ORYGEN BY-LAWS

ACN 098 918 686

30 May 2022

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PREAMBLE

These By-Laws define the relationship and obligations between Orygen Limited and its Accredited Practitioners.

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

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

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

Credentialing and defining the Scope of Clinical Practice are governance responsibilities of the Chief of Clinical Practice (CCP) and may be delegated as appropriate. Accreditation, Credentialing, Re-accreditation and the process for defining and amending Scope of Clinical Practice is a non-punitive process, with the paramount consideration being the safety, quality and experience of patients.

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

Those who accept Appointment as a Facility's Accredited Practitioner agree to respect, observe and act in accordance with those principles embodied in the following:

- Orygen's Mission, Vision and Values;
- Orygen Code of Conduct;
- Orygen's Child Safety Code of Conduct;
- Code of Ethics of the Australian Medical Association;
- These By-Laws;
- Applicable Orygen and Facility policies and procedures;
- Applicable State and Commonwealth policies and legislative requirements; and
- Codes of Conduct articulated by relevant registration authorities.

MISSION STATEMENT AND VALUES

Orygen and the Facility are committed to safe, evidence-based mental health care of an international standard.

We aim to provide an exceptional standard of mental health service to our patients that is personally tailored, diagnostically-driven, intensive and effective.

Wherever possible, we support our patients to remain with their families and community during their mental health treatment journey and recovery.

We develop collaborative and transparent relationships with our patients, their families, and the professionals who engage with us.

Our team will be proud of their work and the achievements of our young people and families we work with.

We expect our staff to live the values of Orygen, including striving for towards professional excellence, driving innovation, always demonstrating respectful behaviours, being accountable and working as a team.

We are committed to ongoing improvement in our standard of professional excellence, to attain our highest value of supporting our patients to achieve the best mental health outcomes they can.

1 BY-LAWS

1.1 Application of By-Laws

Orygen requires that the By-Laws are read in their entirety by an applicant as part of the Accreditation and Re-accreditation process, as well as at any time amendments are made to the By-Laws, given that the By-Laws require strict adherence by Accredited Practitioners. A failure to read the By-Laws and any amendments will not be considered a reasonable excuse for non-compliance.

1.2 Inconsistencies with legislation

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

2 INTERPRETATION AND DEFINITIONS

2.1 Paramount Considerations

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

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

(c) In making decisions with respect to these By-Laws and taking actions pursuant to these By-Laws, the safety, quality and experience of patients will be the paramount considerations.

2.2 Definitions

In these By-Laws, unless otherwise stated:

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

(a) the Scope of Clinical Practice;

(b) any specified Conditions;

(c) the Codes of Conduct;

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

(e) these By-Laws.

Accredited Practitioner means a Medical Practitioner authorised to treat patients at the Facility in accordance with a Scope of Clinical Practice, or such other category of health practitioner approved by the CCP.

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 National Law.

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

Appointment means the employment, engagement or authorisation of an Accredited Practitioner to provide services within the Facility according to the By-Laws, any Conditions defined by law and which may be supplemented by a Contract of Employment or Contract of Engagement, or howsoever named by the Facility.

Behavioural Standards means the standard of conduct and behaviour expected of an Accredited Practitioner arising from personal interactions, communication and other forms of interaction with other Accredited Practitioners, employees and volunteers of Orygen, Board members of Orygen, executives of Orygen, third party service providers, patients, family members of patients and others. The minimum standard required of Accredited Practitioners in order to achieve the Behavioural Standards is compliance with the Code of Conduct, the expectations set out in the *Good Medical Practice: A Code of Conduct for Doctors* in Australia (as applicable), and the Orygen Mission Statement and Values.

Board means the Board of Directors of Orygen.

Clinical Governance Committee means a sub-committee established (and chaired) 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 the Facility:

(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.

Clinical Review Committee means the Clinical Review Committee (**CRC**) set out in Schedule 1 of these By-Laws.

Chief of Clinical Practice (CCP) means the chief medical officer of Orygen as appointed by the Executive Director.

Code of Conduct means the relevant code or codes of conduct of the Facility.

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

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

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

(c) Appeals in accordance with these By-Laws.

Competence means, in respect of a person who applies for Accreditation or Reaccreditation, or holds current Accreditation, that the person is assessed to have the required knowledge, skills, training,

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

Condition means as applicable with respect to an Accredited Practitioner:

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

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

Contract of Employment means an enforceable written agreement in whatever form that establishes an employment relationship between the Facility and an Accredited Practitioner and defines the rights and obligations of each party.

Contract of Engagement means an enforceable written agreement in whatever form that establishes a contractual relationship between the Facility and an Accredited Practitioner and defines the rights and obligations of each party.

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

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

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

Executive Director means the executive director or equivalent of Orygen as appointed by the Board.

Facility means the Orygen Recovery (YPARC) health facility owned and operated by Orygen, and in which health services are provided, located at 35 Poplar Road, Parkville, Victoria.

Medical Advisory Committee means the Medical Advisory Committee (**MAC**) set out in Schedule 1 of these By-Laws.

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

National Law means *Health Practitioner Regulation National Law Act 2009* as it applies in Victoria.

New Clinical Service, Procedure, or Other Intervention means that which would be considered by a reasonable body of medical opinion to be significantly different from existing clinical practice or if currently used are planned to be used in a different way or significantly altered from that previously approved. 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 has the same meaning prescribed to that term in the National Law.

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

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

Orygen means Orygen Limited.

PC&W Team means the people culture and wellbeing team of Orygen.

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

Professional Indemnity Insurance means the insurance of an Accredited Practitioner taken out if and as required in accordance with By-Law 8.5.

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

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

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

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 (Australian Health Practitioner Regulation Agency).

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

Scope of Clinical Practice means the process following on from Credentialing and involves delineating the extent of an Accredited Practitioner's clinical practice within the Facility based on the individual's Credentials, Competence, Performance, Current Fitness, professional suitability and the Organisational Need and Organisational Capabilities of the Facility to support the Accredited Practitioner's Scope of Clinical Practice.

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

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

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

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

2.3 General Interpretation

(a) Rules for interpreting these By-Laws:

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

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

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

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

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

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

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

(b) Quorum

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

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

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

(c) Resolutions without meetings

A decision may be made by a Committee or group established pursuant to these By-Laws (except that established by By-Law 17) 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.

(d) Meeting by electronic means

A Committee or group established pursuant to these By-Laws (except that established by By-Law 17) 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.

(e) Voting

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

(f) Delegation

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

(g) Compensation

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

3 PRIVACY AND CONFIDENTIALITY

3.1 Privacy

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

3.2 Privacy Obligations on Accredited Practitioners

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

(a) business information concerning Orygen or the Facility;

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

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

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

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

3.3 Committees

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

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

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

3.4 Obligation of Confidentiality

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

3.5 Exceptions to Confidentiality

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

(a) where disclosure is required or specifically authorised by law;

(b) where use and/or disclosure of personal information is consistent with By-Law 3.1;

(c) where disclosure is required by a regulatory body in connection with the Accredited Practitioner;

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

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

3.6 Privacy and Confidentiality Obligations Continue

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

3.7 Information Sharing

Subject to By-Law 8.2, 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 appointment, conduct and any other matters related to these By-laws to any professional college that the Accredited Practitioner is a member of.

