SESLHD HANDBOOK COVER SHEET

NSW GOVERNMENT | Health South Eastern Sydney Local Health District

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SUMMARY	This document outlines the principles and processes for the development and endorsement of policies, procedures, guidelines, business rules and related documents in SESLHD.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY
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Framework for Governance of Policy Documents in South Eastern Sydney Local Health District

SESLHDHB/019

October 2021

Health
South Eastern Sydney
Local Health District

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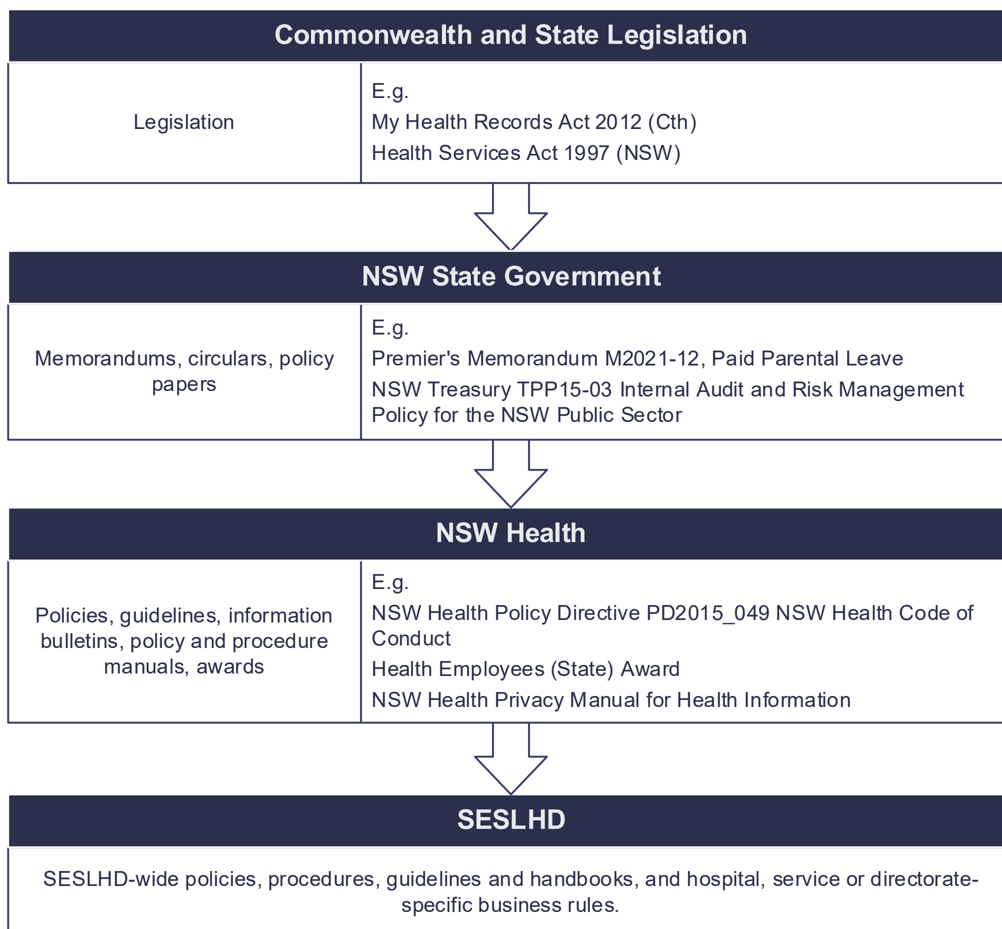
1 Introduction

1.1 Background and context

As an organisation that provides healthcare services to the community, it is important that South Eastern Sydney Local Health District (SESLHD) and its staff have access to information, advice, directions and best practice guidance to support SESLHD to deliver safe and effective care.

SESLHD, as part of New South Wales (NSW) Health, is a NSW Government organisation and as such must operate within the national and state legislative and governance context outlined below.



As a principle, SESLHD documents must not be inconsistent with higher-level governance documents. Where there is any inconsistency, the higher-level governance document will apply.

The Board and Chief Executive of SESLHD are responsible for ensuring that SESLHD has mechanisms in place to support adherence to relevant legislation, policies and procedures. All staff members within SESLHD have responsibilities in relation to policy.

As per the NSW Health Code of Conduct, all SESLHD staff are required to comply with all applicable NSW Health and SESLHD policy documents, keep up to date with best practice and observe all laws relating to their profession.

SESLHD aims to have policy documents that are based on best practice, enhance clarity and are current, relevant and accessible. SESLHD also aims to promote consistency of process and practice across the organisation.

1.2 About this Framework

The purpose of the Framework for Governance of Policy Documents in SESLHD is to outline the principles, requirements and standards for policy documents within SESLHD.

The Framework is intended to provide guidance to staff across SESLHD on the principles and best practice for developing and managing policy documents. Additionally, it outlines the governance processes that exist for these documents within SESLHD.

While acknowledging the overarching national and state governance and policy context, this Framework is focused on the arrangements that SESLHD has in place to manage SESLHD policy documents.

