHA and Facility targeted programs with respect to safety and quality of patient care, including medication, falls, infection control / hand hygiene and venous thromboembolism;

(d) give consideration to their own potential fatigue and that of other staff involved in the provision of patient care, when making patient bookings and in utilising operating theatre and procedural Facility time;

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

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

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

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

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

(j) where required by the FCEO, assist with, provide information and participate in incident management, complaint management, investigation, reviews (including root cause analysis and system reviews), open disclosure and the duty of candour (if the duty of candour is applicable in the relevant jurisdiction).

9.7. Professional Indemnity Insurance

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

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

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

(c) that is with an insurance company acceptable to the Facility, in an amount and on terms and conditions acceptable to the Facility.

9.8. Annual disclosure

Accredited Practitioners must furnish annually to the Facility evidence of:

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

(b) professional occupational 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 his or her specialist college or professional body.

9.9. Continuous disclosure

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

(a) Credentials;

(b) Scope of Clinical Practice;

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

(d) Professional Indemnity Insurance status;

(e) Registration with the relevant National Health Practitioner Board, including any Conditions or limitations placed on such registration; and

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

9.10. Advice of material issues

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

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

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

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

(d) the initiation or conclusion of any process, inquiry, investigation or proceedings by any external body, including other health facilities, Regulatory Authority, registration boards, relevant colleges, police, coroner, tribunal, court, complaints body or private health fund involving the Accredited Practitioner, irrespective of whether this relates to a patient of the Facility;

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

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

(g) anything impacting upon his or her Current Fitness;

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

(i) receipt of a written complaint from a patient of the Facility or notification of a complaint being received by an external agency, including relating to an adverse outcome, injury, incident, loss or fee;

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

(k) matters regarded as Reportable Conduct; and

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

9.11. Medical records

Accredited Practitioners must:

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

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

  (ii) to allow nursing staff to undertake care and such that another suitably qualified Accredited Practitioner can expeditiously take over the care of the patient if required;

  (iii) in a way which enables SVHA to collect revenue in a timely manner, including meeting health fund obligations; Including at a minimum:

    (A) pre-admission notes or a letter about the patient's condition and management plan, including allergies and co-morbidities;

    (B) full and informed written patient consent;

    (C) completed admission forms within 24 hours of admission;

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

    (E) therapeutic orders and instructions;

    (F) pathology and radiology reports;

    (G) each attendance upon the patient with the entries dated, timed, signed and specifying the designation of the practitioner, including observations of the patient's progress;

    (H) notes of any incidents, complications, variations or deviations from the expected management pathway or standard clinical pathways; and

    (I) discharge notes, completed discharge summary and documentation of requirements and arrangements for follow-up at the time of discharge or within a reasonable time following discharge.

    (J) utilise any electronic medical record and ehealth technology (including prescribing) that may be in place;

(b) complete an operation, procedure or anaesthetic report (as the case may be) that shall include a detailed account of the findings at surgery, the surgical technique undertaken, anaesthetic used, complications and post-operative orders, and the full name of any Surgical Assistant, anaesthetist and other Medical Practitioner present. Operation reports shall be written or dictated as soon as is practicable and the report

signed by the attending Accredited Practitioner and made part of the patient's Facility medical record;

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

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

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

(f) acknowledge and agree that medical records of patients of the Facility are owned by the relevant SVHA Group Entity operating the Facility, so that access to or disclosure of that medical record by the Accredited Practitioner other than for the direct and primary purpose of providing health care to the patient must occur through the appropriate Facility mechanisms, in accordance with Facility policy and in compliance with applicable legislation, and medical records are not copied or removed from the Facility without prior arrangement or approval of the FCEO.

9.12. Continuing education

Accredited Practitioners must:

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

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

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

9.13. Clinical activity and utilisation

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

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

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

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

(d) Facility resources are being appropriately managed and utilised to maximum potential, and unless specified otherwise to include as a minimum either:

i) 30 surgical procedures per year; or

ii) 30 patient admissions per year.

(e) If the FCEO is not satisfied about any of the above matters over the preceding 12 months, a show cause process may be initiated pursuant to this provision of the By-Laws. The show cause process may result in notification of inactivation or withdrawal

of Accreditation due to insufficient utilisation and there will be no appeal available pursuant to these By-Laws if such a decision is made by the FCEO.

