Townsville
DAY SURGERY

Medical Practitioners By-Laws

TABLE OF CONTENTS

1. Preface

Townsville Day Surgery is a purpose-built day hospital established in 2003, committed to the promotion and advancement of safe, cost effective, same day surgery using modern 'state of the art' theatre and endoscopy equipment and technology.

Townsville Day Surgery provides quality patient centred care by the selection of competent staff, the provision of high-quality equipment and clear and appropriate work practices. Townsville Day Surgery is committed to providing a safe working environment for employees, a safe environment for patients and visitors, and strives to continually assess the quality of its activities to improve patient outcomes and the peri-operative experience.

2. Mission and Objectives of Townsville Day Surgery

Townsville Day Surgery Mission

Through its pursuit of best practice initiatives and its commitment to continuous quality improvement, Townsville Day Surgery is dedicated to deliver an effective model for day surgery service to the community.

As such we partner with the community to support and enable individuals, families, and significant others to maintain, restore or improve their health status without prolonged hospitalisation.

Townsville Day Surgery Objectives

In order to achieve its mission, Townsville Day Surgery will strive to:

- Provide a safe environment for patients, staff and public in accordance with Australian Standards.
- Deliver care without prejudice and with respect for patients' privacy, dignity, rights, and beliefs.
- Participate in the development and maintenance of a Quality Improvement Program.
- Achieve and maintain accreditation with the Australian Council for Health Care Standards and ensure services meet all relevant professional and legislative standards.
- Foster peer group interaction in a warm, caring, and professional environment.
- Support new developments in technique.

The mission and objectives, where applicable, should be used to guide the application of the By-Laws.

Part A – Definitions and introduction

3. Definitions and interpretation

3.1 Definitions

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

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

Accreditation Category means as part of Accreditation, the appointment of an Accredited Practitioner to one or more of the following categories as listed in Annexure 18.1.1. The Board may from time to time approve other Accreditation Categories.

Accreditation Type means as part of Accreditation, the appointment of an Accredited Practitioner to one or more of the following privileges as listed in Annexure 18.1.2. The Board may from time to time approve other Accreditation Types.

Accredited means the status conferred on a Medical Practitioner, Dentist or Allied Health Professional to provide services within Townsville Day Surgery after having satisfied the Credentialing and Scope of Practice requirements provided in these By-Laws.

Accredited Practitioner means a Medical Practitioner, Dentist or Allied Health Professional who has been Accredited to provide services within Townsville Day Surgery, and who may be an Accredited Medical Practitioner, Accredited Dentist or Accredited Allied Health Professional. The accredited practitioner may additionally be referred to as a Visiting Allied Health Professional, Visiting Dentist, Visiting Medical Officer, Visiting Medical Practitioner or Visiting Nurse Practitioner.

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

Advisory of the Board means is a group of health care professionals who can offer advice to the Board of Director/s that is reported through the Medical Advisory Committee or the Clinical and Corporate Governance Committee..

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

Allied Health Privileges means the entitlement to provide treatment and care to Patients as an Allied Health Professional within the areas approved by the Hospital Manager of Townsville Day Surgery in accordance with the provisions of these By-Laws.

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

Behavioural Sentinel Event means an episode of inappropriate or problematic behaviour which indicates concerns about an Accredited Practitioner's level of functioning and suggests potential for adversely affecting Patient safety and welfare or organisational outcomes.

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 Townsville Day Surgery, Board members, Hospital Manager, 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, policies in place at Townsville Day Surgery relating to behaviour, and the expectations set out in the *Good Medical Practice; A Code of Conduct for Doctors* in Australia (as applicable).

Board means the Board of Directors of Townsville Day Surgery.

By-Laws means these by-laws.

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

Clinical Visitor A health practitioner registered with AHPRA or professional body other than a Medical Practitioner, attending the Facility for further their own professional development, education and/or training through observation (no direct patient care) or supervised clinical practice.

Clinicians Code of Conduct means the relevant Code of Conduct in place at Townsville Day Surgery.

Code of Conduct for Accredited Practitioners means the relevant Code of Conduct in place at Townsville Day Surgery.

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

Credentials means, in respect of a person who applies for Accreditation or Re-Accreditation, the identity (including the required level of identity check), 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.

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

range of services which an Accredited Practitioner is competent to perform.

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

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

Director of Medical Services means a member of the Medical Advisory Committee appointed by the Board to act as the Director of Medical Services in compliance with the Medical Advisory Committee Terms of Reference.

Disruptive Behaviour means aberrant behaviour manifested through personal interaction with Medical Practitioners, hospital personnel, health care professionals, Patients, family members, or others, which interferes with Patient care or could reasonably be expected to interfere with the process of delivering quality care or which is inconsistent with the Mission, Objectives and values of Townsville Day Surgery.

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

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

Facility means the Townsville Day Surgery to which an application for accreditation has been made.

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

Government Agency means any government or any public, statutory, governmental, semi-governmental, local governmental or judicial body, entity or authority and includes a Minister of the Crown or the Commonwealth of Australia and any person, body, entity or authority exercising a power pursuant to an Act of Parliament.

Hospital Manager means the person appointed to the position of Facility Manager or Nurse Unit Manager, of the Facility or any person acting, or delegated to act, in either of those positions.

Interim Accreditation see Temporary Accreditation.

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

Medical Advisory Committee (MAC) means the Medical Advisory Committee of the Facility.

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

Modern Slavery means:

i. 'slavery and human trafficking' as defined in the Modern Slavery Act 2015 (UK);

ii. 'modern slavery' as defined under the Modern Slavery Act 2018 (Cth);

iii. 'modern slavery' as defined under the Modern Slavery Act 2018 (NSW); and

iv. any other analogous conduct or practices

New Clinical Services means clinical services, treatment, procedures, techniques, technology, instruments or other interventions that are being introduced into the organisational setting of the Facility for the first time, or if currently used are planned to be used in a different way, and that depend for some or all of their provision on the professional input of Medical Practitioners.

Nurse Unit Manager means the person appointed to the position of Nurse Unit Manager, or equivalent position by whatever name, of the Facility or any person acting, or delegated to act, in that position.

Organisational Capability means the Facility's ability to provide the facilities, services, clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions. Organisational Capability will be determined by consideration of, but not limited to, the availability, limitations and/or restrictions of the services, 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, clinical services capability framework, Introduction of New Procedures policy, and Admission Criteria policy.

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's 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, and the clinical services capability framework.

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

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

Re-accreditation means the process provided in these By-Laws by which a person who already holds Accreditation may apply for and be considered for Accreditation following the probationary period or any subsequent term.

Scope of Practice means the extent of an individual Accredited Practitioner's permitted Clinical Practice within the Facility based on the individual's Credentials, Competence, Performance and professional suitability, and the Organisational Capability and Organisational Need of the organisation to support the Accredited Practitioner's scope of clinical practice. Scope of Practice may also be referred to as delineation of clinical privileges. Scope of Practice applied for fall within one or more of the clinical practice categories listed in Annexure 18.1.3. The Board may from time to time approve other Scope of Practice categories.

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

Temporary Accreditation (also referred to as **Interim Accreditation**) means the process provided in By-Laws whereby a Medical Practitioner, Dentist or Allied Health Professional is Accredited for a limited period.

The Hospital means Townsville Day Surgery.

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

Townsville Day Surgery means Townsville Day Surgery Pty Ltd.

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

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

Visiting Medical Practitioner (VMP) or Visiting Medical Officer (VMO) means a Medical Practitioner who is not an employee of the Facility, who has been granted Accreditation and Scope of Practice pursuant to these By-Laws. Visiting Medical Practitioners include visiting Specialist Medical Practitioners.

3.2 Interpretation

(a) Headings in these By-Laws are for convenience only and are not to be used as an aid in interpretation.

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

(c) The Hospital Manager may delegate any of the responsibilities conferred upon him/her by the By-Laws in his/her complete discretion, but within any delegation parameters approved by the Board.

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

3.3 Meetings

(a) Where a reference is made to a meeting, the quorum requirements that will apply are those specified in the terms of reference of the relevant committee. If there are no terms of reference, where there is an odd number of members a quorum will be a majority of the members, or where there is an even number of members a quorum will be half of the number of the members plus one.

(b) Committee resolutions and decisions, if not specified in the terms of reference, must be

supported by a show of hands, verbal confirmation or ballot of committee members at the meeting.

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

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

(e) A committee established pursuant to these By-Laws may hold any meeting by electronic means or by telephonic communication whereby participants can be heard.

(f) Resolutions may be adopted by means of a circular resolution.

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

(h) Any member of a committee who has a conflict of interest or material personal interest in a matter to be decided or discussed shall inform the chairperson of the committee and take no part in any relevant discussion or resolution with respect to that particular matter, and where applicable shall absent themselves from the room. This will include a member of the Medical Advisory Committee whose application for accreditation is being considered.

(i) Each Accredited Practitioner serving on any committee formed pursuant to these By-Laws is indemnified in respect of actions taken as a member of that committee or claims made against the member of the committee, provided the member has acted in good faith, with due care and diligence, in accordance with the By-Laws, in accordance with the terms of reference of the committee and in accordance with any common law or legislation governing their conduct or the committee.

4. Introduction

4.1 Purpose of this document

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

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

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

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

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

(f) These By-Laws will take effect and supersede any previous published version. These By-Laws

will be operational and effective regardless of when an issue or circumstance arose (for example at a time previous By-Laws were in place) or if an issue or circumstance has been previously subject to contemplation in a previous version of the By-Laws.

(g) Although these By-Laws may refer to specific policies that have a direct relevance to the processes of Accreditation and defining an Accredited Practitioner's Scope of Practice, these By-Laws do not:

(i) Communicate every policy of Townsville Day Surgery; or

(ii) Prevent the Board from making decisions that will have an effect on these By-Laws.

Part B – Terms and conditions of Accreditation

5. Compliance with By-Laws

(a) It is a requirement for continued Accreditation that Accredited Practitioners comply with the By- Laws at all relevant times when admitting, caring for or treating Patients, or otherwise providing services at the Facility.

(b) Any non-compliance with the By-Laws may be grounds for suspension, termination or imposition of conditions. As an alternative to suspension, termination or imposition of conditions for a breach of By-Law 5, the Board or delegate may decide that the circumstances require a different approach, which may involve agreement with the Accredited Practitioner on actions to take or failing agreement a direction is given by the Board or delegate to the Accredited Practitioner. If the agreement or direction is not complied with, this will be a breach of the By-Laws and the Board or delegate may decide to suspend or terminate accreditation based upon breach of the agreement or direction.

(c) Unless specifically determined otherwise by the Board or delegate in writing for a specified Accredited Practitioner, the provisions of these By-Laws in their entirety prevail to the extent of any inconsistency with any terms, express or implied, in a contract of employment or engagement that may be entered into. In the absence of a specific written determination by the Board or delegate, it is a condition of ongoing Accreditation that the Accredited Practitioner agrees that the provisions of these By-Laws prevail to the extent of any inconsistency or uncertainty between the provisions of these By-Laws and any terms, express or implied, in a contract or employment or engagement.

