SESLHD GUIDELINE COVER SHEET

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RESPONSIBLE DIRECORATE	Office of the Chief Executive
EXECUTIVE SPONSOR	Chief Executive
AUTHOR	Manager Executive Services
SUMMARY	This document outlines the principles and processes for the development and endorsement of policies, procedures, guidelines, business rules and related documents in SESLHD. It provides guidance to authors / custodians, working parties, clinical streams, governing committees and Executive Sponsors.

Feedback about this document can be sent to seslhd-executiveservices@health.nsw.gov.au

SESLHD Framework for Policies, Procedures, Guidelines and Business Rules

Section 1 - Background

The Minister for Health through the NSW Ministry of Health sets policy for health services in NSW. These documents are released as NSW Health Policy Directives and employees of all public health facilities within the state are required to comply with them.

The SESLHD Framework for Policies, Procedures, Guidelines and Business Rules is intended to streamline the District's policy process and to provide consistency across the District.

The framework outlines a system for managing policies, procedures, guidelines and business rules. It aims to reduce the overall number of policy documents and prevent their future proliferation, promote best practice, standardise patient care, and enhance clarity, currency and relevance. It describes the requirements for the development and approval of policies, procedures and guidelines at all sites in SESLHD.

The Framework is consistent with the National Safety and Quality Health Service Standards.
Standard 1.7 states:
The health service organisation uses a risk management approach to:

1. *Set out, review, and maintain the currency and effectiveness of policies, procedures and protocols*
2. *Monitor and take action to improve adherence to policies, procedures and protocols*
3. *Review compliance with legislation, regulation and jurisdictional requirements*

The Framework includes a mechanism for aligning the organisation's policies, procedures and/or protocols to the National Standards.

A flow chart is provided at Appendix A to assist staff understanding of the Framework and governance system.

Section 2 - Principles of the Framework

1. NSW Health is a single entity that incorporates all Local Health Districts in NSW. Its Policy Directives (PDs), Guidelines (GLs) and Information Bulletins (IBs) provide information about changes to legislation and govern the activities of staff employed at all public health facilities in the state. SESLHD will comply with all legislation and with the directives of NSW Health. It will not duplicate or override any NSW Health PD, GL or IB.

2. SESLHD may only produce a policy, procedure, or guideline when there is no corresponding NSW Health PD or GL. Procedures, guidelines and protocols can also be developed to help implement a NSW Health PD, GL or IB.

3. The LHD may be directed by a NSW Health PD to develop a protocol or procedure at either the LHD or facility level as part of the mandated implementation of a NSW Health Policy.

4. Endorsement from the Chief Executive, member of the District Executive Council or Director of a Clinical Stream will be required before any policy, procedure or guideline (including those created to support NSW Health documents) is developed.

5. In the first instance, policies, procedures and guidelines will be developed at the District level to ensure consistency of practice across the LHD. LHD policies, procedures and guidelines should be written in a way to cover all facilities and reduce the need for local business rules or operating protocols.

6. Sites, departments and networks should only develop business rules or related documents (covering both administrative and clinical issues) as a second option, when there is a need to specify distinct local processes such as reporting lines and the use of resources.

7. Business rules must be endorsed by the site, department or network manager and must not contravene legislation or policy. They should always reference the relevant NSW Health or SESLHD policy.

8. SESLHD policies, procedures, guidelines and business rules will be available only on the internet and intranet. Hard copy manuals or reservoirs of policy documents on shared computer drives in any ward, hospital, community centre or clinic are not valid and cannot be used to guide practice.

9. All SESLHD policies, procedures, guidelines and business rules (including interim documents and those in draft) will be accessed from a single internet site. Hospital or other facilities intranet and internet sites must ensure their link to SESLHD policies, procedures and guidelines is back to this one site.

10. All SESLHD policies, procedures, guidelines and business rules will use a standard template and a single numbering system.

11. All SESLHD policies, procedures, guidelines and business rules will undergo a standardised, transparent process of development. This includes appropriate consultation, endorsement from an Executive Sponsor and approval by the Chief Executive.

12. All SESLHD policies, procedures, guidelines and business rules will be reviewed using a standard review template in accordance with the requirements of the document's risk rating (a period of one to five years) but can be reviewed more frequently as necessary.

13. All managers will be responsible for providing their staff with information about existing, new and altered legislation, policies, procedures and guidelines and maintaining evidence that they have done so.

14. All SESLHD policies, procedures and guidelines will:

    - identify the problem being addressed and the intent of the document
    - be based on the best existing scientific evidence and best practice
    - contain a risk rating
    - clearly state actions to be followed
    - be written in plain English language
    - identify an author and an Executive Sponsor
    - contain the date and number of the current revision on each page of the document
    - include an implementation plan
    - reference National Safety and Quality Health Service Standards as appropriate
    - any changes to document after a review, clearly stated in the Revision Section.

EXCLUSIONS

This Framework refers to the development of policies, procedures and guidelines (clinical and non-clinical) or similar documents, howsoever named, for example: protocol, framework, handbook.

Local documents such as business rules or local operating protocols are to be developed in line with the general principles of this framework and with the approval of the site / facility / service Director or General Manager.

It does not refer to the development of safe work practices, job descriptions, audit tools, leaflets, information brochures and similar documents, though these may require similar levels of document control and standardisation throughout SESLHD and be in line with the District Style Guide.