(a) As part of the application process for Accreditation or following approval of Accreditation, the Accredited Practitioner will be required to provide all necessary consents for the collection, holding, accessing, using and disclosing sensitive and confidential information relating to and/or about a breach of the Behavioural Standard or the conduct of the Accredited Practitioner.

(b) Given the mandatory requirement for an applicant for Accreditation, or following Accreditation, Re-Accreditation or By-Law amendments, that the By-Laws and any amendments will be read in full, this By-Law will be taken as sufficient notice to the Accredited Practitioner pursuant to the *Privacy Act 1988* (Cth).

3.8 Mandatory Notification of Notifiable Conduct

Notwithstanding By-Laws 3.1 to 3.8, all registered health practitioners acting in a management role with Orygen 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 practise of their profession or suffers from an impairment that may place the public at substantial risk of harm.

4 BOARD POWERS

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

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 CCP may establish any Committees for the Facility.

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

5.2 Terms of Reference

Schedule 1 provides the terms of reference for Committees specific to these By-Laws.

5.3 Indemnification

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

(a) acted in good faith;

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

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

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

6 DISCLOSURE OF INTEREST OF MEMBERS OF COMMITTEES

6.1 Disclosure of Interest

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

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

(b) 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 Compliance with Oyrgen Conflict of Interest Policy

All persons must comply with Oyrgen's conflict of interest policy (**COI Policy**). To the extent that there is any inconsistency between these By-Laws and the COI Policy, these By-Laws shall prevail.

6.3 Nature of Disclosure

Disclosure by a person at a meeting that the person:

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

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

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

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

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

6.4 Chairperson to notify CCP

The chairperson of the relevant Committee will:

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

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

6.5 Determination regarding disclosed matter

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

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

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

7 APPOINTMENT OF ACCREDITED PRACTITIONERS

7.1 Application Form

Any Medical Practitioner who wishes to apply for Accreditation, Re-accreditation or an amendment of Scope of Clinical Practice at the Facility (the **Applicant**) must obtain from the Facility an Application Form (and any related material, including a copy of these By-Laws) and must read the By-Laws and complete the Application Form in its entirety and submit to the CCP via Orygen PC&W team. If an electronic process for lodgement of applications is in place at the Facility, then this must be utilised.

7.2 Applications for Appointment

A duly completed Application Form will be considered by the CCP and PC&W team in accordance with the following process:

(a) Consideration of the application in the context of its completeness, the applicant's Credentials, Organisational Need, Organisational Capabilities, and otherwise satisfying the requirements of the By-Laws, and may make any inquiries, consultation, request verification of information or documents, and request permission to contact third parties (including referees), that is relevant to that consideration as he or she thinks fit. Following this consideration, it may be determined that the application process be discontinued or further consideration given to the process as outlined in these By-Laws.

(b) Obtaining verbal references or verbal confirmation of written references. A verbal reference should be recorded by completing the template for verbal references.

(c) Seeking advice or feedback from the head of the division(s) or department(s) of the Facility most relevant to the application (where applicable).

(d) The application, with all relevant material obtained or identified above, will then be considered by the MAC , and an assessment made by that Committee of the Credentials, Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services within specific Facility environments, as well as the character and ability of the applicant to cooperate with management and staff at the Facility, and will make a recommendation to the CCP as to the Accreditation and Scope of Clinical Practice sought by the applicant.

(e) Provision of further information to the MAC if requested to assist with making a recommendation.

(f) Make a final determination on the application and will have complete discretion to seek further information before making a decision, approve or disapprove each application for Accreditation or Re-accreditation after following the provisions set out in By-Laws 7.2(a) to 7.2(g) (where applicable).

(g) The CCP (after receiving the recommendation from the MAC) may define particular additional categories and types of Scope of Clinical Practice or limit the Scope of Clinical Practice to be granted, as the individual circumstances may require.

(h) The CCP must notify each applicant in writing of the decision.

(i) Any delineation of approved Scope of Clinical Practice for the Applicant must be specifically defined on the Appointment letter.

(j) On receiving notice of Appointment, the applicant must indicate his or her acceptance in writing of the Orygen and Facility By-Laws, policies and procedures and Orygen's Mission Statement and Values.

7.3 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 CCP 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 10.1.

7.4 Period of Appointment

Unless otherwise determined by the CCP and People, Culture and Wellbeing Team appointments to positions as Accredited Practitioners are made in accordance with the requirements of the Facility and will be for a period of three (3) years. The date of Appointment is the date on which the CCP approves the Appointment.

7.5 Nature of Appointment

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

(b) As a condition of the granting of, and ongoing Accreditation, Accredited Practitioners acknowledge and agree:

(i) that the granting of Accreditation establishes only:

(A) that the Accredited Practitioner is a person able to provide services at the Facility; and

(B) the obligations and expectations with respect to the Accredited Practitioner while providing services for the period of Accreditation; and

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

7.6 Provisional Appointment

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

7.7 Temporary Appointment

(a) The CCP may approve Temporary Appointment and may grant Accreditation to such temporarily appointed Medical Practitioners.

(b) In considering whether to approve the Temporary Appointment of a Medical Practitioner, the CCP may consult with the chairperson of the ACC.

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

(d) Accreditation granted under this By-Law 7.7 will remain in force for a period of up to 90 days from the date of determination by the CCP, with the period of Temporary Appointment in the complete discretion of the CCP. Any extension is at the discretion of the CCP, will be no longer than an additional 90 days and must be approved in writing by the CCP.

(e) Should any Medical Practitioner granted Temporary Appointment wish to obtain Accreditation under By-Law 8.2, that Medical Practitioner must lodge the Application Form and supporting material with the CCP at which time the process in By-Law 7.2 will be applied.

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

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

7.8 Urgent Appointments

(a) The CCP, in consultation with the People, Culture and Wellbeing Team may approve Urgent Appointments and may grant Accreditation to such urgently appointed Medical Practitioners.

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

(i) Confirm registration with AHPRA; and

(ii) Obtain a verbal reference from one other Accredited Practitioner at the Facility.

(c) An individual seeking or granted Urgent Appointment must provide evidence of Professional Indemnity insurance within 24 hours of appointment if and as required.

(d) The CCP will advise the Accredited Practitioner in writing of the completion of the Urgent Appointment.

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

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

7.9 On-Call Arrangements

(a) Although the CCP may require participation by an Accredited Practitioner in on-call arrangements, an Accredited Practitioner has no entitlement to request participation in or remain in on-call arrangements.

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

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

7.10 Accreditation of Other Health Practitioners

(a) The CCP and People,Culture and Wellbeing Team may establish an Accreditation process at the Facility with respect to all or some categories of allied health professional or nurse practitioner.

(b) Prior to the Accreditation of an allied health professional or nurse practitioner, the People,Culture and Wellbeing team will ensure appropriate registration and professional indemnity insurance arrangements.

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

(d) There is no right of appeal pursuant to these By-Laws with respect to decisions made regarding Accreditation (including decisions not to grant), Re-Accreditation (including decisions not to grant), Scope of Clinical Practice and conclusion of Accreditation with respect to an allied health professional or nurse practitioner.

