HEALTH SERVICES ACT 1997
Sections 39 and 60
ORDERS AS TO MODEL BY-LAWS

Hunter New England Local Health District By-Laws 2019

Part 1 - Preliminary

1. Name of the By-law

This By-law may be cited as the Hunter New England Local Health District By-law.

2. Definitions

Expressions used in this By-law are defined in the Dictionary at the end of the By-law.

3. Making and Amendment of By-laws

(1) The Chief Executive of the organisation may make, amend or repeal the organisation's By-laws in accordance with the Health Services Act 1997.

(2) The Board must approve the making of, amendment to, or repeal of the By-laws by the Chief Executive.

(3) Any motion to approve the making of, amending of, or repeal of a By-law must be considered at a meeting of the Board.

(4) Written notice of the motion to make, amend, or repeal a By-law must be provided to each member of the Board at least 21 calendar days before the date of the meeting.

(5) The Board is to refer any proposed amendment of Parts 6 - 11 of the By-laws to the medical staff executive council and the local health district clinical council;

Explanatory Note: The Model By-laws establish a set of core governance provisions. Changes to these core governance provisions require approval of the Health Secretary or delegate. LHDs can amend local by laws by addition without this approval.

4. Availability of By-laws

(1) The Chief Executive is to ensure that a current version of the By-laws, that incorporate all changes approved by the Board, is accessible to staff of the organisation and the public.

(2) If an amendment is made to the By-laws in accordance with clause 3, the Chief Executive is to:

(a) ensure the amendments are promptly incorporated into the By-Laws; and

(b) provide a copy of any variation to the Health Secretary.

Explanatory Note: Clause 4 expands on the 2012 Model to ensure changes to the By-laws are incorporated, and provides a process for changes being made available to the Health Secretary.

Part 2 - The seal

5. The seal

(1) The seal of the organisation is to be affixed only to documents on behalf of the organisation when the Chief Executive signs such documents and the signature and sealing of the document are formally witnessed.

(2) The Chief Executive is to ensure

(a) the safe custody of the seal of the organisation;

(b) the Board is notified when the seal is affixed to a document of the organisation; and

(c) a Register is maintained, listing documents of the organisation to which the seal is affixed.

Explanatory Note: Clause 5 expands on the 2012 Model to provide additional governance oversight through notification of the Board, and establishment of a register for sealed documents.

Part 3 – Conduct of Board meetings

6. Procedure – Board meetings

Procedures for meetings of the Board are set out in Part 3 of Schedule 4A of the Health Services Act 1997.

Explanatory Note: Schedule 4A of the Health Services Act 1997 deals with the constitution and procedures for LHD. Part 3 of Schedule 4A deals with the conduct of meetings, covering issues such as quorum, noting, attendance and presiding member. Part 3 of Schedule 4A takes precedence over the By-Laws to the extent of any inconsistency.

Part 4 – Conduct of meetings of committees, sub-committees, councils established by the By-Laws

7. Application of this Part

The procedures set out in this Part 4 apply to any meeting, including a special meeting, of any committee, sub-committee or council provided for under these By-laws, and on this basis in this Part:

(a) "Committee" means any such committee, sub-committee or council;

(b) "participate" includes, in relation to a member, the right to vote.

8. Attendance

(1) Any person may be invited by the Committee to attend a meeting of a Committee.

(2) Where the Chair of the Medical Staff Executive Council attends or is nominated to attend a meeting of a Committee established under this By-law in his or her ex officio status, that Chair, may, if not available, nominate an alternative member to attend in his or her place.

9. Attendance from a remote location

(1) A Committee may approve a member or invitee participating from a location other than the place where the meeting is being held.

(2) Participation from another location may be by telephone, video or other electronic medium as is appropriate to the circumstances or the business being transacted.

(3) A member participating from a remote location shall be regarded as being present at the meeting for the purposes of the calculation of a quorum, voting or any other similar matter required under these By-laws.

(4) A Committee may determine a protocol or procedure for remote participation of members or other persons in its meetings.

10. Quorum

(1) Subject to subclause (2), the quorum for any meeting is a majority of the appointed number of the members.

(2) This clause does not apply to meetings of medical staff councils and medical staff executive councils under Part 7 of these By-laws.

11. Voting

(1) Only members of a Committee may vote at a meeting.

(2) A decision supported by a majority of the votes cast at a meeting at which a quorum is present is to be the decision of the Committee.

12. Minutes

The member presiding at a meeting of a Committee is to ensure that minutes are kept of all meetings of the Committee.