Section 3 - Definitions

NSW Health Policy Directive (PD): a document that contains material that is expected to be understood by relevant staff and must be complied with, and implemented, by the NSW public sector health system

NSW Health Guideline (GL): a document that provides advice or guidance but does not require compliance. Such documents are required to be accountable and subject to review and removal from the system if outdated

NSW Health Information Bulletin (IB): a document that provides a mechanism for the distribution of information within the NSW public health system. Information Bulletins are not to be used for policy or guideline matters, although they may be used to advise the existence or changes in status of such documents. Information Bulletins can cover:

- Industrial award variations
- Fee increases (gazetted under legislation)
- Advice re introduction of new legislation
- Training courses
- Public holidays

SESLHD policy is a document that:

- Describes SESLHD's position towards a particular issue
- Contains principles that mandate or constrain actions of SESLHD employees
- Applies to workers employed at all SESLHD sites
- Requires compliance and describes actions to be taken when there is non-compliance
- Is ratified by the Chief Executive

SESLHD procedure is a document that:

- Outlines how a NSW Health policy or process is to be implemented, the responsibilities of particular workers in relation to the policy and at what time and in what circumstances the policy is to be implemented
- Describes the customary, standard or expected way of handling a situation
- Contains a series of interrelated steps
- Requires compliance and describes actions to be taken when there is non-compliance
- Applies to workers employed at all SESLHD sites.

SESLHD guideline is a document that:

- Identifies, summarises and evaluates the best evidence and most current data about a particular issue, disease or disorder. It can describe clinical care or administrative functions.
- Outlines the most desirable course of action and guides decision making
- Does not require mandatory compliance, but documented explanations are required for any deviation
- Applies to workers employed at all SESLHD sites

Business Rule (BR): a document that describes a process, reporting line or use of resources in a particular site, service or department. These can be clinical or administrative business rules. Business rules must be endorsed by the site, department, facility or service manager or Director and must not contravene legislation or policy.

Local Business rules should not be developed where it is describing a practice that should be consistent across the LHD.

Frameworks, Protocols and Handbooks are also descriptions of documents that fall within the scope of this Framework.

Author/Author Group: the person and/or committee with the overall responsibility for developing or reviewing, implementing and maintaining a policy, procedure or guideline.

Executive Services Consultant: works in Executive Services and is responsible for facilitating the development of policies, procedures and guidelines within SESLHD.

Executive Sponsor: the person in charge of a portfolio.

Executive Clinical Sponsor: the person in charge of a clinical portfolio – the director of a clinical stream or district wide clinical service (such as the Director of Mental Health, or the Director of the Cancer Services Clinical Stream).

Line Managers: Nursing Unit Managers, Team Leaders and others responsible for managing a cost centre, ward, team or group of staff.

Portfolio: contains policies, procedures and guidelines within a broad category.

Senior Management: (with delegation for document approval within their portfolio of responsibility)

Chief Executive; Director Finance; Director Operations Mental Health; Director Nursing and Midwifery; Director Clinical Governance and Medical Services; Director Corporate and Legal Services; Director People and Culture; Director Population and Community Health; Director Strategy Innovation and Improvement; Executive Director Operations; Director of Allied Health; Direct Health ICT; Director Internal Audit; General Manager Prince of Wales and Sydney/Sydney Eye Hospital; General Manager St George Hospital; General Manager Royal Hospital for Women; General Manager Sutherland Hospital and Garrawarra Centre; General Manager Organ and Tissue Donation Service; Manager Media and Communications.

Section 4 - Responsibilities

The Chief Executive is responsible for:

- All policies, procedures and guidelines developed in SESLHD, and
- SESLHD's compliance with all NSW Health PDs and relevant legislation.

Tier 2 Directors / Service Managers / Clinical Stream Directors and Senior Managers are responsible for:

- Distributing information about the NSW Health PDs, GLs, IBs and SESLHD policies, procedures and guidelines to Line Managers and/or employees
- Facilitating discussion about NSW Health PDs, GLs & IBs and SESLHD policies, procedures and guidelines (including those in Draft for Comment stage) in a regular minuted forum and retaining records of these meetings for accreditation and incident investigation
- Working with authors/ site representatives to implement relevant policies, procedures and guidelines in their teams and ensuring their staff's compliance with them
- Developing strategies to manage any non-compliance and reporting this to Executive Services or Chief Executive
- Assisting with the development or review of policies, procedures or guidelines as required (or delegating this to a suitable staff member), and
- Providing reports on adherence to policies, procedures or guidelines as required.

Executive Sponsors/Executive Clinical Sponsors are responsible for:

- Deciding when a District procedure is required to support the implementation of a NSW Health PD, GL or IB that falls within the confines of their portfolio
- Endorsing the development of policies, procedures and guidelines that fall within the confines of their portfolio
- Providing advice to the author about membership of the working party, the required level of consultation and other issues as necessary
- Deciding the risk rating of the document
- Endorsing the final document and presenting it to the Clinical Council (for clinical documents) or District Executive Council (for non-clinical documents) for advice to the Chief Executive (CE)
- Reviewing or delegating the review of policies, procedures and guidelines in their portfolio in accordance with risk ratings (or more frequently if necessary), and
- Confirming that the document does not contravene NSW Government Legislation and that it meets relevant legislative requirements.

Authors/Author group are responsible for:

- Ensuring there is a need for the development of a new policy, procedure or guideline
- Applying to Executive Services to develop a policy, procedure or guideline

- Convening a working party with representation appropriate to the purpose of the document (if required).
- Conducting literature searches relating to best practice and to ensure compliance with NSW Health Policy Directives, NSW Legislation, National Safety and Quality Health Service Standards.
- Drafting the document
- Assigning a preliminary risk rating to the document
- Ensuring the draft document has adequate consultation and expert input, including from Aboriginal Health staff, Work Health and Safety, staff, consumer, carer and industrial bodies as necessary
- Mapping the document to the relevant National Safety and Quality Health Service Standard. For clinical documents this it to be completed in consultation with the Clinical Governance Unit. A table to assist with the mapping is available on the Policies and Procedures template Intranet page
- Retaining a copy of all feedback received and outlining any resulting changes made to the document
- Completing an Aboriginal Health Impact Statement (and Checklist if necessary) ***for all new policies, procedures, guidelines and handbooks***
- Compiling a plan that covers implementation, communication and evaluation of the document
- Clearly outlining education and training requirements associated with implementation of the document including any resource implications
- Ensuring the final document is approved by the peak governing body in the relevant Directorate, Clinical Stream or Service before endorsement by the Executive Sponsor/Executive Clinical Sponsor
- Assisting with the implementation plan for the document (including pilot tests if necessary)
- Monitoring compliance with the document with assistance from the Clinical Governance Unit / Clinical Practice Improvement Unit and relevant managers/stakeholders
- Reviewing the completed document to ensure its currency and relevance, and
- Keeping records of any comments received about the completed document to be used in future reviews.