7.11 Third Party Providers

(a) If certain services are delivered by a third party provider, the CCP may require Medical Practitioners or other categories of health practitioner delivering the services on behalf of the third party provider to firstly be granted Accreditation pursuant to these By-Laws or alternatively may require the third party provider to undertake its own Accreditation process.

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

7.12 Options with Respect to Ongoing and Conclusion of Accreditation

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

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

7.13 Monitoring of Accreditation

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

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

(c) The Facility will implement processes to monitor and improve the effectiveness of Credentialing and Accreditation processes.

8 TERMS AND CONDITIONS OF APPOINTMENT OF ACCREDITED PRACTITIONERS

8.1 Compliance with By-Laws

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

8.2 General Terms and Conditions

Accredited Practitioners must:

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

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

(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) maintain their professional registration with AHPRA and furnish annually to the Facility when requested to do so, evidence of registration and advise the CCP immediately of any material changes to the conditions or status of their professional registration (including suspension and cancellation);

(f) comply with, act in accordance with and achieve at a minimum the Behavioural Standards;

(g) consent to the sharing of information relating to their conduct within Orygen and to any professional college that they are a member of, but only to the extent necessary to obtain appropriate expert advice and provided the Facility has in place an agreement with the relevant professional college which includes terms and conditions applicable to sharing of information of Accredited Practitioners;

(h) not engage in any conduct that may be perceived as a reprisal against another person for making a report or supplying information relating to the Behavioural Standards programs in place across Orygen;

(i) where applicable, provide appropriate professional mentorship and support to maintain the health and well-being of junior medical staff including active supervision for junior medical practitioners in training whether in accredited or non-accredited positions;

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

(k) adhere to the generally accepted ethics of medical practice, including the ethical codes and codes of good medical practice of the Australian Medical Association and all relevant standards or guides issued by the Medical Boards of Australia as issued from time to time in relation to his or her colleagues, Facility employees and patients;

(l) adhere to general Conditions of clinical practice applicable at the Facility;

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

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

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

(p) seek relevant approvals from the relevant Committee and, in regard to any research, experimental or innovative treatments, including any new or revised technology in accordance with the requirements of these By-Laws;

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

(r) provide all reasonable and necessary assistance where the Facility requests assistance from the Accredited Practitioner in order to comply with or respond to requests or enquires, including a legal request or information requests from external agencies;

(s) not purport to represent Orygen in any circumstances, including the use of the letterhead of the Facility or Orygen, unless with the express written permission of the CCP; and

(t) subject to the requirement of relevant laws, keep confidential details of all information which comes to his or her knowledge concerning patients, clinical practice, quality assurance, peer review and other activities which relate to the assessment and evaluation of clinical services.

8.3 Responsibility for Patients

Accredited Practitioners must:

(a) other than in respect of any compulsory treatment (as permitted or required by law), obtain and document fully informed patient consent prior to treatment (except where it is not practical in cases of emergency) from the patient or their legal guardian or substituted decision maker in accordance with accepted medical and legal standards and any Facility requirements;

(b) if 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;

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

(d) Accredited Practitioners must 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 the patients;

(e) work with and as part of the multi-disciplinary health care team, including effective communication – written and verbal, to ensure the best possible care for patients. This includes communication to other members of the team, referring doctors, Facility executive, patients and the patient's family or next of kin;

(f) provide adequate instructions and clinical handover to Facility staff and other Accredited Practitioners to enable them to understand what care is required to be delivered to patients. This will be underpinned by the values and expectations of a multidisciplinary model of care and service delivery;

(g) attend 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;

(h) attend patients subject to the limits of any Conditions imposed by the CCP;

(i) upon request by staff of the Facility, attend in person upon patients under their care for the purposes of the proper care and treatment of those patients. This provision still applies despite COVID-19 restrictions;

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

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

(l) ensure that patients are discharged in compliance with the discharge policy of the Facility, and ensuring that 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.

8.4 Safety and Quality

Accredited Practitioners must:

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

(b) familiarise themselves with and comply with Orygen and Facility targeted programs with respect to safety and quality of patient care, including but not limited to medication and infection control / hand hygiene;

(c) give consideration to their own potential fatigue and that of other staff involved in the provision of patient care;

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

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

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

(g) adhere to general Conditions of clinical practice applicable at the Facility;

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

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

(j) where required by the CCP or the CRC, assist with and provide relevant information and participate in incident management, complaint management, investigation, reviews (including root cause analysis and other system reviews) and open disclosure.

8.5 Professional Indemnity Insurance

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

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

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

(c) that is in an amount and on terms and conditions acceptable to the Facility; and

(d) that is with an insurance company acceptable to the Facility.

8.6 Annual Disclosure

Accredited Practitioners must furnish annually to the Facility evidence of:

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

(b) medical registration;

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

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

8.7 Continuous Disclosure

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

(a) Credentials;

(b) Scope of Clinical Practice;

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

(d) Professional Indemnity Insurance status;

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

(f) Matters requiring notification or notified pursuant to By-Law 8.8.

8.8 Advice of Material Issues

Without limiting By-Law 8.7, Accredited Practitioners must advise the CCP in writing as soon as possible but at least within two (2) business days if any of the following matters occur or come to the attention of the Accredited Practitioner:

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

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

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

(d) the initiation or conclusion of any process, inquiry, investigation or proceedings by any external body, including, but not restricted to, other health facilities, regulatory authorities, relevant registration boards, relevant colleges, polices, coroner, tribunal, court, complaints body or private health fund involving the Accredited Practitioner, irrespective of whether this relates to a patient of the Facility;

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

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

(g) he or she incurs an illness or disability which may adversely affect his or her Current Fitness;

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

(i) receipt of a written complaint from a patient of the Facility or notification of a complaint being received by an external agency, including but not limited to a complaint relating to an adverse outcome, injury, incident, loss, unexpected expense or charge that has been levied;

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

(k) matters regarded as Reportable Conduct; and

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

8.9 Medical Records

Accredited Practitioners must:

(a) maintain full, accurate, legible and contemporaneous medical records for patients for whom they provide care or ensure that such adequate clinical records are maintained in the patient's Facility medical record:

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

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

(iii) in a way which enables Orygen to receive funding in a timely manner and collect any other data reasonably required in respect of a Facility, including:

(A) pre-admission notes or a letter on the patient's condition and plan of management, including notifying the Facility of significant co-morbidities;

(B) full and informed written patient consent;

(C) completing admission forms authorised by the Facility within 24 hours of admission;

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

(E) therapeutic orders;

(F) particulars of all procedures;

(G) observations of the patient's progress;

(H) notes of any special problems or complications;

(I) discharge notes, completed discharge summary and documentation of requirements and arrangements for follow-up;

(J) each attendance upon the patient with the entries dated, timed, signed and specifying the designation of the practitioner; and

(K) any additional information required to meet contractual health fund obligations.

(b) if and as required ensure the provision of Medicare Benefits Schedule item numbers and prompt notification to the Facility of any subsequent change 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), enter those orders in the medical record within twenty-four hours;

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

(e) ensure that complications, incidents, variations and deviations from standard clinical pathways and expectations are recorded in the Facility medical record;

(f) take all reasonable steps to ensure that, following the discharge of each patient, the Facility's medical record is completed within 7 days after the patient's discharge;

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

(h) acknowledge and agree that medical records of patients of the Facility are owned by Orygen, so that access to or disclosure of that medical record by the Accredited Practitioner other than for the direct and primary purpose of providing health care to the patient must occur through the appropriate Facility mechanisms, in accordance with Facility policy and in compliance with applicable legislation and.