(f) Despite 9.13(e), the FCEO may allocate operating theatre and procedural service time as he or she sees fit and may re-allocate as considered appropriate, without any requirement for a show cause process before making such change.

9.14. Participation in Committees

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

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

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

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

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

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

9.15. Emergency/disaster planning

Accredited Practitioners must:

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

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

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

9.16. Working with children checks/criminal record checks

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

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

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

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

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

(iv) will not engage in Reportable Conduct;

(c) The Accredited Practitioner must inform SVHA immediately if he or she is unable to give the undertakings set out in By-Law 9.16(b).

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

9.17. Teaching and supervision

Unless otherwise determined by the FCEO, Accredited Practitioners must:

(a) participate in the education and training of students, junior medical officers and other accredited health practitioners 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.

(b) provide supervision to more junior practitioners involved in care, the frequency and extent of which will depend on the level of experience of the more junior practitioner and complexity of patient care required, with the Accredited Practitioner retaining ultimate responsibility for patient care.

9.18. Notice of leave

An Accredited Practitioner must:

(a) notify the FCEO in writing, at least four weeks in advance of leave, unless this relates to unforeseen leave and in these circumstances the notification must occur as soon as possible, and

(b) provide the name of a backup Accredited Practitioner who will provide care and treatment to the Accredited Practitioner's patients during their absence.

10. TRANSFER OF ACCREDITATION STATUS BETWEEN FACILITIES

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

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

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

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

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

11. Surgical Assistants

11.1. Use of Surgical Assistants

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

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

11.2. Accreditation

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

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

11.3. Term of Appointment

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

11.4. Appointments discretionary

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

11.5. Terms and conditions

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

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

(b) agree to the requirements and undertakings set out in By-Law 9.16.

11.6. No admitting or patient management rights

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

11.7. Amending Scope of Clinical Practice

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

11.8. Appeal

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

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

12.1. Notice from Accredited Practitioner

Unless a shorter timeframe is agreed by the FCEO, not less than three months before expiry of his or her Accreditation (Initial Accreditation), an Accredited Practitioner seeking a further period of Accreditation must lodge an application for Re-accreditation.

12.2. Apply for Re-accreditation

An Accredited Practitioner must apply for Re-accreditation before the expiration of the term of their Initial Accreditation in order to maintain Accreditation with the Facility. The Accredited Practitioner's Initial Accreditation continues until such time as the FCEO makes a determination of the Accredited Practitioner's application for Re-accreditation.

12.3. Amendments

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

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

  (ii) at any other time.

(b) The FCEO may also instigate a review of the Accredited Practitioner's Scope of Clinical Practice in considering the Accredited Practitioner's application for Re-accreditation.

12.4. Process

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

13. Review of accreditation or scope of clinical practice

13.1. Grounds for review

(a) The FCEO may initiate an internal or external review of the Accredited Practitioner's Accreditation or Scope of Clinical Practice where concerns have been identified or an allegation made about any of the following:

  (i) a law may be contravened;

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

  (iii) non-compliance with the Scope of Clinical Practice;

  (iv) non-compliance with the Behavioural Standards;

  (v) non-compliance with the Facility policy, procedure or protocol;

  (vi) concerns with respect to Competence, Performance or Current Fitness;

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

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

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

(x) all or a component of the Accredited Practitioner's Scope of Clinical Practice may not be in accordance with current or best practice or clinical care may fall below the standard as expected by peers or Facility management;

(xi) incompatibility with Organisational Capabilities, Organisational Need or SVHA's Mission and Values;

(xii) the efficient operation of the Facility, a SVHA Group Entity or SVHA could be hindered, interrupted, disrupted, or threatened;

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

(xiv) the potential non-adherence, loss or breach of the Facility's accreditation or licence or the potential imposition of any conditions on the Facility's licence.

(b) In addition or as an alternative to conducting an internal or external review, the FCEO will notify Ahpra, the National Health Practitioner Boards and/or other Regulatory Authority of details of the concerns raised if required by legislation, if the FCEO considers it is in the interests of patient health and safety to do so, in the interests of the protection of the public (including patients at other facilities) to do so, or it is considered that the Regulatory Authority is more appropriate to investigate and take necessary action. Following the outcome of any action taken by the Regulatory Authority, the FCEO may elect to take action, or further action under the By-Laws.