Explanatory Note: Part 4 sets out machinery provisions for all committees and other bodies established under the By-laws. These provisions remain effectively the same as those under the 2012 Model, with minor changes to simplify and update language and establish a distinction between procedures for committees/councils/bodies established by the By-Laws (set out in this Part) and procedures for Board meetings (which are set out in the Health Services Act).

Part 5 – Committees of the organisation

13. Establishment of Committees generally

(1) The Board is to establish the following committees:

(a) audit and risk;

(b) finance and performance;

(c) quality and safety; and

(d) community and patient partnership.

(2) The Board may establish such other committees as it determines appropriate to provide advice or other assistance to enable the organisation perform its functions under the Act.

14. Audit and Risk Committee

(1) The Audit and Risk Committee is to comprise at least three, and no more than five, members.

(2) Members of the Committee are to be independent of the organisation and appointed in accordance with relevant NSW Government and NSW Health Policy Directives, as amended from time to time.

(3) The Chairperson of the Audit and Risk Committee may not be the chairperson of the finance committee (or other similar committee).

(4) In the event of inconsistency between this clause 14 and Part 5, this clause applies to the extent of the inconsistency.

Explanatory Note: Clause 14 revises the 2012 Model provisions so they are consistent with NSW Treasury Policy TPP15-03 *Internal Audit and Risk Management Policy for the NSW Public Sector* and NSW Health Policy Director 2016_051 *Internal Audit*. Clause 3.1.5 of TTP15-03 sets the criteria for what is an "independent member" and requires them to be selected from the prequalified panel held by Department of Finance and Services. Clause 3.1.6 of TTP15-03 also recognises that board members (including members of LHD boards) are eligible for appointment as chairs and members of the Audit and Risk Committee provides (i) they are not employees; and (ii) they meet the other independence requirements set out in cluse 3.1.5.

15. Committee chairpersons and secretaries of Board committees

The Board is to appoint:

(a) a chairperson of each committee established under this Part 5; and

(b) in consultation with the Chief Executive, a person to act as the secretary of each committee. The same person may act as secretary for more than one committee.

16. Functions of committees

(1) A committee is to provide advice or other assistance on issues as requested by the Board.

(2) These issues may include, but are not limited to:

(a) efficient and economic operation of:

i. the organisation;

ii. industrial relations;

iii. human resources; and

iv. financial and asset management;

(b) adequate standards of patient care and services;

(c) health needs of the community serviced by the organisation;

(d) strategies to ensure an appropriate balance in the provision and use of resources for health protection, health promotion, ethics and medical research, health education and treatment services;

(e) effective communication with other health services and health service providers;

(f) adequate arrangements for effective communication and cooperation between medical practitioners, including general practitioners, providing medical services within the geographic area of the local health district.

17. Committee membership

(1) The Board may appoint such committee members as it thinks fit, such members may also include a member of the Board.

(2) The Board is to appoint at least one representative of the executive staff of the local health district to each committee.

(3) The Board is to appoint such clinician representation as it considers appropriate to each committee (other than the finance committee).

(4) Where there is to be a clinical representative on a committee, the Board is to consult with the Medical Staff Executive Council or any relevant Medical Staff Council, or the Local Health District Clinical Council as applicable, on the proposed appointee.

(5) The Board may remove any committee member as it thinks fit, subject to any corporate governance policy issued by the Ministry from time to time.

18. Term of office

Any person nominated to a committee holds office for such period as the Board may determine, subject to any corporate governance policy issued by the Ministry from time to time.

19. Meetings

A committee is to meet as specified by the Board, subject to any corporate governance policy issued by the Ministry from time to time.

20. Notice of meetings and special meetings

(1) The chairperson of a committee, or a person authorised by the chairperson to do so, is to give written notice of a meeting to each committee member at least 7 days prior to the meeting.

(2) When the chairperson of a committee considers that a matter is of such urgency that a special meeting of a committee should be held within a period of not less than 48 hours of such a request, the chairperson may request the Board Chair to give written approval to the conduct of such a special meeting. The written approval of the Board Chair may determine, subject to this clause, the business and conduct of such a special meeting.

(3) A copy of the Board Chair's approval under 20(2) is to be provided to the Chief Executive.

(4) A special meeting shall be held, if approved, not later than seven days after receipt by the Board Chair of such a request.

(5) The chairperson of a committee is to ensure that at least 24 hours' notice is given of a special meeting to each member and each person invited to attend the meeting.

(6) Notice of a special meeting is to specify the business to be considered at that meeting.

(7) Only business specified in the notice of a special meeting is to be considered at the special meeting.