(i) medical records must not be removed or copied from the facility or it's systems without prior arrangement or approval.

8.10 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 the requirements of the relevant college/professional body for Continuing Professional Development and provide formal evidence of this to the CCP;

(c) 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

(d) co-operate and participate in appropriate quality improvement activities, including satisfying the mandatory attendance and participation requirements of the CRC as set out in Schedule 1.

8.11 Clinical Activity and Utilisation

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

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

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

(c) Facility resources are being appropriately managed and utilised to maximum potential;

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

(e) Facility resources are being appropriately managed and utilised to maximum use of such resources; and

(f) If the CCP is not satisfied about any of the above matters over the preceding 12 months, a Show Cause process may be initiated pursuant to this provision of the By-Laws. The Show Cause process may result in notification of inactivation or withdrawal of Accreditation due to insufficient utilisation and there will be no appeal available pursuant to these By-laws if such a decision is made by the CCP.

8.12 Participation in Committees

(a) Accredited Practitioners must participate in the CRC in accordance with Schedule 1 unless otherwise excused under Schedule 1.

(b) In addition to the requirement under By-Law 8.12(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 8.12(a), the CCP may require an Accredited Practitioner to nominate him or herself to act as a member of a Committee. Before doing so, the CCP must have regard to:

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

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

(iii) any extenuating circumstances which the CCP 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).

8.13 Emergency and 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.

8.14 Working with Children Checks and Criminal Records Checks

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

(b) The Accredited Practitioner must undertake to Orygen 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 Orygen immediately if he or she is unable to give the undertakings set out in By-Law 8.14(b).

(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.

8.15 Teaching and Supervision

Unless otherwise determined by the CCP, 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:

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

(b) consent being given by the patient.

8.16 Notifiable Conduct and Mandatory Reporting

All Accredited Practitioners must comply with their obligations of mandatory reporting of Notifiable Conduct as prescribed in the National Law.

8.17 Notice of Leave

Where Accreditation has been granted in respect of the Facility, an Accredited Practitioner must notify the CCP in writing, at least four weeks in advance of holidays.

9 RE-ACCREDITATION AND AMENDMENTS TO SCOPE OF CLINCAL PRACTICE

9.1 Notice to Accredited Practitioner

Not less than three months before the date fixed for expiry of the Accreditation of an Accredited Practitioner, the CCP 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.

9.2 Applying for Re-Accreditation

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

9.3 Amendments

An Accredited Practitioner may make an application to the CCP for amendment of his or her Scope of Clinical Practice:

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

(b) at any other time.

9.4 Process

Subject to Orygen policy or as otherwise determined by the CCP for a specific application, the processes for Re-accreditation and/or amending the Scope of Clinical Practice of Accredited Practitioners under this By-Law 10 will otherwise be the same as for an initial Accreditation pursuant to By-Law 7.

9.5 Review

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.

10 INQUIRY ARISING FROM CONCERNS, ALLEGATIONS OR COMPLAINTS

10.1 CCP May Make Investigations

The CCP in consultation with the People, Culture and Wellbeing team may make inquiry regarding a concern raised, allegation or complaint against an Accredited Practitioner if the CCP considers that any of the following consequences may occur or may have already occurred:

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

(b) non-compliance with Scope of Clinical Practice;

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

(d) patient health or safety could be compromised;

(e) concerns have been raised or identified that all or a component of Scope of Clinical Practice may not be in accordance with current or best practice;

(f) concerns may arise with respect to Competence, Performance or Current Fitness;

(g) incompatibility with Organisational Capabilities or Organisational Need;

(h) clinical conduct that falls below the standard as determined by the clinician's peers or management;

(i) the efficient operation of the Facility could be hindered;

(j) the reputation of the Facility or Orygen could be threatened or brought into disrepute;

(k) the potential loss or breach of the Facility's accreditation or licence, including associated terms or conditions;

(l) the potential imposition of any conditions on the Facility's licence;

(m) non-compliance with the Behavioural Standards;

(n) the interests of a patient, staff, another Accredited Practitioner or someone engaged in or at the Facility could be impacted or affected adversely; or

(o) a law may be contravened.

10.2 Notice to Accredited Practitioners and Procedural Matters

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

(b) The CCP will decide on all procedural matters relevant to advising the Accredited Practitioner under By-Law 11.2(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) requirement for any other person to be present at the time the Accredited Practitioner is advised and the designation of that person, 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 11. 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.

10.3 Action by the CCP

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

(a) the CCP may decide to take no further action;

(b) if in the opinion of the CCP the matter can be dealt with appropriately by reviewing the Accredited Practitioner's Scope of Clinical Practice, the CCP may request a review of the Accredited Practitioner's Scope of Clinical Practice in accordance with By-Law 12;

(c) if in the opinion of the CCP the matter cannot be dealt with appropriately by a review of the Accredited Practitioner's Scope of Clinical Practice, the CCP in consultation with the chairperson of any relevant Committee may establish a Committee to consider the matter further; and/or

(d) the CCP may suspend or impose conditions on the Accreditation of the Accredited Practitioner until such time as the CCP is satisfied that the concern, allegation or complaint has been resolved.

10.4 Committee to Assess Issue of Concern

A Committee to assist the CCP established under By-Law 11.3(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 CCP with its written conclusions and/or opinions in a timely manner and supported by reasons.

10.5 Notifiable Conduct and Mandatory Reporting

(a) The CCP must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the National Law.

(b) The CCP must advise the Executive Director of any mandatory reporting made under By-Law 11.5(a).

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

11 REVIEW OF ACCREDITATION OR SCOPE OF CLINICAL PRACTICE

11.1 Surveillance of AHPRA Registration Database

The CCP will ensure processes are in place to conduct periodic and active surveillance of the AHPRA registration database to ensure currency of registration and accuracy of any Conditions imposed.

11.2 Grounds for Review

The CCP may initiate a review, if the CCP considers that any of the following consequences may occur or may have already occurred:

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

(b) non-compliance with Scope of Clinical Practice;

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

(d) patient health or safety could be compromised;

(e) concerns may arise with respect to Competence, Performance or Current Fitness;

(f) all or a component of Scope of Clinical Practice may not be in accordance with current or best practice;

(g) incompatibility with Organisational Capabilities or Organisational Need;

(h) loss of confidence in the Accredited Practitioner;

(i) the efficient operation of the Facility could be hindered;

(j) the reputation of the Facility or Orygen could be threatened or brought into disrepute;

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

(l) the potential imposition of any conditions on the Facility's licence;

(m) non-compliance with the Behavioural Standards;

(n) the interests of a patient, staff, another Accredited Practitioner or someone engaged in or at the Facility could be affected adversely; or

(o) a law may be contravened.

11.3 CCP Initiated Internal Review

(a) The CCP may, at any time, initiate an internal review to examine a ground or grounds set out in By-Law 12.2 and following such review the CCP will make a decision concerning the continuation, amendment, suspension or termination of Accreditation.

(b) An internal review will be undertaken by a person or persons or Committee that is internal to Orygen.