5.3 Compliance with policies and procedures

(a) Accredited Practitioners must comply with all policies and procedures, including the Clinicians Code of Conduct (distributed with these By-Laws) of Townsville Day Surgery and the Facility.

5.4 Compliance with Open Disclosure

(a) Accredited Practitioners must comply with the Townsville Day Surgery's Open Disclosure (distributed with these By-Laws).

5.5 Compliance with legislation

(a) Accredited Practitioners must comply with all relevant legislation, including but not limited to legislation that relates to health, public health, drugs and poisons, privacy, coroners, criminal

law, health practitioner registration, research, environmental protection, workplace health & safety, occupational health and safety, anti-discrimination, bullying, harassment, industrial relations, care of children, care of persons with a disability, substituted decision making and persons with impaired capacity, mental health, Medicare, health insurance, competition and consumer law, intellectual property, and other relevant legislation regulating the Accredited Practitioner, provision of health care or impacting upon the operation of the Facility.

(b) In addition, Accredited Practitioners must ensure compliance with, or assist the Facility to comply with, any Commonwealth or State mandated service capability frameworks, licensing requirements or minimum standards, and any legislation imposing obligations upon the Facility.

5.6 Clinical Services Capability Framework (CSCF)

(a) Accredited Practitioners are advised the following CSCF licence requirements for Townsville Day Surgery as dictated by Queensland Health:

Services	CSCF Level
Anaesthetic Services – Children's > 14 years	Level 3
Anaesthetic Services	Level 3
Medical Imaging Services	Level 2
Medication Services	Level 2
Pathology Services	Level 2
Perioperative Services – Day Surgery Services	Level 3
Perioperative Services – Endoscopy Services	Level 3
Perioperative Services – Operating Suite Services	Level 3
Perioperative Services – Post-Anaesthetic Care Services	Level 3
Persistent Pain Management Services	Level 2

(b) Accredited Practitioners must at all times adhere to the levels outlined in the Hospitals Clinical Services Capability Framework licensing certifications.

5.7 Insurance and registration

(a) Accredited Practitioners must at all times maintain adequate Professional Indemnity Insurance.

(b) Accredited Practitioners must at all times maintain eligibility for membership of their professional association and registration with AHPRA that is sufficient for the Scope of Practice granted.

(c) Accredited Practitioners are required to provide evidence annually, or at other times upon request, of adequate Professional Indemnity Insurance and registration with AHPRA, and all other relevant licences or registration requirements for the Scope of Practice granted. If further information is requested in relation to insurance or registration, the Accredited Practitioner will assist to obtain that information, or provide permission for the Facility to obtain that information directly.

(d) It is a proactive responsibility of the Accredited Practitioner to submit the written evidence referred to in By-Law 5.6 annually or at times of any change to insurance or registration. The information can be gained from the Accredited Practitioner's insurer through digital platforms with the Accredited Practitioner's permission. At the election of the Facility, a failure to do so may result in accreditation becoming 'inactive' until compliance to the satisfaction of the

Facility. The consequence of inactive accreditation is that patients of the Accredited Practitioner will not be admitted to the Facility or the Accredited Practitioner cannot exercise accreditation until this occurs.

5.8 Standard of conduct

(a) The Facility expects a high standard of professional and personal conduct from Accredited Practitioners, who must conduct themselves in accordance with:

(i) the Behavioural Standards;

(ii) Clinicians Code of Conduct for Townsville Day Surgery;

(iii) the Code of Ethics of the Australian Medical Association or any other relevant code of ethics;

(iv) the Code of Practice of any specialist college or professional body of which the Accredited Practitioner is a member;

(v) the Values of the Facility;

(vi) the strategic direction of the Facility;

(vii) the limits of their registration or any conditions placed upon Scope of Practice in accordance with these By-Laws; and

(viii) all reasonable requests made with regard to personal conduct in the Facility.

(b) Accredited Practitioners must continuously demonstrate Competence and Current Fitness, must not engage in Disruptive Behaviour, and must observe all reasonable requests with respect to conduct and behaviour.

(c) Accredited Practitioners must 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.

(d) Upon request by the Board, Medical Advisory Committee or Hospital Manager, the Accredited Practitioner is required to meet with them to discuss matters in (a) to (c) above, or any other matter arising out of these By-Laws.

5.9 Notifications

(a) Accredited Practitioners must immediately advise the Hospital Manager, and follow up with written confirmation within 2 days, should:

(i) an investigation or complaint be commenced in relation to the Accredited Practitioner, or about his/her Patient (irrespective of whether this relates to a Patient of the Facility), by AHPRA, the Accredited Practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency;

(ii) The Accredited Practitioner receive a written complaint from a patient of the Facility, or notification of a complaint from AHPRA or the Office of Health Ombudsman (or equivalent body in another state or territory) in relation to a patient of the Facility;

(iii) The Accredited Practitioner receive an initial notice or notice of claim pursuant to the Personal Injuries Proceedings Act, or be served with court proceedings (or from any other State or Territory jurisdiction), making a compensation claim in relation to a

patient of the Facility;

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

(v) an adverse finding (including but not limited to a reprimand, criticism or adverse comment about the care or services provided by the Accredited Practitioner) be made against the Accredited Practitioner by a civil court, AHPRA, the practitioner's registration board, disciplinary body, Coroner, a health complaints body, or another statutory authority, State or Government agency, irrespective of whether this relates to a Patient of the Facility;

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

(vii) professional indemnity membership or insurance be made conditional or not be renewed, or should limitations be placed on insurance or professional indemnity coverage;

(viii) the Accredited Practitioner's appointment, clinical privileges or Scope of Practice at any other facility, hospital or day procedure centre alter in any way, including through resignation or if it is withdrawn, suspended, restricted, or made conditional, and irrespective of whether this was done by way of agreement;

(ix) any physical or mental condition or substance abuse problem occur that could affect his or her ability to practise or that would require any special assistance to enable him or her to practise safely and competently;

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

(xi) the Accredited Practitioner make a mandatory notification to a health practitioner registration board in relation to another Accredited Practitioner of the Facility; and

(xii) the Accredited Practitioner be charged with having committed or is convicted of a sexual, violent, physical harm, psychological harm, child related or other criminal offence (regardless of whether it relates to the provision of patient or health care). The Accredited Practitioner must provide the Facility with an authority to conduct at any time a criminal history check with the appropriate authorities.

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

(b) In addition, Accredited Practitioners should inform themselves of their personal obligations in relation to external notifications and ensure compliance with these obligations.

(c) It is expected that Accredited Practitioners will conduct themselves in an open and transparent way with the Facility, and arising from this, in interpreting this By-Law and assessing matters requiring notification pursuant to this By-Law, the interpretation and action should favour notification.

5.10 Continuous disclosure

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

(i) the Accreditation of the Accredited Practitioner;

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

(iii) the ability of the Accredited Practitioner to safely deliver health services to his/her Patients within the Scope of Practice, including if the Accredited Practitioner suffers from an illness or disability which may adversely affect his or her Current Fitness;

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

(v) the inability of the Accredited Practitioner to satisfy a medical malpractice claim by a Patient;

(vi) adverse outcomes or complications that result in injury, disability or harm in relation to the Accredited Practitioner's Patients (current or former) of the Facility;

(vii) complaints, compensation claims, reportable deaths and coronial investigations in relation to the Accredited Practitioner's Patients (current or former) of the Facility;

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

(ix) the reputation of the Facility.

(b) Subject to restrictions directly relating to or impacting upon legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the Hospital Manager informed and updated about the commencement, progress and outcome of compensation claims, coronial investigations or inquests, police investigations, Patient complaints, health complaints body complaints or investigations, or other inquires involving Patients of the Accredited Practitioner that were treated at the Facility.

(c) It is expected that Accredited Practitioners will conduct themselves in an open and transparent way with the Facility, and arising from this, in interpreting this By-Law and assessing matters requiring disclosure pursuant to this By-Law, the interpretation and action should favour disclosure.

5.11 Representations and media

(a) Unless an Accredited Practitioner has the prior written consent of the Hospital Manager an Accredited Practitioner may not use the Facility’s name, or letterhead, or in any way suggest that the Accredited Practitioner represents these entities.

(b) The Accredited Practitioner must obtain the Board’s prior approval before interaction with the media regarding any matter involving the Facility or a Patient.

(c) If there is any instance of non-compliance with any of the matters set out above, in addition to this constituting a breach of the By-Laws, the Accredited Practitioner is required to follow the directions of the Board in managing the consequence of non-compliance, including a retraction or agreed public statement.

5.12 Committees

(a) The Facility requires Accredited Practitioners, as reasonably requested by the Board, to assist it in achieving its objectives through membership of committees of the Facility. This includes committees responsible for developing, implementing and reviewing policies in all clinical areas; participating in medical, nursing and other education programs and attending meetings of Medical Practitioners, Dentists and/or Allied Health Professionals.

5.13 Confidentiality

(a) Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with the Facility's policy and the 'Australian Privacy Principles' established by the *Privacy Act 1988 (Cth),* and other legislation and regulations relating to privacy and confidentiality, and will not do anything to bring the Facility in breach of these obligations.

(b) Accredited Practitioners will comply with the various legislation governing the collection, handling, security, storage and disclosure of health information, as well as notification of data breaches.

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

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

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

(ii) The particulars of these By-Laws;

(iii) Information concerning Facility's insurance arrangements;

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

(v) information which comes to their knowledge concerning Patients, Accredited Practitioners, Clinical Practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services, including from membership of or participation in Facility committees.

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

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

(ii) where disclosure is required by law;

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

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

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

(f) The confidentiality requirements continue with full force and effect after the Accredited Practitioner ceases to be Accredited.

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

5.14 Communication within the Facility

(a) Accredited Practitioners are required to familiarise themselves with the organisational structure of the Facility.

(b) Accredited Practitioners acknowledge that in order for the organisation to function, effective communication is required, including between the Board, Hospital Manager, Facility Manager, Nurse Unit Manager, Committees of the Facility, staff of the Facility and other Accredited Practitioners.

(c) Accredited Practitioners acknowledge and consent to communication between these persons and entities of information, including their own personal information, that may otherwise be restricted by the Privacy Act 2008 (Cth). The acknowledgment and consent is given on the proviso that the information will be dealt with in accordance with obligations pursuant to the Privacy Act 2008 (Cth) and only for proper purposes and functions.

6. Safety and quality

6.1 Admission, availability, communication & discharge

(d) Visiting Medical Practitioners, Visiting Dentists and Visiting Allied Health Professionals will admit (if applicable) and treat Patients at the Facility on a regular basis and be an active provider of services at the Facility.

(e) Visiting Medical Practitioners or Visiting Dentists who admit Patients to the Facility for treatment and care must ensure that they are available to treat and care for those Patients at all times, or failing that, that other arrangements as permitted by the By-Laws are put in place to ensure the continuity of treatment and care for those Patients. Visiting Allied Health Professionals who treat Patients must ensure they are available to treat and care for those Patients at all times or ensure continuity for treatment and care.

(f) Accredited Practitioners will not provide services or practice outside of the defined service capability of the Facility.

