HOSPITAL BY-LAWS

Commercial in confidence

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FOREWORD

1. This document sets out the by-laws that are to be adopted by iMH Pty Ltd (**iMH**).

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

3. These By-Laws apply to all Facilities of iMH.

4. These By-Laws must be read in conjunction with the Clinical Credentialing and Scope of Practice Policy and all other relevant iMH policies and annexures adopted by the Board and each of the iMH subsidiaries.

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

6. Any variation to these By-Laws approved by the Board that are relevant to one or more of the iMH Facilities, as a result of specific legislative obligations or operational procedures, shall be set out in Schedule 1.

7. For the composition of Committees, membership constitution, method of selection of appointees, term of Appointment, review of Scope of Clinical Practice, frequency of meeting and quorum of Committees refer to the Terms of Reference for each Facility in Schedule 2.

8. The composition of each Committee will reflect the Facility's organisational requirements, organisational capacity and organisational need for the clinical services provided.

9. Where the Facility Chief Executive Officer (FCEO) has delegated their authority to a Delegated Authority in respect of any power under a particular By-Law, a reference to the Facility Chief Executive Officer in that By-Law will also include that Delegated Authority. Any specific delegations existing as at the date of these By-Laws are set out in Schedule 1.

PREAMBLE

The By-Laws mandate the Accreditation, Credentialing, Re-accreditation and process for defining and amending the Scope of Clinical Practice for Medical Practitioners, and Allied Health Professionals providing services to their patients at an iMH Facility.

The purpose of this process is to assess the training, experience, competence, judgement, professional capabilities and knowledge, fitness and character of a Medical Practitioner, Nurse Practitioner, or Allied Health Professional who holds Accreditation or seeks Accreditation at an iMH Facility. Relevantly, there is the ability to amend, suspend or terminate a Medical Practitioner's, Nurse Practitioner's or Allied Health Professional's Accreditation or Scope of Clinical Practice in the interest of patient safety, the needs and capacity of the Facility or if the Accredited Practitioner displays conduct inconsistent with iMH's mission, vision or values.

Credentialing and defining the Scope of Clinical Practice are governance responsibilities of the

FCEO and may be delegated as appropriate. The Credentialing, Re-accreditation and the process for defining and amending Scope of Clinical Practice is a non-punitive process. These processes, as set out in these By-Laws, are fair and transparent.

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

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

OVERVIEW

About iMH

iMH is joint venture between Aurora Healthcare and Amplar Health which was formalized in March 2023. The partnership draws on Aurora Healthcare's established expertise in the delivery of private mental health services and the combined experience of both partners in the joint venture in introducing innovative models of care across Australia. iMH is Australia's first single specialty private hospital operator providing a dedication and focus on private mental health service delivery.

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

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

iMH VISION MISSION, VALUES AND CARE STATEMENTS

Vision

Seamless and integrated mental health care available to everyone, when and where they need it.

Mission

To empower patients and clinicians through real choice in their health care experience.

Purpose

To help people on their mental health care journey.

Values

iMH's core values are:

1. Care with compassion.
2. Guided by curiosity.
3. Empower patients and providers.
4. Pursue excellence.
5. Work collaboratively.

Care Statement

1. iMH fundamentally believes at its Hospitals it is **"Your mental health is a journey we take with you".**

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

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

Care

Our care is

- Provided in an environment underpinned by iMH's Mission and Values.
- Holistic and centered on the needs of each patient, inclusive of their family/carer.
- Innovative in it's delivery ensuring that the right care is provided to patients at the right time in the right location.
- High quality, safe and continuously improved to ensure best practice.
- Innovative and informed by current research using contemporary techniques and technology.
- Delivered by a team of dedicated, appropriately qualified people who are supported

in a continuing development of their skills and knowledge.

- Value-based and focused on achieving best patient outcomes.

1. BY-LAWS

1.1 Function of the By-laws

a) Day to day managerial responsibility of iMH Hospitals is delegated by the Board to the FCEO. The By-Laws provide direction from the Board to the FCEO in relation to exercise of certain aspects of their managerial responsibility.

b) Medical care at iMH Hospitals is provided by Accredited Practitioners who have been granted access to the Hospital and the use of the Hospital facilities. The By-Laws define the relationship and obligations between iMH and its Accredited Practitioners.

c) iMH aims to maintain a high standard of patient care and to continuously improve the safety and quality of its Hospital services. The By-Laws, schedules and annexures implement measures aimed at maintenance and improvements in safety and quality.

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

1.2 By-Laws apply to Facilities

This document sets out the By-Laws that apply to all Facilities at which the Board has determined they will apply.

1.3 Inconsistencies with legislation

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

1.4 Modification of By-Laws

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

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

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

d) The iMH Chief Executive Officer (iMH CEO) (or delegate) or Chief Clinical Governance Officer (NCGM) (or delegate) may approve the annexures that accompany these By-Laws, and amendments that may be made from time to time, and the annexures once approved by the iMH CEO or NCGM (or delegate) will form part of the By-Laws.

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

2. INTERPRETATION

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

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

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

  b) any specified Conditions;

  c) the Code of Conduct;

  d) the policies and procedures at the Facility; and

  e) these By-Laws.

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

  (a) applications for Accreditation or re-accreditation by Medical Practitioners, or Allied Health Professionals;

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

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

  (d) disputes, complaints and reviews in relation to items (a) to (c).

- **ACCREDITATION CLASSIFICATION** means one or more of the designated classifications of an Accredited Practitioner as set out in Schedule 1 in respect of the Facility to which Accreditation has been granted.

- **ACCREDITED PRACTITIONER** means a Medical Practitioner who has Accreditation at a Facility in accordance with a specified Accreditation Classification and Scope of Clinical Practice.

- **ACCREDITED PROFESSIONAL** means an Allied Health Professional or Nurse Practitioner who has Accreditation at a Facility.

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

  a) the Facility and its operation;

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

  c) the health services provided by, and the conduct of, the Accredited Practitioner.

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

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

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

- **BOARD** means the Board of Directors of iMH.

- **BOARD QUALITY AND SAFETY COMMITTEE** means a committee established by the Board to ensure systems are in place and are being monitored for the purposes of providing information to the Board so that the Board can assess and determine whether in respect of iMH Group and its Facilities:

  a) all clinical risks are being appropriately managed;

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

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

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

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

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

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

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

c) Appeals in accordance with these By-Laws;

d) Patient care and clinical outcomes; and

e) Clinical services

- **CONDITION** means as applicable with respect to an Accredited Practitioner or an Accredited Professional**:**

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

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

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

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

- **CREDENTIALING** means the formal process used to verify the qualifications, experience, professional standing and other relevant professional attributes of a Medical Practitioner, Allied Health Professional, an Accredited Practitioner or an Accredited Professional for the purpose of forming a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific Facility environments. Credentialing involves obtaining evidence contained in verified documents to delineate the theoretical range of services, which an Accredited Practitioner is competent to perform.

- **CREDENTIALS** means the qualifications, professional training, clinical experience, current registration and status, indemnity insurance, training and experience in leadership, research, education, communication and teamwork that contribute to the competence, performance and professional suitability to provide safe, high quality health care services at the Facility.

- **CURRENT FITNESS** means the current fitness required of an Accredited Practitioner (or Accredited Professional) to carry out the Scope of Clinical Practice sought or currently held. An individual does not have current fitness if that person suffers from any physical or mental impairment, disability, condition or disorder which detrimentally affects, or is likely (in the FCEO's reasonable opinion) to detrimentally affect the individual's physical or mental capacity to practice medicine or provide the relevant allied health service and carry out the Scope of Clinical Practice sought or currently held.

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

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

- **FACILITY (or HOSPITAL)** means a hospital or day procedure center conducted by an iMH Group Entity.

- **FACILITY CHIEF EXECUTIVE OFFICER (FCEO)** means the Chief Executive Officer of a Facility however titled. That is General Manager/Director of Nursing, General Manager, Chief Executive Officer, Chief Executive Officer/Director of Clinical Services.

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

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

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

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

- **iMH** means Integrated Mental Health and its subsidiaries.

- **iMH CEO** means the Chief Executive Officer of iMH.