(c) The CCP will make a final determination in relation to the matter, subject to the provisions of By-Law 17.

11.4 CCP Initiated External Review

(a) The CCP may, at any time, initiate an external review to examine a ground or grounds set out in By-Law 12.2 and following such review the CCP will make a decision concerning the continuation, amendment, suspension or termination of Accreditation.

(b) An external review will be undertaken by a person or persons or Committee that is external to Orygen.

(c) The CCP will make a final determination in relation to the matter, subject to the provisions of By-Law 17.

11.5 Notice to Accredited Practitioners

(a) The CCP will advise the Accredited Practitioner in respect of whom a review is being conducted under either By-Law 12.3 or 12.4 of the commencement, ground(s) and substance of the review, the extent to which the Accredited Practitioner may participate in the review and the opportunity to respond that will be provided.

(b) The CCP will make a determination whether to impose an interim suspension or conditions pending the outcome of the review, and if this occurs, it will be done in accordance with By-Law 13, except that the appeal provisions pursuant to these By-Laws will not apply with respect to an interim suspension or conditions, and the Accredited Practitioner will be advised of the fact of the interim suspension or conditions and that an appeal is not available pursuant to these By-Laws.

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

(i) terms of reference, process and reviewers;

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

(iii) timeframes;

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

(v) format for review findings; and

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

(d) 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 12. 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.

(e) The CCP must advise the Executive Director that the review is being undertaken under either By-Law 12.3 or 12.4.

11.6 Action the CCP May Take Following Review

Following a review under By-Law 12.3 or 12.4 the CCP will consider the review findings and make a decision, which will include a determination whether or not to continue (including with conditions), amend, suspend or terminate Accreditation in accordance with the provisions set out in these By-Laws and, in the event a decision is make to continue with conditions this may include a decision that the Accredited Practitioner will:

(a) practise a restricted range of medical procedures; or

(b) not admit or manage patients unless in consultation with another Accredited Practitioner qualified in the same field of practice.

11.7 Notice of Outcome of the Review

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

(b) (b) The CCP must notify the Executive Director of the outcome of any review undertaken under By-Law 12.

11.8 Notifiable Conduct and Mandatory Reporting

(a) The CCP must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the National Law outlined in By-Law 11.5 in relation to actions taken by the CCP following a review under By-law 12.

11.9 Interrelationship with By-Law 11

(a) For the avoidance of any doubt, the CCP is not required to comply with By-Law 11 before proceeding with a review pursuant to By-law 12.

12 SUSPENSION

12.1 Grounds for Suspension

The CCP may immediately suspend Accreditation, in whole or in part, and afford the Accredited Practitioner an opportunity to "Show Cause" as to why their accreditation should not be terminated. Suspension pursuant to this section may be exercised should the CCP believe, or have a concern, about any of the following matters:

(a) it is in the interests of patient care or safety;

(b) patient health or safety is compromised, including by reason that all or a component of Scope of Clinical Practice is not considered to be in accordance with current or best practice;

(c) continuance of the current Scope of Clinical Practice raises concern about the safety and quality of health care to be provided;

(d) professional registration has been suspended in whole or in part;

(e) professional registration has been amended, conditions imposed or undertakings agreed;

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

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

(h) the Accredited Practitioner has breached any Conditions of Accreditation;

(i) the Accredited Practitioner has breached the By-Laws;

(j) the behaviour or conduct does not comply with the Behavioural Standards, a direction given, is such that it is unduly hindering the efficient operation of the Facility at any time, is bringing the Facility into disrepute or is otherwise damaging the reputation of the Facility;

(k) the behaviour or conduct of the Accredited Practitioner is inconsistent with the Facility's mission statement or the Code of Ethics of the Australian Medical Association;

(l) based upon information notified pursuant to By-Laws 8.6 or 8.7;

(m) a failure to notify or provide continuous disclosure of a matter required pursuant to By-Laws 8.6 or 8.7;

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

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

(p) based upon the outcome of a review carried out pursuant to By-Law 12;

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

(r) there are other issues or unresolved concerns (including with respect to an ongoing or completed investigation that is internal or external to Orygen) in respect of the Accredited Practitioner that the CCP considers is a ground for suspension.

12.2 Suspension Framework

(a) Suspension by the CCP will, at a minimum, be consistent with that imposed by the professional registration board or AHPRA with respect to the professional registration of the Accredited Practitioner.

(b) Prior to making the decision to impose a suspension, the CCP will ordinarily consult with the Executive Director, however it is recognised that in the interests of patient safety on occasion this may not be possible.

(c) A ground for suspension may relate to matters external to the Facility or Orygen.

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

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

12.3 Notification of Suspension Decision

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

(i) the fact of the suspension;

(ii) the period of suspension;

(iii) the reasons for the suspension;

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

(v) if the CCP considers it appropriate in the circumstances, any actions that must be performed for the suspension to be lifted and the timeframe for the actions to occur; and

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

(b) As an alternative to an immediate suspension, the CCP may elect to deliver a Show Cause notice to the Accredited Practitioner advising of:

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

(ii) the grounds upon which suspension may occur;

(iii) an invitation for a written response from the Accredited Practitioner, including a response as to why the Accredited Practitioner may consider suspension is not appropriate;

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

(v) a timeframe in which a response is required from the Accredited Practitioner to the Show Cause notice.

(c) Following receipt of a response to the Show Cause notice in paragraph 13.3(b) above, the CCP will determine whether the Accreditation will be suspended. If suspension is to occur, then notification will be sent in accordance with paragraph 13.3(a) above. Otherwise the Accredited Practitioner will be advised that suspension will not occur, however this will not prevent the CCP from taking other action at this time, including imposition of conditions, and will not prevent the CCP from relying upon these matters as a ground for suspension or termination of Accreditation in the future.

12.4 Suspension Effective Immediately

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

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

12.5 Alternative Arrangements for Patients

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

12.6 Appeal Rights

Unless otherwise provided in these By-Laws, the affected Accredited Practitioner will have the rights of appeal established by these By-Laws, noting that an appeal is not available for an interim suspension pursuant to By-Law 12.5(b).

12.7 Notification to Board

The CCP will notify the Executive Director of any suspension of Accreditation of an Accredited Practitioner. The Executive Director will notify the Board of any suspension of Accreditation of an Accredited Practitioner.

12.8 Notifiable Conduct and Mandatory Reporting

(a) The CCP must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the National Law outlined in By-Law 11.5 in relation to actions taken by the CCP under this By-law 13.

12.9 Interrelationship with By-Laws 11 and 12

(a) For the avoidance of any doubt, the CCP is not required to comply with By-Laws 11 or 12 before proceeding with action pursuant to By-law 13.

13 TERMINATION OF ACCREDITATION

13.1 Immediate Termination

Accreditation of Accredited Practitioners will be terminated immediately by the CCP (in consultation with the People, Culture and Wellbeing team) if the following has occurred, or if it appears based upon the information available to the CCP that the following has occurred:

(a) the Accredited Practitioner is found guilty of Professional Misconduct (or equivalent) 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 given;

(c) the Accredited Practitioner is convicted of an offence involving a child, sex or violence or any offence in relation to the Accredited Practitioner's practice as a Medical Practitioner;

(d) the Accredited Practitioner fails, refuses or is unable to comply with the requirements and undertakings set out in By-Law 8.8, or is dishonest in respect of the undertakings given in By-Law 8.8;

(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 CCP (unless the situation is rectified by the Accredited Practitioner within 24 hours from when he or she becomes aware that his or her Professional Indemnity Insurance has been cancelled, lapsed or does not cover his or her Scope of Clinical Practice).