(g) The admission, and continued admission, of an Accredited Practitioners patient to the Facility is subject to:

(i) Procedure/operating list availability;

(ii) The availability or adequacy of nursing or allied health staff or facilities at the hospital, relevant to the type or treatment proposed to be conducted by the Accredited Practitioner;

(iii) Compliance with the clinical services capability framework (however described in the relevant State or Territory), private hospital licensing and/or ASA classifications applicable to the Facility; and

(iv) Compliance with any Facility admission policy in place at the Facility, which may include requirements for transfer out of the Facility in the event of an emergency or the patient no longer meeting admission, clinical services capability framework, private hospital licensing or ASA classification requirements.

(h) Accredited Practitioners must visit all Patients admitted or required to be treated by them as frequently as is required by the clinical circumstances of those Patients and as would be judged appropriate by professional peers.

(i) Planned operating booking lists must be provided prior to the planned list within the specified

timeframe set by the Facility.

(j) An Accredited Practitioner will be contactable to review the Patient in person or their on-call or locum cover is available as requested by nursing staff to review the Patient in the Facility. If locum or back-up cover is not available to attend and review the Patient, this must be immediately notified to the Nurse Unit Manager.

(k) Accredited Practitioners must ensure that all reasonable requests by Facility staff are responded to in a timely manner and in particular Patients are promptly attended to when reasonably requested by Facility staff for clinical reasons. If Accredited Practitioners are unable to provide this level of care personally, he/she shall secure the agreement of another Accredited Practitioner to provide the care and treatment, and shall advise the staff of the Facility of this arrangement. If locum or back-up cover is not available to attend and review the Patient, this must be immediately notified to the Nurse Unit Manager.

(l) Accredited Practitioners must be available and attend upon Patients of the Accredited Practitioner in a timely manner when requested by Facility staff or be available by telephone in a timely manner to assist Facility staff in relation to the Accredited Practitioner's Patients. Alternatively, the Accredited Practitioner will make arrangements with another Accredited Practitioner to assist or will put in place with prior notice appropriate arrangements in order for another Accredited Practitioner to assist, and shall advise the staff of the Facility of this arrangement. If locum or back-up cover is not available to attend and review the Patient, this must be immediately notified to the Nurse Unit Manager.

(m) It is the responsibility of the Accredited Practitioner to ensure any changes to contact details are notified promptly to the Hospital Manager. Accredited Practitioners must ensure that their communication devices are functional and that appropriate alternative arrangements are in place to contact them if their communication devices need to be turned off for any reason.

(n) A locum must be approved in accordance with these By-Laws and the Accredited Practitioner must ensure that the locum's contact details are made available to the Facility and all relevant persons are aware of the locum cover and the dates of locum cover.

(o) Accredited Practitioners must only treat Patients within the Scope of Practice granted.

(p) Accredited Practitioners are required to work with and as part of a multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care for Patients. Accredited Practitioners must at all times be aware of the importance of effective communication with other members of the health care team, referring doctors, the Facility executive, Patients and the Patient's family or next of kin, and at all times ensure appropriate communication has occurred, adequate information has been provided, and questions or concerns have been adequately responded to.

(q) The Accredited Practitioner must appropriately supervise the care that is provided by the Facility staff and other practitioners. This includes providing adequate instructions to, and supervision of, Facility staff to enable staff to understand what care the Accredited Practitioner requires to be delivered.

(r) Adequate instructions and clinical handover is required to be given to the Facility staff and other practitioners (including their on-call and locum cover) to enable them to understand what care the Accredited Practitioner requires to be delivered. The Accredited Practitioner must appropriately supervise the care that is provided by the Facility staff and other practitioners.

(s) If care is transferred to another Accredited Practitioner, this must be noted on the Patient medical record and communicated to the Nurse Unit Manager or other responsible nursing

staff member.

(t) Accredited Practitioners must recognise limitations on the patients that may be admitted to the Facility, and patients that must be transferred out of the Facility, including promptly transferring out a patient of the Facility in the event of an emergency (following immediate management of the emergency) or the patient no longer meeting admission, clinical services capability framework, private hospital licensing or ASA classification requirements.

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

(v) Where on-call arrangements are in place, Accredited Practitioners must participate in formal on-call arrangements as reasonably required by the Facility. Persons providing on- call or cover services must be Accredited at the Facility.

(w) The Accredited Practitioner must ensure that their Patients are not discharged without the approval of the Accredited Practitioner, complying with the discharge policy of the Facility and completing all Patient discharge documents required by the Facility. It is the responsibility of the Accredited Practitioner to ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the referring practitioner, general practitioner or other treating practitioner.

6.2 Surgery

(a) Accredited Practitioners will admit (if applicable) and/or treat Patients at the Facility on a regular basis and be an active provider of services at the Facility.

(b) Accredited Practitioners understand and accept that despite the granting of accreditation, the Facility has the right to allocate theatre and procedural suite access and time as it sees fit and retains the right to re-allocate theatre/procedural suite sessions depending upon its needs and expectations.

(c) Accredited Practitioners understand and accept that despite the granting of accreditation, the Facility has the right to cancel allocated theatre and procedural site access at short notice due to but not limited to urgent or preventative maintenance and repairs, compromised staff or patient safety, underutilisation of allocated theatre/procedure session or any other matters the Facility sees fit.

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

(e) The sessions allocated to the Accredited Practitioner remains Townsville Day Surgery’s to allocate and is not the Accredited Practitioners operating room to claim ownership.

(f) Wherever possible, an Accredited Practitioner must give to the Hospital Manager adequate notice of any times during which he or she will not fully utilise any operating sessions that have been assigned to him or her. The Facility may specify the required notice period and this will be regarded as 'adequate notice' for the purpose of this By-Law.

(g) An Accredited Practitioner must give the Hospital Manager adequate notice of his or her intention to reduce or terminate use of allocated operating sessions. The Facility may specify the required notice period and this will be regarded as 'adequate notice' for the

purpose of this By-Law.

(h) Accredited Practitioners are permitted to only utilise surgical assistants who are accredited pursuant to the By-Laws and with scope of practice as a surgical assistant.

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

(j) Accredited Practitioners must give consideration to their own potential fatigue and that of other staff involved in the provision of patient care, when making patient bookings and in utilising operating theatre and procedural time. This includes the total number of patients, number of consecutive patients in one day or on a list, number of consecutive working days, total hours worked in a day and over the preceding days, responsibilities at other health facilities and matters unrelated to surgery that have an impact on fatigue. Absent an unexpected occurrence or emergency on a particular day, for elective surgery to commence beyond 6pm (18.00) will require the written approval of the Nurse Unit Manager.

(k) Accredited Practitioners acknowledge the importance of, and will strictly adhere to, various measures aimed at ensuring safety and quality during surgery, which includes but is not limited to Facility policies, participating in or allowing to occur procedures relating to correct site surgery, team time out, infection control and surgical item counts.

6.3 Facility, State Based and National Safety Programs, Initiatives and Standards

(a) Accredited Practitioners acknowledge the importance of ongoing safety and quality initiatives that may be instituted by the Facility based upon its own safety and quality program, or safety and quality initiatives, programs or standards of State or Commonwealth health departments, statutory bodies or safety and quality organisations (including for example the national Australian Commission on Safety and Quality in Health Care, a State based division of a Health Department, or a State based independent statutory body).

(b) Accredited Practitioners will participate in and ensure compliance with these initiatives and programs (including if they are voluntary initiatives that the Facility elects to participate in or undertake), whether these apply directly to the Accredited Practitioner or are imposed upon the Facility and require assistance from the Accredited Practitioner to ensure compliance, 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.

6.4 Treatment and financial consent

(a) Accredited Practitioners must obtain fully informed consent for 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 in accordance with the policy and procedures of the Facility. For the purposes of this provision, an emergency exists where immediate treatment is necessary in order to save a person's life or to prevent serious injury to a person's health.

(b) The consent will be evidenced in writing and signed by the Accredited Practitioner and Patient or their legal guardian or substituted decision maker.

(c) It is expected that fully informed consent will be obtained by the Accredited Practitioner

under whom the Patient is admitted or treated, in accordance with the Medical Practitioner's / Dentist's non delegable duty of care. The consent process will ordinarily include an explanation of the Patient's condition and prognosis, treatment and alternatives, inform the Patient of material risks associated with treatment and alternatives, and then obtain the consent to treatment. The consent process must also satisfy the Facility's requirements from time to time as set out in its policy and procedures.

(d) Accredited Practitioners must provide full financial disclosure and obtain fully informed financial consent from their Patients in accordance with the relevant legislation, health fund agreements, policy and procedures of the Facility and medical standards.

6.5 Patient Records

(a) Accredited Practitioners must ensure that:

(i) Patient records held by the Facility are adequately maintained for Patients treated by the Accredited Practitioner;

(ii) Patient records satisfy the Facility policy requirements, legislative requirements, the content and standard required by the Australian Commission on Safety and Quality in Health Care, accreditation requirements, and health fund obligations;

(iii) Their access to and use of Facility patient records is compliant with privacy and confidentiality obligations owed to the patient. Arising from this, Accredited Practitioners may only access and if necessary, obtain a copy (including photograph) of Facility patient records to facilitate the on-going care of the patient. In addition, to comply with privacy and confidentiality obligations set out in the By-Laws and in accordance with legal obligations, if access to or copies of Facility patient records is sought for a purpose other than ongoing care of the patient, the Accredited Practitioner will ensure that they obtain the written consent of the patient and the Facility.

(iv) they maintain full, accurate, legible and contemporaneous medical records, including in relation to each attendance upon the Patient, with the entries dated, time and signed;

(v) they comply with all legal requirements and standards in relation to the prescription and administration of medication, and properly document all drugs orders clearly and legibly in the medication chart maintained by the Facility;

(vi) Patient records include all relevant information and documents reasonably necessary to allow Facility staff and other Accredited Practitioners to care for Patients, including provision of pathology, radiology and other investigative reports in a timely manner;

(vii) A procedure report is completed including a detailed account of the findings, technique undertaken, complications and post procedure orders;

(viii) An anaesthetic report is completed, as well as documentation evidencing fully informed anaesthetic consent and post-anaesthetic evaluation;

(ix) A discharge summary is completed that includes all relevant information reasonably required by the referring practitioner, general practitioner or other treating practitioner for ongoing care of the Patient.

(x) They respond positively to any organisational review and feedback about clinical documentation of the Accredited Practitioner, including where this is to facilitate

improved written communication and capture of clinical assessment, interventions and patient outcomes for clinical coding.

(xi) If introduced within the Facility or a part of the Facility, they participate in electronic medical record and ehealth initiatives.

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

1) The technology is permitted;

2) The technology is managed in accordance with any applicable Facility policy and procedure;

3) The privacy and confidentiality obligations of the patient are strictly adhered to (including pursuant to the *Privacy Act (Cth)*); and

4) the communication is additionally documented in a timely and comprehensive way in the Facility patient record.

6.6 Financial information and statistics

(a) Accredited Practitioners must record all data required by the Facility to meet health fund obligations, collect revenue and allow compilation of health care statistics.

(b) Accredited Practitioners must ensure that all Pharmaceutical Benefits Scheme prescription requirements and financial certificates are completed in accordance with Facility policy and regulatory requirements.

