UnitingCare

UnitingCare Hospitals By-laws for Accredited Practitioners (2022)

Contents

1. PREFACE

The *Uniting Church in Australia Act 1977* (Qld) ('the Act') gives legal recognition to The Uniting Church in Australia ('the Uniting Church'). The Synod of the Uniting Church in Queensland has established the UnitingCare Queensland Board ('the Board'), which is commissioned and empowered by the Synod to be responsible for the Uniting Church's involvement in health and community services in Queensland. The Board is responsible for the overall stewardship, strategic direction, governance and performance of UnitingCare Queensland and its network of agencies and services.

UnitingCare Health is a service group established and constituted by the UnitingCare Queensland Board to deliver health care and related services in Queensland. UnitingCare Health hospitals include The Wesley Hospital, St Andrew's War Memorial Hospital, St Stephen's Hospital and Buderim Private Hospital.

The UnitingCare Queensland Board has approved these By-Laws and the delegations contained within these By-Laws.

2. MISSION AND VALUES

OUR MISSION

The Uniting Church embraces the tradition of the Christian Church, and lives to share the Good News of Jesus Christ. The life, death and resurrection of Jesus Christ as witnessed to in the scriptures, is the foundation for the Church's mission in community services. *"God is the author of mission, Jesus Christ embodies the content of mission, the Spirit is the enabler of mission, the Church is an agent of mission, and the world is the arena of mission."*[1]

The Uniting Church, in response to God's grace, has a deep and abiding commitment to health and community services. The Uniting Church engages in these services because it believes that the work of healing, growth, liberation, renewal and reconciliation is God's work in the lives of people and in the life of the world. Jesus' life and ministry challenge us to give more serious attention to the way in which we relate to and serve each other and the world.

UnitingCare Queensland is committed to:

- Uniting in Christ
- Acting with love
- Living with hope
- Witnessing in faith
- Working for Justice.

UnitingCare Queensland claims its place in the mission of God through its health and community services, research, advocacy and community development. The mission of UnitingCare Queensland is to improve the health and wellbeing of individuals, families and communities as we: Reach out to people in need; Speak out for fairness and justice; Care with compassion, innovation and wisdom.

UnitingCare Health, together with other UnitingCare Queensland agencies, Blue Care and UnitingCare Community, are vital expressions of this mission.

UnitingCare Health and all those involved in provision of its services embrace this mission statement and commit to it by living the mission and values through the work that we do every day.

[1] Walker, C. "Towards a Theology Relating to Mission". National Assembly of the Uniting Church in Australia, 2010

OUR VALUES

Compassion

Through our understanding and empathy for others we bring holistic care, hope and inspiration.

For each UnitingCare Health employee, volunteer, and Accredited Practitioner this means;

- I will be responsive to your needs
- I will make time to listen to you
- I will find ways to improve the wellbeing of others
- I will appreciate the gift of volunteering
- I will not ignore or dismiss you
- I will not treat you as a burden

Respect

We accept and honour diversity, uniqueness and contribution.

For each UnitingCare Health employee, volunteer, and Accredited Practitioner this means;

- I will be honest and truthful with you
- I will encourage you to express your point of view
- I will honour all information that is entrusted to me
- I will speak respectfully to you and of you
- I will not abuse, bully or harass you
- I will not deny or denigrate your culture and beliefs

Justice

We commit to focus on the needs of the people we serve and to work for a fair, just and sustainable society.

For each UnitingCare Health employee, volunteer, and Accredited Practitioner this means;

- I will speak out if I see people being harmed or abused
- I will be committed in making sure the people we serve receive the best care possible
- I will use all resources wisely and well
- I will be open and transparent in my actions and behavior
- I will not support a blame culture
- I will not take credit for others' contributions

Working Together

We value and appreciate the richness of individual contributions, partnerships and teamwork.

For each UnitingCare Health employee, volunteer, and Accredited Practitioner this means;

- I will share the load
- I will work constructively with you, regardless of your position
- I will take responsibility for my actions and be accountable to others
- I will acknowledge my way is not the only way
- I will not have an attitude of "it's not my job"

- I will not exclude you

Leading through Learning

Our culture encourages innovation and supports learning.

For each UnitingCare Health employee, volunteer, and Accredited Practitioner this means;

- I will foster a creative, fun, passionate and innovative working environment
- I will share my experience and knowledge
- I will nurture the skills and attributes of others
- I will admit to what I do not know and seek assistance
- I will not conceal or withhold knowledge and/or information
- I will not resist organisational changes which benefit the people we care for

PART A – GENERAL MATTERS AND DEFINITIONS

3. PARAMOUNT CONSIDERATIONS, DEFINITIONS AND COMMITTEES

3.1 PARAMOUNT CONSIDERATIONS FOR DECISIONS AND INTERPRETATION

Accreditation, Credentialing and Scope of Practice are key elements of the clinical governance system within UnitingCare Health in order to achieve the organisational objective of maintaining the safety of Patients. This includes implementation of processes so that Medical Practitioners and other categories of approved practitioner who are suitably experienced and qualified to practice in a competent and ethical manner will practice within UnitingCare Health.

Safety and quality of health care for Patients involves a mutual commitment from UnitingCare Health, its staff and Accredited Practitioners. It is the expectation of UnitingCare Health that all involved in the care of Patients work towards this mutual commitment.

In making decisions with respect to these By-laws and taking actions pursuant to these By-laws, the safety and quality of health care for Patients will be the paramount consideration.

In accordance with a process of continuous improvement, these By-laws and the processes of Accreditation, Credentialing and Scope of Practice will be subject to audit, review and validation on a regular basis. The aim will be to ensure that the processes and outcomes remain diligent and effective and the objectives set out above continue to be achieved in the most effective manner.

3.2 INTERPRETATION

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

Any dispute or difference or uncertainty which may arise as to the meaning or interpretation or application of these By-laws shall be determined by the CEO, with no appeal available from such a determination by the CEO.

Reference to staff in these By-laws, unless the context indicates otherwise, is a broad term to encompass the clinical workforce, including employees and contractors, and when used outside of a clinical context refers more broadly to Relevant Hospital employees, volunteers and contractors.

3.3 DELEGATION

The UCQ CEO, CEO and General Manager may delegate in writing any of the responsibilities conferred by these By-laws.

The General Manager may request assistance from a Director of Medical Services appointed at another UnitingCare Health Relevant Hospital to assist the General Manager with any aspect set out in these By-laws and in these circumstances the Director of Medical Services will be regarded as a delegate of or working under the direction of the General Manager.

3.4 DEFINITIONS

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

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

"Accredited" means the status conferred on a Medical Practitioner or other approved health practitioner or other approved category of health practitioner to provide services within UnitingCare Health after having satisfied the Credentialing and Scope of Practice requirements in these By-laws.

"Accredited Practitioner" means a Medical Practitioner or other approved health practitioner or other approved category of health practitioner who has been Accredited to provide services within UnitingCare Health within an approved Scope of Practice. When referring to a Medical Practitioner, an Accredited Practitioner includes an Employed Medical Practitioner and Visiting Medical Practitioner unless the context of the particular By-law indicates otherwise.

"Adequate Professional Indemnity Insurance" means insurance to cover all potential liability of the Accredited Practitioner and any employees or agents of the Accredited Practitioner, for all potential liability arising during the period of Accreditation (even if a claim were to be made following the conclusion of Accreditation), that is with a reputable insurance company acceptable to UnitingCare Health, in an amount and on terms that UnitingCare Health considers in its absolute discretion to be sufficient. For a Medical Practitioner this will at a minimum include professional indemnity insurance in the amount of $20 million for each and every claim. The insurance must be adequate for Scope of Practice and level of activity. Umbrella professional indemnity insurance available as part of membership of a union or other representative organisation will not be regarded as Adequate Professional Indemnity Insurance.

"Behavioural Standards" means the standard of behavior expected of Accredited Practitioners arising from personal interactions and communication with other Accredited Practitioners, employees of UnitingCare Queensland and UnitingCare Health, Board members of UnitingCare Queensland, executive of UnitingCare Queensland and UnitingCare Health, third party providers of services, Patients, family members of Patients and others. The minimum standard required of Accredited Practitioners in order to achieve the Behavioural Standards is compliance with the Code of Conduct, the expectations set out in the *Good Medical Practice: A Code of Conduct for Doctors in Australia*, the Mission and Values of the Uniting Church and any specific written directions or undertakings.

"By-laws" means these By-laws.

"Chief Executive Officer" or **"CEO"** means the Group Executive, UnitingCare Health or

any person acting or delegated to act in that position. Where a responsibility is attributed to the CEO in these By-laws, the CEO may provide a written delegation to another person to perform that responsibility.

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

"Code of Conduct" means the code of conduct and any associated policies with respect to behaviour endorsed by and operational within UnitingCare Health and the Relevant Hospital.

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

"Credentialing Committee" means the sub-committee of the Medical Advisory Committee of the Relevant Hospital performing Credentialing responsibilities in accordance with these By-laws and the approved terms of reference for that committee.

"Credentials" means, in respect of a person who applies for Accreditation or Re-Accreditation, the identity, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees/awards/fellowships/certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence, and other skills/attributes (for example in leadership, research, education, communication, teamwork), that contribute to the person's Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services. This will consider the particular clinical specialty of the Specialist Medical Practitioner. The applicant's history of and current status with respect to Clinical Practice and outcomes at the Relevant Hospital during prior periods of Accreditation, disciplinary actions, By-law actions, compensation claims, complaints and concerns – clinical and behavioural, professional registration, indemnity insurance and criminal regard are relevant to Credentials.

"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, education, formal qualifications, equivalency of overseas qualifications, post-graduate degrees/awards/fellowships/certificates, professional training, continuing professional development, professional experience, recency of practice, maintenance of clinical competence and other skills/attributes (for example in leadership, research, education, communication, teamwork) for the purpose of forming a view about their Credentials, Competence, Performance, Current Fitness and professional suitability to provide safe, competent, ethical and high quality health care services to the standard required by the CEO and with respect to the Scope of Practice sought. This will take into account the particular clinical speciality of the Specialist Medical Practitioner and that a role of Visiting Medical Practitioner involves unsupervised clinical practice.

"Current Fitness" is the ability 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,

having regard to any relevant physical or mental impairment, disability, condition or disorder (including due to alcohol and drugs) which detrimentally affects or is likely to detrimentally affect the person's capacity to provide health services at the expected level of safety and quality.

"Employed Medical Practitioner" means a Medical Practitioner who is an employee of the Relevant Hospital and who has been granted Accreditation and Scope of Practice pursuant to these By-laws, and is distinguished from a Visiting Medical Practitioner.

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

"General Manager" means the general manager of a Relevant Hospital or any person acting or delegated to act in that position. Where a responsibility is attributed to the General Manager in these By-laws, the General Manager may provide a written delegation to another person to perform that responsibility.

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

"Medical Advisory Committee" means the medical advisory committee of the Relevant Hospital performing responsibilities in accordance with these By-laws and the approved terms of reference for that committee.

"Medical Practitioner" means a person currently registered by the Australian Health Practitioner Regulation Agency pursuant to the *Health Practitioner Regulation National Law Act 2009* as a medical practitioner, who may be further registered in a category of Specialist Medical Practitioner.

"New Clinical Services" means clinical services, treatment, procedures, techniques, technology, instruments or other interventions that are being introduced into the organisational setting of the Relevant Hospital for the first time, or if currently used are planned to be used in a different way or significantly altered than previously approved.

"Organisational Capability" means the Relevant Hospital'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 Relevant Hospital's private health licence, Clinical Services Plan of UnitingCare Health and the Relevant Hospital, and the Queensland Health Clinical Services Capability Framework applicable to the Relevant Hospital.

"Organisational Need" means the extent to which the Relevant Hospital 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, in order to provide a balanced mix of safe, high quality health care services that meet the Relevant Hospital, consumer and community needs and aspirations.

Organisational Need will be determined by, but not limited to, allocation of limited resources, funding, the strategic direction of UnitingCare Health, Clinical Services Plan, business and operational plans of UnitingCare Health and the Relevant Hospital, and the Queensland Health Clinical Services Capability Framework applicable to the Relevant Hospital.

"Patient" means a person admitted to, or treated as an outpatient at, the Relevant Hospital.

"Performance" means the extent to which an Accredited Practitioner provides health care services in a manner which is considered to be consistent with known good Clinical Practice and results in expected patient benefits.

"Queensland Health Clinical Services Capability Framework" means the Clinical Services Capability Framework for Public and Licensed Private Health Facilities, and where applicable, the Relevant Hospital's service level and associated requirements and criteria that apply to each clinical service.

"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 conclusion of the previous term of appointment. This includes a review of Performance over the preceding periods of Accreditation and a reconsideration of the suitability for continuing Scope of Practice.

"Relevant Hospital" means a particular hospital within the UnitingCare Health network to which an application for Accreditation is made or at which the individual holds Accreditation.

"Scope of Practice" means the extent of an individual Accredited Practitioner's permitted Clinical Practice within the Relevant Hospital, that is assessed and documented in writing based on the individual's Credentials, Competence, Performance, Current Fitness, professional suitability, Organisational Capability and Organisational Need.

"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 Australian Health Practitioner Regulation Agency in accordance with the requirements of the *Health Practitioner Regulation National Law Act 2009* (Qld).

"Temporary Accreditation" means the process provided in these By-laws whereby an Accredited Practitioner is Accredited for a limited period.