13.2 Unprofessional Conduct

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

13.3 Termination When not Immediate

In the event of a decision to terminate Accreditation, an Accredited Practitioner in accordance with any of the items below, the CCP may, in considering circumstances that may impact on patient safety, agree to a limited period of time for the termination to take affect enabling the Accredited Practitioner to continue to manage inpatients if and as required within the facility.

(a) based upon any of the matters in By-Law 13.1 and it is considered by the CCP that suspension is an insufficient response in the circumstances;

(b) based upon the findings of a review carried out pursuant to By-Law 12 it is identified that the Accredited Practitioner, previously suspended, failed to observe the terms and Conditions of his or her Accreditation or failed to abide by these By-Laws or the Facility’s policies and procedures and failed to rectify the breach;

(c) the Accredited Practitioner is not considered by the CCP as having Current Fitness to retain Accreditation or the Scope of Clinical Practice, or the CCP does not have confidence in the continued appointment of the Accredited Practitioner;

(d) conditions have been imposed by, or undertakings agreed with, the Accredited Practitioner's registration board that restricts practice or imposes supervision and the CCP does not have the

capacity to meet or is not willing to meet the results of the conditions imposed or undertakings agreed;

(e) the Accreditation or Scope of Clinical Practice is no longer supported by the Organisational Need or Organisational Capabilities of the Facility;

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

(g) the conduct or continuing Accreditation of the Accredited Practitioner compromises the efficient operation or the interests of the Facility or Orygen;

(h) 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;

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

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

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

13.4 Termination Framework

(a) Prior to making the decision to terminate Accreditation, the CCP will ordinarily consult with the Executive Director, however it is recognised that in the interests of patient safety, on occasion this may not be possible.

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

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

13.5 Notification of Termination Decision

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

(i) the fact of the termination;

(ii) the reasons for the termination;

(iii) if the CCP considers it appropriate in the circumstances, invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider termination should not have occurred; and

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

(b) As an alternative to an immediate termination, the CCP may elect to deliver a Show Cause notice to the Accredited Practitioner advising of:

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

(ii) the grounds upon which termination may occur;

(iii) an invitation for a written response from the Accredited Practitioner, including a response as to why the Accredited Practitioner may consider suspension is not appropriate;

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

(v) a timeframe in which a response is required from the Accredited Practitioner to the Show Cause notice.

(c) Following receipt of a response to the Show Cause notice in paragraph 14.5(b) above, the CCP will determine whether the Accreditation will be terminated. If termination is to occur then notification will be sent in accordance with paragraph 14.5(a) above. Otherwise the Accredited Practitioner will be advised that termination will not occur, however this will not prevent the CCP from taking other action at this time, including imposition of conditions, and will not prevent the CCP from relying upon these matters as a ground for suspension or termination of Accreditation in the future.

13.6 Notification to Board

The CCP will notify the Executive Director of any termination of Accreditation of an Accredited Practitioner. The Executive Director will notify the Board of any termination of Accreditation of an Accredited Practitioner.

13.7 Notifiable Conduct and Mandatory Reporting

(a) The CCP must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the National Law outlined in By-Law 11.5 in relation to actions taken by the CCP under this By-law 14.

13.8 Interrelationship with By-Laws 11 and 12

13.9 For the avoidance of any doubt, the CCP is not required to comply with By-Laws 11 or 12 before proceeding with action pursuant to By-law 14.

14 IMPOSITION OF CONDITIONS

14.1 Imposing Conditions in Lieu of Suspension or Termination

(a) At the conclusion of or pending finalisation of a review pursuant to By-Law 12, or in lieu of a suspension of Accreditation pursuant to By-Law 13 or in lieu of a termination of Accreditation pursuant to By-Law 14, the CCP may elect to impose conditions upon Accreditation or Scope of Clinical Practice.

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

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

(i) the conditions imposed;

(ii) the reasons for it;

(iii) the consequences if the conditions are breached;

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

(v) if the CCP considers it appropriate in the circumstances, invite a written response from the Accredited Practitioner, including a response why the Accredited Practitioner may consider the conditions should not be imposed.

(d) If the Conditions are breached, then suspension of Scope of Clinical Practice or termination of Accreditation 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 CCP 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 15.

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

14.2 Notification to Board

The CCP will notify the Executive Director of any imposition of Conditions on the Accreditation of an Accredited Practitioner. The Executive Director will notify the Board of any imposition of Conditions on the Accreditation of an Accredited Practitioner.

14.3 Notifiable Conduct and Mandatory Reporting

The CCP must comply with his or her obligations of mandatory reporting of Notifiable Conduct as prescribed in the National Law outlined in By-Law 11.5 in relation to actions taken by the CCP under this By-law 15.

15 APPEAL RIGHTS

15.1 No Appeal Rights Against Refusal of Initial or Probationary Appointment

There will be no right of appeal against a decision not to make an initial Appointment, not to extend a provisional Appointment, in relation to the specific Scope of Clinical Practice granted or where otherwise stated in these By-Laws.

15.2 Appeal Rights Generally

Except where these By-Laws state otherwise, a Medical Practitioner who has Accreditation in respect of the Facility and whose Accreditation is amended, made conditional, suspended, terminated, not renewed or conditionally renewed by the Facility, will have the rights of appeal set out in By-Law 17.

15.3 Concurrent Appeal Rights

Despite any other provision of these By-Laws, where an Accredited Practitioner has appeal rights under these By-Laws concurrently with appeal rights under any legislation or mandatory directive

and/or policy in respect of the same circumstances, the appeal rights under these By-Laws will cease to be available to the Accredited Practitioner. For the avoidance of doubt, if this By-Law 16.3 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.

16 APPEAL PROCEDURE

16.1 Appeal Must be Lodged in Fourteen Days

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

(b) Upon receipt of a notice of appeal, the CCP will forward the notice of appeal to the Executive Director.

(c) Unless decided otherwise by the CCP, lodgement of an appeal does not result in a stay of the decision under appeal and the decision will stand and be actioned accordingly.

16.2 Relevant Committee Established to Hear Appeal

The Executive Director will establish an appeals Committee to hear the appeal. The appeals Committee must at a minimum include:

(a) a nominee of the Executive Director, who may be an Accredited Practitioner, who must be independent of the decision under appeal and who will be the chairperson of the appeals Committee;

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

(c) any other member or members who bring specific expertise to the decision under appeal, with at least one member preferably but not necessarily practising in the same area of practice or speciality of the appellant, as determined by the Executive Director, who must be independent of the decision under appeal and who may be an Accredited Practitioner. The Executive Director in his or her complete discretion may invite the appellant to make suggestions or comments with respect to the proposed additional members of the appeals Committee, but is not bound to follow the suggestions or comments.

16.3 Commissioning and Commencement

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

(b) The Executive Director will prepare terms of reference and submit relevant material to the chairperson of the appeals Committee.