6.7 Quality improvement, risk management and regulatory agencies

(a) Accredited Practitioners are required to attend and participate in the Facility's safety, quality, risk management, education and training activities, including clinical practice review and peer review activities, and as required by relevant legislation, standards and guidelines (including those standards and guidelines set by relevant Commonwealth or State governments, health departments or statutory health organisations charged with monitoring and investigating safety and quality of health care). This includes a requirement to meaningfully participate in clinical review and peer review committee meetings, including review of clinical data and outcomes and respond to requests for information regarding statistical outliers, adverse events and cases flagged in incidents, clinical indicator or key performance indicator reporting.

(b) Accredited Practitioners will report to the Facility incidents, complications, post-operative infections, adverse events, deaths and complaints (including in relation to the Accredited Practitioner's Patients) in accordance with the Facility's policy and procedures and where required by the Hospital Manager will assist with incident management, investigation and reviews (including root cause analysis and other systems reviews), complaints management and open disclosure processes.

(c) Accredited Practitioners will participate in risk management activities and programs, including the implementation by the Facility of risk management strategies and recommendations from system reviews, and will maintain and comply with the ongoing minimum competency and continuing professional development requirements of their professional college with respect to the approved Scope of Practice. Where requested and, as part of Accreditation applications, Accredited Practitioners will provide evidence of external education and

continuing professional development.

(d) Accredited Practitioners must provide all reasonable and necessary assistance in circumstances where the Facility requires assistance from the Accredited Practitioner in order to comply with or respond to a legal request or direction, including for example where that direction is pursuant to a court order, or from a health complaints body, AHPRA, Coroner, Police, State Health Department and its agencies or departments, Private Health Unit, and Commonwealth Government and its agencies or departments.

(e) Accredited Practitioners shall comply with, and take all reasonable actions to assist the Facility to comply with, each of the National Safety and Quality Health Service Standards issued by the Australian Commission on Safety and Quality in Health Care and any associated clinical guidelines.

6.8 Clinical specialty committees

(a) The Board may establish clinical specialty committees for the purpose of reviewing and advising the Board on performance of the clinical specialty by reference to the Facility's clinical services, Organisational Capability and Organisational Need. These committees may include but are not limited to peer review and quality activities.

(b) Each clinical specialty committee, in consultation with the Board, will establish terms of reference for the committee and will report annually, or as required by the Board, on its activities to the Medical Advisory Committee, and make recommendations to the Medical Advisory Committee on issues relevant to the clinical specialty.

6.9 Participation in clinical teaching activities

(a) Accredited Practitioners, if requested, are required to reasonably participate in the Facility's clinical teaching program.

6.10 Research

(a) The Board approves, in principle, the conduct of research (including a clinical trial) in the Facility. However, no research will be undertaken without the prior approval of the Board and a Human Research Ethics Committee, following written application by the Accredited Practitioner.

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

(c) For aspects of the research falling outside an indemnity from a third party (including the exceptions listed in the indemnity), the Accredited Practitioner must have in place adequate insurance with a reputable insurer to cover the medical research.

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

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

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

6.11 Obtain written approval for New Clinical Services

(a) Before treating patients with New Clinical Services, an Accredited Practitioner is required to obtain the prior written approval of the Board (who may consult with and obtain a recommendation from the Medical Advisory Committee) and what is proposed must fall within the Accredited Practitioner's Scope of Practice or an amendment to the Scope of Practice has been obtained and must fall within the license service capability of the facility.

(b) The Accredited Practitioner must provide evidence of Adequate Professional Indemnity Insurance to cover the New Clinical Service, and if requested, evidence that private health funds will adequately fund the New Clinical Services.

(c) The Accredited Practitioner must provide progress reports, at intervals set out in the written approval, to the Hospital Manager, who will include the progress reports in briefing material for the Medical Advisory Committee, and must comply with any subsequent directions received from the Hospital Manager (who may consult with the Medical Advisory Committee).

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

(e) The Board's decision is final and there shall be no right of appeal from denial of requests for New Clinical Services.

6.12 Utilisation

(a) Accredited Practitioners will be advised upon Accreditation or Re-Accreditation, or at other times as determined by the Hospital Manager, of the expectations in relation to exercising Accreditation and utilisation of the facility. This may include the minimum number of patient admissions over a specified period of time, the minimum number of theatre sessions per month or annually, the minimum notice period for cancellation of theatre sessions and expectations with respect to adherence to start times for commencement of theatre sessions. Accredited Practitioners must adhere to these requirements as a condition of Accreditation or Re-Accreditation, subject only to provision of a reasonable excuse for a particular non-compliance, with acceptance of that reasonable excuse within the complete discretion of the Hospital Manager

(b) Absent special circumstances, the Accredited Practitioner must exercise Accreditation or utilise the facility in accordance with the specified expectations.

6.13 Students

(a) An Accredited Practitioner may be accompanied by a student provided that the following requirements are complied with:

(i) The student must be enrolled to undertake training at a recognised tertiary institution and the Accredited Practitioner is responsible for verifying that enrolment;

(ii) The student must have the prior approval of the Hospital Manager to attend the Facility and supply any requested information or documents;

(iii) The Accredited Practitioner must provide effective and adequate supervision of the student at all times;

(iv) The student is not permitted to perform any direct clinical services upon or provide clinical care to a Patient;

(v) The Accredited Practitioner must seek the consent of the Patient for the attendance of

student and clearly inform the Patient that the status of the individual is a student;

(b) The student must comply with any direction or requirement of the Hospital Manager, as well as the policies and procedures of the Facility.

6.14 Modern Slavery

(a) The Accredited Practitioner represents and warrants to Townsville Day Surgery that, at the date of agreeing to these By-Laws, and as a condition of appointment as an Accredited Practitioner and during the period of Accreditation, the Accredited Practitioner:

(i) has not been convicted of any offence involving Modern Slavery and, to the best of the Accredited Practitioner's knowledge having made reasonable enquiries, neither its Affiliates nor Representatives have been convicted of any offence involving Modern Slavery;

(ii) does not engage in any conduct or omission which would amount to an offence involving Modern Slavery and, to the best of the Accredited Practitioner's knowledge having made reasonable enquiries, neither its Affiliates nor Representatives engage in any conduct or omission which would amount to an offence involving Modern Slavery;

(iii) to the best of the Accredited Practitioner's knowledge having made reasonable enquiries, is not and has not been, and its Affiliates and Representatives are not or have not been, the subject of any investigation, inquiry or enforcement proceedings by any governmental, administrative or regulatory body regarding any offence or alleged offence involving Modern Slavery;

(iv) has no knowledge of any Modern Slavery currently occurring within its operations and supply chain; and

(v) takes and will continue to take reasonable steps to identify the risk of, and reduce or prevent the occurrence of, Modern Slavery within its operations or supply chains.

(b) The Accredited Practitioner must, in connection with performing its obligations under the By-Laws and as a condition of Accreditation:

(i) comply, and ensure that its Representatives comply, with Townsville Day Surgery's policies relating to Modern Slavery; and

(ii) not, and ensure that its Representatives do not, engage in any conduct or omission which would amount to an offence involving Modern Slavery.

(c) The Accredited Practitioner must promptly notify Townsville Day Surgery upon becoming aware of any potential, suspected or actual Modern Slavery within its operations or supply chain and of any other information that would make the representations and warranties given under paragraph (a), if repeated, false.

(d) If requested by Townsville Day Surgery, the Accredited Practitioner must, subject to any existing confidentiality requirements and any relevant law, provide Townsville Day Surgery with any information, reports or documents in relation to any Modern Slavery or any risk of Modern Slavery within the Accredited Practitioner's operations or supply chain.

Part C– Accreditation of Medical Practitioners

7. Credentialing and scope of practice

7.1 Eligibility for Accreditation as Medical Practitioners

(a) Accreditation as Medical Practitioners will only be granted if Medical Practitioners demonstrate adequate Credentials, are professionally Competent, satisfy the requirements of the By-Laws, and are prepared to comply with the By-Laws and Facility's policies and procedures, and provide written acknowledgment of such preparedness.

(b) By granting of Accreditation, the Medical Practitioner accepts compliance with the By-laws and the Hospital policies and procedures.

(c) Any Medical Practitioner who falls outside of Accreditation requirements and therefore is not subject to a Credentialing process, before being permitted to attend the Townsville Day Surgery and be involved in clinical care of patients, will be provided with, and agree to 'terms of attendance' (however phrased) that will govern attendance at the Hospital, including appropriate supervision.

7.2 Nature of Appointment and Entitlement to treat patients at the Facility

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

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

(c) A Medical Practitioner's use of the Facility's facilities for the treatment and care of Patients is limited to the Scope of Practice granted and subject to the conditions upon which the Scope of Practice is granted, resource limitations, and Organisational Need and Organisational Capability. Accredited Practitioners acknowledge that admission or treatment of a particular Patient is subject always to bed availability, the availability or adequacy of nursing or allied health staff, appropriate facilities, equipment and other resources, given the treatment or clinical care proposed.

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

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

(f) Accredited Practitioners acknowledge and agree as a condition of the granting of, and ongoing Accreditation, that:

(i) 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;

(ii) The granting of Accreditation creates no rights or legitimate expectation with respect to access to the Facility or its resources; and

(iii) While representatives of the Facility will generally conduct themselves in accordance with these By-Laws, they are not legally bound to do so and there are no legal consequences for the Facility and its representatives in not doing so.

(g) Holding Accreditation does not give the Accredited Practitioner any right or entitlement to, or guarantee of:

(i) Any level of availability of theatre / procedural room access;

(ii) Any allocation of operation / procedural session time; or

(iii) The allocation of any patient

7.3 Responsibility and basis for Accreditation and granting of scope of practice

(a) The Board will determine the outcome of applications for Accreditation as Medical Practitioners and defined Scope of Practice for each applicant. In making any determination, the Board will make independent and informed decisions and in so doing will have regard to the matters set out in these By-Laws and will have regard to the recommendations of the Medical Advisory Committee. The Board may, at its discretion, consider other matters as relevant to the application when making its determination.

7.4 Credentialing and Accreditation

(a) The Board will establish the process and mechanism by which practitioners applying for accreditation will be credentialed within the Facility.

(b) The Facility will also establish any requirements that must be met if accreditation is approved and prior to the exercise of accreditation, which may apply to all applicants or certain applicants based upon specified criteria. This may include requirements for vaccination, police checks and fit testing for masks.

(c) A role of a Medical Advisory Committee will be to review the credentialing requirements set out in these By-Laws, along with any associated approved policies and procedures, and make recommendations to the Board about the suitability of the applicant to receive accreditation and the sought after Scope of Practice.

(d) Applications will include a signed declaration (or will be electronically agreed) by the applicant that the information provided is true and correct, that the applicant has read the By-Laws and in the event the application is successful they will comply in every respect with the By-Laws.

(e) Prior to proceeding with an application or at any time during the credentialing process, the Hospital Manager or Medical Advisory Committee may request the applicant to attend an interview (along with any other representative of the Facility) to:

(i) discuss the application;

(ii) request further information or documents;

(iii) request verification of certain information or documents

(iv) request permission to directly contact third parties to discuss the applicant or any information set out in the application; and/or

(v) to discuss and assess aspects of organisational need.