- **NCGM** means the National Clinical Governance Manager of Risk and Quality, a shared service provider from Aurora.

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

- **MAC** means Medical Advisory Committee appointed by an iMH Group Entity for a Facility for the purpose of advising the relevant iMH Group Entity (in its capacity as licensee of the Facility) on the Accreditation and Re-accreditation of Medical Practitioners, and Allied Health Professionals at the Facility and various other matters relating to the safety and quality of services at the Facility as defined in the relevant State and Territory Private Health Facility legislation

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

- **NATIONAL LAW** means *the Health Practitioner Regulation National Law Act* (2009) as in force in each State and Territory from time to time.

- **NEW CLINICAL SERVICES, PROCEDURES, OR OTHER INTERVENTIONS** means (including medical or surgical procedures, and the use of prostheses and implantable devices or diagnostic procedures) that are considered by a reasonable body of medical opinion to be significantly different from existing clinical practice. It includes a procedure that has not been performed at the Facility, as well as variations to an existing procedure or treatment where a new device or item of equipment is introduced.

- **NOTIFIABLE CONDUCT** means conduct as defined in the *Health Practitioner Regulation National Law Act* 2009, as in force in each State and Territory, and amended from time to time, in relation to a registered health practitioner, and currently means the practitioner has:
  a) practiced the practitioner's profession while intoxicated by alcohol or drugs; or

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

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

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

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

- **ORGANISATIONAL CAPABILITIES** means the Facility's ability to provide facilities, services and clinical and non-clinical support necessary for the provision of safe, high quality clinical services, procedures or other interventions and associated allied health services in compliance with the relevant Private Health Facility Act in force in the State or Territory

in which the Facility is located and otherwise as required to satisfy the clinical services capability framework of the relevant Facility.

- **ORGANISATIONAL NEED** means the extent to which the Facility elects to provide a specific clinical service, procedure or other intervention or associated allied health service in order to provide a balanced mix of safe, high quality health care services that meet patient and community need and expectation. This will include consideration of the strategic, operational and business plans, goals and objectives of iMH and the relevant iMH Group Entity, including the need for and profitability of various specialty services at specific Facilities.

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

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

- **PROFESSIONAL INDEMNITY INSURANCE** means the insurance of an Accredited Practitioner or Accredited Professional taken out in accordance with By-Law 9.4.

- **PROFESSIONAL MISCONDUCT** has the same meaning prescribed to that term and the term "Unsatisfactory Professional Conduct" in the *Health Practitioner Regulation National Law Act* 2009 or associated Act as in force in each State and Territory and includes (but is not limited to):

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

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

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

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

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

- **REGISTERED NURSE (employed by Visiting Medical Officer)** means a registered nurse visiting the Hospital and employed by a Visiting Medical Officer.

- **REGISTERED NURSE (working in a specialist area)** means a registered nurse visiting the Hospital and working in a specialist area.

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

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

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

- **SCOPE OF CLINICAL PRACTICE** means the process following on from Credentialing and involves delineating the extent of an Accredited Practitioner's (or Accredited Professional's) clinical practice within a particular Facility based on the individual's Credentials, competence, performance and professional suitability and the Organisational Need and Organisational Capabilities of the Facility to support the Accredited Practitioner's (or Accredited Professional's) Scope of Clinical Practice.

- **SPECIALIST PRACTITIONER** means an Accredited Practitioner who is:
    i. recognised as a specialist for the purposes of the Health Insurance Act 1973 (Cth); and
    ii. is appointed by the Board in the category of Specialist Practitioner

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

- **TEMPORARY APPOINTMENT** means an appointment of an Accredited Practitioner (or Accredited Professional) for a specified period of less than 90 days, unless otherwise determined by the FCEO.

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

2.2 General Information

Rules for Interpreting these By-Laws

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

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

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

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

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

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

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

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

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

b) *Titles*

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

c) *Quorum*

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

ii.

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

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

d) *Resolutions without meetings*

i. A decision may be made by a Committee or group established pursuant to these By-Laws (except that established by By-Law 19) without a meeting if a consent in writing, including electronic means, setting forth such a decision is signed by all the Committee or group members, as the case may be.

e) *Meeting by electronic means*

i. A Committee or group established pursuant to these By-Laws (except that established by By-Law 19) may hold any meeting by electronic means whereby participants can be heard and can hear but are not necessarily in the same place. The requirements of these By-Laws will nonetheless apply to such a meeting.

f) *Voting*

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

g) *Delegation*

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

h) *Compensation*

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

3. PRIVACY AND CONFIDENTIALITY

3.1 Privacy

a) Accredited Practitioners will comply with and assist the Facility to comply with the Australian Privacy Principles established by the *Privacy Act 1988* (Cth) and the various statutes governing the privacy of health information within each State and Territory in Australia (or equivalent laws if the facility is located in another jurisdiction).

3.2 Accredited Practitioners

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

a) business information concerning iMH, iMH Group Entity or the Facility.

b) information concerning the insurance arrangements of iMH, iMH Group Entity or the Facility where applicable.

c) personal, sensitive or health information concerning any patient, clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services and any employee or contractor of iMH or an iMH Group Entity.

d) the particulars of these By-laws

3.3 Committees

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

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

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

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3.4 What confidentiality means

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

3.5 When confidentiality can be breached

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

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

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

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

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

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

3.6 Privacy and confidentiality obligations continue

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

3.7 iMH Group Entity

a) The Facility will be entitled to disclose an Accredited Practitioner's confidential information (including personal information and sensitive information as those terms are defined in the *Privacy Act 1988* (Cth)) in relation to their Accreditation or any other matters related to these By-laws to other iMH Group Entities.

3.8 Mandatory notification of Notifiable Conduct

a) Notwithstanding By-Laws 3.1 to 3.7, all Accredited Practitioners acting in a management role with iMH must comply with their responsibilities under the National Law in regard to mandatory notification of Notifiable Conduct by another practitioner or a student undertaking clinical training where they have formed a reasonable belief that a health practitioner has behaved in a way that constitutes Notifiable Conduct in relation to the practice of their profession or suffers from an impairment that may place the public at substantial risk of harm.

4. BOARD POWERS AND TRANSITIONAL ARRANGEMENTS

4.1 Board powers

a) The Board is empowered to make By-Laws, rules, regulations, and policies for the operation of the Facility as it may deem necessary from time to time.

b) Unless otherwise specified, changes take effect from the time of the resolution by the Board.

c) Any changes under By-Law 4.1(b) take effect from the date the change is approved by the Board and apply to all Accredited Practitioners from that date.

4.2 Transitional arrangements

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

5. COMMITTEES

5.1 Power to establish Committees

a) The iMH Board, board of each iMH Group Entity and FCEO may establish any Committees deemed necessary to comply with any Act or for the effective and compliant conduct of the Facility.

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

5.2 Terms of Reference for Committees

a) Schedule 2 provides the Terms of Reference for Committees.

5.3 Indemnification

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

i. acted in good faith;

ii. acted in accordance with their delegated authority; and

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

5.4 Statutory immunity for Committees

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

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

5.5 Committee access to the iMH Board

a) The iMH Board will have a standing agenda item to discuss and escalate issues of a complex credentialing nature to the full iMH Board.

6. DISCLOSURE OF INTEREST OF MEMBERS OF COMMITTEES

6.1 Disclosure of interest

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

i. in a matter that has been considered, or is about to be considered, at a meeting, such a member or person must not, subject to By-Law 6.5, participate in the relevant discussion or resolution; or

ii. in a matter being considered or a decision being made by the Facility and must as soon as possible after the relevant facts have come to the person's knowledge, disclose the nature of the interest at the meeting.