(8) Each provision of this clause shall be subject to any corporate governance policy issued by the Ministry from time to time.

Part 6 – Clinician consultation and input into the organisation

21. Structures

The organisation is to establish the following structures and forums to provide input for medical, nursing and allied health staff:

(a) Medical Staff Councils and Medical Staff Executive Councils as set out in Part 7 ;

(b) Hospital Clinical Councils and Joint Hospital Clinical Councils as set out in Part 8;

(c) A Local Health District Clinical Council as set out in Part 9.

Explanatory Notes: The clinician consultation processes set out in Parts 6 to 9 remain largely the same as in the 2012 Model. The main changes are in relation to:
- Recognition of LHDs and SHNs (the 2012 Model used one term "local health district" defined to mean both LHDs and SHNs, across the board);
- Recognition of staff specialist pathologists appointed by NSW Health Pathology (see note Part 7)
- Simplification of process for identifying staff members for clinical councils (see note in Part 8).

22. Objectives

The objectives of the structures for clinician input are to:

(a) facilitate effective patient care and services through a co-operative approach to the management and efficient operation of public hospitals between hospital executive management, clinical staff (including medical practitioners, nurses, midwives and allied health practitioners) and clinical support staff; and

(b) provide a forum for information sharing and to support feedback to staff on issues affecting the administration of the hospital(s) through the members of the councils.

Part 7 Medical Staff Councils and Medical Staff Executive Councils

23. Definitions applying under Part 7

In this Part, *member* means a member of a Medical Staff Council or a member of a Medical Staff Executive Council.

24. Establishment of medical staff councils

(1) The Chief Executive is to establish a medical staff executive council and at least two medical staff councils.

(2) Medical staff councils are to be composed of:

(a) all visiting practitioners, staff specialists, career medical officers and dentists appointed to the organisation or the hospital or hospitals the council represents; and

(b) staff specialist pathologists appointed by NSW Health Pathology whose principal area of work is in the organisation or the hospital or hospitals the council represents.

Explanatory Note: Clause (2)(b) clarifies that staff specialist pathologists appointed to NSW Health Pathology can participate in the Medical Staff council associated with the facility where they undertake most of their work.

(3) Sufficient medical staff councils should be established to ensure that all visiting practitioners, staff specialists, career medical officers and dentists of the local health district are members.

Explanatory Note: For medical staff councils with 5 members or less refer to the special provisions under clause 32.

25. Medical Staff Executive Council

(1) A Medical Staff Executive Council shall be composed of representatives of the Medical Staff Councils for the hospitals under the control of the local health district.

(2) Subject to subclause (4), each Medical Staff Council shall nominate as its representative or representatives on the Medical Staff Executive Council:

(a) if the Medical Staff Council has 50 members or less, one member of that council, provided that such a member may by agreement also act as the proxy representative for one or more other councils with less than 50 members; or

(b) if the Medical Staff Council has more than 50 members, one member of that council for every 50 members or part thereof; or

(c) if the Medical Staff Council has more than 50 members, and such an arrangement has been mutually agreed between the Medical Staff Council and the Chief Executive, by the chairperson and one other representative of the council or their nominated alternate.

(3) For the purposes of subclause (2), the number of members of a Medical Staff Council shall be determined as at 1 January in the relevant year.

(4) The number of representatives from any single Medical Staff Council on a Medical Staff Executive Council shall not exceed 50% of the total number of members of the Medical Staff Executive Council.

26. Functions of Councils

The medical staff executive council or the medical staff council (if there is only one council for the local health district) is to:

(a) provide advice to the Chief Executive and Board on medical matters; and

(b) nominate, every 3 years from the date of issuing of this By-law, a short list of up to 5

medical practitioners to be included on the NSW Health Board Appointments Register to be available to the Minister for Health when considering the appointment of a member or members of the Board.

27. Voting at meetings of councils

Any matter put to the vote at any meeting of a council is to be decided by a show of hands, or by secret ballot if requested by a member present at that meeting.

28. Office bearers of councils

(1) A council is to elect a chairperson of the council and other office bearers it considers necessary from among the members.

(2) Such elections are to be held at an ordinary meeting of a council once each calendar year.

(3) An office bearer (including the chairperson) is to hold office until vacation of the office or until the next election, whichever occurs first.

(4) An office bearer (including the chairperson) shall be eligible for re-election to the same office, provided that no more than three (3) consecutive terms are served, unless there are special circumstances and a further consecutive term has been approved by the Chief Executive

(5) If an office becomes vacant between elections, the vacancy is to be filled by an election at a special meeting of the council. The special meeting is to be held within 30 days of the vacancy occurring.