"Threshold Credentials" means the minimum Credentials for each clinical service, procedure or other intervention, which will be applied during Credentialing and consideration of the Scope of Practice sought, that is required to be achieved before any application will be processed and approved. Threshold Credentials will be approved by the CEO and may be incorporated into an Accreditation policy.

"UnitingCare Queensland" or **"UCQ"** means the health and community service provider of that name and of the Uniting Church in Queensland created by the Queensland Synod of the Uniting Church in Australia.

"UnitingCare Queensland Board" means the Board commissioned and empowered by the Queensland Synod of the Uniting Church in Australia to be responsible for the Uniting Church's involvement in health and community services in Queensland through UnitingCare Queensland.

"UnitingCare Queensland Chief Executive Officer" or **"UCQ CEO"** means the Chief Executive Officer of UnitingCare Queensland or any person acting or delegated to act, in that position. Where a responsibility is attributed to the UCQ CEO in these By-laws, the UCQ CEO may provide a written delegation to another person to perform that responsibility.

"UnitingCare Health" means the service group established and constituted by the UnitingCare Board to deliver health care and related services in Queensland.

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

3.5 COMMITTEES

Matters of procedure for committees and groups established pursuant to these By-laws will be set out in the terms of reference of that committee or group, with the terms of reference and any amendments to be approved by the CEO.

A meeting of a committee or group established pursuant to these By-laws may be conducted by electronic means or by telephonic communication whereby participants can be heard.

Resolutions may be adopted by means of a circular resolution.

Information provided to a member or attendee, or discussed at, a committee or group that is established pursuant to these By-laws 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, unless formal approval to disclose in writing has been obtained from the CEO.

Any member of a committee or group established pursuant to these By-laws 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 unless decided otherwise shall take no part in any relevant discussion or resolution with respect to that particular matter and shall absent themselves from the room during discussions about the matter.

UnitingCare Health will indemnify the members of each approved committee (including a craft group) in respect of actions taken as a member of the committee or claims made against the member of the committee, provided the member has acted in good faith, acted with due care and diligence, acted in accordance with the By-laws, acted in accordance with the terms of reference of the committee and acted in accordance with any common law or legislation governing their conduct or the committee (including but not limited to the *Competition and Consumer Act* and laws relating to defamation).

4. INTRODUCTION

4.1 UNITINGCARE HEALTH COMMITMENT TO SAFETY AND QUALITY

UnitingCare Health is committed to providing safe and high quality care to our Patients. These By-laws assist in achieving this objective by defining the requirements for Accreditation within UnitingCare Health and supporting the selection and retention of health practitioners who possess the qualifications, experience, expertise and behavioural standards necessary to deliver on a mutual commitment to safe and high quality health care.

4.2 PURPOSE OF THIS DOCUMENT

a. These By-laws set out the terms and conditions on which Medical Practitioners or other approved health practitioners 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 UnitingCare Health hospitals, and the terms and conditions for continued Accreditation.

b. UnitingCare Health requires that the By-laws are read in their entirety by an applicant as part of the application process, given that agreement is required from the applicant to comply with the By-laws if the application is successful.

4.3 TRANSITIONAL REQUIREMENTS

Accredited Practitioners who were Accredited prior to commencement of these By-laws must comply with the requirements set out in these By-laws from the date of commencement of these By-laws.

Any applications for Accreditation lodged prior to commencement of these By-laws, will be processed in accordance with these By-laws.

PART B – TERMS AND CONDITIONS OF ACCREDITATION

5. GENERAL TERMS AND CONDITIONS

5.1 COMPLIANCE WITH BY-LAWS

a. It is a requirement for continued Accreditation that Accredited Practitioners comply in full with these By-laws at all times.

b. Any non-compliance with the By-laws may be grounds for suspension under By-law 12.1, termination under By-law 12.2 or imposition of conditions under By-law 12.3.

5.2 COMPLIANCE WITH POLICIES AND PROCEDURES

Accredited Practitioners must comply with all policies and procedures in place at the Relevant Hospital and UnitingCare Health.

As part of the application process, Accredited Practitioners will be provided with key policies and procedures to ensure an understanding of expectations prior to applying for Accreditation (which may be provided by way of an electronic link to the policies and procedures). If certain policies and procedures are not provided to the Accredited Practitioner during the application process, this will not be considered as a reasonable excuse for a failure by the Accredited Practitioner to comply with any policies and procedures in place at the Relevant Hospital and UnitingCare Health.

5.3 COMPLIANCE WITH LEGISLATION

a. Accredited Practitioners must comply with all applicable legislation, including legislation that relates to health and aged care, workplace health & safety, occupational health and safety, anti-discrimination, bullying, harassment, care of children, care of the aged, professional health registration, and any other relevant legislation regulating the Accredited Practitioner and provision of health care in Queensland.

b. The Accredited Practitioner must provide the Relevant Hospital with an authority to conduct a criminal history check at any time with the appropriate authorities.

5.4 INSURANCE AND REGISTRATION

a. Accredited Practitioners must at all times maintain Adequate Professional Indemnity Insurance.

b. Accredited Practitioners must at all times maintain professional registration with the relevant National Board under the National Registration and Accreditation Scheme ('NRAS') and have their registration recorded on the public register by the Australian Health Practitioner Regulation Agency that is sufficient for the Scope of Practice granted.

c. Accredited Practitioners will submit written evidence annually at the time of confirmation of renewal of insurance and registration, or at other times upon request, of Adequate Professional Indemnity Insurance and professional registration, and all other applicable licences, approvals or requirements with respect to the Scope of Practice granted. This is a proactive responsibility of the Accredited Practitioner to submit this written evidence.

d. If an Accredited Practitioner does not provide written evidence of confirmation of renewal of insurance, the Accreditation of the Accredited Practitioner will automatically become inactive from the date of expiration of the Accredited Practitioner's insurance cover, until such time as compliance with this requirement occurs. Subject to By-law 12, Accreditation will only be returned to active status at the time of receipt by the Accredited Practitioner of written confirmation from the Relevant Hospital confirming that the requirement is now satisfied and active status of Accreditation is returned.

e. Accredited Practitioners at the time of granting of Accreditation (or at such other time as requested by UnitingCare Health or the Relevant Hospital) will be required to sign a consent so that a representative of UnitingCare Health or the Relevant Hospital is permitted if required, to contact the Accredited Practitioner's insurer directly for information and documentation relating to insurance arrangements and the Accredited Practitioner's professional registration board or the Australian Health Practitioner Regulation Agency with respect to all matters relating to registration, including but not limited to confirmation of registration, complaints and investigations.

5.5 STANDARD OF CONDUCT AND BEHAVIOUR

a. A high standard of conduct and behaviour is required from Accredited Practitioners.

b. Accredited Practitioners must comply with and achieve at a minimum the Behavioural Standards.

c. Accredited Practitioners must act with proper respect for the mission and values set out in By-law 2.

d. Accredited Practitioners must comply with all specific requests and directions with regard to conduct and behaviour in the Relevant Hospital.

e. Upon request by the CEO or General Manager, the Accredited Practitioner is required to meet with and discuss matters relevant to a) to d) above, or any other matter arising out of these By-laws.

f. UnitingCare Health recognises that endorsement, modelling and championing by peers of the Behavioural Standards is critical to achieving and exceeding the Behavioural Standards with respect to all Accredited Practitioners. As such, any Accredited Practitioner who identifies a breach of the Behavioural Standards by another Accredited Practitioner is expected to promptly report this to the CEO or General Manager. Any action by an Accredited Practitioner that may be perceived as a reprisal for making such a report will be regarded as a breach of the Behavioural Standards.

g. UnitingCare Health encourages Relevant Hospital staff to report to line managers any breach of the Behavioural Standards, including by Accredited Practitioners. Any action by an Accredited Practitioner that may be perceived as a reprisal for making such a report will be regarded as a breach of the Behavioural Standards.

5.6 NOTIFICATIONS

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

a. an investigation be commenced in relation to the Accredited Practitioner, or about care provided by or conduct of the Accredited Practitioner, irrespective of whether this relates to a Patient of the Relevant Hospital, by the Accredited Practitioner's professional registration board, Australian Health Practitioner Regulation Agency, Office of the Health Ombudsman, College, Police, Coroner, or another statutory authority;

b. the Accredited Practitioner provide notification to the Coroner of a reportable death in relation to a Patient of the Relevant Hospital or should the Accredited Practitioner receive notification of a coronial investigation or inquest in relation to a Patient of the Relevant Hospital;

c. the Accredited Practitioner receive a written complaint from a Patient of the Relevant Hospital, or notification of a complaint from the Australian Health Practitioner Regulation Agency, Accredited Practitioner's professional registration board, Office of Health Ombudsman or College in relation to a Patient of the Relevant Hospital;

d. the Accredited Practitioner receive an initial notice or notice of claim pursuant to the *Personal Injuries Proceedings Act 2002* (Qld) (or its successor or equivalent legislation, including equivalents in other jurisdictions), or be served with court proceedings making a compensation claim, in relation to a Patient of the Relevant Hospital;

e. the Accreditation 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 Relevant Hospital;

f. an adverse or critical finding be made about the Accredited Practitioner by a civil court, the practitioner's registration board, disciplinary body, Australian Health Practitioner Regulation Agency, Coroner, Office of the Health Ombudsman, College, criminal court or another statutory authority, irrespective of whether this relates to a Patient of the Relevant Hospital;

g. 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 Relevant Hospital and irrespective of whether this is noted on the public register or is privately agreed with the Australian Health Practitioner Regulation agency or a professional registration board;

h. professional indemnity membership or insurance be made conditional or not be renewed, should limitations be placed on insurance or professional indemnity coverage or should material changes occur to insurance or professional indemnity coverage;

i. the Accredited Practitioner's appointment, clinical privileges or Scope of Practice at any other facility, hospital (public or private) or day procedure centre alter in any way, including if it is withdrawn, terminated, suspended, restricted or made conditional; or

j. the Accredited Practitioner be under investigation, charged with having committed or is convicted of a sex, violence, child related or other criminal offence.

5.7 CONTINUOUS DISCLOSURE

a. The Accredited Practitioner must keep the General 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 their Patients within the Scope of Practice;

   (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, including but not limited to denial of indemnity by an insurer;

(vi) adverse outcomes, complications, complaints, compensation claims, police investigations and coronial investigations in relation to the Accredited Practitioner's Patients (current or former) of the Relevant Hospital;

(vii) the reputation of the Accredited Practitioner as it relates to the provision of Clinical Practice, the reputation of the Relevant Hospital and UnitingCare Health;

(viii) any of the matters notified or that ought to have been notified pursuant to By-law 5.6.

b. Subject to restrictions directly relating to or impacting upon legal professional privilege or statutory obligations of confidentiality, every Accredited Practitioner must keep the General Manager informed and updated about the commencement, progress and outcome of compensation claims (including a *Personal Injuries Proceedings Act* initial notice or notice of claim), coronial investigations or inquests, police investigations, complaints body (including the Office of the Health Ombudsman) complaints or investigations, or other inquires involving Patients of the Accredited Practitioner that were treated at the Relevant Hospital.

5.8 REPRESENTATIONS AND MEDIA

a. Unless an Accredited Practitioner has the prior written consent of the CEO, an Accredited Practitioner may not use Uniting Church, The Uniting Church in Australia Property Trust (Q.), UnitingCare Queensland, UnitingCare Health or the Relevant Hospital name, logos, or letterhead.

b. Unless an Accredited Practitioner has the prior written consent of the CEO or General Manager, the Accredited Practitioner may not in any way suggest, or cause a misunderstanding by omission, that the Accredited Practitioner represents or communicates on behalf of the entities referred to in paragraph a) above.

c. The Accredited Practitioner must obtain the prior written approval of the CEO or General Manager before interaction with the media regarding any matter involving or relating to the Relevant Hospital, a patient of the Accredited Practitioner admitted to or previously admitted to the Relevant Hospital, a patient admitted to or previously admitted to the Relevant Hospital, or any matter involving or relating to UnitingCare Health.

d. If approval is given by the CEO or General Manager, the Accredited Practitioner must comply with the UnitingCare Health media policy.

e. If there is any instance of non-compliance with any matters set out in a) to d) above, in addition to constituting a breach of these By-laws, the Accredited Practitioner is required to follow the directions of the CEO or General Manager in managing the consequence of non-compliance, including a retraction or agreed public statement.

f. The Accredited Practitioner must obtain the prior approval of the General Manager to communicate (publicly or privately) information or documents obtained during the course of appointment as an Accredited Practitioner, exercising Scope of Practice or performing any roles or functions set out in these By-laws, but such prior approval is not required if the communication is directly relevant to care or treatment provided to a Patient, it is communicated in the course of facilitating ongoing care or treatment and is otherwise compliant with applicable privacy, health information and information security laws.

5.9 COMMITTEES AND CRAFT GROUPS

Accredited Practitioners will assist the Relevant Hospital with its functions and objectives, and personally engage in continuous education, reflection and improvement, through membership of and active participation in committees and craft groups. This includes committees and craft groups responsible for: developing, implementing and reviewing policies and protocols in clinical areas; participating in medical, nursing and other training and education programs;

Accreditation and Credentialing; clinical oversight and peer review through review; safety and quality initiatives and programs.