13.2. Facility Chief Executive Officer initiated internal review

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

(b) Following such internal review, the FCEO will make a decision concerning the continuation, amendment, imposition of conditions, suspension or termination of Accreditation or Scope of Clinical Practice.

13.3. Facility Chief Executive Officer initiated external review

(a) An external review will be undertaken by a person or persons nominated by the FCEO who is external to SVHA and the Accredited Practitioner.

(b) Following such external review, the FCEO will make a decision concerning the continuation, amendment, imposition, suspension or termination of Accreditation or Scope of Clinical Practice.

13.4. Notice to Accredited Practitioners

(a) The FCEO may in their absolute discretion meet with the Accredited Practitioner, along with any other persons the FCEO considers appropriate, advise of the concern or allegation raised, and invite a preliminary response from the Accredited Practitioner (in writing or orally as determined by the FCEO) before the FCEO makes a determination of whether a review will proceed and if so, the type of review.

(b) The FCEO will advise the Accredited Practitioner in respect of whom a review is being conducted under either By-Law 13.2 or 13.3 of the commencement, ground(s) and substance of the review, the extent to which the Accredited Practitioner may participate in the review and the opportunity to respond that will be provided.

(c) The FCEO will make a determination whether to suspend or impose interim conditions pending the outcome of the review or any determination by AHPRA or the

National Health Practitioner Boards, and if this occurs, it will be done in accordance with By-Laws 14 or 15. The appeal provisions pursuant to these By-Laws will not apply with respect to an interim suspension or interim conditions.

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

(i) terms of reference which may include a wider review than the initial concerns or allegations, process and reviewers;

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

(iii) timeframes;

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

(v) any other past concerns, inquiries, investigations or reviews related to the Accredited Practitioner that ought to be considered as part of this review;

(vi) format for review findings; and

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

(e) 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.

13.5. Action the Facility Chief Executive Officer may take

Following a review under By-Law 13.2 or 13.3 the FCEO will consider the review findings and make a decision with or without input from a Committee, which will include a determination whether or not to continue (including with conditions), amend, suspend or terminate Accreditation or to continue (including with conditions), amend or suspend the Accredited Practitioner's Scope of Clinical Practice in accordance with the provisions set out in these By-Laws.

13.6. Notice of outcome of the review

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

(b) The FCEO must notify the SVHA Chief Medical Officer and the DCEO of the outcome of any review undertaken under By-Law 13.

13.7. Notifiable Conduct and mandatory reporting in relation to review of scope of clinical practice

(a) The FCEO must comply with his or her obligations of mandatory reporting of Notifiable Conduct.

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

14. SUSPENSION

14.1. Grounds for Suspension

Suspension of Accreditation pursuant to this By-Law may be exercised should the FCEO believe, or have a concern, about any of the following matters:

(a) it is in the interests of patient care or safety, including that the continuance of the current Scope of Clinical Practice raises concern about the safety and quality of health care to be provided;

(b) professional registration has been suspended (in whole or in part), amended, conditions imposed or undertakings agreed;

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

(d) it is in the interests of staff or another Accredited Practitioner's wellbeing or safety;

(e) the Accredited Practitioner has breached any Conditions of Accreditation or the By-Laws;

(f) the behaviour or conduct does not comply with the Behavioural Standards, is inconsistent with the Facility's mission statement or the Codes of Ethical Standards for Catholic Health and Aged Care Services in Australia, breaches a direction given, is such that it is unduly hindering the efficient operation of the Facility, is bringing the Facility into disrepute or is otherwise considered to be damaging to the reputation of the Facility or SVHA;

Note: where a SVHA / Facility policy or code applies to an Accredited Practitioner with respect to behaviour or conduct, the standard and expectations are set out in that SVHA / Facility policy or code, however the process and action that may be taken is pursuant to these By-Laws rather than the process and action that may apply to an employee.

(g) based upon information notified pursuant to By-Laws 9.9 or 9.10, or a failure to notify or provide continuous disclosure pursuant to By-Laws 9.9 or 9.10;

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

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

(j) based upon the outcome of a review carried out pursuant to By-Law 13;

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

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

14.2. Suspension framework

(a) Suspension by the FCEO will, at a minimum, be consistent with any that is imposed by the National Health Practitioner Board.