Line Managers are responsible for:

- Distributing information about NSW Health PDs, GLs, IBs and SESLHD policies, procedures and guidelines to their staff and maintaining a record of such action
- Facilitating discussion about NSW Health PDs, GLs, IBs and SESLHD policies, procedures and guidelines (including those in Draft for Comment) in a regular minuted forum such as a staff meeting and retaining records of these meetings for accreditation and incident investigation
- Working with authors or stream managers (for clinical documents) to implement relevant policies, procedures and guidelines in their units or teams and ensuring compliance of their staff
- Developing strategies to manage any non-compliance and reporting this to their manager
- Assisting with the development or review of policies, procedures or guidelines as directed by their manager (or delegating this to a suitable staff member), and
- Monitoring compliance to policies, procedures or guidelines and providing reports as required.

Employees are responsible for:

- Complying with all NSW Health Policy Directives and SESLHD policies and procedures, and reporting non-compliance to their Line Manager, and
- Assisting with the development or review of policies, procedures or guidelines as directed by their Line Manager.

Executive Services Consultants are responsible for:

- Providing a central point for managing the development and review of all policies, procedures and guidelines in SESLHD
- Providing any necessary support to the author/author group
- Stewarding policies, procedures and guidelines through the review process from Executive Sponsor to Chief Executive
- Liaising with the Manager, Aboriginal Health about Aboriginal Health Impact Statement requirements.
- Proof reading and formatting documents to ensure a consistent look and feel
- Consulting with Directors to identify an appropriate Executive Sponsor / Executive Clinical Sponsor, risk rating and level of consultation for each policy, procedure or guideline
- Liaising with the author about the status of their document and its progression through the system.
- Monitoring the timeliness of the progression of policies, procedures and guidelines through the system
- Maintaining a master register and records of all policies, procedures and guidelines in SESLHD in the District's Electronic Records Management System
- Maintaining the intranet site for SESLHD policies, procedures and guidelines
- Including new SESLHD policies, procedures and guidelines and those in draft for comment on the staff electronic Noticeboard
- Including new NSW Health policies, information bulletins and guidelines each week on the staff electronic Noticeboard
- Notifying the SESLHD Clinical and Quality Council and DET Committee each month of new NSW Health policies, information bulletins and guidelines
- Notifying the St. George/Sutherland, POWH-SSEH, RHW and Mental Health Clinical Councils each month of new NSW Health policies, information bulletins and guidelines
- Notifying Executive Sponsors six months before a policy, procedure or guideline is due for review
- Providing reports on adherence to policies, procedures and guidelines and other related matters to the CE / NSW Health as required, and
- Providing training about the system of policies, procedures and governance.

Section 5 - Portfolios

Policies, procedures and guidelines fall within broad categories called portfolios that are managed by an Executive Sponsor. All policies, procedures and guidelines in SESLHD require support from the Executive Sponsor for the relevant portfolio prior to their development and again before ratification of the final document from the Chief Executive.

Senior Management: (with delegation for document approval within their portfolio or responsibility)

EXECUTIVE SPONSOR	PORTFOLIO CONTENTS	EXECUTIVE SPONSOR	PORTFOLIO CONTENTS
Executive Director Operations	Hospital and Service operations Clinical Streams Liaison with ACI INR (Interventional Neuroradiology)	*Director Allied Health*	Allied Health Policy Advice Allied Health Standards and Professional Governance Allied Health Workforce Management Cerner Allied Health Data System
Director Clinical Governance & Medical Services	Clinical Quality and Safety Management Clinical Audit Liaison with CEC Clinical Incidents and Complaints Management Disaster Management HSFAC – disaster response Medical Workforce Quality Use of Medicine	*Director Corporate and Legal*	Legal matters Coronial matters Assets and Energy Service Level Agreements Property Management Business Development Risk Management Corporate Governance
Director Finance	Financial Systems Management Revenue Management Financial Internal reporting Financial Accounting Liaison with HSS Fleet Services Statutory Reporting Billing Services Taxation Services Salary Packaging	*Director Health ICT*	Liaison with e Health Information Technology Systems Website management
Director Innovation and Improvement	Business Intelligence Performance Unit Innovation Improvement Programs Health Service Planning Community Partnerships NGO Grant Management Leading Better Value Care	*Director Nursing and Midwifery Services*	Nursing and Midwifery Services Nursing and Midwifery Workforce Nursing and Midwifery Practice Development Nursing and Midwifery Standards and Professional Governance Clinical redesign Lord Howe Island Services Access and Surgical Performance
Director People and Culture	Human Resources HR Consulting People Management Conduct and ethics Employment screening Recruitment and workforce transaction services Industrial and employee relations Organisational Development and Learning Employee Assistance program Workplace Health and Safety and Injury management	*Director Population and Community Health*	Aboriginal Health Child, Youth and Family Health Child Protection Child Sexual Assault CHIME Management Chronic Care Drug and Alcohol Families NSW General Practice Liaison Homelessness Health Interagency Liaison Keeping them Safe Multicultural Health Oral Health