Accredited Practitioners who are based outside of the immediate geographical vicinity of the Relevant Hospital are expected to contribute in the same way as other locally based Accredited Practitioners, with the extent and manner of participation, and the means by which that participation occurs, as agreed with the General Manager.

Peer review will be consistent with relevant College guidelines and the Australian Commission on Safety and Quality in Health Care – Credentialing Guidelines and National Safety and Quality Health Service Standards. Peer review will extend beyond clinical outcomes and encompass broader matters as set out in the definition of 'Credentials" in these By-laws.

5.10 CONFIDENTIALITY

a. Accredited Practitioners will manage all matters relating to the confidentiality of information in compliance with UnitingCare Health policy and the *'Australian Privacy Principles'* established by the *Privacy Act 1988* (Cth) and will not do anything to bring UnitingCare Health and the Relevant Hospital in breach of these obligations.
b. Accredited Practitioners will comply with the various legislation relating to; the collection, access, handling, storage and disclosure of patient and health information.
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 UnitingCare Health and the Relevant Hospital;
    (ii) Matters being managed or carried out pursuant to these By-laws;
    (iii) Information concerning UnitingCare Health's insurance arrangements;
    (iv) Information concerning any Patient, relative or carer of a Patient, employee, volunteer or contractor of a Relevant Hospital;
    (v) Information which comes to their knowledge concerning Patients, Clinical Practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services.
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, the Relevant Hospital, or UnitingCare Health;
    (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.

5.11 COMMUNICATION WITHIN UNITINGCARE QUEENSLAND AND UNITINGCARE HEALTH

a. Accredited Practitioners are required to familiarise themselves with the organisational structure and various committees of the Relevant Hospital, UnitingCare Health, UnitingCare Queensland and the Uniting Church in Australia Queensland Synod.

b. Accredited Practitioners acknowledge that in order for the organisation to function effectively, communication is required, including between the executive and management team of the Relevant Hospitals, executive and management team of UnitingCare Health, executive and management team of UnitingCare Queensland, UnitingCare Queensland Board and Uniting Church in Australia Queensland Synod.

c. Accredited Practitioners acknowledge and consent to communication between these persons and entities above, including individuals working at their direction, with respect to information (including their own personal information) which may otherwise be restricted by the *Privacy Act 1988* (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 1988* (Cth) and for proper purposes and functions.

6. SAFETY AND QUALITY

6.1 ADMISSION, AVAILABILITY, PATIENT CARE, UTILISATION, COMMUNICATION AND DISCHARGE

a. Accredited Practitioners will admit or treat Patients on a regular basis and be an active provider of services to the Relevant Hospital. Continued Accreditation is conditional upon the Accredited Practitioner admitting or treating patients and fully utilising allocated operating theatre and procedural facilities on a regular basis and being an active provider of services. Audits of activity will be conducted. If there has been no or limited activity or inadequate use of allocated operating theatre time or procedural facilities over a certain period~~,~~ as determined by the General Manager, a show cause process may be initiated pursuant to this provision of the By-laws. The show cause process may result in notification of inactivation or withdrawal of Accreditation due to insufficient utilisation.

b. Accredited Practitioners must strictly adhere to approved Scope of Practice and to these By-laws. Audits of compliance will be conducted, as well as ongoing evaluation, monitoring and review of Credentials. Audit results will be communicated to Relevant Hospital committees, craft groups (including for peer review activities) and individual Accredited Practitioners. Accredited Practitioners will meaningfully assist with and participate in these activities and be responsive to audit results. Action may be taken pursuant to these By-laws with respect to non-compliance with these By-laws, non-compliance with approved Scope of Practice, or lack of meaningful assistance, participation or response to audits.

c. Accredited Practitioners who admit Patients will accept complete responsibility for those Patients. Accredited Practitioners must ensure that they are readily available to treat and care for those Patients at all times, or failing that, other arrangements as permitted by these By-laws are put in place to ensure continuity of Patient care.

d. Accredited Practitioners must attend in person upon all Patients admitted or required to be treated by them as frequently as is required by the clinical circumstances or as reasonably requested by Relevant Hospital staff. Absent special circumstances, an Accredited Practitioner will review a Patient in person within 24 hours of the Patient being admitted under that Accredited Practitioner, or within a shorter timeframe if clinically appropriate or if requested by Relevant Hospital staff. Prior to the initial attendance, the Accredited Practitioner will provide adequate written instructions for management of the Patient. Absent special circumstances that are recorded in the medical record, an Accredited Practitioner will thereafter review the Patient within clinically appropriate timeframes, which at a minimum will be in person 24 hourly or through their on call or locum cover. If Accredited Practitioners are unable to personally provide the level of care set out in this By-law, the Accredited Practitioner will secure the agreement of another Accredited Practitioner to provide the care and will notify the Relevant Hospital in writing of this arrangement.

e. Accredited Practitioners must be available to provide instructions by telephone in a timely manner. 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 Relevant Hospital in writing of this arrangement.

f. Accredited Practitioners must familiarise themselves with, support and strictly adhere to UnitingCare Health and Relevant Hospital policies with respect to patient deterioration, including but not limited to the actions required to be taken with respect to deterioration. UnitingCare Health will have a zero tolerance with respect to any aspect of non-compliance and this zero tolerance will be reflected in the serious action that will be taken pursuant to these By-laws for non-compliance.

g. It is the responsibility of Accredited Practitioners to ensure any changes to their contact details are notified promptly, 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. Accredited Practitioners will notify the Relevant Hospital in writing of an emergency contact who is another Accredited Practitioner with the same Scope of Practice who has agreed to assist if immediate instructions or attendance is required and the Accredited Practitioner cannot be contacted.

h. Accredited Practitioners must ensure that they have in place on call and cover arrangements with Accredited Practitioner(s) at the Relevant Hospital and that those arrangements are communicated in writing to the Relevant Hospital, including but not limited to the name, contact details and period of cover. A locum must be approved in accordance with these By-laws. Prior to taking leave, the Accredited Practitioner should ensure adequate handover and where possible avoid undertaking major surgery or procedures in circumstances where the post-operative care is to be transferred to a locum or on call Accredited Practitioner.

i. Accredited Practitioners must familiarise themselves with and strictly adhere to UnitingCare Health and Relevant Hospital policies with respect to surgical safety, including but not limited to completing and participating in pre-procedure and pre-anaesthetic checks, leading team time out and end of procedure checks and allowing Relevant Hospital staff sufficient time to complete surgical safety requirements. UnitingCare Health will have a zero tolerance with respect to any aspect of non-compliance and this zero tolerance will be reflected in the serious action that will be taken pursuant to these By-laws for non-compliance.

j. Accredited Practitioners accept complete responsibility for, and must directly supervise, surgical assistants who assist the Accredited Practitioner with surgical and other procedures. For surgical assistants engaged by the Accredited Practitioner in order to provide surgical and procedural assistance, the Accredited Practitioner must ensure that seven (7) days' advance notice and required information is provided with respect to surgical assistants who will be attending on a particular day, the surgical assistant is appropriately qualified, experienced and registered in order to assist with the particular surgery or procedure, must ensure that Adequate Professional Indemnity Insurance is in place with respect to the surgical assistant and must provide evidence to the Relevant Hospital of Adequate Professional Indemnity Insurance. For surgical assistants performing services as part of the pool that are made available to the Accredited Practitioner, the Relevant Hospital will have in place a system to confirm registration and Adequate Professional Indemnity Insurance, however the Accredited Practitioner maintains complete responsibility for, and must directly supervise, those surgical assistants from the available pool who assist the Accredited Practitioner with surgical and other procedures.

k. Accredited Practitioners must familiarise themselves with and comply with UnitingCare Health and Relevant Hospital targeted programs with respect to safety of Patient care. In particular, (but without limitation) it is expected that Accredited Practitioners will strictly comply with UnitingCare Health and Relevant Hospital policies and procedures for

medication safety, quality use of medicines, patient safety, incident management, infection control, hand hygiene and venous thromboembolism prevention.

l. Accredited Practitioners must not engage in any conduct that may be perceived, regardless of the intention of the Accredited Practitioner, as a reprisal against another person for making a report or supplying information relating to issues of safety, quality or behaviour of the Accredited Practitioner or about a patient of the Accredited Practitioner, including as part of any speaking up for safety initiative in place at the Relevant Hospital.

m. Accredited Practitioners must work as part of a multi-disciplinary team, including effective communication – written and verbal, to ensure the best possible care for Patients. Accredited Practitioners must at all times ensure that they provide effective communication to other members of the team, referring doctors, the Relevant Hospital executive, Patients and the Patient's family, support persons or next of kin.

n. Accredited Practitioners must give consideration to their own potential fatigue and that of other staff involved in provision of Patient care, when making patient bookings and in utilising operating theatre and procedural facility 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 and responsibilities at other health facilities. Absent an unexpected occurrence on a particular day, for elective surgery to commence beyond 10pm, written approval of the General Manager is required.

o. Adequate instructions and clinical handover must be given to Relevant Hospital staff and other health practitioners (including on-call and locum cover) so as to understand and to provide the care the Accredited Practitioner requires to be delivered. The Accredited Practitioner must directly supervise the care provided by the Relevant Hospital staff and other health practitioners.

p. With respect to patients transferred to an intensive care or critical care unit of the Relevant Hospital following performance of surgery or a procedure, the Accredited Practitioner surgeon/proceduralist and anaesthetist remain responsible for matters relating to the surgery/procedure and anaesthetic. They must attend upon the Patient as clinically appropriate and provide sufficient instructions (that are reduced to writing in the medical record) and assistance to the intensive care or critical care team to ensure sufficient surgical/procedural and anaesthetic input into the continuing care while the Patient remains in the intensive care or critical care unit.

q. If care is be formally 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.

r. Accredited Practitioners must participate in formal on call arrangements as required by the Relevant Hospital, acknowledging that the manner and scheduling of on call arrangements will ultimately be determined by the Relevant Hospital to ensure service flow, service continuity and safety of Patients, with Accredited Practitioners informing themselves and ensuring compliance with competition and consumer law obligations relating to rostering and similar arrangements.

s. Accredited Practitioners must ensure that their Patients are not discharged without review by and the written approval of the Accredited Practitioner, complying with the discharge policy of the Relevant Hospital. The Accredited Practitioner must ensure all information reasonably necessary to ensure continuity of care after discharge is provided to the Patient, Patient's carer, referring practitioner, general practitioner and/or other treating practitioners. The Accredited Practitioner must ensure documentation of the treatment provided is received by the Relevant Hospital within 48 hours.

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u. Accredited Practitioners must cooperate and assist the Relevant Hospital to comply with any audits relating to documents and associated requests for clarification of information recorded including but not limited to documentation queries.

6.2 TREATMENT AND CONSENT

a. All Accredited Practitioners will obtain and document fully informed consent to treatment (except where it may be implied in cases of emergency) from the Patient or their legal guardian or substituted decision maker in accordance with accepted medical standards and in line with best practice outlined in *Good Medical Practice: A Code of Conduct for Doctors in Australia, The Australian Commission on Safety and Quality in Health Care (the Commission) National Safety and Quality Health Services (NSQHS) Standards requirements and Queensland Health Guide to Informed Decision-making in Healthcare* and accepted legal standards (including section 22 of the *Civil Liability Act 2003* (Qld)). 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. Fully informed consent to treatment will be evidenced in writing, signed by the Accredited Practitioner and signed by the Patient or their legal guardian or substituted decision maker. The Accredited Practitioner will provide, prior to the commencement of treatment a copy of the signed consent form to the Relevant Hospital evidencing fully informed consent to treatment.

c. It is not permissible for the Accredited Practitioner to delegate responsibilities with respect to obtaining fully informed consent to treatment.

d. The consent process for treatment must satisfy the Relevant Hospital's policy and procedures

e. Given the importance of the treatment consent documentation completed by the Accredited Practitioner and Patient to the Relevant Hospital's surgical safety processes, and the zero tolerance for non-compliance with associated policies and procedures, admissions will not be accepted and/or surgery/procedures will not proceed until complete compliance has occurred.

f. Accredited Practitioners must provide full financial disclosure and obtain and document fully informed financial consent from their Patients in accordance with medical standards (including in section 3.5 of the *Good Medical Practice: A Code of Conduct for Doctors in Australia*), legal standards, UnitingCare Health contractual obligations with health funds and policies of the Relevant Hospital, and when requested, provide a copy of the fully informed financial consent document to the Relevant Hospital.