(f) As determined by the Hospital Manager, any refusal or failure to fully respond to the requests made in (i) above may result in rejection of the application.

(g) Prior to proceeding with an application for re-accreditation or at any time during the credentialing process for re-accreditation, the Hospital Manager or Medical Advisory Committee may seek out any information regarding the applicant during prior periods of accreditation at the Facility in order to fully assess the application. As a condition of submitting the application, applicants understand and consent to such internal communication and access to information (including personal information) within the Facility, including as it relates to competence, performance, current fitness and professional suitability to provide safe, high quality health care.

(h) Unless specific dispensation is received, any written references submitted with the application must have been completed and signed by the referee in the preceding six months before the application was submitted. If referees are unknown to the Board, Medical Advisory Committee or the Hospital Manager, or the written reference is considered insufficient to assist with consideration of the application, the applicant consents for direct contact to be made by the Board, Medical Advisory Committee or the Hospital Manager with the referee to discuss matters relevant to competence, performance, current fitness and professional suitability to provide safe, high quality healthcare. As determined by the Board or Hospital Manager, any refusal or failure to consent may result in rejection of the application.

(i) Unless specific dispensation is received, for an application for re-accreditation, at least one referee must be from the applicant's Clinical Specialty Group. Any written references submitted with the application must be compliant with the requirements of the current policy and procedures of the Facility at the time the application is submitted and completed.

7.5 Principles of Credentialing and Accreditation

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

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

(b) Processes of Credentialing and Accreditation are complemented by registration requirements and individual professional responsibilities that protect the community.

(c) Effective processes of Credentialing and Accreditation benefit patients, communities, health care organisations and health care professionals.

(d) Credentialing and Accreditation are essential components of a broader system of organisational management of relationships with health care professionals.

(e) Credentialing and Accreditation and any reviews should be a non-punitive process, with the

objective of maintaining and improving the safety and quality of health care services.

(f) Processes for Credentialing and Accreditation depend for their effectiveness on strong partnerships between health care organisations and professional colleges, associations and societies.

(g) Processes of Credentialing and Accreditation should be fair and transparent, although recognising the ultimate ability of the Board to make decisions that they consider to be in the best interests of the organisation, its current and future patients.

7.6 Medical Advisory Committee

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

(b) The purposes of the MAC is to:

(i) Advise the Hospital Manager/Board with respect to the clinical and related issues placed before it;

(ii) Represent the collective views of Accredited Practitioners;

(iii) Provide a representative forum for communication from and on behalf of the Hospital Manager/Board and vice versa to Accredited Practitioners;

(iv) Inform the Hospital Manager/Board with respect to matters of clinical safety, risk identification and assessment and quality of care that require expert review, whether this be either the Facility's own clinical governance committees or to external authorities or professional organisations;

(v) To review clinical outcomes and make recommendation on any clinical variation in practice

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

(c) The MAC members will be a majority of Accredited Practitioners, including the chairperson.

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

(e) The Nurse Unit Manager will also be a member of the MAC (non-voting).

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

(g) In the absence of a Credentialing Committee, the role will be performed by the MAC. If the jurisdiction in which the Facility is located requires a separate Credentialing Committee to consider and make recommendations relating to Credentialing, but the role is performed by the MAC, the terms of reference for the Credentialing Committee will include a process that provides for closing the MAC meeting and reconvening it as a Credentialing Committee meeting, including recording of separate minutes.

(h) In addition to the terms of reference established for the MAC or Credentialing Committee, the Committees must be constituted according to and the members of the Committees must conduct themselves in accordance with any legislative obligations, including standards that have mandatory application to the Facility and Committee members. For example, the obligations imposed pursuant to the *Private Health Facilities Act 1999*.

(i) The Facility Manager will be entitled to attend meetings of the MAC as an ex-officio member, such that they will not have an entitlement to vote in relation to decisions or recommendations of the MAC and Credentialing Committee.

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

8. The process for appointment and re-appointment

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

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

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

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

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

8.2 Consideration by the Medical Advisory Committee

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

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

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

granted.

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

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

(i) initiate an Internal Review;

(ii) initiate an External Review;

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

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

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

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

(g) Following receipt of the recommendation from the Medical Advisory Committee and/or Credentialing Committee, the Board will decide:

(i) Whether the application should be rejected or approved; and

(ii) If the application is approved, the scope of practice, period of accreditation and whether any additional terms or conditions will apply.

8.3 Consideration of applications for Initial Accreditation by the Board

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

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

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

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

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

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

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

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

(f) The Board will forward a letter to the Medical Practitioner advising the Medical Practitioner whether the application has been approved or rejected. If the application has been approved, the letter will also contain details of the Scope of Practice granted.

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

8.4 Initial Accreditation tenure

(a) Initial Accreditation as a Medical Practitioner at the Facility may, at the election of the Board, be for a probationary period of 6 months.

(b) Prior to the end of any probationary period established pursuant to By-law 8.4(a), a review of the Medical Practitioner's level of Competence, Current Fitness, Performance, compatibility with Organisational Capability and Organisational Need, and confidence in the Medical Practitioner will be undertaken by the Board. The Board may seek assistance with the review from the relevant Medical Advisory Committee or Specialty Committee where established. The Board, Medical Advisory Committee or the Hospital Manager may initiate the review at any time during the probationary period where concerns arise about Performance, Competence, Current Fitness of, or confidence in the Medical Practitioner, or there is evidence of Behavioural Sentinel Events exhibited by the Medical Practitioner.

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

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

(ii) a review conducted by the Board, Medical Advisory Committee or the Hospital Manager at any time during the probationary period,

causes the Board or Medical Advisory Committee to consider:

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

(ii) the probationary period should be terminated, or

(iii) the probationary period should be extended, or

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

the Medical Practitioner will be:

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

and

(vi) be given an opportunity to be heard and present his/her case.

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

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

(i) amend the Scope of Practice granted; or

(ii) decide that Accreditation will not be granted.

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

8.5 Re-Accreditation

(a) The Hospital Manager or delegate will, at least one month prior to the expiration of any term of Accreditation of each Medical Practitioner (other than a probationary period), provide to that Medical Practitioner an application form to be used in applying for Re-Accreditation.

(b) Any Medical Practitioner wishing to be Re-Accredited must send the completed application form to the Hospital Manager or delegate at least two weeks prior to the expiration date of the Medical Practitioner's current term of Accreditation.

(c) The Board, the Hospital Manager and Medical Advisory Committee will deal with applications for Re-Accreditation in the same manner in which they are required to deal with applications for Initial Accreditation as Medical Practitioners.

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

8.6 Re-Accreditation tenure

(a) Granting of Accreditation and Scope of Practice subsequent to any probationary period will be for a term of up to three years, as determined by the Board using recommendations from the Medical Advisory Committee.

8.7 Nature of appointment

(a) Medical Practitioners who have received Accreditation pursuant to the By-Laws are entitled to make a request for access to facilities for the treatment and care of their Patients within the limits of the defined Scope of Practice attached to such Accreditation at the Facility and to utilise facilities provided by the Facility for that purpose, subject to the provisions of the By-

Laws, policies, resource limitations, and in accordance with Organisational Need and Organisational Capability.

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

(c) A Medical Practitioner's use of the facilities for the treatment and care of Patients is limited to the Scope of Practice granted and subject to the conditions upon which the Scope of Practice is granted, resource limitations, and Organisational Need and Organisational Capability. Accredited Practitioners acknowledge that admission or treatment of a particular Patient is subject always to bed availability, the availability or adequacy of nursing or allied health staff or facilities given the treatment or clinical care proposed.

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

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

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

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

9. Extraordinary Accreditation

9.1 Temporary Accreditation

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

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

(c) Temporary Accreditation may be terminated by the Hospital Manager for failure by the Medical Practitioner to comply with the requirements of the By-Laws or following provisions of

Temporary Accreditation requirements.

(d) Temporary Accreditation will automatically cease upon a determination by the Hospital Manager of the Medical Practitioner's application for Accreditation or at such other time following such determination as the Hospital Manager decides with consultation with the Medical Advisory Committee. The period of Temporary Accreditation shall be determined by the Medical Advisory Committee, which will be for a period of no longer than three (3) months.

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

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

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

9.2 Emergency Accreditation

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

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

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

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

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

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

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

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

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

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

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

9.3 Locum Tenens

(a) Locums must be approved by the Board before they are permitted to arrange the admission of

and/or to treat Patients on behalf of Visiting Medical Practitioners.

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

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

10. Variation of Accreditation or scope of practice

10.1 Practitioner may request amendment of Accreditation or scope of practice

(a) An Accredited Medical Practitioner may apply for an amendment or variation (including expansion) of their existing Scope of Practice or any term or condition of their Accreditation, other than in relation to the general terms and conditions applying to all Accredited Practitioners as provided in these By- Laws.

(b) The process for amendment or variation (including expansion) is the same for an application for Initial Accreditation or Re-Accreditation, and the Medical Practitioner will be required to provide relevant documentation and references in support of the amendment or variation.

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

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

11. Review of Accreditation or scope of practice

11.1 Initiation of review of Accreditation or scope of practice

(a) The Board, Medical Advisory Committee or Hospital Manager may at any time initiate a review of a Medical Practitioner's Accreditation or Scope of Practice where concerns or an allegation are raised about any of the following:

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

(ii) the rights or interests of a Patient, staff or someone engaged in or at the Facility has been adversely affected or could be infringed upon;

(iii) non-compliance with the Behavioural Standards;

(iv) the Medical Practitioner's level of Competence;

(v) the Medical Practitioner's Current Fitness;

(vi) the Medical Practitioner's Performance;

(vii) compatibility with Organisational Capability and Organisational Need;

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

(ix) confidence in the Medical Practitioner;

(x) compliance with these By-Laws, including terms and conditions;

(xi) a possible ground for suspension or termination of Accreditation may have occurred;

(xii) the efficient operation of the Facility could be threatened or disrupted, the potential loss of the Facility's licence or accreditation, or the potential to bring the Facility into disrepute;

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

(xiv) as elsewhere defined in these By-Laws.

(b) The Board, in consultation with the Medical Advisory Committee, will determine whether the process to be followed is an;

(i) Internal Review; or

(ii) External Review.

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

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

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

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

11.2 Internal Review of Accreditation and scope of practice

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

(b) The terms of reference, process, and reviewers will be as determined by the Board in consultation with the Medical Advisory Committee. The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral.

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

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

(e) Following consideration of the report, the Board, in consultation with the Medical Advisory Committee, is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate a Medical Practitioner's Accreditation in accordance with these By-Laws.

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

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

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

11.3 External Review of Accreditation and scope of practice

(a) The Board, in consultation with the Medical Advisory Committee, will make a determination about whether an External Review will be undertaken.

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

(c) The terms of reference, process, and reviewers will be as determined by the Board, in consultation with the Medical Advisory Committee. The process will ordinarily include the opportunity for submissions from the Medical Practitioner, which may be written and/or oral.