				Primary and Community Health Programs State Dementia Policy Unit Women's Health / Sexual Assault District Falls Prevention HARP Health Promotion Public Health Sexual Health Equity
Director Research	Research Governance		*General Manager Mental Health*	Mental Health inpatient and community services
General Manager Prince of Wales and Sydney/Sydney Eye Hospitals	POWH and SSEH Hospital Services Community Health Services		*General Manager St George Hospital*	STG Hospital Services Community Health Services
General Manager Sutherland Hospital	TSH Hospital Services Community Health Services		*General Manager Royal Hospital for Women*	RHW Hospital Services
Director Internal Audit	ICAC matters Public Interest Disclosure Complaints against staff Internal review of practices and organisational activity		*Clinical Stream Directors*	Clinical policies for relevant stream (detailed table on following page)
Manager Media and Communications	Communication with Minister for Health Liaison with MPs Media Liaison District Communication		*Manager Executive Services*	District Corporate Record Keeping GIPA Act Policy Framework Parliamentary Liaison and Correspondence Legislative Compliance Framework

Executive Clinical Sponsors are the Directors of the Clinical Streams in SESLHD

EXECUTIVE CLINICAL SPONSOR	PORTFOLIO CONTENTS
Director Aged Care and Rehabilitation	Community Health (Aged and Carer and Rehabilitation) Extended Care General Rehabilitation Geriatric Medicine Geriatric Rehabilitation Neuro-Rehabilitation Spinal Rehabilitation
Director Cardiac and Respiratory	Cardiology Cardioth**oracic Surgery Cardiac Rehabilitation Heart Failure Perfusion Pulmonary Rehabilitation Respiratory Medicine Sleep Medicine
Director Mental Health	Acute Mental Health Child and Adolescent Mental Health Community Mental Health Mental Health Rehabilitation Older People Mental Health Aboriginal mental health Perinatal and infant mental health Multicultural mental health Eating disorders (mental health) Consumer, Community, Carer Programs mental health Intellectual disability mental health Youth mental health Clinical and corporate provision of Mental Health services
Director Surgery and Anaesthetics	Acute and Chronic Pain Anaesthetic Services Colorectal Endocrine Endoscopy ENT General GI Hand Head and Neck Hepatobiliary Maxillofacial Neurosurgery Neuro-Vascular Surgery Opthalmology Oral Surgery Orthopaedic Perioperative Services Plastics Reconstructive Spinal Surgery Sterilising Urology Vascular

EXECUTIVE CLINICAL SPONSOR	PORTFOLIO CONTENTS
Director Cancer Services	Adolescent and Young Adult BreastScreen NSW Cancer Service Haematology Medical Oncology Non - Malignant Haematology Non- Malignant Palliative care Palliative Care Radiation Oncology
Director Critical Care and Emergency Medicine	Biomedical Engineering Clinical Engineering Emergency Medicine High Dependency Hyperbaric Medicine Intensive Care Trauma Surgery
Director Medicine	Dermatology Endocrinology Gastroenterology General Medicine Hepatology Immunology Infectious Diseases Neurology Renal Rheumatology Stroke
Director Women's and Children's	Adolescent Health Child and Adolescent Community Child Health Health Feto-maternal Services Gynaecology Gynaecological Oncology Paediatric Services Perinatal Services Maternity and Obstetrics Neonatology Women's Health Women's and Babies Health

Section 6 - Dissemination of NSW Health Policies

NSW Health Policy Directives, Guidelines and Information Bulletins are received by the Office of the Chief Executive and sent to appropriate Executives for distribution and implementation. They are then distributed to a range of relevant officers within the organisation. Executive Sponsors complete the compliance response confirming distribution, implementation and compliance. If there are any issues regarding implementation or compliance, a brief must be completed outlining these issues and steps taken to address these and sent to Executive Services. This will then be progressed to the Manager Executive Services and if required to the Chief Executive.

Executive Services sends information about new NSW Health NSW PDs, GLs, IBs and SESLHD policies, procedures and guidelines each month to the:

- SESLHD District Executive Committee
- SESLHD Clinical and Quality Council
- RHW Clinical Council
- Prince of Wales and Sydney/Sydney Hospital Clinical Council
- St George Clinical Council
- Sutherland Clinical Council, and
- Mental Health Clinical Council.

New NSW Health, SESLHD policies, procedures and guidelines and those posted as Draft for Comment are also noted on the SESLHD Noticeboard.

This information is to be tabled at all relevant meetings, including staff meetings, to ensure all members of staff are made aware of their responsibilities and accountabilities. Line Managers are required to maintain records that this information has been distributed and discussed with their staff. Records can include the minutes of meetings or staff sign-off sheets for particular high risk policies or procedures.

More specifically targeted communication plans may be required in some circumstances, particularly for extreme and high risk documents.

Local facilities should have a process in place for the dissemination of NSW Health NSW PDs, GLs, IBs and SESLHD policies, procedures and guidelines.

Section 7 - Development

Policies, procedures and guidelines in SESLHD will often stem from the NSW Health and some will eventuate as a result of internal processes, incidents, audits, complaints, risk, legislation or new evidence. All policies, procedures and guidelines require approval from an Executive Sponsor before they are developed to ensure appropriate governance within the organisation and to prevent proliferation.

Considerations

Policies, procedures and guidelines are more successful when their implementation has been considered from the outset.

Before developing a policy, procedure or guideline, consider the following:

- What do you want to achieve?
- What other strategies might help you achieve this?
- Is there a similar policy, procedure or guideline in NSW Health or in another site in SESLHD that covers this topic? How has this been implemented? Can it be amended to cover your issue?
- What is your target audience? How will you consult with them sufficiently to ensure that your document is practical and realistic?
- What resources might be needed for implementation?
- Are there any education and/or training requirements associated with implementation? If so, what will this entail and how will it be resourced?
- What are the risks of implementation versus leaving things as they are?
- What are the potential barriers to implementation?
- How will you let people know there's been a change in practice?
- How will you monitor effectiveness and compliance?
- Is this to explicitly describe local needs and not applicable across SESLD? Would a local business rule be more appropriate?