6.3 PATIENT RECORDS

Accredited Practitioners must ensure that:

a. Patient medical records held by the Relevant Hospital contain adequate documentation of the care and treatment provided by the Accredited Practitioner to the Patient, including at a minimum:

   (i) a pre-admission note or a letter about the patient's condition and plan of management, including significant co-morbidities, allergies, previous adverse reactions and management issues or concerns relevant for nursing staff;

   (ii) fully informed patient consent;

   (iii) completion of admission forms within 24 hours of admission;

   (iv) recording an appropriate patient history, reason for admission, physical examination, diagnosis or provisional diagnosis, and treatment plan before treatment is undertaken, unless involving an emergency situation and in these circumstances, documentation will occur following the emergency;

   (v) therapeutic orders;

   (vi) details of all procedures; and

   (vii) details of pathology and radiology reports.

b. Patient records satisfy UnitingCare Health and Relevant Hospital policy requirements, legislative requirements, the content and standard required by the Australian Council on Healthcare Standards, accreditation requirements, health fund obligations, Queensland Health and other bodies' requirements;

c. they cooperate with audits of compliance relating to documentation;

d. they maintain full, accurate, legible and contemporaneous medical records, including in relation to each attendance upon the Patient, with entries:

   (i) dated, timed and signed;

   (ii) specifying the designation of the attending practitioner;

   (iii) setting out the Patient's progress;

   (iv) recording any special problems or complications;

   (v) including any additional information advised to the Accredited Practitioner that is required to meet contractual health fund obligations.

e. if a contemporaneous record is not possible, for example if instructions are provided by telephone, then at the next attendance as required under By-law 6.1(d) the Accredited Practitioner will place a copy of their contemporaneous notation in the Relevant Hospital medical record or will make a retrospective entry in the Relevant Hospital medical record;

f. Patient records held by the Relevant Hospital include all relevant information and documents reasonably necessary to allow Relevant Hospital staff and other Accredited Practitioners to care for Patients, including instructions, orders and treatment plans;

g. Complications, incidents, variations and deviations from standard clinical pathways and expectations are recorded in the Relevant Hospital medical record as well as being brought to the attention of Relevant Hospital staff;

h. A procedure report is completed, including:

   (i) a detailed account of the findings;

   (ii) the surgical technique undertaken;

   (iii) complications;

   (iv) post-operative orders;

   (v) the full name of any surgical assistant, anaesthetist and other medical practitioner or observer present;

   and ensuring that the procedure report is dictated or written as soon as is practicable, signed by the Accredited Practitioner and made part of the Patient records held by the Relevant Hospital;

   (vi) Anaesthetic Records should comply with ANZCA 'Guidelines For The Anaesthetic Record (PG06 (a)) 2020", or its successor, and should ensure the anaesthetic report is dictated or written as soon as is practicable, signed by the Accredited Practitioner and made part of the Patient records held by the Relevant Hospital.

i. Following discharge, all reasonable steps are taken by the Accredited Practitioner to ensure that the Relevant Hospital's medical record is up to date with all relevant information relating to the Patient including discharge documentation, discharge correspondence, completed discharge summary and this documentation will include requirements relating to ongoing care (including medication) and follow up to ensure continuity of Patient care and treatment. The Accredited Practitioner must ensure documentation of the treatment provided is received by the Relevant Hospital within 48 hours.

i. If the Accredited Practitioner requires access to or a copy of the Patient medical records held by the Relevant Hospital, for a purpose not directly related to ongoing clinical care of the Patient, then the Accredited Practitioner will submit to the Relevant Hospital a consent for release signed by the Patient or substituted decision maker.

To avoid any doubt, Accredited Practitioners understand that the above requirements apply to all Accredited Practitioners involved in the treatment of a Patient, including but not limited to anaesthetists and other practitioners consulted or providing input into the care of a Patient who is formally under the care of another Accredited Practitioner.

6.4 FINANCIAL INFORMATION AND STATISTICS

Accredited Practitioners will record in the Relevant Hospital medical record all data required by the Relevant Hospital, including but not limited to data required to carry out coding, to comply with reporting obligations and to meet the requirements of health funds, and must ensure that all Pharmaceutical Benefits Scheme prescription requirements and Department of Health certificates are completed in accordance with Relevant Hospital policy and regulatory requirements. Accredited Practitioners will respond in a timely manner to queries, requests for information and completion of documentation relating to these matters.

6.5 SAFETY, QUALITY IMPROVEMENT, RISK MANAGEMENT AND REQUIREMENTS OF REGULATORY AGENCIES

a. Accredited Practitioners are required to participate in orientation (which includes expectations, obligations, role and responsibilities) prior to commencement of Initial Accreditation and at any subsequent time as required by the General Manager.
b. Accredited Practitioners are required to attend and meaningfully participate in UnitingCare Health and the Relevant Hospital's safety, quality, risk management, education and training activities, and craft group meetings (the latter may include clinical audit, morbidity and mortality review, clinical oversight and peer review activities in which the Accredited Practitioner's outcomes, statistics and other matters relevant to the Accredited Practitioner's Credentials are being considered).
c. Accredited Practitioners must inform themselves of the safety and quality initiatives instituted by UnitingCare Health or the Relevant Hospital based upon its own safety and quality program, or safety and quality initiatives, programs or standards of Queensland or Commonwealth health departments, statutory bodies or safety and quality organisations. Accredited Practitioners will participate in and ensure compliance with these initiatives, programs and standards, whether these apply directly to the Accredited Practitioner or require assistance from the Accredited Practitioner to ensure compliance by UnitingCare Health or the Relevant Hospital. Accredited Practitioners must particularly be familiar with, ensure compliance with and assist the Relevant Hospital to comply with the National Safety and Quality Health Service Standards and Clinical Care Standards of the Australian Commission on Safety and Quality in Health Care.
d. Accredited Practitioners must maintain and comply with the ongoing minimum competency and continuing professional development requirements of their professional college with respect to the Scope of Practice granted, including with respect to any sub-specialty areas and the minimum annual procedure requirements in order to maintain competency with respect to that procedure. Accredited Practitioners will provide all necessary information, documentation and assistance so that audits may be conducted with respect to compliance.
e. Accredited Practitioners will report, and provide all relevant information, to the Relevant Hospital about incidents, complications, adverse events, complaints, reportable deaths to the Coroner, reportable events to Private Health Regulation in accordance with the Relevant Hospital policy, procedures and regulatory obligations. Where required by the General Manager, Accredited Practitioners will assist with, provide relevant information and participate in incident management, complaint management, investigation, reviews (including root cause analysis and other systems reviews) and open disclosure.
f. UnitingCare Health requires the support of all Accredited Practitioners and Relevant Hospital staff in order to achieve a high level of safety and quality. In support of this objective, UnitingCare Health encourages all Accredited Practitioners and Relevant

Hospital staff to report to the CEO, General Manager or line manager any safety and quality concerns, including if it relates to the practice of an Accredited Practitioner or Relevant Hospital staff member. Accredited Practitioners must not engage in any conduct that may be perceived, regardless of the intention of the Accredited Practitioner, as a reprisal against another person for making a report or supplying information relating to issues of safety, quality or behaviour of the Accredited Practitioner or about a patient of the Accredited Practitioner, including as part of any speaking up for safety initiative in place at the Relevant Hospital, and if this occurs it will be regarded as a breach of the Behavioural Standards.

g. Accredited Practitioners acknowledge and agree that, as part of its clinical governance and safety obligations to patients, UnitingCare Health or the Relevant Hospital may conduct case reviews with respect to the care provided to a patient or patients of the Accredited Practitioner, that may involve obtaining external opinion. This initial assessment phase may not involve communication with the Accredited Practitioner, however if a review of Accreditation or Scope of Practice is to occur, then the process set out in By-law 11 will be initiated.
h. Accredited Practitioners will participate in risk management activities and programs, including by assisting in the implementation of risk management strategies and recommendations from root cause analysis and system reviews.
i. Accredited Practitioners must provide all reasonable and necessary assistance where the Relevant Hospital requests or requires assistance from the Accredited Practitioner in order to comply with or respond to a valid legal request or order; in order to respond to requests from Government, regulators or other bodies (including but not limited to Queensland Government and its agencies or departments, Private Health Regulation, Office of Health Ombudsman, Australian Health Practitioner Regulation Agency, Health Funds, Coroner, Police, Commonwealth Government and its agencies or departments); or any of the matters arising out of the notification or continuous disclosure obligations contained in By-laws 5.6 and 5.7.

6.6 CRAFT GROUPS

a. The General Manager may establish clinical specialty committees, referred to as ‘Craft Groups’, for each major clinical speciality within the Relevant Hospital.
b. The terms of reference, approved by the General Manager, will set out the purpose and procedure of the craft groups, as well as required reporting to the Medical Advisory Committee, quality assurance committee (if any) and General Manager. The responsibilities may include general business with respect to the clinical speciality; clinical oversight and peer review through presentation by the Accredited Practitioner of their own clinical outcomes, statistics and other criteria set out in the definition of 'Credentials' pursuant to these By-laws; review of clinical outcomes and statistics (including morbidity and mortality) on a case by case and hospital wide basis with respect to all Accredited Practitioners; review of audit results; developing, implementing and reviewing policies and protocols in clinical areas; advising the General Manager on performance of and continuing professional development of Medical Practitioners and other health practitioners working within the clinical specialty by reference to the Relevant Hospital’s clinical services, Organisational Capability and Organisational Need.
c. In accordance with the National Safety and Quality Health Service Standards, Craft Groups are responsible for providing input into and assisting Accredited Practitioners within the clinical speciality with information about relevant best-practice guidelines, integrated care pathways, clinical pathways and decision support tools relevant to their clinical practice, and to support Accredited Practitioners within the clinical specialty to use the best available evidence, including relevant Clinical Care Standards developed by the Australian Commission on Safety and Quality in Health Care.

d. Clinical governance representatives of UnitingCare Health will support Craft Groups to monitor variation in practice against expected health outcomes, provide feedback to clinicians on variation in practice and health outcomes, review performance against external measures, support clinicians to participate in peer and clinical review of their practice including against the criteria set out in the definition of 'Credentials' pursuant to these By-laws, use information on unwarranted clinical variation to inform improvements in safety and quality systems and record the risks identified from unwarranted clinical variation in the risk management system.

6.7 QUALITY ASSURANCE COMMITTEE

a. The CEO may approve establishment of, and the terms of reference for, a quality assurance committee.

b. A quality assurance committee will be established and operate in accordance with the *Hospital and Health Boards Act 2011* (Qld), requirements of the Department of Health and the approved terms of reference.

6.8 PARTICIPATION IN CLINICAL TEACHING ACTIVITIES

Accredited Practitioners are required to reasonably participate in the Relevant Hospital's clinical teaching and education program.

6.9 RESEARCH

a. UnitingCare Health approves, in principle, the conduct of research (including a clinical trial). However, no research will be undertaken without the prior written approval of the General Manager and the UnitingCare Health / Queensland Human Research Ethics Committee, following written application by the Accredited Practitioner.

b. For quality activities (for example retrospective chart audit) that require ethics approval, the Quality Ethics Sub-committee of the UnitingCare Queensland Human Research Ethics Committee will provide the necessary written approval, rather than the UnitingCare Queensland Human Research Ethics Committee.

c. The activities to be undertaken in the research must fall within the Scope of Practice of the Accredited Practitioner or the process provided for in these By-laws for variation of Scope of Practice must occur.

d. An approval for research may be conditional upon an indemnity from a third party being obtained on terms satisfactory to UnitingCare Health (including the exceptions listed in the indemnity), and if the research is not covered by the UnitingCare Health insurance program then the Accredited Practitioner must have in place adequate insurance with a reputable insurer to cover the research.

e. 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.

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

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

6.10 NEW CLINICAL SERVICES

a. Before treating Patients with New Clinical Services, an Accredited Practitioner must obtain the prior written approval of the General Manager and what is proposed must fall within the Accredited Practitioner's Scope of Practice or else a variation to Scope of Practice must be obtained pursuant to these By-laws.

b. Requests for the New Clinical Services should be made in accordance with the UnitingCare Health New Clinical Services policy requirements and application form.
c. The Accredited Practitioner must provide evidence of Adequate Professional Indemnity Insurance to cover the New Clinical Services, and if requested, evidence that private health funds will adequately fund the New Clinical Services.
d. If research is involved, then By-law 6.9 must additionally be complied with.
e. The decision of the General Manager is final and there shall be no right of appeal from denial of requests for New Clinical Services.

PART C – ACCREDITATION

7. CREDENTIALING AND SCOPE OF PRACTICE

7.1 ELIGIBILITY FOR ACCREDITATION

Accreditation will only be granted if the applicant demonstrates to the satisfaction of the General Manager, adequate Credentials, meets requirements of Organisational Capability and Organisational Need, otherwise satisfies the requirements of the By-laws, agrees to comply with and accept all terms, conditions and processes set out in the By-laws, and provides written acknowledgment of such preparedness by signing the required declaration.

7.2 ACCESS TO FACILITIES AND RESOURCES

a. Conferral of Accreditation provides the Accredited Practitioner with an ability on each occasion to make a request for access to facilities of the Relevant Hospital for the treatment and care of a Patient, within the limits of the Accredited Practitioner's Scope of Practice, and to utilise facilities provided by the Relevant Hospital for that purpose, subject always to the provisions of the By-laws, UnitingCare Health and Relevant Hospital policies, resource limitations, and in accordance with Organisational Capability and Organisational Need at the time of the request for access.
b. The decision to grant access to facilities or particular resources for the treatment and care of a Patient is on each occasion within the sole discretion of the General Manager. The grant of Accreditation contains no general entitlement to or right of access to facilities. The General Manager retains a right of refusal for a particular treatment, use of resources or Patient.
c. The decision of the General Manager is final and there shall be no right of appeal from a decision made pursuant to By-law 7.2.

7.3 ACCREDITATION AND SCOPE OF PRACTICE

The General Manager will make the final decision with respect to applications for Accreditation and defined Scope of Practice. The General Manager will make independent and informed decisions and in so doing will have regard to the matters set out in these By-laws and any recommendations submitted. The General Manager may, at his/her discretion, consider other matters as relevant to the application when making his/her determination.