29. Ordinary meetings of councils

(1) Ordinary meetings of a council are to be held at least twice a year, and at such additional times and places as determined by the council.

(2) The chairperson of a council, or other office bearer of the council authorised by the chairperson to do so, is to provide written notice to each member, at least 7 days prior to an ordinary meeting.

(3) The medical administrator (however designated) of the local health district is to be invited to attend all meetings of the council (unless already a member). However the council may exclude the medical administrator from any meeting, or part of a meeting, where the business under consideration relates to the conduct or performance of the medical administrator in that position.

(4) A council may invite any other person, including any staff member of the local health district, to attend any of its meetings.

(5) The council may exclude any invitee from any meeting, or part of a meeting.

30. Special meetings of councils

(1) A special meeting of a council may be called by the chairperson of the council.

(2) A special meeting of a council is to be called by the chairperson within 48 hours after the chairperson of the council receives:

(a) for a council with 6 to 20 members, a written request signed by a majority of the members of the council;

(b) for a council with more than 20 members, a written request signed by at least 11 members of the council.

(3) The chairperson of a council is to give at least 24 hours' notice of a special meeting of the council to all members.

(4) Notice of a special meeting of a council is to specify the business to be considered at the meeting.

(5) Only business specified in the notice is to be considered at a meeting.

31. Quorum

The quorum for a meeting of a council is:

(a) for a medical staff executive council, a majority of the members;

(b) for a medical staff council with 6 to 20 members, a majority of the members of the council;

(c) for a medical staff council with more than 20 members, one tenth of the members or 11 members of the council, whichever is the greater number.

32. Smaller medical staff councils

For a council with five members or less:

(a) clauses 12 and 26-28 of this By-law do not apply;

(b) the Chief Executive, or a person authorised on his or her behalf, is to call a meeting of the council not later than seven days after receiving a written request for such a meeting from a member of the council;

(c) the Chief Executive, or a person authorised on his or her behalf, is to give written notice of a meeting of the council to all members and to the medical administrator (however designated) of the local health district;

(d) the medical administrator (however designated) of the local health district is to be invited to attend all duly convened meetings of the council. However the council may exclude the medical administrator from any meeting, or part of a meeting, where the business under consideration relates to the conduct or performance of the medical administrator in that position;

(e) the council is to ensure that minutes of a meeting of the council are kept; and

(f) the quorum for a meeting of the council is a majority of its members.

Part 8– Hospital Clinical Councils

33. Objective of Hospital Clinical Council

(1) Hospital clinical councils provide a structure for consultation with, and involvement of, clinical staff in management decisions impacting public hospitals and related community services.

(2) A hospital clinical council is a key leadership group for its public hospital or hospitals and is designed to participate with the management team in ensuring that the hospital/s deliver high quality health and related services for its/ their patients.

34. Definitions

In this Part:

clinical staff means a member of the NSW Health Service working in a medical, dental, nursing (including enrolled nurses, midwives and assistants in nursing) or allied health clinical position in connection with the local health district, and medical and dental practitioners appointed as visiting practitioners under the Health Services Act 1997;

general manager means the person responsible to the Chief Executive for the operation or management of a public hospital or hospitals;

hospital clinical council includes (except in clause 35(2) a joint hospital clinical council;

member means a member (including an ex officio member) of a hospital clinical council.

35. Establishment of hospital clinical councils

(1) Hospital clinical councils are to be established within the organisation to provide management input for clinical staff of public hospitals.

(2) The Chief Executive is to establish a hospital clinical council for each public hospital in the organisation, and where appropriate that council may be a joint hospital clinical council covering more than one hospital.

(3) In determining whether to establish individual hospital clinical councils or joint hospital clinical councils under subclause (2), the Chief Executive is to have regard to:

(a) the size and budget of the public hospitals within the organisation;

(b) the number of clinical staff working at each public hospital within the organisation;

(c) whether a joint structure is the most practicable alternative for smaller hospitals;

(d) whether the relevant hospitals are under a common executive management structure.

36. Membership of hospital clinical councils

(1) The following members are ex officio members of a hospital clinical council:

(a) the general manager (however called) of the hospital or hospitals (who shall be the Chairperson);

(b) the executive medical director (however called) for the hospital or hospitals;

(c) the director of nursing and midwifery for the hospital or hospitals;

(d) the lead allied health manager (however called) for the hospital or hospitals;

(e) the principal financial officer (however called) for the hospital or hospitals.