6.2 Nature of disclosure

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

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

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

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

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

6.3 Chairperson to notify Facility Chief Executive Officer

a) The chairperson of the relevant Committee will:

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

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

6.4 Record of disclosure

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

6.5 Determination to effect of matter disclosed

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

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

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

7. CLINICAL REVIEW COMMITTEES

7.1 Objectives

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

a) Accreditation and Credentialing Committee , howsoever named;

b) a Medical Advisory Committee which will have the following objectives, inter alia:

i. assessment and evaluation of quality of health services including the review of clinical practices or clinical competence of persons providing those services;

ii. reviewing clinical outcomes to identify system or individual practices that impact on patient outcomes;

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

iv. reviewing the Credentials of applicants seeking Accreditation;

v. review and consider New Clinical Services, Procedures and Other Inventions;

vii reporting to Regulatory Authorities; and

viii considering any Act relevant to the Facility and advising the FCEO actual or potential breaches of any Act or standards of clinical service,

and shall comply with terms of reference set out in Schedule 2 to these By-Laws and the statutory provisions and regulations governing the constitution and responsibilities of the MAC; and

c) Patient Care Review Committee (**PCR Committee**)

7.2 Patient Care Review Committee Function

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

i. review clinical indicators;

ii. review mortality and morbidity reports and make recommendations where appropriate; encourage participation in quality projects to improve patient outcomes;

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

iv. review specific cases identified as an outcome of the reviews undertaken in By-Law 7.2(I) – (iii); and

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

7.3 Meetings of PCR Committee

a) The PCR Committee must meet at least four times per year for formal quality, morbidity and mortality review meetings (**Formal Meetings**) or as otherwise required by the FCEO.

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

7.4 Minutes and reporting

a) The chairperson, or their delegate for this purpose, must record minutes of the Formal Meetings of the PCR Committee.

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

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

7.5 Mandatory attendance

a) It is a Condition of Accreditation that:

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

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

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

8. APPOINTMENT OF ACCREDITED PRACTITIONERS

8.1 Principles

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

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

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

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

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

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

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

g) Processes of Credentialing and Accreditation should be fair and transparent, with the By-Laws drafted to accommodate these principles; therefore compliance with the By-Laws and its processes is important.

8.2 Application On-Line Form

a) Any Medical Practitioner, Allied Health Professional or other Health Practitioner who wishes to apply for Accreditation, Re-accreditation or an increase in Scope of Clinical Practice at the Facility must contact the FCEO to be invited to complete the iMH e-credentialing system on-line application form and obtain any related material, including a copy of these By-Laws. The on-line Application Form must be completed and relevant documents uploaded and submitted through the iMH e-credentialing system to the FCEO.

8.3 Applications for Appointment

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

a) The FCEO will consider the application in the context of the Organisational Need and Organisational Capabilities of the Facility and may make any inquiries or consultation relevant to that consideration as he or she thinks fit. Following this consideration, the FCEO may determine to discontinue with the application process or give further consideration to the process as outlined at By-Law 8.3(b) – (n) below. The FCEO may liaise with the Accreditation and Credentialing Committee in relation to this stage of enquiry

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

c) The FCEO (or their delegate) may contact up to three referees nominated by the Applicant, but for an application to proceed the FCEO must **receive no less than 2**, to request written references and must also check the Applicant's qualifications, Professional Indemnity Insurance and Credentials (including verifying registration and current entitlement to practice). Referees must include a current supervisor at the facility or a supervisor not at the same facility but currently practicing in the same specialty as the potential appointee.

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

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

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

g) The FCEO will liaise with the Accreditation and Credentialing Committee during the process of enquiry and review identified in (b) above to (i) below and prepare an

application report which includes consideration of and recommendations relating to the application, Organisation Capabilities, Credentials, Scope of Clinical Practice, Current fitness, character and applicant integration (**Application Report**).

h) If the Application Report recommends granting Accreditation, the FCEO must provide a copy of the Application Report to the MAC, and an assessment made by that Committee of the Application.

i) The MAC via the Accreditation and Credentialing Committee will make recommendations to the FCEO as it deems appropriate relating to the Application generally and in particular regarding the Credentials, Current Fitness, requested Scope of Clinical Practice and any Conditions to the Accreditation.

j) The MAC Recommendations will then be considered by the FCEO prior to making a final determination as to the Accreditation sought by the applicant.

k) The FCEO will make a final determination on the application and will have complete discretion to approve or disapprove each application for Accreditation or Re-accreditation after following the provisions set out in By- Laws 8.3(a) to 8.3(l) (where applicable).

l) The FCEO must notify each applicant in writing of their decision.

m) Any delineation of approved Scope of Clinical Practice for the Applicant must be specifically defined in the letter of Accreditation. Approval is granted by the FCEO.

n) The term of the initial Accreditation must not exceed one (1) year and for recredentialing must not exceed five (5) years or any other lesser period as determined by relevant state legislation from the date of approval. *(NB: The state of Victoria mandates no more than three (3) years accreditation)*.

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

8.4 Recency of Practice

a) To practise competently and safely, an Accredited Practitioner must have recent practice in the fields in which they intend to work and maintain an adequate connection with their profession.

b) The specific requirements for recency depend on the profession, the level of experience of the practitioner and, if applicable, the length of absence from the field.

c) The FCEO may at any time make inquiry regarding concerns raised regarding an Accredited Practitioner's Recency of Practice where patient health and safety could be compromised. Inquiry and or investigation will take the form outlined in By-Law 13.1.

8.5 Temporary Appointment (including Locum Appointment)

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

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

c) In considering whether to approve the Temporary Appointment of a Medical Practitioner, or Allied Health Professional, the FCEO must satisfy the application process set out in By-Law 8.3 and consult with the head of the division or department most relevant to the applicant's specialty.

d) Accreditation granted under this By-Law 8.5 will remain in force for a period of up to 90 days from the date of determination by the FCEO. This period can be extended at the discretion of the FCEO but the total period cannot exceed 12 months. Any extension must be approved in writing by the FCEO.

e) Provisional appointment may be granted by the FCEO, after initial review of the complete application but only in circumstances where there is a genuine need to expedite the Accreditation to ensure provision of medical services for the benefit of identifiable patients and provided that the FCEO continues the final Accreditation process set out in Rule 8.3 in a timely manner.

f) The FCEO will notify the Accredited Practitioner in writing.

g) There will be no right of appeal in respect of the cancellation or suspension of Accreditation of a Medical Practitioner, or Allied Health Professional holding a Temporary Appointment or the decision of the FCEO in relation to a Temporary Appointment application.

8.6 Urgent Accreditation

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

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

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

ii. obtain a verbal reference from one other Accredited Practitioner at the Facility or from a practitioner not at the same Facility but currently practicing in the same specialty as the potential appointee; or from the Director of Medical Services at the applicants place of current Accreditation;

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

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

d) Urgent Accreditation granted under this By-Law 8.6 applies only to the specific patient or episode of care for which the Accreditation is sought.

e) The FCEO will advise the Accredited Practitioner in writing of the completion of the Urgent Accreditation.

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

g) There will be no right of appeal in respect of an application or cancellation of a Medical Practitioner's, or an Allied Health Professional's Urgent Accreditation status.

8.7 Appointments made periodically

a) Subject to 8.3 n) above unless otherwise determined by the FCEO, Accreditation of Medical Practitioners, Allied Health Professionals or Other Health Practitioners are to be made in accordance with the requirements of the Facility and a periodic cycle determined by the FCEO.

1. one (1) year;
2. two (2) years;
3. three (3) years;
4. four (4) years (not applicable to iMH Victorian (VC) Hospitals – three (3) year maximum term); or
5. five (5) years (not applicable to iMH VIC Hospitals – three (3) year maximum term)

b) Subject to 8.3 n) and excluding VIC hospitals as per 8.7a) 4 and 8.7a) 5 the period will be determined by the FCEO and shall commence from the date the FCEO approves the Accreditation.

c) Where Accreditation is granted and it coincides with the commencement of any periodic cycle referred to in By-Law 8.7a), the Accreditation will be for the specified period. Where Accreditation is granted after a periodic cycle has commenced, Accreditation will be for the unexpired portion of that specified period. Unless the FCEO has elected that the hospital's accreditation cycle for the Accredited Practitioner commences from the date of appointment for the period specified in 8.7a).

d) Subject to 8.3 n) the periods of up to one year, two years, three years, four years or five years for the purpose of these By-Laws will begin and conclude in accordance with the sequence customary at the Facility.