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

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

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

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

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

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

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

12.1 Suspension

(a) The Board may, following consultation with the Medical Advisory Committee where practicable, immediately suspend a Medical Practitioner's Accreditation should the Board believe, or have a sufficient concern:

(i) it is in the interests of Patient care or safety. This can be based upon an investigation by an external agency including a registration board, disciplinary body, Coroner or health complaints body, and may be related to a patient or patients at another facility not operated by Townsville Day Surgery;

(ii) the continuance of the current Scope of Practice raises a significant concern about the safety and quality of health care to be provided by the Medical Practitioner;

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

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

(v) the Medical Practitioner fails to observe the terms and conditions of his/her Accreditation;

(vi) the behaviour or conduct is in breach of a direction or an undertaking, or the Facility By-Laws, policies and procedures;

(vii) the behaviour or conduct is such that it is unduly hindering the efficient operation of the Facility at any time, is bringing the Facility into disrepute, does not comply with the Behavioural Standards, is considered disruptive or a Behavioural Sentinel Event or is inconsistent with the values of Townsville Day Surgery;

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

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

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

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

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

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

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

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

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

(xvii) an Internal Review or External Review has been initiated pursuant to these By-Laws and the Board considers that an interim suspension is appropriate pending the outcome of the review;

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

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

(i) the fact of the suspension;

(ii) the period of suspension;

(iii) the reasons for the suspension;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12.2 Termination of Accreditation

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

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

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

(iii) based upon the information contained in a notification required to be given pursuant to these By-laws, it is considered that continued Accreditation is untenable;

(iv) based upon a finding of professional misconduct, unprofessional conduct, unsatisfactory professional conduct or some other adverse professional finding (however described) by a registration board or other relevant

disciplinary body or professional standards organisation for the Medical Practitioner and it is considered that continued Accreditation is untenable;

(v) the Medical Practitioner has been convicted of or pleaded guilty to a crime (excluding a driving offence that does not result in a prison term) and it is considered that continued Accreditation is untenable or impacts adversely on the interests of the Facility;

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

(vii) the Medical Practitioner is not regarded by the Board as having the appropriate Current Fitness to retain Accreditation or the Scope of Practice, or the Board does not have confidence in the continued appointment of the Medical Practitioner;

(viii) conditions have been imposed by the Medical Practitioner's registration board on clinical practice that restricts practice and the Board elects not to accommodate the conditions imposed;

(ix) the Scope of Practice is no longer supported by Organisational Capability or Organisational Need, including with respect to the services necessary to support the Scope of Practice; or

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

(b) Accreditation may be terminated by the Board, following consultation with the Medical Advisory Committee where practicable, if the following has occurred, or if it appears based upon the information available to the Board the following has occurred:

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

(ii) based upon a finalised Internal Review or External Review pursuant to these By-Laws and termination of Accreditation is considered appropriate in the circumstances or in circumstances where the Board does not have confidence in the continued appointment of the Medical Practitioner;

(iii) the Medical Practitioner is not regarded by the Board as having the appropriate Current Fitness to retain Accreditation or the Scope of Practice, or the Board does not have confidence in the continued appointment of the Medical Practitioner;

(iv) conditions have been imposed by the Medical Practitioner's registration board on clinical practice that restricts practice and the Facility elects not to accommodate the conditions imposed;

(v) the Medical Practitioner has not exercised Accreditation or utilised the facilities at the Facility for a continuous period of 12 months, or at a level or frequency as otherwise specified to the Medical Practitioner by the Hospital Manager;

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

(vii) the Medical Practitioner becomes permanently incapable of performing his/her duties which shall for the purposes of these By-Laws be a continuous period of six months’

incapacity; or

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

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

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

(i) the fact of the termination;

(ii) the reasons for the termination;

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) Accredited Practitioners accept and agree, as part of the acceptance of Accreditation, that a termination of Accreditation carried out in accordance with these By-Laws is a safety and

protective process rather than a punitive process, and as such it does not result in an entitlement to any compensation, including for economic loss or reputational damage.

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

12.3 Imposition of conditions

(a) At the conclusion of or pending finalisation of a review or in lieu of a suspension or in lieu of a termination the Board, following consultation with the Medical Advisory Committee where practicable, may elect to impose conditions on the Accreditation or Scope of Practice.

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

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

(d) If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the Board.

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

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

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

12.4 Resignation and expiry of Accreditation

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

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

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

an application for Initial Accreditation.

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

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

13. Appeal rights and procedure

13.1 Rights of appeal against decisions affecting Accreditation

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

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

13.2 Appeal process

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

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

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

(d) Upon receipt of an appeal notice the Board will immediately forward the appeal request to the Medical Advisory Committee.

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

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

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

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

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

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

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

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

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

(k) A nominee of the Board may present to the Appeals Committee in order to support the decision under appeal.

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

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

(n) The chairperson of the Appeal Committee shall determine any question of procedure for the Appeal Committee, with questions of procedure entirely within the discretion of the chairperson of the Appeal Committee.

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

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

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

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

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

Part D – Accreditation of Dentists

14. Accreditation and scope of practice of Dentists

(a) By-Laws 7 to 13 are hereby repeated in full substituting where applicable Dentist for Medical Practitioner.

(b) Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the Board.

Part E– Accreditation of Visiting Allied Health Professionals, Surgical Assistants and Dental Assistants

15. Accreditation and scope of practice of Visiting Allied Health Professionals, Surgical Assistants and Dental Assistants

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

(b) By-Laws 7 to 13 are hereby repeated in full substituting where applicable Visiting Surgical Assistant for Visiting Medical Practitioner and Surgical Assistant for Medical Practitioner.

(c) By-Laws 7 to 13 are hereby repeated in full substituting where applicable Visiting Dental Assistant for Visiting Medical Practitioner and Dental Assistant for Medical Practitioner.

(d) Where other categories of health practitioner have been approved, this By-Law 15 may be utilized.

(e) Applications for Initial Accreditation and Re-Accreditation should be submitted on the relevant form to the Board.

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

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

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

(b) All Accredited Medical Practitioners, Dentists and Allied Health Professionals will be bound by amendments to the By-Laws from the date of approval of the amendments by the Board, even if Accreditation was obtained prior to the amendments being made. If amendments are to have retrospective application, this must be specifically stated by the Board.

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

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

17. Audit and Compliance

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

(b) The audit process will include identification of opportunities for quality improvement in the Credentialing and Accreditation processes that will be reported to the Board and Medical Advisory Committee.

18. Annexures

18.1 Annexure A: Clinical Privileges – Categories and Scope of Practices

1. Accreditation Category

- Dental Assistant (No Admitting Rights)
- Dental Practitioner
- Fellow Medical Practitioner
- General Medical Practitioner
- Locum Tenens
- Registered Nurse (Employed by VMO)
- Registered Nurse (Working in Specialised Area)
- Specialist Medical Practitioner
- Supporting Personnel
- Surgical Assistant – Medical Practitioner (No Admitting Rights)

2. Accreditation Type

- Admitting Privileges
- Anaesthetic Privileges
- Consulting Privileges
- Nursing Assessment & Patient Education Privileges
- Procedural Privileges
- Sedation (GP Only) Privileges
- Supporting Personnel – IVF Scientist Privileges
- Supporting Personnel – Medical Scribe Privileges
- Surgical Privileges
- Surgical Assist – Medical Practitioner Privileges
- Surgical Assist – Registered Nurse Privileges

3. Scope of Practice

- Anaesthesia
  - Sedation Only
  - Other
- Dental Assistant
- Dental Practitioner
- Gastroenterology
  - Endoscopy
  - Other
- General Surgery
  - Endoscopy
  - Laparoscopic
  - Colorectal
  - Other
- Gynaecology
  - Gynaecology General
  - Uro-gynaecology
  - Ultrasound
  - Advanced Endoscopic
  - Laparoscopic
  - IVF
  - Other
- Medical Imaging
- Ophthalmology
  - Other

- Orthopaedics
    - Other
- Pain Management
    - Other
- Plastic & Reconstructive
    - Other
- Registered Nurse
- Supporting Personnel
    - IVF Scientist
    - Medical Scribe
    - Other
- Surgical Assistant
- Urology
    - Other
- Vascular
    - Other

18.2 Annexure B: Medical Advisory Committee (MAC) Terms of Reference

1. Definitions

1.1 Definitions used in this Terms of Reference are those used in the Townsville Day Surgery Medical Practitioners By-Laws.

2. Terms of Reference Purpose and Function

2.1 These Terms of Reference are the management policies approved by the Board which apply to the appointment and conduct of the Medical Advisory Committee.

2.2 Amendment to Terms of Reference

2.2.1 In consultation with the Medical Advisory Committee, these Terms of Reference may be amended by the Board from time to time.

2.3 Medical Practitioners By-laws

2.3.1 These Terms of Reference are to be read in conjunction with the Medical Practitioners By-laws as amended from time to time.

3. Role of the Medical Advisory Committee

3.1 To review and provide advice to the Board and Hospital Management in relation to the accreditation of Medical Practitioners, patient care and safety, and to provide a forum for open communication.

3.2 Advise the Board and Hospital Manager on:

3.2.1 The range of clinical services, procedures or other interventions that can be provided safely in the specific organisational setting;

3.2.2 The facilities and clinical and non-clinical support services reasonably necessary to sustain the safe, high-quality provision of specific clinical services, procedures or other interventions;

3.2.3 The minimum criteria necessary for a Medical Practitioner to fulfil competently the duties of a specific position i.e. Scope of Practice, within the facility;

3.2.4 The information that should be requested and provided by applicants for appointment to specific Medical Practitioner positions or for specific Scope of Practice

3.3 Accepting requests to undertake the processes of credentialing and defining the Scope of Practice in line with the range of clinical services, procedures and other interventions:

3.3.1 relevant to all Medical Practitioners applying for initial appointment at the Facility;

3.3.2 at any time, from an Authorised Person, in respect of a review of the Accreditation of a Medical Practitioner or their Scope of Practice;

3.3.3 from any Accredited Medical Practitioner who requests a review of their Scope of Practice.

3.4 Ensuring the Credentials of each Medical Practitioner are reviewed and verified in accordance with the By-laws and policies of the Facility.

3.5 In respect of each Medical Practitioner, considering Credentials, Competence and performance in the context of the Organisational Need and Organisational Capability, and confidence in each individual and recommend Scope of Practice that is appropriate in the circumstance for each Medical Practitioner.

3.6 Advising the Board and Hospital Manager of the committee's recommendations in relation to the Scope of Practice of each Medical Practitioner.

3.7 At the request of the Board or Hospital Manager with existing Accreditation at Facility, undertake an internal review regarding the Credentials and Scope of Practice granted to a

Medical Practitioner.

3.8 Participate in the strategic planning, development and implementation of clinical programs, new clinical services procedures and other interventions and clinical education and research at the Facility.

3.9 Review and provide advice to the Board and Hospital Manager regarding:
- 3.9.1 Investigations involving AHPRA;
- 3.9.2 Internal and external audit findings;
- 3.9.3 Registration and scope of practice issues relating to Accredited Medical Practitioners;
- 3.9.4 Conflicts of interest involving medical practitioners.