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

(c) Accredited Practitioners will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 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) Accredited Practitioners accept and agree that, as part of the acceptance of Accreditation, a suspension of Accreditation carried out in accordance with these By-Laws does not result in an entitlement to any compensation, including for economic loss or reputational damage.

14.3. Notification of suspension decision

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

(i) the fact of the suspension;

(ii) the period of suspension;

(iii) the reasons for the suspension;

(iv) if the FCEO considers it appropriate in the circumstances, invite a written response from the Accredited Practitioner and advise of any actions that must be performed by the Accredited Practitioner for the suspension to be lifted and the timeframe for the actions to occur; and

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

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

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

(ii) the grounds upon which suspension may occur;

(iii) invite a written response from the Accredited Practitioner; and

(iv) a timeframe in which a response is required.

(c) Following receipt of a response to the show cause notice in paragraph (b) above, the FCEO will determine whether the Accreditation will be suspended or some other action ought be taken, such as imposition of conditions pursuant to By-Law 16. If suspension is to occur, then notification will be sent in accordance with paragraph (a) above. Otherwise the Accredited Practitioner will be advised that suspension will not occur, however this will not prevent the FCEO from relying upon these matters as a ground for suspension or termination of Accreditation in the future.

14.4. Suspension effective immediately

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

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

14.5. Alternative arrangements for patients

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

14.6. Appeal rights

Unless otherwise provided in these By-Laws, the affected Accredited Practitioner will have the rights of appeal established by these By-Laws, noting that an appeal is not available for an interim suspension pursuant to By-Law 13.4(c).

14.7. Notification to Board

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

14.8. Notifiable Conduct and Mandatory Reporting

(a) The FCEO must comply with the obligations of mandatory reporting of Notifiable Conduct.

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

14.9. Interrelationship with By-Law 13

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

15. TERMINATION OF ACCREDITATION

15.1. Immediate termination

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

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

(b) the Accredited Practitioner ceases to be registered or ceases to be registered in the specialty for which Accreditation has been given;

(c) 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;

(d) the Accredited Practitioner is convicted of an offence involving a child, of a sexual or violent nature, or an offence directly related to practice as a Medical Practitioner or Dental Practitioner;

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

(f) any relevant authority determines that the Accredited Practitioner poses an unacceptable level of risk to children; or

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

15.2. Termination with notice

Termination of Accreditation pursuant to this By-Law may be exercised should the FCEO believe, or have a concern, about any of the following matters:

(a) based upon any of the matters in By-Law 14.1 and it is considered by the FCEO that suspension is an insufficient response in the circumstances;

Note: where an SVHA/Facility policy or code applies to an Accredited Practitioner with respect to behaviour or conduct, the standard and expectations are set out in that SVHA/Facility policy or code, however the process and action that may be taken is pursuant to these By-Laws rather than the process and action that may apply to an employee.

(b) based upon the findings of a review carried out pursuant to By-Law 13;

(c) the Accredited Practitioner is found guilty of Unprofessional Conduct (or equivalent) by any inquiry, Regulatory Authority, court, tribunal, disciplinary body or professional standards organisation;

(d) the Accredited Practitioner is not considered by the FCEO as having Current Fitness to retain Accreditation or the Scope of Clinical Practice;

(e) the FCEO does not have confidence in the continued Appointment of the Accredited Practitioner;

(f) conditions have been imposed by, or undertakings agreed with, the Accredited Practitioner's registration board that the FCEO considers the Facility does not have the capacity to meet or the FCEO considers it is not appropriate in the circumstances for the Accredited Practitioner to hold Accreditation under those imposed conditions or undertakings;

(g) the Accreditation or Scope of Clinical 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, SVHA Group Entity or SVHA;

(j) the Accredited Practitioner’s agreement with a contracted services provider for whom the Accredited Practitioner provides services terminates,

(k) if the Accredited Practitioner’s employment engagement with the contracted service provider terminates;

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

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

15.3. Termination framework

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

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

(c) The Accredited Practitioner will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 15.