Timeframes for the development and endorsement of a policy, procedure or guideline

Developing and endorsing policies, procedures and guidelines can be a lengthy process to allow time for consultation and endorsement by the relevant committees. Three to four months from the end of the Draft for Comment period to publication is the anticipated time frame for endorsement of the completed document, though some variation is to be expected.

All members of staff and committees responsible for endorsing policies, procedures and guidelines are expected to complete work in a timely manner. The Executive Services Consultant is responsible for monitoring time frames from approval to publication and expediting the process.

Interim documents

An interim document can be developed by a site, network or district service as an urgent response to a critical incident or new development. Such documents will use a SESLHD template and follow the same path as draft documents, but can be retained on the intranet to guide practice for a period of time negotiated with the Manager Executive Services. Interim documents will be removed from the intranet after this time.

Document development working parties are responsible for ensuring that interim documents are circulated to all relevant staff / units and groups for consultation and for ensuring the document follows the standard process of approval and implementation during the interim period.

Approval to develop a policy, procedure or guideline

Staff members wanting to create a policy, procedure or guideline at any site in SESLHD for applicability across the SESLHD must obtain approval from the relevant Executive Sponsor before commencing work on the document.

They must complete an Application to Develop a Policy/Procedure/Guideline and outline the practical implications of their proposal. This includes a preliminary assessment of any resource and educational requirements, implementation responsibilities and how the document will be monitored for compliance and effectiveness. The plan outlined on this form can be expanded upon in the Implementation Plan after the final document has been written. The application to develop is then sent to Executive Services.

The author must not proceed to develop the document without formal notification of the success or otherwise of their application. Amongst other factors that may arise, approval to develop a document will be based on:

- The strength and practicality of the document and its implementation plan
- The priority of implementing the document in comparison with other SESLHD initiatives
- Ethical and equity issues raised by the document
- Risks and barriers to its implementation, and
- The track record of similar documents in the Local Health District (indicating its potential success or otherwise).

It is important to note that approval to develop a policy, procedure or guideline does not guarantee approval of the final document.

Role of the author/author group

Authors, in conjunction with the document's Executive Sponsor, are responsible for creating and coordinating the implementation of a document and may chair a working party to assist with the process. The working party will consist of staff from across the Local Health District who represent the range of people expected to implement the document and who can provide expert opinion on its contents. It may include representatives from Aboriginal Health services, the Work Health and Safety team, the Clinical Governance Unit, Multicultural Health and consumer or carer groups. Policies, procedures and guidelines should be written to consider the whole of the lifespan so, if there are implications for the care of children or older persons, members of the working party must be chosen to provide this perspective.

Advice on the membership of the working party may be received from the Executive Sponsor when the author receives approval to develop the document.

Developing Consensus

The diversity of experience of working party members combined with a multitude of rapidly changing, often seemingly conflicting, information can make it difficult for working parties to reach consensus. Working parties in SESLHD will make evidence based decisions using the NHMRC Hierarchy of Evidence. Personal preference without substantial evidence will not be acceptable.

The chair of the working party (generally the author) is responsible for facilitating equitable discussion amongst members of the working party. Members of the working party are responsible for participating equally and actively in discussion – those who are unable to do so must withdraw and may nominate an alternative member or accept the decisions of the remainder of the group. The Executive Sponsor will be the final arbiter for working parties unable to reach consensus within six months.

Policies, procedures and guidelines about medications / drugs

NSW Ministry of Health Policy Directive PD2013_043 - Medication Handling in NSW Public Health Facilities requires drug committees to be responsible for considering all aspects of drug use, including the development and approval of drug related policies/protocols and procedures. SESLHD Drug & QUM Committee will approve the development of medication related policies, procedures and guidelines, and advise about the proposed development. A pharmacist with relevant experience must provide input during the development phase of such documents.

The final version of the document is submitted for SESLHD Drug & QUM Committee endorsement prior to Executive Sponsor and Clinical and Quality Council endorsement. The SESLHD Drug & QUM Committee will also be consulted about the review of documents concerning medication and determine the review period relative to risk.

Policies, procedures and guidelines - Infection Prevention and Control

SESLHD Infection Prevention and Control Committee will approve the development of any infection prevention and control related policies, procedures and guidelines, and advise about the proposed development.

The final version of the document is submitted for SESLHD Infection Prevention and Control Committee endorsement prior to Executive Sponsor and Clinical and Quality Council endorsement. The SESLHD Infection Prevention and Control Committee will also be consulted about the review of documents concerning infection prevention and control.

Risk Ratings

Risks and being risk aware are an integral part of organisational operations and must be identified and managed at the appropriate level for an organisation to be effective.

Risk ratings are assigned to policies, procedures and guidelines to ensure that documents that concern issues of high risk are prominent, receive appropriate resources and are reviewed regularly and thoroughly.

The level of risk is determined by the relationship between the consequences, or impact of the risk and the likelihood or probability of this risk occurring. Consideration will be given to the impact of non-compliance with a document on patients, visitors, staff or SESLHD as an organisation.

Risk ratings will be assigned to all new SESLHD policies, procedures and guidelines.

The risk rating of a document (Extreme, High, Medium or Low) should be determined in line with the *Ministry of Health Policy Directive PD2015_043 - Risk Enterprise-Wide Risk Management Framework* and the associated Risk Matrix, as outlined below.

In rating risks, it is important to use the matrix and follow these steps:
Step 1 – rank the consequence
Step 2 – rank the likelihood (probability/frequency)
Step 3 – classify the level of risk

It should also be noted that documents are required to undergo a review if there is a change of circumstance, for example a change in legislation, in response to an incident, or availability of new evidence.