8.8 Appointments of Directorships

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

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

c) The FCEO has authority to extend the appointment of a Directorship beyond the maximum duration of three (3) years where the continuation is in the best interest of the hospital.

d) The FCEO has complete authority to withdraw an appointed Directorship within the three (3) year tenure or at anytime. There will be no appeal against such a decision.

8.9 Basis of Accreditation

Accreditation does not of itself constitute an employment contract nor does it establish a contractual relationship between the Accredited Practitioner and the Facility or a right of access to the Facility or use of its facilities. It is a condition of accepting Accreditation, and of ongoing Accreditation, that the Accredited Practitioner understands and agrees that:

a) these By-Laws set out processes and procedures available to the Accredited Practitioner with respect to all matters relating to and impacting upon Accreditation;

b) 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;

c) the granting of Accreditation establishes only that the Accredited Practitioner is a person able to provide services at the Facility, as well as the obligations and expectations with respect to the Accredited Practitioner while providing services at the Facility for the period of Accreditation;

d) the granting of Accreditation creates no rights or legitimate expectation with respect to access to the Hospital or its resources or facilities;

e) while iMH and the Facility will generally conduct itself in accordance with the By-Laws, it is not bound to do so and there are no legal consequences for not doing so.

f) iMH and the Facility may make amendments to the accreditation process in their absolute discretion at any time during the period of accreditation of an Accredited Practitioner or Accredited Professional;

9. TERMS AND CONDITIONS OF ACCREDITATION

9.1 Conditions applicable to all Accredited Practitioners

a) Approval of Accreditation for a Medical Practitioner, Allied Health Professional or Other Health Practitioner is conditional on the Accredited Practitioner complying with all matters and Conditions set out in this By-Law 9.

9.2 General

Accredited Practitioners must:

a) comply with their authorised Scope of Clinical Practice;

b) comply with the Code of Conduct and any other reasonable directions given or policies adopted by the FCEO in relation to standards of behavior to be maintained by Accredited Practitioners;

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

d) comply with their responsibilities under the National Law in regard to mandatory notification of Notifiable Conduct by another practitioner or a student undertaking clinical training where the Accredited Practitioner has formed a reasonable belief that a health practitioner has behaved in a way that constitutes Notifiable Conduct in relation to the practice of their profession or suffers from an impairment that may place the public at substantial risk of harm.

e) comply with these By-Laws and the rules and policies and procedures of the Facility as modified from time to time;

f) maintain their professional registration with AHPRA (and/or other relevant Regulatory Authority) and furnish annually to the Facility when requested to do so, evidence of registration and advise the FCEO immediately of any material changes to the conditions or status of their professional registration (including suspension or termination);

g) attend patients subject to the limits of any Conditions imposed by the FCEO;

h) observe all requests made by the Facility with regard to their conduct in the Facility and with regard to the provision of services within the Facility;

i) adhere to the generally accepted ethics of medical, allied health practice and other health practitioners practice including the ethical codes and codes of good medical practice of the Medical Board of Australia, Allied Health Professions Australia and other applicable health practitioners associations, as applicable, and all relevant standards or guides issued by the Medical Boards of Australia as issued from time to time in relation to their colleagues, Facility employees and patients and the “Good Medical Practice: A Code of Conduct for Doctors in Australia” published by the Medical Board of Australia.

j) adhere to general Conditions of clinical practice applicable at the Facility, including

compliance with and assisting the Facility to comply with the National Safety and Quality Health Service Standards Version 2 accreditation requirements through a reputable accreditation agency or such other additional accreditation requirements as nominated by the Facility as well as assisting the Facility to comply with specific requirements of private health insurers as may be advised by the CFEO from time to time during the period of Accreditation;

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

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

m) participate, when requested by the FCEO, in Committee meetings, including review of clinical data and outcomes and respond to requests for information regarding statistical outliers, adverse events and cases flagged in incidents, clinical indicator or key performance indicator reporting;

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

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

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

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

r) subject to the requirement of relevant laws, keep confidential details of all 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;

s) co-operate with and participate in any clinical quality assurance, quality improvement or risk management process, project or activities as required by the Facility and these By-Laws, including assisting in and providing information with respect to adverse events and, system reviews, including but not limited to Root Cause Analysis (RCA); and

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

9.3 Responsibility for patients

Accredited Practitioners must:

a) obtain full and informed written patient consent prior to a procedure being performed;

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

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

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

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

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

g) attend upon patients in a timely manner, using their best endeavours to attend promptly after being requested to do so, or being available by telephone in a timely manner to assist Facility staff in relation to Accredited Practitioner's patients;

h) prior to or on admission of a patient to the Facility, the patient's Accredited Practitioner must provide adequate written instructions for the initial management of their patient on admission;

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

j) if Accredited Practitioner is unable to continue to provide care for a patient at any time during the period of the patient's admission at the Facility, the Accredited Practitioner

must immediately notify the FCEO and other relevant Facility staff and ensure that the patient's care is handed over to another Accredited Practitioner;

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

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

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

n) attend their patients properly, and with the utmost care and attention, after taking into account the requirements of the Facility and Scope of Clinical Practice granted to the Accredited Practitioner;

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

p) except in an emergency, not give instructions in relation to a patient where another Accredited Practitioner is responsible for the management of that patient without a formal request for consultation from the consulting clinical team;

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

r) be willing, in an emergency or on request by the FCEO (or another person authorised by the FCEO for this purpose) to assist the staff and other practitioners, where possible and necessary;

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

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

u) ensure that patients are not discharged without review by and written approval of the Accredited Practitioner, complying with the discharge policy of the Facility. The Accredited Practitioner must ensure all information reasonably necessary to ensure

continuity of care after discharge is provided to the patient, patient's carer, referring practitioner, general practitioner and/or other treating practitioners;

v) where applicable, provide full financial disclosure to patients and obtain and document fully informed financial consent from patients in accordance with medical, legal, ethical and health fund obligations, including with respect to medical out of pocket expenses; and

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

9.4 Professional Indemnity Insurance

Accredited Practitioners must maintain a level of professional indemnity insurance (including run off/tail insurance where appropriate) consistent with requirements of the relevant Regulatory Authority:

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

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

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

9.5 Annual disclosure

Accredited Practitioners must furnish annually to the Facility evidence of:

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

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

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

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

9.6 Continuous disclosure

Each Accredited Practitioner must keep the FCEO continuously informed of matters which have a material bearing upon their Credentials and Scope of Clinical Practice, including;

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

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

c) Professional Indemnity Insurance status;

d) registration with the relevant professional registration board, including any Conditions or limitations placed on such registration; and

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

9.7 Advice of material issues

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

a) an adverse finding (formal or informal, current or former) made against them by any registration, disciplinary, investigative or professional body;

b) their professional registration being revoked, suspended or amended (including the imposition of any Conditions);

c) the initiation of any process, inquiry or investigation by the relevant board or coroner or tribunal (or equivalent body in any other jurisdiction, as applicable) or a health care complaints body (howsoever described) involving the Accredited Practitioner or the initiation of a legal process relevant to the medical practice which impacts or arises from their practice of medicine or provision of health care services;

d) any change in their Professional Indemnity Insurance, including but not limited to the attaching of Conditions, non-renewal or cancellation;

e) their Appointment to Accreditation or Scope of Clinical Practice at any other facility, hospital or day procedure centre is altered in any way other than at the request of the Accredited Practitioner;

f) they incur an illness or disability which may adversely affect their Current Fitness;

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

h) being charged with, or convicted of, any indictable offence or under any laws that regulate the provision of health care services or health insurance.

9.8 Medical records

Accredited Practitioners must:

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

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

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

   iii. in a way which enables the iMH Group Entity operating the Facility to collect revenue in a timely manner and any other data reasonably required in respect of a Facility, including as a minimum:

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

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

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

d) complying with all legal requirements and standards in relation to the prescription, administration, discard and safeguarding of medication, and properly documenting all drug orders correctly and legibly in the iMH medication chart of the patient's Hospital medical record;

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

f) take all reasonable steps to ensure that, following the discharge of each patient, the Facility's medical record is completed within a reasonable time after the patient's discharge; and

g) acknowledge and agree that medical records of patients of the Facility are owned by the relevant iMH Group Entity operating the Facility.