This Framework is supported by a range of resources, including guides, checklists, forms and templates that form part of the governance process.

1.2.1 Local frameworks

The principles of this Framework apply to all policy documents in SESLHD. However, hospitals, services and directorates within SESLHD may develop a local document to further detail their processes. Any local guidance documents should apply the principles of this Framework and comply with relevant requirements.

1.3 Key terms

In this Framework, 'policy document' is used as a collective term to refer to policies, procedures, guidelines, frameworks, business rules and other documents types that are managed under the policy governance processes within SESLHD.

'Hospital, service or directorate' is used as a collective term to refer to the top-level portfolios that make up SESLHD, in line with the SESLHD Executive Structure. A list of the hospitals, services and directorates within SESLHD can be found at **Appendix A.**

A list of other definitions and acronyms used in this Framework can be found at **Section 14.**

2 Principles

The following principles apply to all policy documents across SESLHD:

a. All policy documents in SESLHD will undergo a standardised and transparent process of development, including appropriate consultation and approval prior to publishing. (See **Section 7**)

b. SESLHD policy documents will reference national or state-level governance documents, such as legislation or NSW Health policy documents, as appropriate. SESLHD policy documents will not be inconsistent with higher-level governance documents. (See **Section 1**)

c. A policy document will only be developed by SESLHD where there is no corresponding NSW Health policy document, unless the NSW Health document directs that a local document must be produced, or when necessary to facilitate local implementation of a NSW Health document. (See **Section 7**)

d. Wherever possible, policy documents will be developed as SESLHD-wide documents, except where individualised local information is required and cannot be reasonably incorporated into a SESLHD-wide document. (See **Section 7**)

e. Policy documents will be based on best evidence, and will be developed following thorough research and consultation. (See **Section 7**)

f. Policy documents will use the required template, and use consistent language, style and referencing standards. (See **Section 7**)

g. Policy documents will include a risk rating of the topic addressed by the document in line with the risk matrix set out by NSW Health Policy Directive *PD2015_043 - Risk Enterprise-Wide Risk Management Framework.* (See **Section 6**)

h. Policy documents will be subject to strict records management to ensure currency and version control. Records will be kept of changes to policy documents in a revision history section of the document or within the records management system. (See **Section 3**)

i. Policy documents will be assigned a review date, with a maximum review period of five years, in line with guidance from the NSW Ministry of Health. (See **Section 6**)

j. SESLHD-wide policy documents will be accessible from a single internet page. Each hospital, service or directorate will make their business rules available from a single intranet page for that hospital, service or directorate. (See **Section 5**)

3 Governance

SESLHD has committees, resources and practices in place to provide governance of policy documents across SESLHD, which are outlined below.

3.1 SESLHD-wide documents

SESLHD-wide policy documents are coordinated by the Governance and Policy team, part of the Corporate and Legal Services Directorate. For these documents, the Governance and Policy team supports authors in their development, ensures that the correct process has been followed and that appropriate approvals have been received.

All new SESLHD-wide policy documents are reviewed and endorsed by one of the SESLHD Peak Executive Committees. All of the Peak Executive Committees have the Chief Executive, SESLHD as chair or co-chair; and as such, approval by the committee is considered final approval for the policy document to be published.

The SESLHD Peak Executive Committees are:

- SESLHD Clinical and Quality Council
- SESLHD Corporate Executive Council
- SESLHD Executive Council.

The Governance and Policy team maintains records of all SESLHD-wide policy documents, and monitors the status of these documents to enable authors and document coordinators to maintain document currency. Regular reports and information is communicated to senior managers and staff across SESLHD on the topic of policy.

The Governance and Policy team is responsible for maintaining this Framework, as well as the forms, templates and resources that support the processes outlined in this Framework. The Governance and Policy team also coordinates the process to seek compliance with NSW Health policy documents. Hospitals, services and directorates may have business rules outlining their local processes for coordinating compliance with NSW Health policy documents.

SESLHD has a Policy Governance Committee that has oversight of the policy development process and related matters. The committee's membership includes representatives from hospitals, services and directorates across SESLHD.

3.2 Hospital, service or directorate documents

Hospitals, services and directorates across SESLHD should have staff members in their structure that are responsible for supporting or contributing to the development and management of policy documents for their service.

Each hospital, service and directorate has established processes in place to ensure appropriate governance and approval of local documents, consistent with the principles of this Framework. This may include committees that review and endorse policy documents, and oversee the process.

3.3 Record keeping

All SESLHD corporate records, which include policy documents, must be managed and disposed of in accordance with the *State Records Act 1998 (NSW).*

Documents are to be registered in SESLHD's electronic records management system, Content Manager, and managed closely to ensure that only one current version of each document exists.

Staff involved in overseeing the policy governance processes across SESLHD are responsible for contributing to and ensuring record keeping practices. *SESLHDHB/022 SESLHD Corporate Records Management* provides further information on the requirements and responsibilities for management of corporate records in SESLHD.

Documents become uncontrolled when printed and storage of hard copy policy documents is not encouraged. Should a document need to be printed for immediate use or reference, it should be disposed of as soon as there is no longer a current need for the document.