3.10 Advise the Board and Hospital Manager regarding the implementation of actions to manage risk and facilitate continuous improvement at the Facility. These may include:
- 3.10.1 Eliminating adverse practices and behaviours that may be considered a risk to patient safety;
- 3.10.2 Introduction of new specialties, services or procedures;
- 3.10.3 Modifying existing approved specialties, services or procedures;
- 3.10.4 Monitoring of performance of VMPs including suspension or cancellation of Clinical Privileges;
- 3.10.5 Changes to the infrastructure and staffing of the Facility.
- 3.10.6 Peer Review
- 3.10.7 Clinical product evaluation
- 3.10.8 Presentation of data or relevant information relating to a Medical Specialist or Health Professional

3.11 Represent the interests and professional needs of the VMP's by making recommendations to the Board and Hospital Manager about (but not limited to) the following:
- 3.11.1 Clinical management policies and standards of patient care.
- 3.11.2 Clinical Governance & Clinical Framework.
- 3.11.3 Risk Quality and Safety management.
- 3.11.4 Medical Equipment.
- 3.11.5 Medical Procedures.
- 3.11.6 Accreditation of medical practitioners.
- 3.11.7 The withdrawal of accreditation.
- 3.11.8 The suspension of accreditation.
- 3.11.9 The dissemination of information about the activities and recommendations of the Board.
- 3.11.10 Infection Control.
- 3.11.11 The monitoring and review of the Infection Control Management Plan.
- 3.11.12 Ethical issues arising from the medical treatment, clinical research and management of those issues.
- 3.11.13 Medical Education.
- 3.11.14 Policy pertaining to medical staff.
- 3.11.15 Appropriate discussion with the Board on matters involving changes in health care structure affecting practice.
- 3.11.16 Medical quality improvement and management issues.
- 3.11.17 Review of Hospital Related Deaths.
- 3.11.18 Review of Unplanned Return to Operating Theatre.
- 3.11.19 Review of Patient Transfer for Overnight Admission.

3.12 Will act as the Credentialing Committee, or if a separate sub-committee is nominated, provide oversight for the Credentialing Committee to undertake the processes of credentialing and defining the scope of clinical practice for Accredited Medical Practitioners. Where the Credentialing Committee is separately established, a reference in these Terms of Reference to the MAC (when performing a credentialing function) will be read as a reference to the Credentialing Committee.

4. Membership of MAC

4.1 The Medical Advisory Committee will be comprised of at least three (3) Medical Practitioners who are accredited and have been granted Scope of Practice at the Facility.

4.2 Membership of the Medical Advisory Committee shall include wherever possible, representatives from surgical specialities, anaesthetists and dentists.

4.3 The Nurse Unit Manager will also be a member of the Medical Advisory Committee, but not having voting rights.

4.4 All of the Medical Advisory Committee Members shall have voting rights (except the NUM).

4.5 A Director of Medical Services shall be appointed by the Board for a term of three years. Where the Board has not appointed a separate MAC Chair, the Director of Medical Services shall also act as MAC Chair with equal voting rights.

4.6 MAC Appointment Process:

- 4.6.1 Members of the Medical Advisory Committee, including the Chairperson shall be appointed by the Board.
- 4.6.2 Except in respect of the Nurse Unit Manager, members of the Medical Advisory Committee shall be appointed for a period of three years unless otherwise notified in writing at the time of their appointment and shall be eligible for re-appointment.
- 4.6.3 The Board will always at their absolute discretion determine to extend the appointment of any personnel appointed to the Medical Advisory Committee or as the Chairperson of the Medical Advisory Committee.
- 4.6.4 The Chair of the Medical Advisory Committee shall be appointed for a period of three years and shall be eligible for re-appointment.
- 4.6.5 The Board must notify each member of the Medical Advisory Committee of the terms of their appointment, with a copy of these By-laws to accompany the notification.
- 4.6.6 Members of the Medical Advisory Committee are not entitled to and waive any and all claims for consideration for or in connection with their appointment to the Medical Advisory Committee (including salary, wages, directors' fees or any other fees and charges).

5. Entitlement to Membership

5.1 To maintain entitlement to membership of the Medical Advisory Committee, members must maintain Accreditation, appointment or employment, as the case may be, at the Facility.

6. Ex-Officio Members

6.1 Where appropriate, staff, representatives of the Board, representatives of educational and/or professional organisations, or other as agreed by the MAC may attend meetings as ex-officio members with no voting rights.

7. Powers to Co-Opt

7.1 In order to discharge the committee functions in respect of Credentialing and defining Scope of Practice, the Medical Advisory Committee may co-opt the services of other Accredited Medical Practitioners and other Health Practitioners with specific clinical skills and experience relevant to the Scope of Practice sought by an applicant, or which are the subject of review, to assist the Medical Advisory Committee for the purposes of the relevant application, or request for review, and those persons will be deemed to be members of the Medical Advisory Committee for those purposes however will have no voting rights.

7.2 The Facility Credentialing Committee will be a sub-committee of the Medical Advisory Committee, to make recommendations for Credentialing and Scope of Practice for Medical Practitioners.

7.3 Subject to approval by the Board, the Medical Advisory Committee may convene sub-committees, receive from and consider reports prepared by those sub-committees and make recommendations to the Board; on matters arising out of those reports. The Medical Advisory Committee may co-opt the services of any other person it considers necessary, however, that person or persons shall have no voting rights at any meeting of the Medical Advisory Committee or subcommittees thereof.

8. Rules of Conduct

8.1 The Medical Advisory Committee, and any sub-committee convened for specific activities of the Medical Advisory Committee, must comply at all times with all legal requirements, including the common law and relevant Queensland and Commonwealth legislation.

8.2 Specifically, the committee must conduct itself according to the rules of natural justice, without conflicts of interest or bias, and in a manner which does not breach relevant legislation, including privacy, trade practices, whistle-blower or equal opportunity legislation.

8.3 Equity and merit must form the basis of all phases of the processes of Credentialing and defining Scope of Practice.

8.4 In particular, where conflict of interest may arise because:
- 8.4.1 The member has a financial, pecuniary, personal or other interest in the application for Accreditation and Scope of Practice or;
- 8.4.2 The member is related to or is in a personal relationship with the Medical Practitioner;
- 8.4.3 The member must declare the conflict and shall not be involved in any way in considering applications for or requests for review of such applications.

8.5 For the purposes of these By-laws, membership of the same college or professional association of the applicant by any member of the Medical Advisory Committee shall not be regarded as conflict of interest.

9. Meetings of the MAC

9.1 The Medical Advisory Committee will meet at least four times per year at regular intervals and as reasonably required by the Board (referred to as ordinary meetings).

9.2 At least Fourteen days' notice in writing shall be provided for each ordinary MAC meeting.

9.3 A quorum will include the Nurse Unit Manager or delegate and three Medical Practitioner MAC members.

9.4 Should it be apparent that there is not, or will not be, enough members to form a quorum, the Nurse Unit Manager may postpone the meeting and re-schedule at the next possible opportunity.

9.5 In the event there is a need for the MAC to address urgent business the Director of Medical Services or Nurse Unit Manager may call an extraordinary/ad hoc meeting. The quorum for an extraordinary/ad hoc meeting will comprise the Director of Medical Services, Nurse Unit Manager and one other MAC Member. The minutes of such meetings are to be tabled and ratified at the next scheduled MAC meeting.

9.6 Decisions shall be made by a majority vote, with each MAC Member having a single vote, the MAC Chair holding a casting vote in the event there is no clear majority. Only those in

attendance at the meeting are entitled to vote at such meeting. There shall be no proxy vote. In matters directly relating to accreditation of Medical Practitioners, the person to whom the discussion relates shall absent themselves from such discussion and endorsement of clinical privileges.

9.7 A decision may be made by a committee or group established pursuant to these "By-Laws" without a meeting if a consent in writing setting forth such a decision is signed by all members of the committee or group as the case may be. 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" shall nonetheless apply to such a meeting.

9.8 Should there be an emergency situation (e.g. emergency situation requiring change in clinical/medical practice) at any time in which it is necessary to obtain the advice of the Medical Advisory Committee, the Director of Medical Services (or if he or she is unavailable, another Accredited Medical Practitioner member of the MAC) and the NUM (or delegate if the NUM is unavailable), in consultation together, shall be empowered to undertake such necessary action (such action to be reviewed by the Medical Advisory Committee at the earliest possible opportunity). Where appropriate, the Director of Medical Services (or alternate) and NUM (or delegate) must consult with the surgeon or anaesthetist involved in the emergency.

9.9 The meetings of the Medical Advisory Committee must be minuted, and copies of minutes provided to the Board

9.10 Comprehensive records shall be maintained on all deliberations, supporting information considered and recommendations relevant to the processes of Credentialing and defining Scope of Practice.

9.11 Draft minutes will be distributed within 30 days to MAC Members for review. Finalised MAC meeting minutes are to be agreed by the MAC Chair as a true representation of MAC meeting proceedings and distributed by the Hospital Manager or delegate and Board.

9.12 A set agenda provides the framework for the Medical Advisory Committee which includes the following framework for review of:

(a) Governance and Quality Improvement Systems

(i) Acknowledgment of the Credentialing and Granting of Clinical Privileges to Medical Practitioners and Health Professionals – New Applications.
(ii) Recredentialing of existing Medical Practitioners and Health Professionals.
(iii) Archiving of existing Medical Practitioners and Health Professionals.
(iv) Presentation of any items arising from the quality management systems core registers such as:
    i. Audits
    ii. Risk Register
    iii. Compliance Requirements
    iv. Customer Feedback
    v. Continual Improvement
    vi. Incidents
    vii. Maintenance and Repairs
    viii. Documents
    ix. Suppliers Register
    x. Training and Licensing Register
(v) Anything relating to risk, safety, and accreditations processes.
(vi) Addresses issues arising from Queensland Health Regulatory Unit interactions.

(vii) Compliance – Legislation and Regulation Updates (note any updates in regulations e.g., amendments to the Drug and Poisons Act)
(viii) Risk Identification: This is an avenue to present, discuss and plan for any high and / or extreme risks faced by the Townsville Day Surgery).

(b) Clinical Practice

(i) Presentation of data or relevant information relating to Medical Specialists or Health Professionals Report on credentialing (vehicle for communication if any issues around wait times, complaints from patients/staff, general issues which is affecting culture).
(ii) Peer review (assessment of outcomes).
(iii) Introduction of new services.
(iv) Clinical Product Evaluation (list of new products being tested or trialled – for discussion).
(v) Infection Control Reports
(vi) Antimicrobial Stewardship (list any issues around usage of antibiotics)
(vii) Medication Management (opportunity to monitor any issues with medications)
(viii) New or Revised Clinical Practices / Policies for Discussion and Noting (if there are any updates to policies that affect the work practices e.g., change in the Comprehensive Care processes)

(c) Business Management

(i) Capital Equipment, Building, Maintenance & Repairs (Discussion point for new equipment – will go from here to the Reporting to the Board for decision).
(ii) Utilisation Reporting (Discussion around procedural numbers).

(d) Performance Skills and Management

(i) Nurse Unit Manager Report (including operational management update)
(ii) Human Resource Plan Review, including competency, staff development, education and training (overview of staff issues, training and education programs)

(e) Comprehensive Care and Consumer Engagement, Cultural Diversity and Health Literacy

(i) Report from Consumer Engagement activities and feedback).
(ii) Patients/Carers' Rights and Engagement.