7.4 MEDICAL ADVISORY COMMITTEE AND CREDENTIALING COMMITTEE

a. The General Manager shall convene a Medical Advisory Committee and Credentialing Committee.
b. The Medical Advisory Committee and Credentialing Committee will operate in accordance with the approved terms of reference (**Annexure A**).
c. The Medical Advisory Committee and Credentialing Committee members, including the chairperson, will be appointed by the General Manager and may be removed at any time by the General Manager.

d. A condition of acceptance by a new member to the Medical Advisory Committee and Credentialing Committee is to participate in an orientation in order to understand their role and responsibilities.

e. Ex officio members of the committees will include the Director of Medical Services (if appointed at the Relevant Hospital) and Director of Clinical Services.

f. The majority of members of each committee will consist of Medical Practitioners.

g. Any member of each committee whose Credentials are under consideration will not participate in that component of the meeting and will not take part in any decision or recommendation.

h. If assessing Credentials of an applicant who is not a Medical Practitioner, a specially convened Credentialing Committee will be convened with the membership as determined by the General Manager.

8. PROCESSES FOR ACCREDITATION AND RE-ACCREDITATION

8.1 APPLICATIONS FOR INITIAL ACCREDITATION AND RE-ACCREDITATION

a. Applications for Initial Accreditation (defined to mean the applicant does not currently hold Accreditation at the Relevant Hospital) and Re-Accreditation (defined to mean the applicant currently holds Accreditation at the Relevant Hospital) must be made in the prescribed way, within the prescribed timeframe and by payment of the prescribed fee.

b. All questions must be fully completed, all required information and documents must be supplied within the prescribed timeframe and the prescribed fee paid before an application for Accreditation or Re-Accreditation will be considered or further considered.

c. Applications for Initial Accreditation that do not comply with all requirements will be rejected and must be re-submitted.

d. Applications for Re-Accreditation that do not comply will all requirements will be rejected and must be re-submitted. Further, if timeframes are not met due to late submission of an application or submission of an incomplete application for Re-Accreditation, unless the General Manager decides otherwise, the current Accreditation will expire. If expiry occurs, in order to be considered for future Accreditation the application will be dealt with as an Initial Accreditation application. The decision of the General Manager is final and there shall be no right of appeal with respect to expiration of Accreditation due to non-compliance with application requirements.

d. In special circumstances, the General Manager may consider granting of Temporary Accreditation pending a decision with respect to Initial Accreditation or Re-Accreditation outside of required timeframes, however this will be an exceptional case and is in the complete discretion of the General Manager.

e. The electronic process for lodgment of applications must be utilised. Declarations and consents required to be made relating to the correctness of the information submitted in an application, the agreement to comply with and accept all terms, conditions and processes set out in the By-laws, and management of information pursuant to the *Privacy Act*, may be made through an electronic declaration/consent rather than written signature.

f. At any time during the Credentialing process, the General Manager may request an interview with the applicant (including involving any representative of the Relevant Hospital or UnitingCare Health that the General Manager considers appropriate), further information or documents from an applicant, request verification of information or documents submitted (for example if an original is not supplied this may require certification by a Justice of the Peace or similar certifying agent) or request permission to directly contact third parties, and any refusal or failure to respond to the request will result in rejection of the application. Consideration of an interview with an applicant will be based on a risk assessment, with this biased towards conducting an interview for applicants seeking Initial Accreditation and applicants unknown to the General Manager.

g. It is a condition of submitting an application for Re-Accreditation that the applicant consents to information sharing within UnitingCare Health, including with respect to personal information of the applicant, so that the application may be completely and properly assessed and all information relevant to the application including Performance and other matters relating to the previous period of Accreditation can be considered by the relevant persons making recommendations and decisions.

h. Written references must have been completed and signed by the referee in the preceding 6 months before the application was submitted in order to be considered. If referees providing a written reference are unknown to the General Manager, including by making enquiry within the Relevant Hospital, the General Manager may in their absolute discretion undertake an identity check of the referee and/or confirm the contents of the written reference.

i. At least one nominated referee should be an existing Accredited Practitioner of UnitingCare Health within the same specialty of the applicant. If this is not possible, the applicant should provide a reason, and the General Manager may in their complete discretion waive this requirement, but may decide to specify criteria in relation to the nominated referees that will be considered acceptable by the General Manager in order to allow the application to proceed.

j. More detailed requirements, guidelines and processes with respect to applications for and consideration of Accreditation and Credentialing (Initial Accreditation and Re-Accreditation) are set out in associated policies and procedures, which may include requirements relating to Threshold Credentials, written references, criteria for referees who may be nominated, referee checks and reference checks.

8.2 CONSIDERATION BY MEDICAL ADVISORY AND CREDENTIALING COMMITTEE

a. The Medical Advisory Committee and Credentialing Committee will consider applications for Accreditation and Re-Accreditation referred to it by the General Manager in order to undertake the responsibility of Credentialing in accordance with their respective terms of reference, any applicable policy and any Threshold Credentials that may be relevant to the application.

b. The responsibility for Credentialing will include assessing and verifying Credentials, Competence and Current Fitness, considering references, contacting referees, assessing information from colleges and professional registration bodies, and documenting the steps taken and outcome so that auditing may occur.

c. The Credentialing function will be primarily performed by the Credentialing Committee, which will report back to the Medical Advisory Committee.

d. If the full Medical Advisory Committee performs the Credentialing function, then its terms of reference will provide that the Medical Advisory Committee will conclude and be reconstituted as the Credentialing Committee meeting.

e. The Credentialing Committee may delegate responsibilities, for example relating to verification of Credentials and checks to be conducted (for example where applicable criminal record and working with children checks), to an appropriate person within the Relevant Hospital who will report back to the Credentialing Committee or Medical Advisory Committee.

f. The Medical Advisory Committee will consider the information received from the Credentialing Committee in order to give complete consideration to applications and fulfill its responsibilities in accordance with these By-laws, any associated policy and its terms of reference.

g. If the Medical Advisory Committee or Credentialing Committee requires further information before making a recommendation, it may refer the matter back to the General Manager before giving further consideration to the application.

h. The Medical Advisory Committee will make recommendations to the General Manager

about approval of applications and the Scope of Practice to be granted.

8.3 CONSIDERATION OF ACCREDITATION BY GENERAL MANAGER

a. The General Manager will consider applications for Initial Accreditation and Re-Accreditation referred by the Medical Advisory Committee in order to undertake their responsibility of Credentialing in accordance with these By-laws and any associated policy, and will decide whether the applications should be rejected or approved and, if approved, the Scope of Practice, period and whether any additional terms or conditions should apply.

b. In considering applications, the General Manager will give due consideration to any recommendations or other information relevant to the application as determined by the General Manager, and may make any additional enquires as the General Manager determines appropriate, with the final decision that of the General Manager.

c. If the Medical Advisory Committee makes a recommendation against granting of Accreditation on the basis that the applicant does not have the necessary Competence to provide the health services, then Accreditation will not be granted or will require further consideration before a final decision is made.

d. The General Manager will provide written notification whether the application has been approved or unsuccessful. If the application has been approved, the letter will contain details of the Scope of Practice granted, period, any additional terms and conditions and the orientation that will occur prior to commencement.

e. There is no right of appeal pursuant to the By-laws from a decision of the General Manager to reject an application for Initial Accreditation, a decision that continued Accreditation will not be granted following the conclusion of a probationary period, or a decision with respect to the Scope of Practice, period, probationary period or any additional terms and conditions that accompany a successful application for Initial Accreditation.

f. The rights of appeal with respect to Re-Accreditation are set out in By-law 13.

8.4 INITIAL ACCREDITATION TENURE, TERMS AND CONDITIONS

a. Initial Accreditation and Scope of Practice will be for a probationary period of one (1) year.

b. The terms and conditions for the probationary period will be within the complete discretion of the General Manager and will be communicated in writing to the applicant.

c. Within one (1) month prior to the end of the probationary period, a review will be undertaken by the General Manager. Should the Accredited Practitioner have an acceptable probationary review outcome, as determined by the General Manager, the General Manager may grant an Accreditation period, up to four (4) years, on the basis of Scope of Practice, terms and conditions as decided and notified by the General Manager.

d. Should the probationary review outcome be considered by the General Manager insufficient to allow the granting of continued Accreditation, the General Manager will provide written notification of the unsuccessful outcome.

8.5 RE-ACCREDITATION TENURE, TERMS AND CONDITIONS

Re-Accreditation, Scope of Practice granted and any additional terms and conditions will be for a period up to five (5) years, with the period in the complete discretion of the General Manager.

8.6 ACCREDITATION AT MULTIPLE UNITINGCARE HEALTH HOSPITALS AND MUTUAL RECOGNITION

a. An applicant who does not currently hold Accreditation at any UnitingCare Health Relevant Hospital may make one application, note on the application the Relevant Hospitals to which the applicant is applying and the Scope of Practice sought at each Relevant Hospital. Following consideration of the documents and information contained within the application, the process for Accreditation in these circumstances is in the complete discretion of the General Manager of each UnitingCare Health Relevant Hospital, who may require that usual requirements and processes for Accreditation are still to be completed, or alternatively may allow for a lead UnitingCare Health Relevant Hospital to consider the application and thereafter the General Manager of each UnitingCare Health Relevant Hospital will make a decision.

b. If an applicant already holds Accreditation at another UnitingCare Health Relevant Hospital, at the time of submitting an application the applicant shall identify the UnitingCare Health Relevant Hospital/s at which the applicant already holds Accreditation. The General Manager will obtain all relevant documents and information from that other UnitingCare Health Relevant Hospital/s in accordance with the declaration given by the applicant. Following consideration of the documents and information from the other Relevant Hospital, the process for Accreditation in these circumstances is in the complete discretion of the General Manager, who may require that usual requirements and processes for Accreditation are still to be completed.

c. Scope of Practice may differ between Relevant Hospital/s depending on the Organisational Need and Organisational Capability of the Relevant Hospital.

d. Accreditation across multiple UnitingCare Health Relevant Hospitals is at all times subject to the limitations on access to facilities and resources set out in By-law 7.2.

e. In the complete discretion of the General Manager, a process for mutual recognition may be established involving the local Hospital and Health Service, that allows for medical practitioners from the public sector attending the Relevant Hospital to treat public patients. This may incorporate a streamlined process to rely upon information supplied by the local Hospital and Health Service regarding its accreditation of that medical practitioner, in order to process the application for Accreditation at the Relevant Hospital, with the granting of limited Accreditation at the Relevant Hospital to provide treatment to a public patient or patients within an approved Scope of Practice.

8.7 NATURE OF APPOINTMENT

a. The granting of Accreditation does not constitute or create an employment contract, employment relationship or contractual relationship nor does it result in any implied contractual terms between the Accredited Practitioner and the Relevant Hospital, UnitingCare Health, UnitingCare Queensland or the Uniting Church.

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

c. It is a condition of accepting Accreditation, and of ongoing Accreditation, that the Accredited Practitioner understands and agrees that:

   (i) the granting of Accreditation does not constitute or create an employment contract, employment relationship or contractual relationship nor does it result in any implied contractual terms between the Accredited Practitioner and the Relevant Hospital, UnitingCare Health, UnitingCare Queensland or the Uniting Church;

   (ii) 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

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

d. 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 Relevant Hospital, 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 Relevant Hospital or its resources; and
   (iii) while representatives of UnitingCare Queensland, UnitingCare Health and the Relevant Hospital 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.

8.8 THIRD PARTY PROVIDERS

a. If certain services are delivered by a third party provider, such as medical imaging or pathology, the UnitingCare Health Relevant Hospital may require Medical Practitioners or other categories of health practitioner delivering the services on behalf of the third party provider to firstly be granted Accreditation pursuant to these By-laws or alternatively may require the third party provider to undertake its own Accreditation process and to ensure that the Credentials, professional registration and professional indemnity insurance are strictly verified and confirmation that this has occurred or suitable evidence is provided to the UnitingCare Health Relevant Hospital.

b. Despite paragraph (a) above, Accreditation pursuant to these By-laws is required for procedural and interventional Medical Practitioners and other categories of health practitioners performing procedural and interventional clinical services within the UnitingCare Health Relevant Hospital.

c. In the event a third party provider undertakes its own Accreditation process, Scope of Practice and access to the UnitingCare Health Relevant Hospital by a particular Medical Practitioner or other category of health practitioner remains the responsibility of the General Manager.

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

9 TEMPORARY ACCREDITATION AND COVER ARRANGEMENTS

9.1 TEMPORARY ACCREDITATION

a. The General Manager may grant Temporary Accreditation and Scope of Practice on terms and conditions considered appropriate by the General Manager.

b. Temporary Accreditation will only be considered on the basis of Patient need, Organisational Capability and Organisational Need.

c. Applications for Temporary Accreditation must be made in writing or through the prescribed electronic means.

d. All questions must be fully answered and required information and documents submitted before an application will be considered, except in cases of emergency and in these circumstances the General Manager will determine on a case by case basis the process that will occur.

e. More detailed requirements, guidelines and processes with respect to applications for and consideration of Temporary Accreditation may be set out in associated policy and procedures.

f. The period of Temporary Accreditation shall be determined by the General Manager, and for an initial period of no longer than three (3) months.

g. If for special circumstances the General Manager considers that a further period of no longer than an additional three (3) months is appropriate, then the General Manager may approve the further period of Temporary Accreditation.

h. Any further period of Temporary Accreditation beyond six (6) months requires approval of the CEO and Temporary Accreditation is not permitted to extend beyond a total of twelve (12) months.

i. Temporary Accreditation may be terminated by the General Manager for failure to comply with the requirements of the By-laws or pursuant to any conditions attached to the Temporary Accreditation.

j. Temporary Accreditation will automatically cease upon the expiry of its term or at such other time as the General Manager decides.

k. The Medical Advisory Committee will be informed of any Temporary Accreditation granted.

l. The Temporary Accreditation process may be used for proctors and observers, modified to suit the specific circumstances, and may be confined to a particular attendance rather than for a period of time. For the avoidance of any doubt, proctors and observers will not be involved in any way in patient care or management, otherwise the full Temporary Accreditation process is required to be completed.

m. There will be no right of appeal pursuant to these By-laws from decisions relating to the granting of Temporary Accreditation or termination of Temporary Accreditation.