16.4 Procedure for Appeal

(a) Unless a shorter timeframe is agreed by the appellant and the appeals Committee, the appellant shall be provided with at least 14 days written notice of the date for determination of the appeal by the appeals Committee.

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

(c) The notice from the appeals Committee will ordinarily set out the date for determination of the appeal, the members of the appeals Committee, the process that will be adopted, information and documents that will be provided, and any conditions that must be met before provision of the information or documents, such as a confidentiality agreement, and invite the appellant to make a submission about the decision under appeal.

(d) 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 required by the appeals Committee.

(e) If the appellant attends before the appeals Committee in order to make a submission, the appeals Committee may request that the appellant answers questions in addition to making a submission.

(f) The CCP (or nominee) may make a submission to the appeals Committee in order to support the decision under appeal. The appeals Committee will determine whether the submission of the CCP will be in writing or in person, or both. The CCP must provide written submissions for the appeals Committee within the timeframe required by the appeals Committee.

(g) 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, as the appeal is intended to be conducted through direct communication between the appellant and appeals Committee.

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

16.5 Recommendation of Appeals Committee

(a) The appeals Committee will make a written recommendation regarding the appeal in accordance with the terms of reference, including provision of reasons for the recommendation, and submit this to the Executive Director.

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

(c) The Executive Director will provide a copy of the written recommendation of the appeals Committee to the Board, CCP and appellant.

(d) The Board will consider the recommendation of the appeals Committee, and any information or documents before the appeals Committee that the Board may require, and the Board will make a decision regarding the appeal.

(e) The decision of the Board will be notified in writing to the Executive Director, CCP and appellant.

(f) Any actions required arising from the decision of the Board, including notifications that may be required internally and externally, will be the responsibility of the CCP.

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

17 RESEARCH

17.1 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 his or her field of clinical accreditation, with appropriate research experience, as a co-investigator, and it falls within the Scope of Clinical Practice of the Accredited Practitioner;

(b) the 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 Human Research Ethics Committee (**HREC**) utilised by the Facility;

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

(e) the CCP may delegate the facilitation of meeting 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 CCP and after all ethical and governance issues have been approved;

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

(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.

17.2 Withdrawal or Disapproval of Research

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

(d) is inconsistent with good professional practice; and

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

18 EXPERIMENTAL OR INNOVATIVE TREATMENT OR TECHNIQUES

18.1 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 Code of Ethics of the Australian Medical Association;

(c) the Accredited Practitioner has submitted details to the CCP for appropriate review and approval by the relevant Committee and, subject to By-Law 19.2, the approval of both has been given and the CCP 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.

18.2 Approval by the CCP

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

(c) There is no appeal available pursuant to these By-Laws from the decision of the CCP.

18.3 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.

18.4 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 CCP for approval.

(b) The CCP 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 determine:

(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 CCP 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 CCP 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 CCP 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 18.1 has been met;

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

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

(v) notify the relevant Committee; and

(i) there is no appeal available pursuant to these By-Laws from the decision of the CCP.

19 MANAGEMENT OF EMERGENCIES

In cases of an emergency, or in other circumstances deemed appropriate, the CCP may take such actions as he or she deems fit in the interests of a patient or patients. This may include a request for attention by an available Accredited Practitioner. In such cases, the following provision 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 CCP of such arrangements.

20 REPUTATION OF THE FACILITY

20.1 Cessation of Procedures, Advice or Treatment

The CCP may, from time to time, on the basis of moral 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.

20.2 Accredited Practitioner to Cease Upon Notice

On being notified by the CCP of a requirement under By-Law 21.1, the Accredited Practitioner will immediately cease to carry out such procedures, give such advice, or recommend such treatment.

20.3 MAC to Make Recommendation to the CCP

(a) Following a decision of the CCP under By-Law 21.1, the Executive Director will refer the matter to the MAC for consideration and discussion. The MAC may convey comments or make recommendations to the CCP in relation to the decision. The CCP may, in its absolute discretion, affirm or vary the decision of the MAC.

(b) There is no right of appeal against a decision of the CCP under this By-Law 21.

21 DISPUTES

21.1 Committees

Any dispute or difference which may arise as to the meaning or interpretation of the powers of any Committee established under these By-Laws or the validity of proceedings of any meeting, excluding the appeals Committee, will be determined by the CCP and the Executive Director.

22 REVISION OF BY-LAWS

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

(b) The Board will initiate a review of these By-Laws not less than every five years.

Schedule 1 – COMMITTEES TERMS OF REFERENCE

1 MEDICAL ADVISORY COMMITTEE

1.1 Objectives

The MAC is the senior advisory committee to the CCP and Facility with respect to clinical matters and standards, related to Credentialing and Accreditation. The MAC is the representative group to the CCP with respect to:

- reviewing and make recommendations to the CCP on formal applications for appointment as Accredited Practitioners and delineation of Scope of Clinical Practice in compliance with the requirements of the By-Laws, Orygen and Facility policies and legislative requirements.

- matters relating to or impacting upon Accredited Practitioners to ensure optimal standards of patient care and adequate communication between Accredited Practitioners and the CCP. The aim of the MAC in collaboration with the CCP and Facility is to achieve safe and high quality provision of care for patients.

1.2 Roles and Functions

The Medical Advisory Committee performs an advisory role to the CCP (who in turn reports to the Executive Director) and shall carry out the following functions:

(a) act in an advisory role to the CCP;

(b) be the formal organisational structure through which the collective views of the Accredited Practitioners of the Facility shall be formulated and communicated;

(c) establish and oversee appropriate sub-committees, receive and, where necessary, act upon their reports and recommendations, including but not limited to the CRC;

(d) provide a forum for communication between the Facility, the Facility's executive and Accredited Practitioners in relation to patient care and safety throughout the Facility;

(e) provide a means whereby Accredited Practitioners can advise the Facility of appropriate policies regarding the clinical organisation and service delivery of the Facility, including contribute to policy making and planning processes;

(f) contribute to and promote clinical education programs and research at the Facility, undergraduate and post-graduate, and making recommendations concerning the suitability, format and content of clinical education programs and research activities;

(g) assist in identifying health needs of the community and advise the Facility on appropriate services which may be required to meet those needs;

(h) endeavour to ensure that the delivery of patient care in the Facility is maintained at an optimal level of safety, quality, efficacy and efficiency based on current best clinical practice and research, including where requested by providing input into policies, procedures, clinical reviews, safety, quality, audit and education;

(i) participates in Orygen’s formal mechanisms for monitoring and review of clinical outcomes and clinical management, including in sub-committees and implementation of a robust peer review process where required;

(j) advising the CCP on minimum criteria that may be necessary to fulfil competency requirements in particular speciality areas; and

(k) review any research or experimental or innovative treatment or techniques and make a recommendation on any necessary amendment of the Scope of Clinical Practice of an Accredited Practitioner.