9.9 Continuing education

Accredited Practitioners must:

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

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

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

9.10 Clinical activity

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

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

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

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

9.11 Participation in Committees

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

b) in addition to the requirement under By-Law 9.11(a), Accredited Practitioners must meet

all reasonable requests to participate in, and contribute actively to, Committees established to co-ordinate and direct the various functions of the Facility.

c) Without limiting By-Law 9.11(a), the FCEO may require any Accredited Practitioner to nominate him or herself to act as a member of a Committee. Before doing so, the FCEO must have regard to:

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

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

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

9.12 Emergency/disaster planning

Accredited Practitioners must:

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

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

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

9.13 Pandemic Preparedness and Response

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

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

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

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

9.14 Working with children checks/criminal record checks

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

b) The Accredited Practitioner must undertake to iMH and the relevant iMH Group Entity that he or she is not a Prohibited Person, and:

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

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

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

iv. will not engage in Reportable Conduct.

c) The Accredited Practitioner must inform iMH immediately if he or she is unable to give the undertakings (set out in By-Law 9.14b).

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

9.15 Teaching and supervision

a) Unless otherwise determined by the FCEO, Accredited Practitioners must participate in the education, training and supervision of students, junior medical officers and other accredited health practitioners as required from time to time, attending the Facility including facilitating the availability of patients for clinical teaching subject to:

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

ii. consent being given by the patient.

9.16 Notifiable Conduct and mandatory reporting

a) All Accredited Practitioners must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009, as in force in each State and Territory.

9.17 Best Practice

a) iMH believes that national clinical guidelines and standards developed collaboratively by organisations such as:

i. Australian Commission on Safety and Quality in Health Care;

ii. National Health and Medical Research Organisation;

iii. National Institute of Clinical Studies;

iv. recognised authorities in evidence based medicine, such as the Cochrane Collaboration;

v. specialist training colleges and organisation accredited by the Australian Medical Council;

vi. the clinical professional organisations and societies; and

vii. various peak clinical non-government organisations (such as RANZCP)

represent the current clinical 'best practice' for many areas of medicine, and should whenever possible and practicable, be consulted for guidance to support informed clinical decision-making and the development of pathways of care that yield optimal clinical outcomes. While all clinical decisions are, ultimately, the prerogative of the treating Accredited Practitioner, iMH expects the use of evidence-based clinical guidelines and medicine at its Hospitals unless the particular clinical circumstances of a patient requires otherwise and iMH may initiate a review pursuant to By-Law 14 and take formal action with respect to Accreditation and Scope of Clinical Practice if the care provided to one or more patients, including post care follow-up, is below the expected standard of care.

9.18 Notice of leave

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

9.19 Notice of Resignation

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

10. TRANSFER OF ACCREDITATION STATUS BETWEEN FACILITIES

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

b) Applications and accompanying documentation from the original Facility in which the Accreditation was approved will be submitted to the FCEO of the new Facility and to the MAC via the Accreditation and Credentialing Committee of the new Facility for consideration and endorsement prior to the approval being granted by the new facility FCEO.

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

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

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

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

11.1 Notice to Accredited Practitioner

a) Not less than three months before the date fixed for expiry of the Accreditation of an Accredited Practitioner, the FCEO must notify the Accredited Practitioner of the pending expiry of their Accreditation and the processes for applying for Re- accreditation and review of their Scope of Clinical Practice.

11.2 Apply for Re-accreditation

a) An Accredited Practitioner must apply for Re-accreditation before the expiration of the term of Accreditation in order to maintain Accreditation with the Facility.

11.3 Amendments

An Accredited Practitioner may make an application to the FCEO for amendment of their Scope of Clinical Practice:

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

b) at any other time.

11.4 Process

a) The FCEO will forward applications for Re-accreditation and/or amendments to Scope of Clinical Practice, together with all other relevant information, to the Accreditation and Credentialing Committee for review and consideration.

b) Subject to iMH or the relevant iMH Group Entity policy, the processes for Re-accreditation and/or amending the Scope of Clinical Practice of Accredited Practitioners under this By-Law 12 will:

i. include an assessment and review of the Accredited Practitioner's performance, Current Fitness, Credentials, character and ability to cooperate with management and staff at the Facility; and

ii. be otherwise the same as for an initial Accreditation, save that By-Law 18.1 will not apply to Re-accreditation or amendments to Scope of Clinical Practice.

11.5 Review

a) All Accredited Practitioners will be subject to the processes of Re-accreditation and review of their Scope of Clinical Practice in accordance with the appointments cycle.

12. INVESTIGATIONS OF CONCERNS, ALLEGATIONS OR COMPLAINTS

12.1 Facility Chief Executive has right to monitor and undertake audits

The FCEO has the right to monitor and undertake audits of the Accredited Practitioner's compliance with their obligations set out in the By-Laws and in particular their compliance with relevant standards and their scope of clinical practice. If any concerns arise from the monitoring/audit process the FCEO may decide to make investigations pursuant to clause 13.2 of these By-Laws.

12.2 Facility Chief Executive Officer may make investigations

The FCEO may make inquiries regarding a concern raised, allegation or complaint against an Accredited Practitioner if the FCEO considers that it warrants making such an inquiry, including in circumstances where the concern raised, or allegation or complaint made has or may result in:

a) patient health or safety could be compromised;

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

c) the reputation of the Facility, an iMH Group Entity or iMH could be threatened;

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

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

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

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

h) staff welfare or safety could be compromised.

12.3 Notice to Accredited Practitioners and procedural matters

a) The FCEO will advise the Accredited Practitioner in respect of whom the concern, allegation or complaint has been made and the substance of the concern, allegation or complaint and provide the Accredited Practitioner with an opportunity to respond.

b) The FCEO will decide on all procedural matters relevant to advising the Accredited Practitioner under By-Law 13.2(a), which may include a determination on:

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

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

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

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

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

12.4 Review by Facility Chief Executive Officer

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

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

b) if in the opinion of the FCEO the matter can be dealt with appropriately by reviewing the Accredited Practitioner's Scope of Clinical Practice, the FCEO must request a review of the Accredited Practitioner's Scope of Clinical Practice in accordance with By-Law 14;

c) if in the opinion of the FCEO the matter cannot be dealt with appropriately by a review of

the Accredited Practitioner's Scope of Clinical Practice, the FCEO in consultation with the chairperson of the MAC may establish a Committee to consider the matter further; and

d) the FCEO may impose an interim suspension or conditions on the Accreditation of the Accredited Practitioner until such time as the FCEO is satisfied that the concern, allegation or complaint has been resolved or until the outcome of a review in accordance with By-Law 14 or a decision with respect to appropriate action arising from consultation in accordance with By-Law 13.3(c).

e) There will be no right of appeal with respect to the imposition of an interim suspension or conditions.

f) The terms of reference, process, and reviewers will be determined by the FCEO.

12.5 Committee to assess issue of concern

A Committee (either the MAC or sub-committee thereof) to assist the FCEO established under By-Law 13.3(c):

a) must ensure the Accredited Practitioner has been advised in writing of the particulars of the allegation and invite the Accredited Practitioner to respond;

b) may invite the Accredited Practitioner to meet with the relevant Committee in person; and

c) must provide the FCEO with its written conclusions and/or opinions in a timely manner and supported by reasons.

12.6 Notifiable Conduct and mandatory reporting in relation to any investigation

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

b) The FCEO must advise the NCGM, Risk and Quality and CEO of any mandatory reporting made under By-Law 13.5(a).

c) The National Risk and Compliance Manager must advise other iMH Group Entities and Facilities where the Accredited Practitioner is accredited of the notification.

d) The Accredited Practitioner must notify other facilities where they hold accreditation of the notification.

13. REVIEW OF SCOPE OF CLINICAL PRACTICE IN LIGHT OF INVESTIGATIONS OF CONCERNS, ALLEGATIONS OR COMPLAINTS

13.1 Surveillance of AHPRA registration database

a) The FCEO will conduct periodic and active surveillance of the AHPRA registration database to ensure currency of registration and accuracy of any Conditions imposed.