9.2 LOCUM, LEAVE AND ON CALL ARRANGEMENTS

a. If locum, leave or on call cover is provided by an Accredited Practitioner who is not an existing Accredited Practitioner, this must be approved through the Temporary Accreditation process provided for in these By-laws before the arrangements can commence.

b. More detailed requirements, guidelines and processes with respect to applications for and consideration of locum, leave or on call arrangements may be set out in associated policy and procedures.

c. There will be no right of appeal from decisions in relation to locum, leave or on call arrangements.

10 VARIATION OF ACCREDITATION OR SCOPE OF PRACTICE

10.1 APPLICATION FOR VARIATION

a. This By-law applies in order to manage changes in Scope of Practice.

b. An Accredited Practitioner may apply for an amendment or variation of their existing Scope of Practice or any term or condition of their Accreditation, which may include an expansion or reduction in Scope of Practice, however an Accredited Practitioner may not make such an application in relation to the general terms and conditions applying to all Accredited Practitioners as provided in these By-laws.

   The process for amendment or variation is the same for an application for Re-Accreditation, except that the applicant will be required to complete a Request for Amendment of Accreditation or Scope of Practice and provide relevant information and documentation in support of the amendment or variation.

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

d. More detailed requirements, guidelines and processes with respect to applications for and consideration of variation may be set out in associated policy and procedures.

e. The rights of appeal conferred upon Accredited Practitioners who apply for amendment or variation are set out in By-law 13, except that an appeal is not available for an application made during a probationary period, or in relation to Temporary Accreditation, locum, leave or on call arrangements.

11 REVIEW OF ACCREDITATION OR SCOPE OF PRACTICE

11.1 INITIATING REVIEW OF ACCREDITATION OR SCOPE OF PRACTICE

a. The General Manager may initiate, at any time, a review of an Accredited Practitioner's Accreditation or Scope of Practice where concerns or potential concerns are identified about any of the following:
   (i) Patient health or safety may be compromised;
   (ii) the rights or interests of a Patient, employee, contractor, volunteer, another Accredited Practitioner or someone engaged in or at the Relevant Hospital may be adversely affected;
   (iii) competence, Current Fitness or Performance;
   (iv) compatibility with Organisational Capability or Organisational Need;
   (v) confidence in the Accredited Practitioner;
   (vi) compliance with Behavioural Standards;
   (vii) compliance with the 'Good Medical Practice: A Code of Conduct for Doctors in Australia';
   (viii) compliance with these By-laws or Scope of Practice;
   (ix) a ground for suspension or termination of Accreditation may arise;
   (x) the efficient operation of the Relevant Hospital could be threatened or disrupted;
   (xi) the potential loss or breach of the Relevant Hospital's licence or accreditation;
   (xii) the potential to bring the Relevant Hospital, UnitingCare Health, UnitingCare Queensland or the Uniting Church into disrepute;
   (xiii) arising from the notification or continuous disclosures provisions in By-laws 5.6 and 5.7; or
   (xiv) as elsewhere defined in these By-laws.
   (xv) The General Manager will determine whether the process to be followed is an:
      i. Internal Review; or
      ii. External Review.

b. Prior to determining whether an Internal Review or External Review will be conducted, the General Manager may in his or her absolute discretion meet with the Accredited Practitioner, along with any other persons the General Manager considers appropriate, advise of the concern, and

c. Invite a preliminary response from the Accredited Practitioner (in writing or orally as determined by the General Manager) before the General Manager makes a determination whether a review will proceed, and if so, the type of review.

d. The General Manager will make a determination whether to impose an interim suspension or conditions upon Accreditation pending the outcome of the review, and if this occurs, it will be done in accordance with By-law 12**,** except that the appeal provisions pursuant to these By-laws will not apply with respect to an interim suspension or conditions.

e. In addition, or as an alternative, to conducting an Internal or External Review, the General Manager may notify the Office of Health Ombudsman and/or other professional body responsible for the Accredited Practitioner of details of the concerns raised if required by legislation, the General Manager consider 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 Office of Health Ombudsman or professional body is more appropriate to investigate and take necessary action.

f. Following the outcome of any action taken by the Office of Health Ombudsman and/or other professional body the General Manager may elect to take action, or further action, under these By-laws.

g. For the avoidance of any doubt, an Internal or External Review is not a necessary precondition to suspension, termination or imposition of conditions upon Accreditation, and the General Manager may decide to proceed directly to any of these actions.

11.2 INTERNAL REVIEW OF ACCREDITATION OR SCOPE OF PRACTICE

a. An Internal Review will be undertaken by a person or persons internal to UnitingCare Queensland.

b. An Internal Review may, at the election of the General Manager, be conducted by the Medical Advisory Committee or Credentials Committee as an Internal Review.

c. The terms of reference, process and reviewers will be as determined by the General Manager.

d. The process will ordinarily include the opportunity for submissions from the Accredited Practitioner, which may be written and/or oral.

e. The General Manager will notify the Accredited Practitioner and CEO in writing of the review, the terms of reference, process and reviewer(s).

f. A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewer(s) to the General Manager.

g. Following consideration of the report, the General Manager is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate Accreditation in accordance with By-law 12.

h. The General Manager will notify the Accredited 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.

i. The findings and decision following the Internal Review will be provided to the CEO.

j. The Accredited Practitioner shall have the rights of appeal established by By-laws 12 and 13 in relation to the final determination made by the General Manager if a decision is made to amend, suspend, terminate or impose conditions on Accreditation.

k. In addition or as an alternative to taking action in relation to the Accreditation following receipt of the report, the General Manager will notify the Office of Health Ombudsman and/or other professional body responsible for the Accredited Practitioner of details of the concerns raised and outcome of the review if required by legislation, the General Manager 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 Office of Health Ombudsman or professional body consider the matter, or it should be done to protect the interests of the Relevant Hospital or UnitingCare Health. The General Manager will notify the CEO of this action.

11.3 EXTERNAL REVIEW OF ACCREDITATION OR SCOPE OF PRACTICE

a. An External Review will be undertaken by a person or persons external to UnitingCare Queensland.

b. The terms of reference, process and reviewers will be as determined by the General Manager.

c. The process will ordinarily include the opportunity for submissions from the Accredited Practitioner, which may be written and/or oral.

d. The General Manager will notify the Accredited Practitioner and CEO in writing of the review, the terms of reference, process and reviewer(s).
e. A detailed report on the findings of the review in accordance with the terms of reference will be provided by the reviewer(s) to the General Manager.
f. Following consideration of the report, the General Manager is required to make a determination of whether or not to continue (including with conditions), amend, suspend or terminate Accreditation in accordance with By-law 12.
g. The General Manager will notify the Accredited 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 findings and decision following the External Review will be provided to the CEO.
i. The Accredited Practitioner shall have the rights of appeal established by By-laws 12 and 13 in relation to the final determination made by the General Manager if a decision is made to amend, suspend, terminate or impose conditions on Accreditation.
j. In addition or as an alternative to taking action in relation to the Accreditation following receipt of the report, the General Manager will notify the Office of Health Ombudsman and/or other professional body responsible for the Accredited Practitioner of details of the concerns raised and outcome of the review if required by legislation, the General Manager 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 Office of Health Ombudsman or professional body consider the matter, or it should be done to protect the interests of the Relevant Hospital or UnitingCare Health. The General Manager will notify the CEO of this action.

12 SUSPENSION, TERMINATION, IMPOSITION OF CONDITIONS, CONCLUSION AND EXPIRY OF ACCREDITATION

12.1 SUSPENSION

a. The General Manager may immediately suspend Accreditation should the General Manager believe, or have a concern, that:
    (i) it is in the interests of Patient care or safety. This can be based upon an ongoing or completed investigation by an external agency including a registration board, disciplinary body, Coroner or the Office of the Health Ombudsman and may be related to a patient or patients at another facility not operated by UnitingCare Health;
    (ii) the continuance of the current Scope of Practice raises concern about the safety and quality of health care to be provided;
    (iii) it is in the interests of the welfare or safety of an employee, contractor, volunteer, another Accredited Practitioner or someone engaged in or at the Relevant Hospital;
    (iv) serious and unresolved allegations have been made in relation to the Accredited Practitioner. This may be related to a patient or patients of another facility not operated by UnitingCare Health, including if these are the subject of review by an external agency including a registration board, disciplinary body, Coroner or the Office of the Health Ombudsman;
    (v) the Accredited Practitioner has failed to observe the terms and conditions of their Accreditation or these By-laws;
    (vi) the behaviour or conduct is in breach of the requirements set out in the By-laws, in breach of a direction or undertaking, is hindering the efficient operation of the Relevant Hospital or is bringing the Relevant Hospital or UnitingCare Health into disrepute;
    (vii) the Accredited Practitioner's professional registration has been suspended;

(viii) 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;

(ix) the Accredited 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 Relevant Hospital;

(x) the Accredited Practitioner has failed to provide satisfactory evidence of Adequate Professional Indemnity Insurance or professional registration;

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

(xii) the Accredited Practitioner has failed 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 or Scope of Practice of the Accredited Practitioner has been suspended, terminated, restricted or made conditional by another health care organisation;

(xiv) the Accredited Practitioner is the subject of a criminal investigation which, if established, could affect his or her ability to exercise his or her Scope of Practice safety and competently or with the confidence of the Relevant Hospital and the broader community;

(xv) the Accredited Practitioner has been convicted of a crime which could affect his or her ability to exercise his or her Scope of Practice safety and competently or with the confidence of the Relevant Hospital and the broader community;

(xvi) based upon a finalised Internal Review or External Review pursuant to By-law 11; or

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

b. The General Manager shall notify the Accredited Practitioner of:

(i) the fact of the suspension;

(ii) the period of suspension;

(iii) the reasons for the suspension;

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

(v) if General Manager 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 (if available), the appeal process and the time frame for an appeal.

c. As an alternative to an immediate suspension, the General Manager may elect to deliver a show cause notice to the Accredited Practitioner advising of:

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

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

(iii) invite a written response from the Accredited Practitioner, including a response why the Accredited 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 Accredited Practitioner to the show cause notice.

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

e. The suspension is ended either by terminating the Accreditation or lifting the suspension. This will occur by written notification by the General Manager.

f. The Accredited Practitioner shall have the rights of appeal established by By-law 13.

g. The General Manager will notify the CEO of any suspension of Accreditation.

h. 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 Accredited Practitioner, including but not limited to, patients outside of UnitingCare Health, 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 General Manager will notify the Office of the Health Ombudsman and/or other relevant regulatory agency of the suspension and the reasons for it. The General Manager will notify the CEO of this action.

i. Accredited Practitioners acknowledge and agree, as part of the acceptance of Accreditation, that a suspension of Accreditation carried out in accordance with these By-laws does not result in an entitlement to any compensation, including for economic loss or reputational damage.

12.2 TERMINATION

a. Accreditation shall be immediately terminated by the General Manager if the following has occurred, or if it appears based upon the information available to the General Manager the following has occurred:

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

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

(iii) a contract of employment (for example with respect to an Employed Medical Practitioner) or to provide services is terminated or ends, and is not renewed.

b. Accreditation may be terminated by the General Manager if the following has occurred, or if it appears based upon the information available to the General Manager 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 By-law 11;

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

(iv) conditions have been imposed by, or undertakings agreed with, the Accredited Practitioner's registration board that restricts practice or imposes supervision and the

Relevant Hospital does not have capacity to meet or is not willing to meet the results of the conditions imposed or undertakings agreed;

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

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

(vii) there is any other issue or concern in respect of the Accredited Practitioner that is considered to be a ground for termination.

c. The General Manager shall notify the Accredited Practitioner of:

(i) the fact of the termination;

(ii) the reasons for the termination;

(iii) if the General Manager considers it applicable and appropriate in the circumstances, invite a written response from the Accredited Practitioner as to 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.

d. As an alternative to an immediate termination, the General Manager may elect to deliver a show cause notice to the Accredited Practitioner advising of:

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

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

(iii) invite a written response from the Accredited Practitioner, including a response as to why the Accredited 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 Accredited Practitioner to the show cause notice;

Following receipt of the response, the General Manager will determine whether the Accreditation will be terminated. If termination is to occur, notification will be sent in accordance with By-law 12.2 (c). Otherwise the Accredited Practitioner will be advised that termination will not occur, however this will not prevent the General Manager from taking other action at this time, including imposition of conditions, and will not prevent the General Manager from relying upon these matters as a ground for suspension or termination in the future.

e. All terminations will be notified to the CEO.