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

(d) Accredited Practitioners accept and agree, as part of the acceptance of Accreditation, that a termination of Accreditation carried out in accordance with these By-Laws does not result in an entitlement to any compensation, including for economic loss or reputational damage.

15.4. Notification of termination decision

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

(i) the fact of the termination;

(ii) the reasons for the termination;

(iii) if the FCEO considers it appropriate in the circumstances, invite a written response from the Accredited Practitioner; and

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

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

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

(ii) the grounds upon which termination may occur;

(iii) invite a written response from the Accredited Practitioner; and

(iv) a timeframe in which a response is required.

(c) Following receipt of a response to the show cause notice in paragraph (b) above, the FCEO will determine whether the Accreditation will be terminated or some other action ought be taken, such as imposition of conditions pursuant to By-Law 16 or suspension pursuant to By-Law 14. If termination is to occur then notification will be sent in accordance with paragraph (a) above. Otherwise the Accredited Practitioner will be advised that termination will not occur, however this will not prevent the FCEO from relying upon these matters as a ground for suspension or termination of Accreditation in the future.

15.5. Notification to Board

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

15.6. Appeal rights

(a) No right of appeal will exist in respect of immediate termination of Accreditation pursuant to By-Laws 15.1.

(b) For a termination of Accreditation pursuant to By-Law 15.2, the Accredited Practitioner shall have the rights of appeal established by these By-Laws.

15.7. Immediate Termination at each Facility

Termination of Accreditation of an Accredited Practitioner at one Facility will cause the automatic immediate termination of Accreditation at any other Facility operated or conducted by an SVHA Group Entity.

15.8. Notifiable Conduct and Mandatory Reporting

(a) The FCEO must comply with his or her obligations of mandatory reporting of notifiable conduct.

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

15.9. Interrelationship with By-Laws 13 and 14

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

16. IMPOSITION OF CONDITIONS

16.1. Imposing Conditions

(a) At the conclusion of or pending finalisation of a review pursuant to By-Law 13, or in lieu of a suspension of Accreditation pursuant to By-Law 14 or in lieu of a termination of Accreditation pursuant to By-Law 15.2, the FCEO may elect to impose conditions upon Accreditation or Scope of Clinical Practice.

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

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

(i) the conditions imposed;

(ii) the reasons for it;

(iii) the consequences if the conditions are breached;

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

(v) if the FCEO considers it appropriate in the circumstances, invite a written response from the Accredited Practitioner.

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

(e) The appeal procedure contained in these By-Laws will apply to an imposition of conditions, except where it is an imposition of interim conditions under By-Law 13.

(f) Accredited Practitioners accept and agree, as part of the acceptance of Accreditation, that an imposition of conditions carried out in accordance with these By-Laws does not result in an entitlement to any compensation, including for economic loss or reputational damage.

16.2. Notification of conditions

The decision to impose Conditions under these By-Laws will be notified to other SVHA Facilities where Scope of Clinical Practice are held by that Accredited Practitioner, as well as notification of whether an appeal has been lodged. 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.

16.3. Notification to Board

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

16.4. Notifiable Conduct and Mandatory Reporting

(a) The FCEO must comply with his or her obligations of mandatory reporting of notifiable conduct.

(b) The FCEO must advise the SVHA Chief Medical Officer and DCEO of any mandatory reporting made under By-Law 16.

17. Appeal rights

17.1. No appeal rights against refusal of initial or probationary Appointment

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

17.2. Appeal rights generally

Except where these By-Laws state otherwise, a Medical Practitioner or Dental Practitioner who has Accreditation in respect of the Facility and whose Accreditation is amended, made conditional (except interim conditions), suspended (except an interim suspension), terminated, not renewed or conditionally renewed by the Facility, will have the rights of appeal set out in By-Law 18.

17.3. Concurrent appeal rights

Despite any other provision of these By-Laws, where an Accredited Practitioner has appeal rights under these By-Laws concurrently with appeal rights under any legislation or mandatory directive and/or policy in respect of the same circumstances, the appeal rights under these By-Laws will cease to be available to the Accredited Practitioner. For the avoidance of doubt, if this By-Law 17.3 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.

18. APPEAL PROCEDURE

18.1. Appeal must be lodged in fourteen days

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

(b) Upon receipt of a notice of appeal, the FCEO will forward the notice of appeal to the DCEO and/or the SVHA Chief Medical Officer.