13.2 Facility Chief Executive Officer initiated internal review

a) The FCEO may, at any time, direct the Accreditation and Credentialing Committee or other appropriate individuals as determined by the FCEO to conduct an internal review of the Accreditation previously granted to an Accredited Practitioner including an assessment if necessary of Current Fitness and Credentials of the Accredited Practitioner and following such review, the Accreditation and Credentialing Committee will make a recommendation to the FCEO, through the MAC concerning the continuation, amendment, suspension or revocation of Accreditation. The FCEO will make a final determination in relation to the matter, subject to the provisions of By-Law 19.2.

13.3 Facility Chief Executive Officer initiated external review

a) The FCEO may, at any time, consult with the Chair of the Accreditation and Credentialing Committee in relation to an independent review of the Accreditation previously granted to an Accredited Practitioner including an assessment if necessary of Current Fitness and Credentials of the Accredited Practitioner and following such review, a recommendation to the MAC must be made concerning the continuation, amendment, suspension or revocation of Accreditation. Such a review process will result in a recommendation to the FCEO who will make a final determination in relation to the matter, subject to the provisions of By-Law 19.2.

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

13.4 Notice to Accredited Practitioners

a) The FCEO will advise the Accredited Practitioner in respect of whom a review is being conducted under either By-Law 14.2 or 14.3 of the commencement and substance of the review and the extent to which the Accredited Practitioner may participate in the review and that the Accredited Practitioner will be provided with an opportunity to respond during the review.

b) The FCEO will decide on all procedural matters relevant to advising the Accredited Practitioner under By-Law 14.4(a) which may include a determination on:

i. how the review in respect of the Accredited Practitioners will be dealt with under these By-Laws;

ii. a requirement for a witness to be present at the time the Accredited Practitioner is advised and the designation of that witness;

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

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

c) The Accredited Practitioner will be afforded the opportunity to be accompanied by a support person in the handling of any procedural matters pursuant to this By-Law 14. The support person is not to participate in the process. Should the support person be a lawyer that same person must not act as a legal representative for the Accredited Practitioner.

d) The FCEO must advise the NCGM and iMH CEO that the review is being undertaken under either By-Law 14.2 or 14.3.

13.5 Action the Facility Chief Executive Officer may take following review

Following a review under By-Law 14.2 or 14.3 the FCEO may direct that the Accredited Practitioner:

a) cease performing surgical, anaesthetic, medical or dental procedures or perform only defined procedures;

b) perform surgical, anaesthetic, medical or dental procedures only when assisted by another Accredited Practitioner qualified in the same field of practice;

c) practise a restricted range of medical, surgical, anaesthetic or dental procedures; or

d) not admit or manage patients unless in consultation with another Accredited Practitioner qualified in the same field of practice,

or may apply additional Conditions to the Accredited Practitioner's Accreditation or suspend or cancel the Accredited Practitioner's Accreditation in accordance with the relevant By-Laws herein.

13.6 Notice of outcome of the review

a) The FCEO must give written notice to the Accredited Practitioner where the FCEO wishes to exercise their rights under this By-Law 14.

b) The FCEO must notify the NCGM and iMH CEO of the outcome of any review undertaken under By-Law 14.

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

a) The FCEO must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009, (including in relation to any mandatory reporting obligations in relation to actions taken by the FCEO following a review under By-law 14) as enforced in each State and Territory.

b) The FCEO must advise the NCGM and iMH CEO of any mandatory reporting made under By-Law 14 (including in relation to any action taken in relation to the Accreditation of an Accredited Practitioner under By-law 14.5).

13.8 Not Contingent

The FCEO's right to proceed with review(s) in accordance with this By-Law 14 is not contingent on the FCEO having first carried out any review in accordance with By-Law 13.

14. SUSPENSION

14.1 Suspension of Accredited Practitioners by Facility Chief Executive Officer

The FCEO may, and without having regard to By-Law 14, and where considered reasonable and appropriate in the circumstances following consultation with the MAC (and/or such other persons as the FCEO considers appropriate) and the NCGM and iMH CEO, based on the information available to the FCEO at that time:

i. suspend all or any portion of an Accredited Practitioner's Accreditation, including the privilege to use the operating theatre ; or

ii. impose Conditions on the Accreditation of an Accredited Practitioner,

whenever the FCEO considers:

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

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

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

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

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

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

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

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

i) serious and unresolved allegations have been made in relation to the Accredited Practitioner (This may be related to a patient or patients of another facility not operated by the Hospital, including if these are the subject of review by an external agency including

a registration board, disciplinary body, Coroner, complaints commission or another health service);

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

k) the behaviour or conduct is inconsistent with a policy, procedure, direction or code of conduct in relation to the expected standard of behaviour or conduct at the Hospital;

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

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

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

o) the Accredited Practitioner has been convicted of a crime which could affect their ability to exercise their Clinical Privileges safely and competently and with the confidence of the Hospital and the broader community;

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

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

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

14.2 Notification of suspension decision and reasons

The FCEO must:

a) notify the Accredited Practitioner of the decision to suspend and conditions and timeframes which will apply to reinstatement and must give reasons; and

b) invite a written response from the Accredited Practitioner within a timely manner of the FCEO's notification.

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

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

14.3 Suspension effective immediately and right to claim

a) Suspension will become effective immediately upon notification to the Accredited Practitioner and it is a condition of Accreditation that the Accredited Practitioner acknowledges and agrees that suspension of his/her Accreditation shall not, in any circumstances, give rise to any right on behalf of the Accredited Practitioner to claim compensation from the Facility, iMH or an iMH Group Entity and the Accredited Practitioner further agrees that this By-Law may be used as an absolute bar to any proceedings in relation thereto..

14.4 Alternative arrangements for patients

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

14.5 Appeal rights

a) Unless otherwise provided in these By-Laws, the affected Accredited Practitioner will have the rights of appeal established by these By-Laws.

14.6 Notification to Board

a) The FCEO will notify the CEO iMH of any suspension of Accreditation of an Accredited Practitioner. The iMH CEO who will notify the Board of any suspension of Accreditation of an Accredited Practitioner.

14.7 Notifiable Conduct and Mandatory Reporting

a) The FCEO must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009*,* (including in relation to any suspension of Accreditation of an Accredited Practitioner under By-law 15), as enforced in each State and Territory.

b) The FCEO must advise the NCGM of any mandatory reporting made under By-Law 15.7(a).

14.8 Alternative to Suspension

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

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

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

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

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

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

f) Following receipt of the response the FCEO will determine whether the Accreditation will be suspended. If suspension is to occur notification will be sent in accordance with the notification requirements of this By-law. Otherwise, the Accredited Practitioner will be advised that suspension will not occur at this stage; however this will not prevent the FCEO from taking other action at this time, including imposition of conditions, and will not prevent the FCEO from relying upon these matters as a ground for suspension or cancellation in the future.

15. CANCELLATION OF ACCREDITATION

15.1 Immediate cancellation

Accreditation of Accredited Practitioners will be canceled immediately by the FCEO and, where considered reasonable and appropriate in the circumstances, in consultation with the NCGM and iMH CEO, if, based on the information available to the FCEO at that time:

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

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

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

d) the Accredited Practitioner fails, refuses or is unable to comply with the requirements and undertakings set out in By-Law 9.13, or is dishonest in respect of the undertakings given in By-Law 9.13(b);

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

f) the Accredited Practitioner's Professional Indemnity Insurance is cancelled, lapses or no longer covers the Accredited Practitioner's Scope of Clinical Practice to the reasonable satisfaction of the FCEO (unless the situation is rectified by the Accredited Practitioner within 24 hours from when he or she becomes aware that their Professional Indemnity Insurance has been cancelled, lapsed or does not cover their Scope of Clinical Practice).

15.2 Unprofessional Conduct

a) Accreditation of Accredited Practitioners may be cancelled immediately if the Accredited Practitioner is found guilty of Unprofessional Conduct by any inquiry, investigation or hearing by any disciplinary body or professional standards organisation.

15.3 Cancellation on incapacity

a) An Accredited Practitioner's Appointment may be cancelled if, in the reasonable opinion of the FCEO (having first obtained independent advice), an Accredited Practitioner becomes incapable of performing their duties for a continuous period of six months or for a cumulative period of six months in any 12 month period.