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

g. For a termination of Accreditation pursuant to By-law 12.2 (b), the Accredited Practitioner shall have the rights of appeal established by By-law 13.

h. Unless it is determined not appropriate in the particular circumstances, the fact and details of the termination will be notified by the General Manager to the Office of Health Ombudsman and/or other relevant regulatory agency.

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

12.3 IMPOSITION OF CONDITIONS

a. At the conclusion of or pending finalisation of a review pursuant to By-law 11 or in lieu of a

suspension pursuant to By-law 12.1 or in lieu of a termination pursuant to By-law 12.2, the General Manager may elect to impose conditions on Accreditation or Scope of Practice.

b. The General Manager must notify the Accredited Practitioner in writing of:
   (i) the conditions imposed;
   (ii) the reasons for it;
   (iii) the consequences if the conditions are breached;
   (iv) the right of appeal, the appeal process and the timeframe for an appeal, if available;
   (v) If the General Manager considers it applicable and appropriate in the circumstances, they may also invite a written response from the Accredited Practitioner as to why the Accredited Practitioner may consider the conditions should not be imposed.

c. If the conditions are breached, then suspension or termination of Accreditation may occur, as determined by the General Manager.

d. The affected Accredited Practitioner shall have the rights of appeal established by By-law 13.

e. 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 General Manager will notify the Office of Health Ombudsman and/or other relevant regulatory agency of the imposition of the conditions and the reasons the conditions were imposed.

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

12.4 NOTIFICATION TO OTHER UNITINGCARE HEALTH RELEVANT HOSPITAL/S

a. The decision to suspend Accreditation and any other relevant information will be notified by the CEO to the other UnitingCare Health Relevant Hospital/s where the Accredited Practitioner is Accredited, as well as notification subsequently whether an appeal has been lodged. The General Manager of that other UnitingCare Health Relevant Hospital may, based upon this information and in consultation with the CEO, elect to immediately suspend Accreditation or may elect to ask the Accredited Practitioner to show cause why a suspension or other action should not occur at their Relevant Hospital.

b. The decision to terminate Accreditation and any other relevant information will be notified by the CEO to the other UnitingCare Health Relevant Hospital/s where the Accredited Practitioner is Accredited, as well as notification whether an appeal has been lodged (if an appeal is available in the circumstances). Unless the CEO decides otherwise in the circumstances of a particular case, the termination of Accreditation at one UnitingCare Health Relevant Hospital will result in automatic termination of Accreditation at all other Uniting Care Health Relevant Hospital/s. If an automatic termination of Accreditation has not occurred, as determined by the CEO, the General Manager of that other UnitingCare Health Relevant Hospital may elect, based upon this information and in consultation with the CEO, to ask the Accredited Practitioner to show cause why a termination or other action should not occur at their Relevant Hospital.

c. The decision to impose conditions and any other relevant information will be notified by the CEO to the other UnitingCare Health Relevant Hospital/s where the Accredited Practitioner is Accredited, as well as notification subsequently whether an appeal has been lodged. The General Manager of the other UnitingCare Health Relevant Hospital/s may, based upon this information and in consultation with the CEO, elect to immediately impose the same conditions or may elect to ask the Accredited Practitioner to show cause why the imposition of conditions or other action should not occur at their Relevant Hospital.

12.5 CONCLUSION, WITHDRAWAL, REDUCTION AND EXPIRY OF ACCREDITATION

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

b. If the Accredited Practitioner's Accreditation or Scope of Practice is no longer supported by Organisational Capability or Organisational Need (which may relate to the full Scope of Practice or a component of the Scope of Practice), if restrictions are applied by a regulator, or if the Accredited Practitioner will no longer be able to meet the terms and conditions of Accreditation, the General Manager will raise these matters in writing with the Accredited Practitioner and invite a meeting to discuss. Arising from the meeting, the General Manager and Accredited Practitioner may agree to a voluntary reduction in Scope of Practice, to conclude their Accreditation, or that Accreditation will expire and they will agree on the date for expiration of Accreditation. Following the date of expiration, if the Accredited Practitioner wishes to admit or treat Patients at the Relevant Hospital, an application for Accreditation must be made as an application for Initial Accreditation. Failing agreement, a formal process may be initiated as provided for in these By-laws.

c. An Accredited Practitioner who intends ceasing treating Patients either indefinitely or for an extended period must notify this intention to the General Manager, and Accreditation will be taken to be withdrawn one month from the date of notification unless the General Manager decides a shorter notice period is appropriate in the circumstances.

d. Applications for Re-Accreditation that do not comply will all requirements will be rejected and must be re-submitted. Further, if timeframes are not met due to late submission of an application or submission of an incomplete application for Re-Accreditation, unless the General Manager decides otherwise, the current Accreditation will expire.

e. Accredited Practitioners with no or limited activity or inadequate use of allocated operating theatre time or procedural facilities over a preceding period of time, as determined by the General Manager following a show cause process initiated pursuant to By-law 6.1(a), may at the discretion of the General Manager be notified of inactivation or withdrawal of Accreditation. If the Accredited Practitioner wishes to subsequently admit or treat Patients at the Relevant Hospital, an application for Accreditation must be made as an application for Initial Accreditation.

f. The provisions in relation to conclusion and expiration of Accreditation in no way limit the ability of the General Manager 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

a. There shall be no right of appeal against a decision to not approve Initial Accreditation; Temporary Accreditation; locum, on call or leave arrangements; continued Accreditation at the end of a probationary period or Temporary Accreditation period; an interim suspension or conditions pursuant to By-law 11.1(d); suspension pursuant to By-law 12.1(a)(vii); or termination pursuant to By-law 12.2(a).

b. Subject to paragraph a. above and as elsewhere provided in these By-laws, an Accredited Practitioner shall have the rights of appeal as set out in these By-laws.

13.2 APPEAL PROCESS

a. An Accredited 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 and received by the General Manager within the fourteen (14) day appeal period or else the right to appeal is lost.

c. Upon receipt of an appeal notice the General Manager will immediately forward the appeal request to the CEO.

d. Following lodgement of an appeal, and with agreement of the CEO, the appeal may be put on hold pending the outcome of any internal or external process.

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

f. The CEO 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.

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

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

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

   (iii) any other member or members who bring specific expertise to the decision under appeal, as determined by the CEO, who must be independent of the decision under appeal and who may be an Accredited Practitioner. The CEO 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.

h. 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 CEO will notify the appellant of the members of the Appeal Committee.

i. 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.

j. 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, information and documents that will be provided (as well as any conditions to be met before provision of the information and documents, such as a confidentiality agreement) and will invite the appellant to make a submission about the decision under appeal.

k. 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.

l. 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.

m. The General Manager (or nominee) may present to the Appeals Committee in order to support the decision under appeal.

n. 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.

o. The appellant shall not be present during Appeal Committee deliberations, except when invited to be heard in respect of their appeal.

p. The chairperson of the Appeal Committee shall determine any question of procedure for the appeal and the Appeal Committee, with questions of procedure entirely within the discretion of the chairperson of the Appeal Committee.

q. The appeal is intended to be conducted through direct communication between the Appeal Committee and the appellant. As such, although the appellant may seek legal advice and assistance, unless decided otherwise by the chairperson of the Appeal Committee, written and oral communication will not be conducted via a lawyer.

r. The Appeal Committee will make a written recommendation regarding the appeal to the CEO, including provision of reasons for the recommendation. The Appeal Committee recommendation may include, but not limited to reinstatement of Accreditation, suspension/termination or amendments to Scope of Practice.

s. 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.

t. A copy of the recommendation will be provided by the CEO to the appellant and the General Manager.

u. The CEO may, within his or her complete discretion, elect to provide the appellant with an opportunity to respond to the recommendation with a period of 7 days or such longer period as allowed by the CEO.

v. The CEO will consider the recommendation of the Appeal Committee and make a decision about the appeal. The decision of the CEO will be notified in writing to the appellant and General Manager.

w. The decision of the CEO is final and binding, and there is no further appeal allowed under these By-laws from this decision.

x. The decision of the CEO in relation to the appeal will be notified to other UnitingCare Health facilities where the Accredited Practitioner holds Accreditation.

y. If a notification has already been given to an external agency, such as the Office of Health Ombudsman, then the CEO will notify that external agency of the appeal decision. If a notification has not already been given, the CEO 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.

z. If the decision under appeal has been made by the CEO, then a representative of the UnitingCare Queensland Board will be substituted in the above By-laws in place of the references to the CEO, except that the final decision will be made by the UnitingCare Queensland Board.

PART D – AMENDING BY-LAWS, ANNEXURES, AND ASSOCIATED POLICIES AND PROCEDURES

14 AMENDMENTS TO, AND INSTRUMENTS CREATED PURSUANT TO, THE BY-LAWS

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

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

c. The CEO may approve the annexures and forms (including electronic) that accompany or are associated with these By-laws, and amendments that may be made from time to time, and the annexures and forms (including electronic) once approved by the CEO are integrated with and form part of the By-laws. These documents 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 CEO may approve 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. These may include but are not limited to Accreditation requirements, including Threshold Credentials, Scope of Practice criteria and other requirements for applications for Accreditation and Committees formed pursuant to these By-laws.

Annexure A

UnitingCare Health Medical Advisory Committee

Terms of Reference

Role of the Medical Advisory Committee

The general role of the Medical Advisory Committee is to:

1. Advise the General Manager of the hospital on clinical services, procedures or other interventions to ensure these are provided by competent Medical Practitioners within environments that support the provision of safe, high quality health care services.
2. Promote efficient clinical processes within the hospital.
3. Advise the General Manager on the safety, efficacy and role of new clinical services, procedures and other interventions, and assist to determine the financial and operational implications of these.
4. Provide a means whereby Medical Practitioners can participate in policy making and planning processes of the hospital by being the formal organisational structure through which the views of the Medical Practitioners shall be formulated and communicated to the General Manager.
5. Assist in identifying health needs of the community and advising the General Manager of appropriate services which may be required to meet these needs.
6. Participate in the planning, development and implementation of clinical programs at the hospital, including ensuring formal mechanisms for review of clinical management and outcomes are in accordance with the requirements of these By-laws.
7. Promote clinical education and research at the hospital, and make recommendations to the General Manager on matters concerning suitability, format and content of clinical educational programs and research activities.

Specifically, the Medical Advisory Committee is charged with advising on credentialing and defining the Scope of Practice of Medical Practitioners by:

1. Providing advice, guidance and/or endorsement to other clinical and advisory committees with regard to policies and procedures, clinical reviews, and safety, quality, audit and education processes;
2. Advising the General Manager and Director of Medical Services / Director of Clinical Services on the range of clinical services, procedures and other interventions that can be provided safely in the hospital setting;
3. Advising the General Manager and Director of Medical Services / Director of Clinical Services on the minimum criteria necessary for a Medical Practitioner to fulfil competently the duties of a specific position i.e. Scope of Practice, within the hospital;
4. Acting as the conduit for communication of relevant activities/issues as defined in these terms of reference to all Medical Practitioners that they represent, and the General Manager;
5. Advising the General Manager on the information that should be requested and provided by applicants for appointment to specific Medical Practitioner positions or for specific Scope of Practice;
6. 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:
    a) relevant to all Medical Practitioners applying for Initial Accreditation at the Relevant Hospital;

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

c) From any Accredited Medical Practitioner who requests a review of their Scope of Practice;

7. Ensuring the Credentials of each Medical Practitioner are reviewed and verified in accordance with the By-laws and policies of the Relevant Hospital;
8. 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;
9. Advising the General Manager of the Committee's recommendations in relation to the Scope of Practice of each Medical Practitioner; and
10. At the request of the General Manager, Director of Medical Services or Director of Clinical Services with existing Accreditation at a Relevant Hospital undertake an internal review regarding the Credentials and Scope of Practice granted to a Medical Practitioner.

Membership of the Medical Advisory Committee

The Medical Advisory Committee will be comprised of at least five Medical Practitioners who are accredited and have been granted Scope of Practice and represent a major clinical speciality at the Relevant Hospital.

The Medical Advisory Committee members, including the Chairperson, will be appointed by the General Manager of the hospital.

The General Manager may accept nominations from Accredited Medical Practitioners representing major clinical specialities provided at the Relevant Hospital or individual Medical Practitioners or Allied Health Professionals for membership of the Medical Advisory Committee and may accept nominations from within the members of the Medical Advisory Committee for the position of Chairperson of that committee. The process to receive nominations will be established by the General Manager of the Relevant Hospital.

Except in respect of the General Manager, the Director of Clinical Services and the Director of Medical Services, the maximum term of membership of the Medical Advisory Committee for any person appointed to the Committee is for a maximum period of three consecutive years.

The Chairperson of the Medical Advisory Committee shall be appointed for a one year term only, but is eligible for re-appointment up to a maximum term of three consecutive years.

The General Manager may however at their absolute discretion determine to extend the appointment of any person appointed to the Medical Advisory Committee or as the Chairperson of the Medical Advisory Committee.

Entitlement to Membership

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

Powers to Co-opt

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.

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

Subject to approval by the General Manager, the Medical Advisory Committee may convene sub-committees, receive from and consider reports prepared by those sub-committees and make recommendations to the General Manager 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 sub-committees thereof.

Rules of Conduct

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.

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.

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

In particular, where conflict of interest may arise because:

a. The member has a financial, pecuniary, personal or other interest in the application for Accreditation and Scope of Practice or;
b. The member is related to or is in a personal relationship with the Medical Practitioner;

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.

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.