(c) Lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly.

18.2. Relevant Committee established to hear appeal

(a) The DCEO or the SVHA Chief Medical Officer will establish an appeals Committee to hear the appeal, which at a minimum will include the following persons:

(i) a nominee of the DCEO, who may be the SVHA Chief Medical Officer, and who will be the chairperson of the appeals Committee;

(ii) a nominee of the FCEO; and

(iii) any other member or members who bring specific expertise to the decision under appeal, as determined by the DCEO.

(b) The appeals Committee members must not have been involved in the making of the decision under appeal, may be constituted by an Accredited Practitioner, an SVHA employee and if a clinical matter one member preferably will be in the same area of practice or speciality as the appellant.

(c) The DCEO in his or her complete discretion may invite the appellant to make suggestions or comments with respect to one or more of the proposed members of the appeals Committee, but is not bound to follow the suggestions or comments.

18.3. Commissioning and Commencement

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

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

18.4. Procedure for appeal

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

(b) The notice from the appeals Committee will ordinarily set out the process that will be adopted, information and documents that will be provided, any conditions that must be met before provision of the information or documents, invite the appellant and FCEO to make written and/or oral submissions about the decision under appeal and the date for determination of the appeal (ordinarily with at least 14 days written notice).

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

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

18.5. Recommendation of appeals Committee

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

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

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

(d) The SVHA Group CEO will make a decision regarding the appeal based upon the written recommendation of the appeals Committee, with no further submissions or hearing involving the appellant, Group CMO, DCEO or FCEO.

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

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

19. RESEARCH

19.1. Approval of research

Clinical research by an Accredited Practitioner in or at the Facility may only commence, and may only continue, if the following requirements are met:

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

(b) the Accredited Practitioner seeking the approval has disclosed to the FCEO all interests and benefits that they have and will derive from the proposed clinical research

(c) the proposed clinical research is consistent with the National Health & Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research (2025) undertaken according to the National Clinical Trials Governance Framework and any relevant jurisdictional legislation or guidelines;

(d) 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);

(e) the HREC is constituted according to the NHMRC National Statement on Ethical Conduct in Human Research (2025);

(f) written approval is received from the HREC and FCEO and after all ethical and governance issues have been approved, noting that in accordance with the NHMRC National Statement on Ethical Conduct in Human Research (2025) the HREC may delegate to an appropriate subcommittee the approval for 'low risk' and 'quality assurance' studies;

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

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

(i) 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 including the National Clinical Trials Governance Framework; and

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

19.2. Withdrawal or disapproval of research

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

(a) the research cannot be conducted by the Accredited Practitioner and/or supported by the Facility at an appropriate standard of safety and quality, including following notification of adverse events or outcomes;

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

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

(d) the research is inconsistent with good professional practice or the Codes of Ethical Standards for Catholic Health and Aged Care Services in Australia;

(e) there is insufficient funding or funding is withdrawn;

(f) conditions of approval are not met; or

(g) a complaint or concerns about research integrity or conduct is received, under investigation or substantiated.

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

20. NEW CLINICAL SERVICES, EXPERIMENTAL OR INNOVATIVE TREATMENT OR TECHNIQUES

20.1. Approval of experimental treatment or techniques

New Clinical Services, Procedures or Other Interventions, 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 New Clinical Services, Procedures or Other Interventions experimental or innovative treatment or technique;

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

(c) the Accredited Practitioner has submitted details to the FCEO's satisfaction for appropriate review and approval by the relevant Committee and, subject to By-Laws 20.2 and 20.4, the approval of both has been given and the FCEO is satisfied that appropriate insurance cover is in place;

(d) the Accredited Practitioner seeking the approval has disclosed to the FCEO all interests and benefits that they have and will derive from the proposed services, interventions, treatments or techniques; and

(e) 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.

20.2. Approval by the FCEO

(a) Accredited Practitioners proposing to introduce, provide or use New Clinical Services, Procedures or Other Interventions, experimental or innovative treatment or techniques will provide the FCEO with supportive evidence to the satisfaction of the FCEO.