The MAC also performs an appointment and credentialing role for the Facility, and shall carry out the following functions:

(a) ensure robustness of the Credentialing and Accreditation processes at the Facility, in order to properly assess an applicant's Competence, Performance, Current Fitness and professional suitability to provide safe, high quality health care services at the Facility in the context of Organisational Capabilities and Need;

(b) assess the Credentials, Competence, Performance, Current Fitness and professional suitability of applicants for Accreditation to ensure as best as possible that they are able to provide safe, high quality health care services within specific Facility environments taking into consideration Organisational Capabilities and Need, as well as the character and ability of the applicant to cooperate with management and staff at the Facility, consistent with the terms and conditions set out in the By-Laws;

(c) make a recommendation to the CCP as to the Accreditation, Re-Accreditation, Scope of Clinical Practice and/or amendment to Scope of Clinical Practice sought by an applicant for Accreditation, consistent with the terms and conditions set out in the By-Laws;

(d) make recommendations to the CCP in relation to applications for appointment and re-appointment as Accredited Practitioners, including Scope of Clinical Practice, in accordance with these By-Laws and any associated Facility policies, with the paramount consideration the safety and quality of patients;

(e) if further information is required before making a recommendation to the MAC as to the Accreditation and Scope of Clinical Practice sought by an applicant for Accreditation, to make such request directed to the CCR that will be communicated via the MAC;

(f) where requested by the CCP, make recommendations regarding Temporary and Urgent Appointments;

(g) at the request of the CCP, establish a sub-committee to conduct an internal review of an Accredited Practitioner to maintain that Accreditation and/or Scope of Clinical Practice, having considered the report of that sub-committee, make a recommendation to the CCP with regard to any action that might be taken; and

(h) review any new or amended use of technology or procedures to treat patients including assessing the infrastructure of the Facility and other matters which are relevant, and make a recommendation on the amendment of the Scope of Clinical Practice of an Accredited Practitioner to the CCP, consistent with the terms and conditions set out in the By-Laws.

1.3 Appointment, Composition, Resignation and Conclusion of Appointment

(a) Membership of the Medical Advisory Committee will be at least 3 current Accredited Practitioners and one member of the PC&W Team.

(b) The CCP appoints members to the MAC and may in the absolute discretion of the CCP, establish a nomination process, with nominees to be considered and decided by the CCP.

(c) The CCP may approve the co-opting of an Accredited Practitioner to the MAC to assist with a specific purpose or function, and the co-opted member will be deemed a member of the MAC for that purpose.

(d) A member of the MAC may resign with at least one month's notice to the CCP.

(e) The CCP may conclude the membership of any member of the MAC prior to their appointed term, may conclude the appointment as chairperson, may suspend membership for a period of time (including if Accreditation is suspended) and membership will automatically conclude if Accreditation is terminated or ends. There are no appeal mechanisms available pursuant to the By-Laws arising from these decisions by the CCP.

1.4 Appointment to specified positions

(a) The chairperson of the MAC shall be elected for a term of two years from amongst the Accredited Practitioner members of the Committee.

(b) The secretary of the MAC shall be elected for a term of two years from amongst the Accredited Practitioner members of the Committee.

1.5 Meetings of the MAC

(a) The Committee shall meet at least four (4) times per year, however may meet more frequently as the circumstances require.

(b) The Committee secretary will provide a minimum of two week’s notice of the next meeting.

(c) Minutes shall be distributed to all members of the Medical Advisory Committee prior to the next meeting.

(d) A quorum for the meeting is 50% plus one of the Committee membership.

(e) Where a vote is required, the Committee will comply with By-Law 2.3(e). Voting will be on a majority basis and only by those in attendance at the meeting. There will be no proxy votes.

1.6 Minutes

(a) Minutes of all meetings of the MAC shall be recorded by the CCP or delegate;

(b) Minutes shall be distributed to all members of the MAC within fourteen days of each meeting;

(c) No business shall be considered at a meeting of the MAC until the minutes of the previous meeting have been confirmed or otherwise disposed of; and

(d) Minutes of a meeting shall be confirmed by resolution and signed by the chairperson at the next meeting and minutes so confirmed and signed shall be taken as evidence of proceedings at that meeting.

1.7 Term of Office

Members of the MAC will be appointed for a term of two (2) years. The CCP may, at his or her discretion, extend the members' term of appointment for additional terms of two (2) years on whatever conditions the CCP believes appropriate. However, any member of the MAC who has served for three (3) consecutive terms is ineligible to be appointed unless the CCP determines that in the particular circumstances of the Facility and expertise required that this requirement will be waived.

1.8 Assessment of Committee Performance

Committee performance will be assessed annually by the CCP through formal review.

1.9 Review of Terms of Reference

The Terms of Reference will be reviewed annually by the Committee at the first meeting of the calendar year and evaluation included in the meeting minutes.

2 CLINICAL REVIEW COMMITTEE

2.1 Objectives

The Facility will have a CRC or equivalent which will have the following objectives:

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

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

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

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

(e) providing a forum to consider and discuss strategies to improve the cultural awareness and cultural competency of Accredited Practitioners to meet the needs of its community, including Aboriginal and Torres Strait Islander patients.

2.2 Roles and Functions

The CRC performs a quality assurance and evaluation role for the Facility, and shall carry out the following functions:

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

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

(c) review Performance against external measures;

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

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

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

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

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

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

(j) as requested, liaise with and provide relevant information to the Board-established Clinical Governance Committee; and

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

2.3 Composition

Clinical Review Committee (or equivalent) shall consist of Accredited Practitioners, Facility staff (Facility Co-ordinator) and Facility Executive (Chief of Clinical Operations and Director of Nursing). The Committee may co-opt the services of any other person at its discretion.

2.4 Appointment to specified positions

(a) The chairperson of the CRC shall be elected for a term of two years from amongst the members of the committee.

(b) Secretariat support will be selected by the Chair of the CRC.

2.5 Meetings of the CRC

(a) The CRC must meet at least four (4) times per year for formal quality review meetings (**Formal Meetings**) or as otherwise required by the CCP, and may meet at other times.

(b) The Committee secretary will provide a minimum of two week's notice of the next meeting.

(c) Minutes shall be distributed to all members of CRC prior to the next meeting.

(d) A quorum will consist of at least 50% of members including two (2) Accredited Practitioners.

(e) Where a vote is required, the Committee will comply with By-Law 2.3(e). Voting will be on a majority basis and only by those in attendance at the meeting. There will be no proxy votes.

2.6 Minutes

(a) The chairperson, or his or her delegate for this purpose, must record minutes of the Formal Meetings of the CRC.

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

(c) No business shall be considered at a meeting of the CRC until the minutes of the previous meeting have been confirmed or otherwise disposed of; and

(d) Minutes of a meeting shall be confirmed by resolution and signed by the chairperson at the next meeting and minutes so confirmed and signed shall be taken as evidence of proceedings at that meeting.

(e) All minutes and actions arising from the Formal Meetings are to be forwarded to the MAC.

2.7 Mandatory attendance

(a) It is a Condition of Accreditation that:

(i) all Accredited Practitioners must attend and participate in a minimum of 50 percent of the Formal Meetings of the CRC; and

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

(b) The CCP may, on demonstration of extenuating circumstances, waive the Condition of Appointment for attendance in By-Law 3.7(a). Waiver may only occur where the CCP has been provided with satisfactory explanation and evidence of the relevant extenuating circumstances and has waived the relevant Condition in By-law 3.7(a) in writing.

2.8 Assessment of Committee Performance

Committee performance will be assessed annually by the CCP through formal review.

2.9 Review of Terms of Reference

The Terms of Reference will be reviewed annually by the Committee at the first meeting of the calendar year and evaluation included in the meeting minutes.