Category	Consequences	Review period	Evidence of understanding
Extreme Risk	Non-compliance could result in the death of a patient or serious consequences to staff, visitors, services, finances or the environment (as per NSW Health Risk Matrix)	Annual	Staff members expected to implement the document must sign off that they understand it **when it is released and then each year**. Managers must retain sign off records and facilitate understanding of high risk documents through training and education.
High Risk	Non-compliance could result in serious permanent injury to a patient or major consequences to staff, visitors, services or the environment (as per NSW Health Risk Matrix)	2 years or more frequently	Staff members expected to implement the document and must sign off that they understand it. Managers must retain sign off records and facilitate understanding of high risk documents through training and education.
Medium Risk	Non-compliance could result in permanent impairment to a patient or moderate consequences to staff, visitors, services or the environment (as per NSW Health Risk Matrix)	3 years or more frequently	Relevant staff members must be aware of the document Managers must retain records of communication about the document, such as staff meeting minutes, emails and memos.
Low Risk	Non-compliance could result in increased care of a patient or minor or no consequences to staff, visitors, services or the environment (as per NSW Health Risk Matrix for minor & minimum)	5 years or more frequently	Relevant staff members must be aware of the document. Managers must retain records of communication about the document, such as staff meeting minutes, emails and memos.

Accreditation Requirements

SESLHD services will be accredited against the National Safety and Quality Health Service Standards (NSQHS).

All clinical policies must, where appropriate, align with one of the eight National Standards:

Standard 1: Clinical Governance

Standard 2: Partnering with Consumers

Standard 3: Preventing and Controlling Healthcare-Associated Infection

Standard 4: Medication Safety

Standard 5: Comprehensive Care

Standard 6: Communicating for Safety

Standard 7: Blood Management

Standard 8: Recognising and Responding to Acute Deterioration

Legislative Requirements

SESLHD is required to have a governance structure in place to fulfil statutory obligations, and to ensure good corporate and clinical governance, as outlined in relevant legislation.

SELSHD has developed a legislative compliance register to ensure that all legislative obligations are managed and reported on. The register cross references the legislation with policy and assigns primary responsibility for ensuring compliance with each Act.

The document development phase is the appropriate point at which to identify if a policy or procedure references legislation and / or contains legislative reporting obligations. Authors will complete a Legislative Compliance form for each new district document.

Aboriginal Health Impact Statements

NSW Ministry of Health Policy Directive - PD2017_034 Aboriginal Health Impact Statement and Guidelines states that the health needs of Aboriginal people must be incorporated into the development of new state and Local Health District policies, strategies and programs. Authors will complete an Aboriginal Health Impact Statement Declaration (and a Checklist if necessary) for each new policy, strategy and program in SESLHD.

When required, the Manager, Aboriginal Health will provide advice to authors about the Aboriginal Health Impact Statement and Checklist. The Executive Services Consultant will maintain a register of all Aboriginal Health Impact Statements in SESLHD for any new policies, procedures or guidelines and provide reports to the Chief Executive and NSW Health as required.

Work Health and Safety Implications

Work Health and Safety (WHS) is an important consideration in the workplace and authors of new policies, procedures and guidelines need to consider the WHS implications of their documents. Because many workplace injuries arise in the clinical environment, WHS implications are of particular importance in clinical procedures. The author may need to seek advice through their local WHS committee or the Workforce Directorate.

Draft documents

Draft documents are to be submitted to the Executive Services Consultant at SESLHD-ExecutiveServices@health.nsw.gov.au. Drafts will be posted on the Draft for Comment web page for four weeks, unless a shorter timeframe is agreed between the author and Executive Services. Comments are received by the author via email and collated using the Feedback Form. At the end of the consultation period any relevant, reasonable changes are made to the document by the author who then sends the document and the feedback form to the Executive Services Consultant with Executive Sponsor approval.

Consultation

Adequate consultation with the people who will be expected to implement them, strengthens policies, procedures and guidelines and makes them more practical. Expert opinion is also important to ensure the content is accurate and current.

The author, in consultation with the Executive Sponsor, is responsible for ensuring that clinical streams and people / groups who can be expected to implement the document are alerted to its existence and have the opportunity to provide comment during the draft stage. Advice on the required level of consultation may be received from the Executive Sponsor when the author receives approval for development.

It is important to record any comments that are received during the draft phase, particularly dissenting comments, on the feedback form.

Section 8 - Review and Endorsement of the Final Document

Policies, procedures and guidelines that have completed the draft stage, received adequate consultation, been amended accordingly and approved by the Executive Sponsor are sent to the Executive Services Consultant for the final approval of the Chief Executive via the peak governing Council (the SESLHD District Executive Council and / or the SESLHD Clinical and Quality Council). They are to be accompanied by an Implementation Plan. The Executive Services Consultant completes the Document Development Checklist to ensure the Framework has been applied. Documents can be sent back to the author for further amendments at any stage during this process.

Questions that guide endorsement include:

- Does the document duplicate or repeat any existing policy, procedure, guideline or business rule?
- Does the document contradict any existing policy, procedure, guideline or business rule?
- Has the document been developed by the appropriate author / working group?
- Have the correct people / groups been consulted about the document?
- Who has commented on the document and what positions do they hold in the organisation?
- What criticisms have been made of the document?
- How have any criticisms been addressed by the author / working group?
- What are the risks of implementation versus leaving things as they are?
- What will be the resource requirements/implications?

Responsibilities for endorsement of the final document

The Chief Executive (CE) has the ultimate responsibility for all SESLHD policies, procedures and guidelines. To fully inform the CE about these documents, all clinical policies, procedures and guidelines are presented to a meeting of the Clinical and Quality Council and all non-clinical policies, procedures and guidelines are presented to a meeting of the District Executive Council for review. The CE sits on each committee and will use these forums to make decisions about SESLHD policies, procedures and guidelines.

The final document and Implementation Plan will require endorsement from the following:

1. Most senior governance committee with the responsibility for reviewing and approving policies, procedures and guidelines in the Directorate
2. Executive Sponsor
3. Chief Executive via the Clinical and Quality Council (for clinical documents only), and
4. Chief Executive via the District Executive Council (for non-clinical documents only).