15.4 Cancellation when not immediate (this should be discussed)

Accreditation of an Accredited Practitioner may be cancelled by the FCEO having, where considered reasonable and appropriate in the circumstances consulted with the NCGM and iMH CEO, by giving the Accredited Practitioner 1 month written notice if:

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

b) the Accredited Practitioner, after due hearing, is considered by the FCEO to have engaged in Professional Misconduct and/or Unprofessional Conduct;

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

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

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

f) the Accreditation is no longer supported by the Organisational Need or Organisational Capabilities of the Facility;

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

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

i) the Accredited Practitioner's agreement with a contracted services provider for whom the Accredited Practitioner provides services terminates, or if the Accredited Practitioner's employment engagement with the contracted service provider terminates;

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

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

l) the Accredited Practitioner has applied for a review of the suspension of their Accreditation under By-Law 15.5 and on review the decision to suspend is upheld; or

m) there are grounds for suspension pursuant to By-Law 15.1 but in the circumstances it is considered that suspension is an insufficient response.

15.5 Notification to Board

a) The FCEO will notify the iMH CEO of any termination of Accreditation of an Accredited Practitioner. The iMH CEO will notify the NCGM who will together coordinate notification to the Board of any cancellation of Accreditation of an Accredited Practitioner. `

15.6 No appeal rights where immediate cancellation

a) No right of appeal will exist in respect of immediate cancellation pursuant to By-Law 16.

15.7 Immediate Cancellation at each Facility and no right to claim

a) The immediate cancellation of Accreditation of an Accredited Practitioner pursuant to By-Law 16.1 at one Facility will cause the automatic cancellation of Accreditation at any other Facility operated or conducted by an iMH Group Entity and it is a condition of Accreditation that the Accredited Practitioner acknowledges and agrees that cancellation of his/her Accreditation shall not, in any circumstances, give rise to any right on behalf of the Accredited Practitioner to claim compensation from the Facility, iMH or an iMH Group Entity and the Accredited Practitioner further agrees that this By-Law may be used as an absolute bar to any proceedings in relation thereto..

15.8 Notifiable Conduct and Mandatory Reporting

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

b) The FCEO must advise the NCGM and iMH CEO of any mandatory reporting made under By-Law 16.8(a) (including in relation to any termination of Accreditation of an Accredited Practitioner under By-law 16).

15.9 Alternative to Cancellation

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

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

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

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

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

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

f) Following receipt of the response the FCEO will determine whether the Accreditation will be cancelled. If cancellation is to occur notification will be sent in accordance with the notification requirements of this By-law. Otherwise, the Accredited Practitioner will be advised that cancellation will not occur at this stage; however this will not prevent the FCEO from taking other action at this time, including imposition of conditions, and will not prevent the FCEO from relying upon these matters as a ground for suspension or cancellation in the future.

16. IMPOSITION OF CONDITIONS

16.1 Imposing Conditions in lieu of suspension or cancellation

a) In lieu of the suspension of the Scope of Clinical Practice or cancellation of Accreditation of an Accredited Practitioner, the FCEO may elect to impose Conditions on the Accreditation or Scope of Clinical Practice of an Accredited Practitioner.

b) The imposition of Conditions may be recommended by the appointments Committee or scope of clinical practice Committee, but is at the ultimate discretion of the FCEO.

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

d) If the Conditions are breached, then suspension of Scope of Clinical Practice or cancellation of Accreditation of an Accredited Practitioner may occur.

e) If there is held, in good faith, a belief that the competence and/or Current Fitness to practice of the Accredited Practitioner is such that continuation of the unconditional right to practise in any other Facility would raise a significant concern about the safety and quality of health care, the FCEO will ensure that the imposition of Conditions is notified to the relevant professional registration board and relevant State or Commonwealth bodies.

f) The appeal procedure contained in these By-Laws will apply to an imposition of conditions under By-law 17.

16.2 Notification of conditions

a) Following expiration of the appeal period, the decision to impose Conditions under these By-laws will be notified to other iMH Facilities where Scope of Clinical Practices are held by that Accredited Practitioner, as well as notification whether an appeal has been lodged, and that other Facility may elect to ask the Accredited Practitioner to show cause why the imposition of Conditions or other action should not occur at that Facility.

16.3 Notification to Board

a) The FCEO will notify the NCGM and the iMH CEO of any imposition of Conditions on the Accreditation of an Accredited Practitioner. The iMH CEO will notify the Board of any imposition of Conditions on an Accredited Practitioner.

16.4 Notifiable Conduct and Mandatory Reporting

a) The FCEO must comply with their obligations of mandatory reporting of notifiable conduct as prescribed in the *Health Practitioner Regulation National Law Act* 2009, as in force in each State and Territory (including in relation to the imposition of Conditions on the Accreditation or Scope of Clinical Practice of an Accredited Practitioner) under By-law 17.

b) The FCEO must advise the iMH CEO and NCGM of any mandatory reporting made under By-Law 17.4(a).

17. APPEAL RIGHTS

17.1 No appeal rights against refusal of initial Accreditation

a) There shall be no right of appeal by an applicant against a decision not to grant an initial Accreditation as an Accredited Practitioner to the Facility or from any terms or conditions that may be attached to an approval of an initial Accreditation as an Accredited Practitioner at the Facility.

b) There shall be no right of appeal if an approval of an initial Accreditation as an Accredited Practitioner at the Facility included an initial probationary period (as determined appropriate by the FCEO) and at the conclusion of the probationary period the FCEO determined that Accreditation would not be granted following conclusion of the probationary period. In such circumstances the Accredited Practitioner will be required, if they seek Accreditation at the Hospital, to make a further application for Accreditation that will be regarded as an application for an initial Accreditation as an Accredited Practitioner at the Hospital.

c) There shall be no right of appeal against a decision not to grant a temporary or emergency Urgent Accreditation

d) There shall be no right of appeal against a decision not to introduce a new or amended use of technology or procedure.

e) Should an applicant holding a current Accreditation as an Accredited Practitioner have that Accreditation rejected, either in whole or in part or varied by the FCEO, the applicant shall have the rights of appeal set out within these By-Laws .

17.2 Appeal rights generally

a) Except where these By-Laws state otherwise (see By-Laws 8.4(g), 11.8, 16.6, 18.1 and 23.3(b) an Accredited Practitioner who has Accreditation in respect of the Facility and whose Accreditation is amended, made conditional, suspended, cancelled, not renewed or conditionally renewed by the Facility, will have the rights of appeal set out in By-Law 19.

17.3 Concurrent appeal rights

a) Despite any other provision of these By-Laws, where an Accredited Practitioner has appeal rights under these By-Laws concurrently with appeal rights under any legislation or mandatory directive and/or policy in respect of the same circumstances, the appeal rights under these By-Laws will cease to be available to the Accredited Practitioner. For the avoidance of doubt, if this By-Law 18.3 applies, the Accredited Practitioner will not have appeal rights under these By-Laws but will continue to have the appeal rights available under any legislation or mandatory directive or policy.

18. APPEAL PROCEDURE

18.1 Appeal must be lodged in fourteen days

a) An Accredited Practitioner will have 14 days from the date of notification of a decision to amend, make conditional, suspend, cancel, not renew or conditionally renew their Accreditation to lodge an appeal against the decision. Such an appeal must be in writing and be lodged with the FCEO.

18.2 Relevant Committee established to hear appeal

The FCEO will establish an appeals Committee to hear the appeal. The appeals Committee must as a minimum include:

a) the NCGM or delegate;

b) the iMH CEO, or delegate; and

c) A nominee of the appropriate professional college of the appellant.

18.3 FCEO

If the decision being appealed and reviewed by the appeals Committee was made:

a) by the FCEO personally or relates to a Facility at which the appellant was previously Accredited, then the FCEO must not be a member of the appeals Committee hearing the relevant appeal; or

b) by a Delegated Authority, then that Delegated Authority must not be a member of the appeals Committee hearing the relevant appeal.

18.4 Chairperson

a) The chairperson of the appeals Committee will be the NCGM or the iMH CEO.