(f) Health and Safety

(i) Health and Safety Issues (avenue for relaying health and safety issues)

10. Confidentiality

10.1 Information provided to any committee or person which is provided in confidence shall be regarded as confidential and is not to be disclosed to any third party or beyond the particular forum purposes for which such information is made available.

10.2 Subject to clause 10.4 of these Terms of Reference, MAC members must keep confidential the following information (but not limited to):
10.2.1 Business information concerning the Company or the Facility;
10.2.2 Information concerning the insurance arrangements of the Facility;
10.2.3 The proceedings for the Accreditation and designation of Scope of Clinical Practice of the Health Practitioner;
10.2.4 Discussions relating to performance of any Accredited Medical Practitioner;
10.2.5 Sentinel events and clinical incidents; and
10.2.6 Information concerning any patient or staff member of the Facility.

10.3 The confidentiality requirements of this clause 10 of these Terms of Reference prohibit

the recipient of the confidential information from using it, copying it, disclosing it to someone else, reproducing it or making it public.

10.4 The confidentiality requirements of clauses 10.1 and 10.2 of these Terms of Reference do not apply in the following circumstances:
- 10.4.1 Where disclosure is required by law;
- 10.4.2 Where disclosure is required by a regulatory body in connection with an Accredited Medical Practitioner or the Facility;
- 10.4.3 Where the person benefiting from the confidentiality consents to the disclosure or waives the confidentiality; or.
- 10.4.4 Where disclosure is required in order to perform some requirement of these Terms of Reference.

10.5 The confidentiality requirements of these Terms of Reference continue with full force and effect after a Medical Advisory Committee member ceases to be a member.

11. Resignation from Membership of the MAC

11.1 Any member of the MAC may resign from such membership by giving at least one month's notice in writing of their intention to resign such appointment to the Board (with copy to the Hospital Manager).

12. Termination of Membership of MAC

12.1 The Board may terminate membership or Chairmanship of the Medical Advisory Committee where the member:
- 12.1.1 fails to attend the majority of meetings;
- 12.1.2 fails to attend three (3) consecutive meetings without prior approval from the Board;
- 12.1.3 is determined, following review, by the Board of the facility as not meeting the requirements of membership of the Medical Advisory Committee.

12.2 Membership of the Medical Advisory Committee will be terminated where the Medical Practitioner has Accreditation terminated.

12.3 Where a member of the Medical Advisory Committee is under review or suspended, the Board may suspend membership.

13. Indemnity to Members of Committees

13.1 The Facility will keep the members of the MAC and its committees indemnified against every cost, claim and demand which is made against any of them in relation to the performance of their functions on a committee, provided that:
- 13.1.1 They have performed their functions in good faith and without demonstrated malice;
- 13.1.2 They have acted in accordance with the terms of reference of the committee and the requirements of the By-Laws; and
- 13.1.3 They maintain confidentiality of any conversation, materials, Accredited Practitioner and patient (or other) outcomes made available for committee review, other than circumstances which legally require disclosure of that confidential information or document.

14. Other Obligations for MAC Members

14.1 No MAC Member may purport to represent the Facility without the express written permission of the Board.

14.2 The marks, logos and symbols of the Company and the Facility may not be used without the written authorisation of the Board or its authorised delegate.

15. Defining the Scope of Practice

15.1 Each Medical Advisory Committee in consultation with the Board will establish an approach to defining the requirements for clinical practice within each clinical speciality provided at the facility. In determining the preferred approach of the facility, the Medical Advisory Committee through the facility Credentialing Committee (where applicable) should consider the processes provided in the National Standard for Credentialing and Defining the Scope of Practice to ensure that decision making regarding the approach taken by the facility occurs in a consistent and transparent manner.

15.2 When defining the Scope of Practice for each Medical Practitioner the Medical Advisory Committee through the Credentialing Committee (where applicable) should:

15.2.1 Review the clinical services, procedures or other interventions which have been requested for inclusion in Scope of Practice and consider whether:

15.2.2 A responsible body of medical opinion deems the relevant clinical services, procedures or other interventions to be beneficial to patients;

15.2.3 in the event that the clinical services, procedures or other interventions are not so recognised by a responsible body of medical opinion, they have been reviewed by an ethics committee of and their introduction has been deemed to be acceptable in the circumstances (with or without conditions); and

15.2.4 in the event the clinical services, procedures or other interventions are new to the facility, they are being introduced in compliance with the facility and Townsville Day Surgery policies for the introduction of New Clinical Services.

15.3 Review and consider the relevance to the specific circumstances in which the Scope of Practice are requested by reference to:

15.3.1 Policies or guidelines published by the professional colleges, associations and societies;

15.3.2 Requirements of the professional colleges, associations and societies for current trainees to gain experience in the requested Scope of Practice;

15.3.3 Credible or peer reviewed publications relating to Competence and performance (including the relationship between volume and quality) in the requested Scope of Practice; and

15.3.4 Organisational Capability and Organisational Need to provide the Scope of Practice sought.

15.4 Consider the volume of the relevant activity undertaken by the Medical Practitioner over the past 12 months and the implications regarding the Medical Practitioners ongoing Competence and performance.

15.5 Review available sources of objective data about the Medical Practitioners Competence and performance including any available registry data and consider:

15.5.1 their validity as measures of the safety and quality of health care services including whether they are appropriately stratified and risk adjusted; and

15.5.2 Whether they contribute to a reliable assessment of the Medical Practitioner's Competence and performance in the requested Scope of Practice.

15.6 Review current references and ensure that they confirm the Medical Practitioner's adequacy of clinical knowledge, technical skill, judgement, experience, Competence and performance in each of the specific areas within the Scope of Practice sought.

15.7 Review referees' comments on the Medical Practitioner's communication skills and teamwork ability insofar as these are likely to contribute to clinical performance.

15.8 Review referees' comments on overall professional performance.

15.9 Consider the specific Facility circumstances in which the clinical services, procedures or other interventions will be provided.

15.10 Following deliberations on all of the relevant information make a recommendation to the Board whether to approve, approve with conditions or reject the application.

15.11 The Medical Advisory Committee through the Credentialing Committee (where applicable) shall ensure appropriate documentation relating to deliberations is maintained.

16. Scope of Practice Categories

16.1 Any applicant applying for clinical privileges at the Facility may be awarded clinical privileges within the following categories and clinical scope of practice as listed in Annexure 18.1 of the Medical Practitioners By-Laws.

17. Criteria for Credentialing

17.1 Completed application Form

17.2 Evidence of credentials:

- 17.2.1 Curriculum Vitae (CV) and evidence of undergraduate and specialist qualifications
- 17.2.2 CPD Certification and Evidence of ongoing education
- 17.2.3 AHPRA Registration
- 17.2.4 Medical Indemnity Insurance
- 17.2.5 College Fellowship Certificate (if applicable)
- 17.2.6 Immunisation History Statement & Serology Results
- 17.2.7 Mandatory Training Certificates
- 17.2.8 Evidence of Compliance with Continuing Professional Development
- 17.2.9 Radiation Licence (where applicable)

17.3 Professional referees:

- 17.3.1 Three (3) current referees who are preferably senior practitioners within the relevant area of specialist practice being applied for and have been in a position to judge the applicant's experience and performance during the last 3 years. A minimum of two (2) written references are required.

17.4 Pre Employment Checks:

- 17.4.1 Proof of Identity

18. Key Performance Indicators

18.1 Key Performance indicators include:

- 18.1.1 % of meetings held as scheduled (number of meetings scheduled and held/number of meetings scheduled). Target: 90% held as scheduled
- 18.1.2 % of meeting minutes signed as correct by the Meeting Chair (number of minutes signed/all minutes taken). Target: 100%
- 18.1.3 % of meeting minutes with task sheets/action plans documented (number of minutes with task sheets/all minutes taken). Target: 100%
- 18.1.4 Internal audit results are reviewed and actioned as required.
- 18.1.5 Measure number of incidents and corrective and preventative actions.
- 18.1.6 Measure number of outstanding tasks/responses from staff noted in the electronic quality management system

19. MAC Review and Evaluation

19.1 Annual Review – every July

19. Document Controls

19.1 Related Policy Documents:

	Document
	Townsville Day Surgery Quality, Risk and Safety Operational Management Plan
	Townsville Day Surgery Strategic Plan
	Townsville Day Surgery Medical Advisory Committee Agenda Template
	Townsville Day Surgery Medical Advisory Committee Meeting Minutes Template
	Townsville Day Surgery Medical Advisory Committee Meeting Task Sheet
	Townsville Day Surgery By-Laws

19.2 References:

Queensland Health – Credentials and Clinical Privileges Standard – COPY to be circulated to MAC
Clinical Services Capability Framework
ISO: 9001, 2008 Healthcare Services
Queensland Health Credentialing and defining the Scope of clinical practice documentation.
National Safety and Quality in Health Service Standards
Australian Commission on Safety and Quality in Healthcare website: http://www.safetyandquality.gov.au/
Australian Commission on Safety and Quality in Health Care, Safety and Quality Council, National Guidelines for Credentials and Clinical Privileges, April 2004.
Australian Commission on Safety and Quality in Health Care, Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners, December 2015.
Australian Commission on Safety and Quality in Health Care, Credentialing of Senior Medical Practitioners to Undertake Transvaginal Mesh Implant Surgery for Stress Urinary Incontinence, 2018.
Australian Commission on Safety and Quality in Health Care, Credentialing of Senior Medical Practitioners to Undertake Transvaginal Mesh Surgery for Pelvic Organ Prolapse, 2018.
Australian Commission on Safety and Quality in Health Care, Credentialing of Senior Medical Practitioners to Undertake Transvaginal Mesh Implant Removal Surgery, 2018. https://www.safetyandquality.gov.au/wp-content/uploads/2018/02/Credentialing-of-SeniorMedical-Practitioners-to-Undertake-Transvaginal-Mesh-Implant-Removal-Surge
Voluntary Assisted Dying Act 2021.

19.3 Risk Rating:

Risk Description	Preventative Measures	Management Plan	Evaluation Method	Impact	Likelihood	Risk Scale Factor
Failure to review issues that the MAC is responsible for including clinical governance.	Committee Meeting quarterly to review all medical practitioners working at Townsville Day Surgery and assess all clinical and infection control processes.	Set agenda. Assessment of RiskClear QMS. Meetings minuted. Credentialing and Scope of Practice terms decided.	Audits of meetings. Review of meeting minutes and action items.	Major	Unlikely	High

19.4 Document Revision History:

Version	Release Date	Amendment(s)	Risk-Rated Review Date
1.0	01/09/2008	Original Version	01/09/2009
1.1	01/09/2009	Review	01/04/2011
1.2	01/04/2011	Review	01/04/2014
1.3	01/04/2014	Review	01/08/2016
1.4	01/08/2016	Review	01/08/2019
1.5	01/08/2019	Review	01/08/2022
2.0	11/12/2023	Full Re-write – Substantial increase in detail	

19.5 Document Review and Approval:

Name (Position/Committee)	Function (Owner/Author/Review/Approve)
Facility Manager	Owner/Author/Review
Medical Advisory Committee	Review
TDS Board	Approve