Publication

Documents that have been ratified by the Chief Executive are entered into a Master Register and assigned a number by the Executive Services Consultant. They are published on the Policies and Procedures page of the intranet and internet. This information is also published at the end of each month on the Intranet staff *Noticeboard.*

A Policy Report is provided each month to the secretariats of District and Site /Service governance committees.

This information is to be tabled at all relevant meetings, including staff meetings, so that all members of staff are made aware of their responsibilities and accountabilities.

Managers are required to keep records about staff notification for the purposes of accreditation and incident investigation.

Section 9 - Implementation

Implementation is an integral part of policy development. All NSW Health PDs, IB and GLs and new SESLHD policies, procedures and guidelines will have an implementation plan, if necessary. The implementation plan for any documents that require compliance will have sufficient detail to provide information about the level of compliance at each relevant site in SESLHD.

Executive Sponsors are responsible for implementing NSW Health PDs, IBs and GLs and are responsible for ensuring SESLHD policies, procedures or guidelines are implemented appropriately throughout SESLHD.

They will develop and oversee an Implementation Plan for SESLHD policies, procedures or guidelines that includes the following information:

- the document's aims
- Key Performance Indicators (KPIs) – this should ideally be data that is already collected, such as bed days, IIMs reports etc.
- a realistic timeline for implementation
- a comprehensive communication strategy for its dissemination
- resource implications
- education implications
- responsibilities for specific strategies, evaluation and review
- review mechanisms to determine its effect

Should there be any concerns or difficulties in relation to implementation of NSW Health PDs, IBs and GLs Executive Sponsors are to provide a brief to the Manager Executive Services for escalation to the Chief Executive. The brief should outline a plan to achieve compliance and a timeframe. Where compliance cannot be achieved within a reasonable timeframe it is appropriate for the Chief Executive to provide advice to the Secretary NSW Health.

Authors of SESLHD documents should report any difficulties with implementation via a brief to the relevant Executive Sponsor.

Section 10 - Monitoring, Compliance and Review

Monitoring and Compliance

A policy, procedure or guideline is pointless unless it is being used by and is useful to staff. Such documents are more likely to succeed in their aims if their uptake is monitored within the first three months of publication.

Executive Sponsors are accountable for monitoring compliance with NSW Health PDs and GLs that fall within their portfolio.

Authors and/or working parties are responsible for developing strategies to monitor the use of the documents they produce. These strategies, which will vary dependent on document content, are to be articulated in the Implementation Plan.

Compliance with NSW Health or SESLHD policy or procedure will be measured through a number of approaches:

- Targeted audits as determined by the relevant SESLHD governance committee
- In response to requests from NSW Health
- Through review of incident notifications
- Through investigation of complaints
- Any other process which may be deemed necessary by the governance committee or Executive Sponsor.

Issues of non-compliance will be referred to the appropriate District Executive for management in accordance with relevant District policies.

Review of Published Documents

Document reviews are to be conducted in line with the review date set at the time of publication.

Executive Sponsors are responsible for ensuring that SESLHD policies, procedures and guidelines will be reviewed according to the relevant risk management protocol (see Section 8, p18).

More frequent review will be required when the information upon which a document is based is updated, such as the release of a new NSW Health PD, GL or IB, a change in legislation, or change in practice as a result of an incident.

Evidence of risk to patients, staff, visitors, the environment or the organisation arising from the use of any document will also lead its review.

All protocols and procedures for the administration of medications by injection must be consistent with NSW Health policies, and be approved and regularly reviewed by the Drug and Therapeutics Committee.

A review of a published document needs to be thorough to ensure the practicality and relevance of the document; a standard review template has been developed to assist authors in this process.

Reviews must be completed for all documents according to the time frame indicated by the risk management protocol. Once the review is completed the review tool form will be sent to the Executive Services Consultant to update the Master Register of Policies, Procedures and Guidelines.

Documents that require major changes should undergo the same development and approval process as new documents; those with minor or no changes require approval only from the Executive Sponsor.

Ultimately Executive Sponsors determine whether the changes are minor or major. However, examples of minor changes are hyperlink updates, a few sentences are changed, update of related forms or references. The intent, meaning and audience of the document are not changed. Examples of major change include where more than 50% of the document has changed, or the audience, intent, purpose or process has changed. If a clinician or officer would be required to change the way tasks are undertaken or substantially change their practice that would constitute a major review.

Information in relation to documents republished following review is posted on the Intranet staff *Noticeboard* each month.

Any policies, procedures or guidelines that are not consistent with NSW Health Policy or are no longer required will be removed from the SESLHD intranet, with approval of the Executive Sponsor, and archived in the records management system in accordance with the State Records Act.

Section 11 - Documentation, References, Revision & Approval History

Documentation

The following documents can be found on the Templates and Forms page of the SESLHD Intranet:

- SESLHD Application to develop a Policy/Procedure/Guideline
- NSW Health Policy Compliance Form
- National Standards and Legislation Declaration
- National Reference Table
- SESLHD Guideline Template
- SESLHD Policy Template
- SESLHD Procedure Template
- SESLHD Business Rule Template
- Development Checklist
- Policy/Procedure/Guideline Implementation Plan
- Policy /Procedure/Guideline Feedback Form
- Aboriginal Health Impact Statement Declaration and Checklist, and
- Policy/Procedure/Guideline Review Tool.