Meetings of ACSC

The Medical Advisory Committee will meet at least four times per year at regular intervals and as reasonably required by the General Manager.

The meetings of the Medical Advisory Committee must be minuted and copies of minutes provided to the General Manager of the Relevant Hospital.

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

Quorum

Quorum requirements for the Medical Advisory Committee are:

a. Where there is an odd number of voting members of the committee, a majority of members;
b. Where there is an even number of voting members for the committee, one half of the members plus one.

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.

Confidentiality

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.

Voting

Where required by these "By-laws", matters shall be determined by consensus or by voting on a simple majority basis and only those in attendance at the meeting are entitled to vote at such meeting. There shall be no proxy vote.

Resignation from Membership of the MAC

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 General Manager.

Termination of Membership of the MAC

The General Manager may terminate membership or Chairmanship of the Medical Advisory Committee where the member:

a. fails to attend the majority of meetings;
b. fails to attend three (3) consecutive meetings without prior approval from the General Manager of the hospital; or
c. is determined, following review, by the General Manager of the hospital as not meeting the requirements of membership of the Medical Advisory Committee.

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

Where a member of the Medical Advisory Committee is under review or their Accreditation is suspended, the General Manager of the Relevant Hospital may suspend their membership of the Medical Advisory Committee.

Insurance cover for MAC Members

UnitingCare Health confirms that any activities performed by the Medical Advisory Committee in accordance with these terms of reference, or any person acting under the direction or request of the Committee, including consideration of granting and review of Credentialing and Scope of Practice at the hospital, provided they act in good faith, will be indemnified by UnitingCare Health.

Committee member's details will be forwarded to the relevant insurance provider and updated as required from time to time. All requests by UnitingCare Health to committee members relating to details for insurance must be complied with.

Reporting

The Director of Medical Services / Director of Clinical Services and Chairperson of the Medical Advisory Committee will facilitate a comprehensive assessment of the Committee's activity annually to the General Manager of the Relevant Hospital on the Committee's performance and contribution to the development of constructive relationships between Accredited Medical Practitioners and Allied Health Professionals; to the safety and quality in the Relevant Hospital and compliance by Accredited Medical Practitioners and Allied Health Professionals with Accreditation and Scope of Practice requirements.

Defining the Scope of Practice

Each Medical Advisory Committee in consultation with the Director of Medical Services / Director of Clinical Services and General Manager will establish an approach to defining the requirements for clinical practice within each clinical speciality provided at the hospital. In determining the preferred approach of the hospital, the Medical Advisory Committee through the Relevant Hospital Credentialing Committee should consider the processes provided in the National Standard for Credentialing and Defining the Scope of Clinical Practice to ensure that decision making regarding the approach taken by the Relevant Hospital occurs in a consistent and transparent manner.

When defining the Scope of Practice for each Medical Practitioner the Medical Advisory Committee through the Credentialing Committee should:

1. Review the clinical services, procedures or other interventions which have been requested for inclusion in Scope of Practice and consider whether:
   a. A responsible body of medical opinion deems the relevant clinical services, procedures or other interventions to be beneficial to patients;
   b. 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 the ethics committee of UnitingCare Health and their introduction has been deemed to be acceptable in the circumstances (with or without conditions); and
   c. in the event the clinical services, procedures or other interventions are new to the hospital, they are being introduced in compliance with the hospital and UnitingCare Health policies for the introduction of New Clinical Services.
2. Review and consider the relevance to the specific circumstances in which the Scope of Practice are requested by reference to:
   a. Policies or guidelines published by the professional colleges, associations and societies;
   b. Requirements of the professional colleges, associations and societies for current trainees to gain experience in the requested Scope of Practice;
   c. Credible or peer reviewed publications relating to Competence and performance (including the relationship between volume and quality) in the requested Scope of Practice; and
   d. Organisational Capability and Organisational Need to provide the Scope of Practice sought.
3. Consider the volume of the relevant activity undertaken by the Medical Practitioner over a certain period and the implications regarding the Medical Practitioner's ongoing Competence and performance.
4. Review available sources of objective data about the Medical Practitioner's Competence and performance including any available registry data and consider:
   a) their validity as measures of the safety and quality of health care services including whether they are appropriately stratified and risk adjusted; and
   b) Whether they contribute to a reliable assessment of the Medical Practitioner's Competence and performance in the requested Scope of Practice.
5. 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.
6. Review referees' comments on the Medical Practitioner's communication skills and teamwork ability insofar as these are likely to contribute to clinical performance.
7. Review referees' comments on overall professional performance.
8. Consider the specific circumstances that apply at the Relevant Hospital in which the clinical services, procedures or other interventions will be provided.

Following deliberations on all of the relevant information make a recommendation to the Director of Medical Services / Director of Clinical Services and General Manager whether to approve, approve with conditions or reject the application.

The Medical Advisory Committee through the Credentialing Committee shall ensure appropriate documentation relating to deliberations is maintained.

Composition of Committee

The Committee is appointed annually by the General Manager. The Chairperson of the Committee is appointed by the General Manager for a period of two years and other members of the Committee are annually elected from the community of the Visiting Medical Practitioners.

Membership of the Medical Advisory Committee:

Representatives from key clinical specialties, Executive Staff Members - General Manager, Director of Medical Services, Director of Clinical Service and other specialty areas as defined by the General Manager

Quorum – Half plus one

Frequency of Meetings

At least 4 times per year.

Key Performance Indicators

KPI	Target
Review and approval of all accreditation applications (including new and renewal) recommended by the Credentialing Committee	100% per year
Review and provide feedback on changes to Hospital policies, as required that require MAC input.	100% per year
Review relevant clinical incidents as referred by hospital executive	100% per year
Review and action internal and external audit results, relating to VMP clinical areas of concern	100% per year
Review Quality and Safety report provided on clinical indicators.	100% per year

Review and Evaluation

Review and approve changes to By-laws every two (2) years.

Revised: Feb 2022

Annexure B

UnitingCare Health Medical Advisory Committee

Credentialing Committee

Terms of Reference

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*The overarching policy for the Accreditation and Credentialing / Scope of Practice for UnitingCare Health is the By-Laws for Accredited Practitioners (2022) and any document which is a successor to it (the **By-laws**).*

The Credentialing Committee is charged with advising on credentialing and defining the Scope of Practice of medical practitioners by:

- Advising the Medical Advisory Committee (**MAC**) on the minimum credentials necessary for a medical practitioner to fulfil competently the duties of a specific position or scope of practice within the hospital;
- Advising the MAC on the information that should be requested and provided by applicants for appointment to specific medical practitioner positions or including relevant scope of practice;
- Accepting requests to undertake the processes of credentialing and defining scope of practice in line with the range of clinical services, procedures and other interventions:
  - relevant to all medical practitioners applying for initial appointment at the Hospital;
  - at any time, from an authorised person in respect of a review of the accreditation of a medical practitioner and/or their scope of practice; and
  - from any accredited medical practitioner who requests a review of their scope of practice.
- Ensuring the credentials of each medical practitioner are reviewed and verified in accordance with the “By-laws”;
- Reviewing changes to UnitingCare Health “By-laws” as approved;
- Review internal and external audits of Accreditation/Credentialing, to implement actions to improve committee performance;
- 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 the scope of practice that is appropriate in the circumstance for each medical practitioner; and
- Advising the Medical Advisory Committee of the Credentialing Committee’s recommendations in relation to the scope of practice of each medical practitioner.

Membership of the Credentialing Committee

The Credentialing Committee will comprise at least three core members, including the Chair of the MAC, the Director of Medical Services, Director of Clinical Services and one other member of the MAC.

The committee members will be appointed by the Chair of the MAC.

Chair of Credentialing Committee

The Director of Medical Services / Director of Clinical Services or their delegate will be the chair of the Credentialing Committee.

Powers to Co-opt

In order to discharge the committee functions in respect of credentialing and defining scope of practice, the Credentialing Committee may co-opt the services of other accredited health professionals 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 Credentialing Committee for the purposes of the relevant application or request for review, and those persons will be deemed to be members of the Credentialing Committee for those purposes.

Rules of Conduct

The Credentialing Committee must comply at all times with all legal requirements, including the common law and relevant Queensland and Commonwealth legislation. 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.

Equity and merit must form the basis of all phases of the processes of credentialing and defining scope of practice. In particular, where conflict of interest may arise because:

a) The committee member has a financial, pecuniary, personal or other interest in the application for accreditation and scope of practice; or
b) The committee member is related to or is in a personal relationship with the medical practitioner or allied health professional;

The committee member must declare the conflict and shall not be involved in any way in considering applications for or requests for review of such applications.

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

Membership of Credentialing Committee

Membership of committee members is for a period of two (2) years, with the option of a further two (2) years’ extension.

Meetings of the Credentialing Committee

The Credentialing Committee will meet at least four times per year at regular intervals and as reasonably required by the General Manager and Chair of the MAC.

The meetings of the Credentialing Committee must be minuted and copies of minutes provided to the Chair of the MAC.

Records shall be maintained on all deliberations, supporting information considered and recommendations relevant to the processes of credentialing and defining scope of practice.

Quorum

Quorum requirements for the Credentialing Committee are attendance by four core members and any co-opted members as required.

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.

Confidentiality

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.

Voting

Where required by these "By-laws", matters shall be determined by consensus or by voting on a simple majority basis and only those in attendance at the meeting are entitled to vote at such meeting. There shall be no proxy vote.

Resignation from Membership of the Credentialing Committee

Any member of the Credentialing Committee may resign from such membership by giving at least one month's notice in writing of their intention to resign such appointment to the Chair of the MAC.

Termination of Membership of the Credentialing Committee

The General Manager may terminate membership or chairmanship of the Credentialing Committee where the member:

- Fails to attend the majority of meetings;
- Fails to attend three (3) consecutive meetings without prior approval from the General Manager of the Hospital;
- Is determined, following review by the General Manager of the Hospital, as not meeting the requirements of membership of the Credentialing Committee; or
- On the recommendation of the Chair of the MAC.

Membership of the Credentialing Committee will be terminated where the medical practitioner has accreditation terminated.

Where a member of the Credentialing Committee is under review or suspended, the General Manager of the Hospital may suspend membership.

Insurance cover for Credentialing Committee Members

UnitingCare Health confirms that any activities performed by the Credentialing Committee in accordance with these Terms of Reference or any person acting under the direction or request of the Committee, including consideration of granting and review of credentialing and scope of practice at the Hospital, provided they act in good faith, will be indemnified by UnitingCare Health.

Committee members' details will be forwarded to the relevant insurance provider and updated as required from time to time. All requests by UnitingCare Health to committee members relating to details for insurance must be complied with.

Defining the Scope of Practice

The Credentialing Committee will establish an approach to defining the requirements for clinical practice within each clinical specialty provided at the Hospital. In determining the preferred approach, the Credentialing Committee should consider the processes provided in the National Standard for Credentialing and Defining the Scope of Clinical Practice to ensure that decision-making regarding the approach taken by the hospital occurs in a consistent and transparent manner.

When defining the scope of practice for each medical practitioner or allied health professional, the Credentialing Committee should:

1. Review the clinical services, procedures or other interventions which have been requested for inclusion in scope of practice and consider whether:
   a) a responsible body of medical opinion deems the relevant clinical services, procedures or other interventions to be beneficial to patients;
   b) 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 the ethics committee of UnitingCare Health and their introduction has been deemed to be acceptable in the circumstances (with or without conditions); and
   c) in the event that the clinical services, procedures or other interventions are new to the hospital, they are being introduced in compliance with the hospital and UnitingCare Health policies for the introduction of new clinical services.
2. Review and consider the relevance to the specific circumstances in which the scope of practice are requested by reference to:
   a) policies or guidelines published by the professional colleges, associations and societies;
   b) requirements of the professional colleges, associations and societies for current trainees to gain experience in the requested scope of clinical practice;
   c) credible or peer-reviewed publications relating to competence and performance (including the relationship between volume and quality) in the requested scope of practice; and
   d) organisational capability and organisational need to provide the scope of practice sought.
3. Consider the volume of the relevant activity undertaken by the medical practitioner over a previous period of time and the implications regarding the medical practitioner's ongoing competence and performance.
4. Review available sources of objective data relevant to the medical practitioner's competence and performance including any available registry data and consider;
5. 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.
6. Review referees' comments on the medical practitioner's communication skills and teamwork ability insofar as these are likely to contribute to clinical performance.
7. Review referees' comments on overall professional performance.
8. Consider the specific Hospital circumstances in which the clinical services, procedures or other interventions will be provided.

Following deliberations on all of the relevant information, make a recommendation to the General Manager via the MAC whether to approve, approve with conditions or reject the application.

The Credentialing Committee shall ensure appropriate documentation relating to deliberations.

The Credentialing Committee shall monitor corrective and preventative actions relating to the committee and effectiveness of actions implemented for improving performance.

Key Performance Indicators

KPI	Target
Committee review all initial accreditation applications and provides feedback and recommendations to the General Manager	100% per year
Committee review all renewal of accreditation applications and provides feedback and recommendations to the General Manager	100% per year

Committee review all requests for amendment of scope of practice applications and provides feedback and recommendations to the General Manager	100% per year
Review and approve all Temporary and/or Emergency accreditation applications	100% per year

Review and Evaluation

Annual review of Terms of Reference (March)

Review and approve changes to By-laws every two (2) years.

Approved: Feb 2022