(2) The following senior clinical staff of the hospital may be appointed as members of a hospital clinical council, provided that at least one person from each category is appointed:

(a) as applicable, clinical divisional heads and program managers ex officio (however called) for the hospital;

(b) the chair of the relevant medical staff council or councils ex officio as a representative of the medical staff council;

(c) such other clinical staff as the Operations Executive determines to enable the council to effectively undertake its functions having regard to the range, size, specialities and services provided by the hospital.

(3) Where a joint hospital clinical council is established under clause 35(2), the council must include at least one senior clinical staff member (from either medicine, nursing or allied health) from each public hospital covered by the joint council.

(4) Operations Executive must appoint to each hospital clinical council (including joint hospital council) one of each of the following categories of clinician from staff who work in the hospital or hospitals covered by the council:

(a) a medical practitioner;

(b) a nurse (who may be either a registered nurse, a registered midwife, an enrolled nurse or an assistant in nursing); and

(c) an allied health professional.

(5) Members appointed under clause 36(4) are to be selected in accordance with local procedures approved by the Board. Such procedures should include communication to staff about the council, its functions and the role of the staff member positions and provision for clinical staff interested in being appointed to the council to nominate to the Operations Executive.

(6) Each hospital clinical council is to consist of a minimum of 11 members.

(7) The hospital clinical council may elect a clinical co-chairperson for a hospital clinical who will be the presiding officer in the absence of the chairperson, and:

(a) Such elections are to be held at an ordinary meeting of a council once each calendar year.

(b) A clinical co-chair is to hold office until vacation of the office or until the next election, whichever occurs first.

(c) A clinical co-chair shall be eligible for re-election provided that no more than three (3) consecutive terms are served, unless these are special circumstances and further consecutive term has been approved by the Board.

(8) Where a member of the hospital clinical council is unable to attend a particular meeting of the council, that member may nominate an alternate member to attend in their place.

(9) Subject to Clause (10), the term of hospital clinical council members is as follows:

(a) For persons appointed ex officio under Clause 36(1) or (2), for the term they hold that office;

(b) For persons appointed under Clause 36(2)(c) or 36(4) for the term appointed by the Chief Executive;

(10) A member of a hospital clinical council ceases to be a member if:

(a) he or she ceases to be a member of the clinical staff working at the hospital;

(b) he or she is removed in accordance with any appropriate governance policy issued by the Ministry.

Explanatory Note: The provisions establishing Hospital Clinical Councils largely remain as per the 2012 Model. The only change is to the process for identifying additional staff members to attend the Council. Under the 2012 Model, this was determined through a statewide staff selection process, which involved a formal electoral process managed by an external provider, with the nomination and ballot processes prescribed in detail under Part 7 of the 2012 Model. The new Model provides for a local process that must be approved by the Board and which must include communication to staff about the council, its functions and the role of the staff member positions.

37. Functions of hospital clinical councils

A hospital clinical council is to exercise the following functions in respect of its hospital/s:

(1) provide leadership of the hospital/s by providing advice and recommendations and participating in management decisions the objective of which is to ensure:

(a) the achievement of the benchmarks and targets set out in the performance agreement

between the Health Secretary and the organisation as they relate to the hospital/s;

(b) the implementation of effective quality and safety programs and the achievement of key quality performance indicators by departments and units within the hospital/s;

(c) the implementation of models of care and evidence based clinical standards developed at a national and state level;

(d) the fostering of innovative solutions at a hospital level to improve the efficiency and effectiveness of the hospital/s;

(e) effective linkages between hospital clinical staff and clinician districts within the organisation;

(f) effective operational performance, and achievement of key operational performance indicators by departments and units, within the hospital/s;

(g) effective management of the budget of departments and units within the hospital/s subject to conditions and directions under law or Government policy, or established by the organisation;

(h) achievement of key financial performance indicators by department and unit managers;

(i) the appropriate linkages between hospital services and other services provided within the organisation and appropriate linkages with external local clinicians, including general practitioners; and

(j) effective communication of key decisions with staff of the hospital/s;

(2) provide advice on resource allocation including on the exercise of delegations for recruitment and expenditure the objective of which is to ensure effective and efficient utilisation of resources within the hospital/s, subject to conditions and directions established by law, Government policy or the organisation;

(3) provide advice the objective of which is to ensure the implementation of strategies to effectively address any non-achievement of performance targets or other remedial action required within the hospital/s;

(4) advise the Chief Executive and Board on planning requirements for services within the hospital/s;

(5) assist in ensuring the effective implementation of Government policy and decisions of the organisation within the hospital/s;

(6) provide reports on the council's activities and decisions to the Chief Executive and the Board each month through dissemination of the minutes of meetings of the council, or provide such reports with the frequency and in the manner determined by the organisation.