18.5 One vote per member

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

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

18.6 Notice

a) The appellant will be provided with appropriate notice by the appeals Committee and will have the opportunity to make a submission to the appeals Committee.

18.7 Submissions

a) The appeals Committee will determine whether the submission of the appellant will be in writing or in person, or both. The appellant must provide written submissions for the appeals Committee within the timeframe reasonably required by the appeals Committee.

18.8 No legal representation

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

18.9 Chairperson determines procedure of the appeals Committee

a) The chairperson of the appeals Committee will determine any question of procedure for the appeals Committee provided that it complies with the conventions of natural justice.

18.10 Final determination of the Appeals process

a) The appeals Committee will make a written recommendation to the FCEO and the

relevant iMH Group Entity Board, which will consider the recommendation and the processes leading to the appeals Committee's recommendation. The Board will then make a determination regarding the appeal. The determination of the iMH Group Entity Board will be final and binding.

18.11 No Stay

a) If an Accredited Practitioner appeals a decision to amend, make conditional, suspend, cancel, not renew or conditionally renew their Accreditation, the appeal will not stay the decision under appeal.

19. RESEARCH

19.1 Approval of research

Clinical research by an Accredited Practitioner in or at the Facility may only commence if:

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

b) the proposed clinical research is consistent with the National Health & Medical Research Council (NHMRC) Statement on Ethical Conduct in Human Research (2007) and any relevant jurisdictional legislation or guidelines;

c) an application to carry out the proposed research is submitted using the appropriate forms – National Ethics Application Form (NEAF) or specific jurisdictional forms to facilitate the Facility's Human Research Ethics Committee (HREC);

d) the HREC is constituted according to the NHMRC Statement on Ethical Conduct in Human Research (2007);

e) the FCEO may delegate the facilitation of the HREC and associated research governance requirements to an appropriately qualified manager and Director of Research;

f) clinical research may only commence after written approval from the HREC and FCEO, after all ethical and governance issues have been approved and evidence of insurance is in place;

g) in accordance with the NHMRC Statement on Ethical Conduct in Human Research (2007) the HREC may delegate to an appropriate subcommittee the approval for 'low risk' and 'quality assurance' studies;

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

i) each Facility will ensure the appropriate insurance cover for the clinical research is in place (refer to iMH Clinical Trials and Research Policy (CORP-CLIN-2.14);

j) all clinical research must comply with relevant legislative provisions, standards and guidelines including but not limited to guardianship legislation, radiation, safety precautions and any other jurisdictional specific matters; and

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

19.2 Withdrawal or disapproval of research

The FCEO may withdraw permission for, or place Conditions upon, the conduct or continuation of research involving treatment of human subjects at the Facility if in their opinion the research:

a) cannot be conducted by the Accredited Practitioner and/or supported by the Facility at an appropriate standard of safety and quality;

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

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

d) is inconsistent with good professional practice.

20. EXPERIMENTAL OR INNOVATIVE TREATMENT OR TECHNIQUES

20.1 Approval of experimental treatment or techniques

Experimental or innovative treatment or techniques (including any new or revised use of technology or incremental development of established treatments, techniques or therapies) will only commence if:

a) it is to be carried out by an Accredited Practitioner with appropriate Credentials and Scope of Clinical Practice granted in accordance with these By-Laws to cover the experimental or innovative treatment or technique;

b) the experimental or innovative treatment or technique is consistent with the Code of Conduct and with the Codes of Ethical Standards of iMH;

c) the Accredited Practitioner has submitted details to the FCEO for appropriate review and approval by the relevant Committee and, subject to By-Law 21.2, the approval of both has been given and the FCEO is satisfied that appropriate insurance cover is in place; and

d) where appropriate, the Accredited Practitioner complies with the relevant provisions of guardianship legislation including but not limited to obtaining any necessary approvals of the relevant guardianship authority.

20.2 Approval by the FCEO

a) The FCEO may, having consulted with the head of the relevant Committee, approve experimental or innovative treatments or techniques where he or she is of the opinion that formal review and approval by the relevant Committee is not necessary.

b) The FCEO must have regard to Facility policy regarding the circumstances where formal review and approval of experimental or innovative treatments or techniques are required.

c) Approval will be subject to iMH insurer noting the experimental or innovative treatments or techniques.

20.3 Ethical issues and human subjects

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

a) the treatment or technique has been referred to and approved by the relevant ethics Committee; and

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

c) subject to iMH insurer noting of such experimental or innovative treatment or technique: and

d) evidence of the Accredited practitioner's insurance noting the experimental or innovative treatment or technique.

20.4 New Clinical Services, Procedures or Other Interventions

a) An Accredited Practitioner who proposes to perform a New Clinical Service, Procedure or Other Intervention at the Facility must apply in writing to the FCEO for approval.

b) The FCEO must refer the application to the relevant Committee which will advise on the safety, efficacy and role of the New Clinical Service, Procedure or Other Intervention in the context of the Facility's Organisational Need and Organisational Capabilities.

c) The relevant Committee will advise the FCEO:

i. whether, and under what conditions, the New Clinical Service, Procedure or Other Intervention could be introduced safely to the Facility; and

ii. whether, the New Clinical Service, Procedure or Other Intervention or equipment is consistent with the Accredited Practitioner's Scope of Clinical Practice.

d) The FCEO may seek additional advice about the financial, operational or clinical implications of the introduction of the New Clinical Service, Procedure or Other Intervention.

e) The FCEO may refuse permission for the introduction of a New Clinical Service, Procedure or Other Intervention.

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

i. be satisfied that the New Clinical Service, Procedure or Other Intervention is consistent with the Organisational Need and Organisational Capabilities of the Facility;
ii. where the New Clinical Service, Procedure or Other Intervention involves research, be satisfied that the requirements of By-Law 20.1 has been met;
iii. be satisfied that the appropriate indemnity and/or insurance arrangements are in place; and
iv. notify the relevant Committee.

21. MANAGEMENT OF EMERGENCIES

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

In such cases, the following provisions will apply:

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

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

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

d) the patient's care will usually be returned, as soon as possible, to the Accredited Practitioner under whose care the patient was admitted, who will then resume the further management of the patient's condition.

22. REPUTATION OF THE FACILITY

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

a) The FCEO may, from time to time, on the basis of ethical or economic grounds, or upon the basis that certain types of medical practice may damage the reputation of the Facility (or otherwise attract adverse publicity), require an Accredited Practitioner to immediately cease carrying out certain types of procedures, giving certain advice or recommending certain forms of treatment.

22.2 Accredited Practitioner to cease upon notice from the FCEO

a) On being notified by the FCEO of a requirement under By-Law 23.1, the Accredited Practitioner will immediately cease to carry out such procedures, give such advice, or recommend such treatment.

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

a) Following a decision of the FCEO under By-Law 23.1, the FCEO will refer the matter to the Accreditation and Credentialing Committee for consideration and discussion. The Committee may convey comments or make recommendations to the FCEO in relation to the decision. The FCEO may, in its absolute discretion, affirm or vary the decision of the Committee.

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

23. ADMISSION AND REMOVAL OR TRANSFER OF PATIENTS

23.1 All admissions subject to approval

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

23.2 Right to request discharge or transfer of patient

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

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

23.3 Facility may do all things necessary to arrange removal

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

24. DISPUTES

24.1 By-Laws

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

24.2 Committees

a) Any dispute or difference which may arise as to the meaning or interpretation of the powers of any Committee established under these By-Laws or the validity of proceedings of any meeting, excluding the Appeals Committee, will be determined by the FCEO or the NCGM

25. REVISION OF BY-LAWS

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

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

26. SERVICE PROVIDERS

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

a) provide that only health professionals who have been accredited to treat patients at the Facility may provide the clinical services; or

b) require the third party contractor to ensure that:

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

ii. the health professionals who provide the services do so only within the Scope of Clinical Practice or under the Accreditation Classification or conditions of Accreditation specified in the contract as generally applicable to all health

professionals providing the services, unless they have been accredited specifically by the Facility as Accredited Practitioners with a modified Scope of Clinical Practice/Accreditation Classification/conditions of Accreditation;

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

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

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

27. FACILITY SCHEDULES

Schedules needed to be read in conjunction with these by-laws.