References

NSW Ministry of Health Policy Directive PD2013_043 - Medication Handling in NSW Public Health Facilities

NSW Ministry of Health Policy Directive PD2019_034 - Incident Management Policy

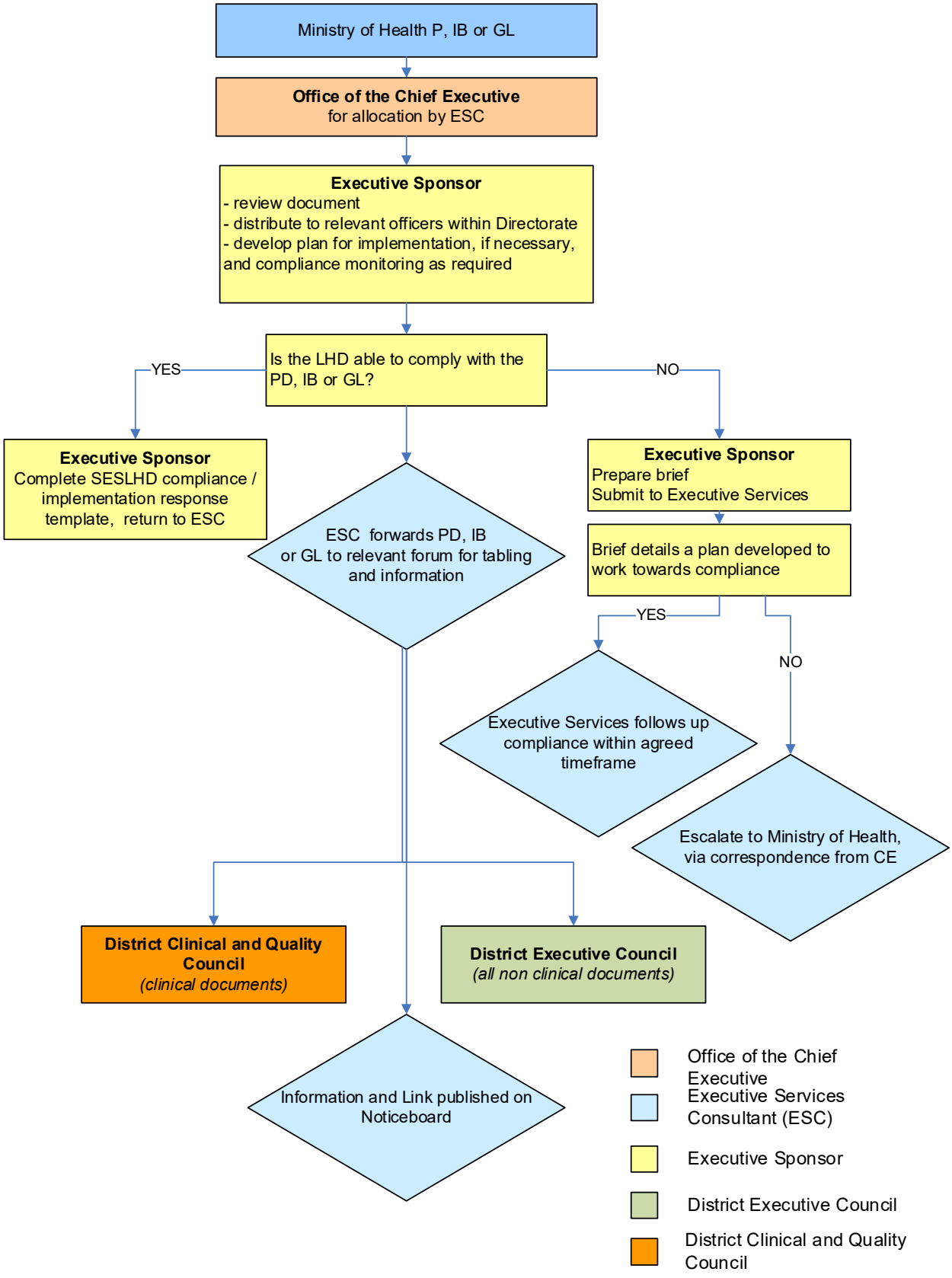
NSW Ministry of Health Policy Directive PD2016_049 - NSW Health Policy Directives and Other Policy Documents

NSW Ministry of Health Policy Directive PD2017_034 - Aboriginal Health Impact Statement

Revision & Approval History

Date	Revision number	Author and approval
June 2009	0	Manager Corporate Governance Approved by Chief Executive at Area Executive Team meeting 9.6.2009
June 2012	1	Feedback from Clinical Governance Unit
July 2012	2	Approved by SESLHD DET with addition of members to DET members
March 2014	3	Framework reviewed by Clinical Governance Unit and Manager Executive Services. Updated to meet accreditation standards and link with EQuIP National. This includes the ten National Safety and Quality Health Service Standards and five additional standards developed by Australian Council on Healthcare Standards (ACHS)
August 2014	3	Approved by DET
October 2015	3	Hyperlink to NSW Health Risk Matrix updated
January 2016	DRAFT	Document reviewed by Policy and Procedure Sub-Committee and returned to Draft status.
February/March 2016	DRAFT	Draft for Comment
May 2016	DRAFT	DET for approval prior to publishing
July 2016	4	Approved by DET
November 2018	5	Minor review. Updated links and reallocated Capital Redesign and Programs and Performance portfolio contents. Replaced Executive Team with District Executive Council.
September 2019	6	Minor review. Removed positions that no longer exist under the new executive structure and included the new positions. Replaced the first version of the NSQHS Standards with the second version. It should be noted Section 5 will require review within the next 12 months when portfolio responsibility are determined.
April 2020	7	Minor review. Update to Risk Ratings as discussed at Policy Governance Committee Meeting.
July 2020	8	Minor review. Reassigned *'Clinical and corporate provision of Mental Health services*' to Director, Mental Health as incorrectly assigned to Director Health ICT.
August 2020	9	Minor review. Portfolio contents table updated. Clinical Stream portfolio contents table marked as under review. Next review scheduled for August 2021.

Appendix A: Distribution and Implementation of NSW Health PDs, IBs and GLs



Health
South Eastern Sydney
Local Health District

Appendix B: Policy, Procedure & Guideline Development in SESLHD