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

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

(d) Before treating Patients with respect to a New Clinical Services, Procedures or Other Interventions, experimental or innovative treatment or techniques:

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

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

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

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

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

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

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

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

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

20.3. Ethical issues and human subjects

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

(a) the treatment or technique has been referred to and approved by the relevant ethics Committee in accordance with By-Law 19; and

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

20.4. Review of New Clinical Services, Procedures or Other Interventions, experimental or innovative treatment or techniques

(a) An Accredited Practitioner who proposes to perform a New Clinical Services, Procedures or Other Interventions, experimental or innovative treatment or techniques 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 Services, Procedures or Other Interventions, experimental or innovative treatment or techniques in the context of the Facility's Organisational Need and Organisational Capabilities. Alternatively, the FCEO may, having consulted with the head of the relevant Committee, approve New Clinical Services, Procedures or Other Interventions, experimental or innovative treatment or techniques where they are of the opinion that formal review and approval by the relevant Committee is not necessary.

(c) The relevant Committee will advise the FCEO:

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

(ii) whether the New Clinical Services, Procedures or Other Interventions, experimental or innovative treatment or techniques, or equipment is consistent with the Accredited Practitioner's Scope of Clinical Practice.

(d) The FCEO may seek additional advice about the financial, operational or clinical implications of the introduction of the New Clinical Service, Procedure or Other Intervention, experimental or innovative treatment or techniques. There is no appeal available pursuant to these By-Laws from the decision of the FCEO.

(e) Before approving the introduction of a New Clinical Services, Procedures or Other Interventions, experimental or innovative treatment or techniques the FCEO must:

(i) be satisfied that the New Clinical Services, Procedures or Other Interventions, experimental or innovative treatment or techniques is consistent with the Organisational Need and Organisational Capabilities of the Facility;

(ii) where the New Clinical Services, Procedures or Other Interventions, experimental or innovative treatment or techniques involves research, be satisfied that the requirements of By-Law 19.1 has been met;

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

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

(v) notify the relevant Committee.

21. 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.

22. REPUTATION OF THE FACILITY

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

The FCEO may, from time to time, on the basis of moral, religious or economic grounds, or upon the basis that certain types of clinical practice or treatment 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.

22.2. Accredited Practitioner to cease upon notice from the FCEO

On being notified by the FCEO of a requirement under By-Law 22.1, the Accredited Practitioner will immediately cease to carry out such procedures, give such advice, or recommend such treatment.

22.3. Scope of clinical practice Committee to make recommendation to the FCEO

(a) Following a decision of the FCEO under By-Law 22.1, the FCEO will refer the matter to the Scope of Clinical Practice Committee for consideration and discussion. The Scope of Clinical Practice Committee may convey comments or make recommendations to the FCEO in relation to the decision. The FCEO may, in its absolute discretion, affirm or vary the decision of the scope of clinical practice Committee.

(b) There is no right of appeal against a decision of the FCEO under this By-Law 22.

23. DISPUTES

23.1. Committees

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

24. REVISION OF BY-LAWS

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

(b) The Board will review these By-Laws periodically and in any event not less than every five years.

25. VIRTUAL AND AT HOME SERVICES

(a) These By-Laws will apply to registered health practitioners providing services to patients under an arrangement with an entity of the SVHA Group Entity, including as part of the services provided under the Division of Virtual and At Home Services.

(b) The By-Laws including the terms and conditions of By-Law 9 will be modified to appropriately apply to the Scope of Clinical Practice and with regard to the location from where the services will be provided.

Facility schedules

See following pages

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Schedule 1

Supplementary and amending By-Laws

1. For the purposes of the definition **Accreditation Classification** in By-Law 2.2, the following are the designated classifications:

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

   (b) Fellow who is 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 do not have admitting direct rights to the Facility and is not eligible to vote or stand for office of any committee or group established under these By-Laws

   (c) General Practitioner (GP) who is a Medical Practitioner recognised as holding specialist qualification in the field of general practice. General practitioners shall not have direct admitting rights to the Facility

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

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

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

      (ii) is appointed in the category of Specialist Practitioner.

2. By-Law 11 Surgical Assistants is amended by adding a new By-Law 11.9 as follows

   11.9 Dental Assistants and Nursing Assistants

   This By-Law 11 will apply to any Dental Assistants and Nursing Assistants.