(7) in this clause 'hospital/s' also includes community services related to services at the hospitals.

38. Information to be made available to hospital clinical councils

The hospital general manager is to ensure the hospital clinical council is provided with such information, including financial and operational performance reports, as is necessary to enable it to properly undertake its functions.

39. Voting at meetings

Any matter put to the vote at any meeting of a hospital clinical council is to be decided by a show of hands, or by secret ballot if requested by a member present at that meeting.

40. Meetings

(1) Hospital clinical councils will meet at least monthly.

(2) Meetings of a council are to be held at times and places determined by the council.

(3) The Chairperson or presiding officer of a council, is to ensure written notice is provided to each member, at least 7 days prior to an ordinary meeting.

(4) A hospital clinical council may invite such executive staff or other staff or other persons to attend all or part of the council's meetings.

41. Special meetings

(1) Where the chairperson of a hospital clinical council considers that a matter is of such urgency that a special meeting of the council should be held within 48 hours, the chairperson may request the Chief Executive to give written approval to the conduct of a special meeting.

(2) A copy of the Chief Executive's approval under clause 41(1) is to be provided to members of the Board.

(3) The written approval of the Chief Executive may determine, subject to this clause and these By-laws, the business and conduct of such a special meeting.

(4) Notice of the special meeting is to specify the business to be considered at the meeting.

(5) The chairperson is to ensure that at least 24 hours' notice is given of a special meeting to each member and each person invited to attend the meeting.

(6) Only business specified in the notice of a special meeting is to be considered at the special meeting.

(7) The special meeting shall be held, if approved, not later than seven days after receipt by the Chief Executive of a request under subclause (1).

Part 9 – Local Health District Clinical Council

42. Establishment

The Chief Executive will establish a "Local Health District Clinical Council" (in this Part called the "Council") to provide the Board and the Chief Executive with advice on clinical matters affecting the organisation.

43. Membership

(1) The membership of the Council is to be composed of:

(a) Chief Executive and such other clinical managers and clinical stream leaders as the Board considers appropriate;

(b) The Chair of the Medical Staff Executive Council , and such other members of that Council as the Board considers appropriate;

(c) At least one clinical member selected from the hospital clinical council(s) or joint clinical council(s) for the district and such other clinical representatives as the Board considers appropriate;

(d) such other persons as the Board determines to enable the council to effectively undertake its functions having regard to the range, size, specialities and services provided by the organisation.

(2) The Council must include at least one senior clinical staff member from each of medicine, nursing and allied health.

(3) The Council is to consist of a minimum of 9 members.

(4) The Board will appoint a chairperson and may also appoint a co-chairperson or deputy chairperson for the Council

(5) Where a member of the Council is unable to attend a particular meeting of the Council, that member may nominate an alternate member to attend in their place.

(6) A member of the Council ceases to be a member if:

(a) he or she is appointed as a clinical staff member and ceases to be a clinical staff member or member of the NSW Health Service working at the hospital;

(b) he or she is removed in accordance with any appropriate governance policy issued by the Secretary.

44. Functions

(1) The Council is to provide the Board and the Chief Executive with advice on clinical matters

affecting the organisation, including on:

(a) improving quality and safety in the hospitals within the organisation;

(b) planning on the most efficient allocation of clinical services within the organisation;

(c) translating national best practice into local delivery of services;

(d) developing innovative solutions that best address the needs of the local communities;

(e) such other related matters as the Board or Chief Executive may seek advice on from time to time.

(2) The Council will provide reports on the council's activities to the Chief Executive and the Board each month through dissemination of the minutes of meetings of the council, or provide such reports with the frequency and in the manner determined by the organisation.

45. Information

The Chief Executive is to ensure the Council is provided with such information, including financial and operational performance reports, as is necessary to enable it to properly undertake its functions.

46. Voting at meetings

Any matter put to the vote at any meeting of the Council is to be decided by a show of hands, or by secret ballot if requested by a member present at that meeting.

47. Meetings

(1) Councils will meet monthly.

(2) Meetings are to be held at times and places determined by the Council.

(3) The Chairperson or presiding officer of The Council, is to ensure written notice is provided to each member, at least 7 days prior to an ordinary meeting.

(4) The Council may invite such executive staff or other staff or other persons to attend all or part of the council's meetings.

48. Special meetings

(1) Where the chairperson of the Council considers that a matter is of such urgency that a special meeting of the council should be held within 48 hours, the chairperson may request the Chief Executive to give written approval to the conduct of a special meeting.

(2) A copy of the Chief Executive's approval under clause 48(1) is to be provided to members of the Board.

(3) The written approval of the Chief Executive may determine, subject to this clause and these by-

laws, the business and conduct of such a special meeting.

(4) Notice of the special meeting is to specify the business to be considered at the meeting.

(5) The chairperson is to ensure that at least 24 hours' notice is given of a special meeting to each member and each person invited to attend the meeting.

(6) Only business specified in the notice of a special meeting is to be considered at the special meeting.

(7) The special meeting shall be held, if approved, not later than seven days after receipt by the Chief Executive of a request under subclause (1).

Part 10 – Medical and dental appointments advisory committee

49. Establishment of medical and dental appointments advisory committee

(1) The Board is to establish a committee called the Medical and Dental Appointments Advisory Committee (in this Part the **"committee"**) which will:

(a) provide advice, and where appropriate make recommendations with reasons, to the Chief Executive concerning matters relating to the appointment or proposed appointment of visiting practitioners, staff specialists or dentists;

(b) consider any application that has been referred to the committee by the Chief Executive for:

(i) appointment of a visiting practitioner, staff specialist or dentist; or

(ii) a proposal to appoint a person as a visiting practitioner, staff specialist or dentist.

(c) provide advice and, where appropriate, make recommendations with reasons to the Chief Executive concerning the clinical privileges which should be allowed to visiting practitioners, staff specialists and dentists.

(2) Where the Chief Executive has delegated such a function to that position, the medical administrator of the local health district (however designated) may appoint a visiting practitioner or staff specialist to an available position for a period not exceeding three (3) months. Such appointment may be extended for one further single 3 month period. However any exercise of this delegation shall be subject to the advice of the committee, if the advice or recommendation of the committee is required for that position.

(3) The committee may form sub-committees, whether at a hospital or otherwise, to provide advice or other assistance to enable it to perform its duties referred to in this clause.

(4) The committee may provide advice, and where appropriate make recommendations with reasons, to the Chief Executive of NSW Health Pathology regarding any one or more of the matters set out in clause 49(1) with respect to the appointment, proposed appointment or clinical privileges of visiting practitioners, staff specialists or dentists appointed, proposed to be appointed or under

consideration for appointment by the Chief Executive of NSW Health Pathology, but only pursuant to a written agreement between the Chief Executive of the organisation and the Chief Executive of NSW Health Pathology.

50. Composition of medical and dental appointments advisory committee

The committee shall be composed of:

(1) two members appointed by the Board (at least one of whom is not a medical practitioner), one of whom is to be nominated as the chairperson of the committee;

(2) two members nominated by the medical staff executive council (or where there is no medical staff executive council the medical staff council);

(3) the Chief Executive or his/her nominee;

(4) the medical administrator (however designated) of the local health district or his/her nominee;

(5) such of the following persons (being medical practitioners or dentists) appointed by the Chief Executive as are necessary, in the Chief Executive's view following consultation with the two representatives appointed under clause 50(2), for the proper consideration of a matter or class of matters referred to the committee:

(a) one representative of the local health district relevant to the matter under consideration;

(b) one representative with qualifications in the speciality or sub-speciality consideration relevant to the matter under consideration and who is not a member of the Medical Staff Executive Council or (or where there is no medical staff executive council the medical staff council);

(c) one representative of a university affiliated with the local health district for the purposes of the training of health practitioners;

(6) where a matter or class of matters referred to the Committee concerns an appointment of a person as a visiting practitioner, staff specialist or dentist to a hospital or hospitals under the control of a local health district, a representative of the medical staff council, if any, for each hospital to which the appointment relates; and

(7) where a matter or class of matters referred to the committee concerns the clinical privileges of a visiting practitioner who is a medical practitioner or of a staff specialist, a representative of the medical staff council, if any, for each hospital to which the appointment relates.

51. Term of Office

(1) A member of the committee who is nominated by the Board shall hold office for such period as the Board determines.

(2) A member of the committee who is a nominee of a medical staff executive council or a medical

staff council is to hold office for such period as the nominating council determines.

(3) Where a member has been appointed to, or is nominated to be on, the committee for the purpose of considering a particular matter or matters, he or she is a member only for the period or periods during which that matter or matters is under consideration by the committee.

(4) A member of the committee shall absent themselves from the meeting during any discussion by the committee of the appointment or clinical privileges of that member.

Part 11 – Credentials (Clinical Privileges) Subcommittee

52. Credentials (Clinical Privileges) Subcommittee

(1) The Medical and Dental Appointments Advisory Committee (in this Part the "**committee"**) is to establish at least one subcommittee called the Credentials (Clinical Privileges) Subcommittee (in this part called the "**subcommittee**") to provide advice to the committee on all matters concerning the clinical privileges of visiting practitioners, staff specialists or dentists, including the following:

(a) the clinical privileges to be allowed to an applicant or person proposed for appointment as a visiting practitioner;

(b) the clinical privileges to be allowed to a staff specialist or dentist on appointment;

(c) the review of the clinical privileges of a visiting practitioner, staff specialist or dentist at the request of the visiting practitioner, staff specialist or dentist; and

(d) the review of the clinical privileges of a visiting practitioner, staff specialist or dentist at the request of the Chief Executive.

(2) Any matter concerning the clinical privileges of any person:

(a) who is appointed as a staff specialist, a visiting practitioner or dentist, or

(b) who the committee is considering recommending for appointment as a visiting practitioner, a staff specialist or a dentist is to be referred to the credentials subcommittee for advice.

(3) In considering all matters concerning clinical privileges the subcommittee is to have regard to the delineated role of the relevant health facility approved by the Ministry of Health and appropriate credentials in relation to the clinical privileges.

53. Composition of the Credentials (Clinical Privileges) Subcommittee

(1) The subcommittee is to consist of:

(a) at least two members of the committee who are either medical practitioners or dentists, nominated by the committee; and

(b) any other medical practitioners or dentists appointed by the committee who the committee

considers are necessary to consider the matter or matters referred to the subcommittee for advice.

(2) The committee is to nominate one of the persons under subclause (1)(a) as chairperson of the subcommittee.

(3) In appointing members of the subcommittee under subclause (1)(b), the committee is to ensure that the appointments are consistent with any Ministry guidelines, Policy Directives or Information Bulletins relating to the delineation of clinical privileges and/or the composition of the subcommittee.

54. Term of Office

(1) A member of the subcommittee who is nominated by the committee shall hold office for such period as the committee determines.

(2) A member appointed to the subcommittee, for the purpose of considering a particular matter or matters, is a member for the period or periods during which the matter or matters is considered by the subcommittee.

(3) A member of the subcommittee shall absent themselves from the meeting during any discussion by the subcommittee of the clinical privileges of that member.

Part 12 – Rules

55. Rules

The Chief Executive may, with the approval of the Board, make rules for the proper functioning of the local health district. These rules should not be inconsistent with the Act, the associated regulations and this By-law.

DICTIONARY

Act means the Health Services Act 1997.

Chief Executive means the chief executive of a local health district.

Board means the Board appointed under s26 of the Act

clinical privileges means the kind of clinical work (subject to any restrictions) that the local health district determines the visiting practitioner or staff specialist is to be allowed to perform at any of its hospitals or health services.

Credentials means a document or other written evidence of an individual's formal qualifications, skills, or competence

Council means a Medical Staff Executive Council, a medical staff council or a clinical council, as applicable

dentist means a person registered, or taken to be registered, as a dentist under the Health Practitioner Regulation National Law.

Ministry means the NSW Ministry of Health.

executive staff means the persons appointed by the local health district to its management structure and any persons appointed to act for the time being in those positions.

health service means any of the following

(a) any hospital service,

(b) any medical service,

(c) any paramedical service,

(d) any community health service,

(e) any environmental health service,

(f) any other service (including any service of a class or description prescribed by the regulations) relating to the maintenance or improvement of the health, or the restoration to health, of persons or the prevention of disease in or injury to persons.

hospital means an institution at which relief is given to sick or injured people through the provision of care or treatment.

Local health district means the local health district constituted under Schedule 1 to the Act

medical practitioner means a person who is registered, or taken to be registered, as a medical

practitioner under the Health Practitioner Regulation National Law.

organisation means local health district

public hospital means a hospital controlled by a local health district.

regulations means the regulations made under the Act.

staff specialist means a medical practitioner employed at local health district as a staff specialist under the Staff Specialist (State) Award.

visiting practitioner means a medical practitioner or dentist who is appointed by a local health district (otherwise than as an employee) to practise as a health practitioner in accordance with such conditions of appointment at any of its public hospitals or health services as may be specified in an appointment agreement (including a clinical academic).

Written notice in respect of giving notice of a meeting includes a notice communicated by electronic means including email and electronic messaging.

Explanatory Note: Certain words and phrases used in the by-law are defined in the Dictionary. These largely repeat those used in the Health Services Act so that the use of such words in the by-law is consistent with the Act.