3.4 Intellectual property

SESLHD welcomes collaboration and sharing of information with external or partner organisations, such as other NSW Local Health Districts, NSW Government colleagues and interstate public health system personnel.

SESLHD policy documents are the intellectual property of SESLHD and cannot be duplicated without permission, however the SESLHD Governance and Policy team reviews and considers all written requests for use of content from SESLHD document, and will grant permission as appropriate and in line with the *Copyright Act 1968 (Cth).*

Staff involved in developing policy documents must ensure that they maintain good practices in consideration of intellectual property, through referencing or seeking permission for reproduction of content as required.

4 Roles and Responsibilities

4.1 Overview

Authors or document coordinators

The following tasks are the responsibility of the individuals or groups that are involved in the development process for a policy document. It is acknowledged that these responsibilities may be shared across more than one staff member.

- Identifying or responding to a need to develop a policy document, and seeking support from the relevant Executive Sponsor for the policy document to be developed.
- Undertaking research on the topic, including literature reviews, to ensure best evidence-based practice, and a review of relevant state or national reference documents to ensure alignment.
- Drafting the policy document, in consultation with relevant staff, experts and stakeholder groups.
- Developing a plan that addresses the implementation, communication and evaluation of the policy document.
- Completing the relevant forms required under the policy development process and seeking Executive Sponsor approval of the final draft document.
- Supporting implementation of the policy document, including communication to relevant staff.
- Undertaking evaluations of the policy document.
- Reviewing the policy document prior to its review period, or when a need arises.

Executive Sponsors

The following tasks are the responsibility of the Executive Sponsor of a policy document.

- Providing direction or approval for a policy document to be developed.
- Overseeing the development process, approving versions of the document at relevant stages, and presenting the document to relevant committees for approval.
- Ensuring that an implementation plan is developed for all new policy documents, and that the document and associated implementation plan are communicated to the hospitals, services and directorates that are required to implement the document.
- Ensuring that policy documents within their portfolio remain current and accurate, and are reviewed in a timely manner, prior to the document's review date.
- Further details regarding the role of the Executive Sponsor are outlined in **Section 4.2.**

All staff

- SESLHD staff are required to comply with all applicable NSW Health and SESLHD policy documents and keep up to date with best practice.
- SESLHD staff members may be responsible for researching, writing, communicating or providing education on topics addressed by policy documents, in line with their area of practice.
- Staff in management or education roles are responsible for communicating relevant policy documents to their teams, implementing strategies to ensure compliance within their teams and escalating issues related to compliance as required.

4.2 Executive Sponsors

All policy documents in SESLHD have an Executive Sponsor. The Executive Sponsor is a senior manager with portfolio responsibility for the topic area addressed by the policy document.

For best practice, policy documents should have one Executive Sponsor only. There may be limited or exceptional circumstances where a document should have more than one Executive Sponsor.

Responsibilities of Executive Sponsors are outlined in **Section 4.1**.

Level of Executive Sponsor

The required level of Executive Sponsor for a policy document is determined based on the type of document, and who the document applies to. The table below outlines the required level of Executive Sponsor for all policy documents in SESLHD.

Table 1

Document type	Document scope	Level of Executive Sponsor
Policy, procedure, guideline or handbook	SESLHD-wide Or More than one hospital, service or directorate	SESLHD Executive or senior manager from the list in **Table 2** below.
Business rule	Hospital, service or directorate-wide Or More than one department of a hospital, service or directorate	General Manager or Director of the hospital, service or directorate
	One department of a hospital, service or directorate	Department manager or higher

The above table should be considered as the minimum level of Executive Sponsor. A hospital, service or directorate may decide that approval is required at a higher level than listed above.

Hospitals, services and directorates should develop and maintain a list of agreed Executive Sponsors for their policy documents.

Changes to Executive Sponsors

Due to changes in portfolios or responsibilities, changes to the Executive Sponsor for a policy document may occasionally be required. The current Executive Sponsor or a member of their staff must contact the new or proposed Executive Sponsor to seek approval for the transfer of a policy document.

Once transfer has been agreed, the change should be documented and communicated to relevant staff. For SESLHD-wide documents, the Governance and Policy team should be notified once the transfer has been agreed.

Executive Sponsors for SESLHD-wide documents

The following table specifies the agreed list of Executive Sponsors for SESLHD-wide documents. SESLHD-wide documents must have one Executive Sponsor only.

Table 2

No.	Position title
1	Chief Executive, SESLHD
2	Clinical Stream Director, Aged Care and Rehabilitation, SESLHD
3	Clinical Stream Director, Cancer, SESLHD
4	Clinical Stream Director, Cardiac and Respiratory, SESLHD
5	Clinical Stream Director, Critical Care and Emergency Medicine, SESLHD
6	Clinical Stream Director, Medicine, SESLHD
7	Clinical Stream Director, Palliative Care and End of Life Care, SESLHD
8	Clinical Stream Director, Surgery, Anaesthetics and Perioperative, SESLHD
9	Clinical Stream Director, Women's and Children's Health, SESLHD
10	Director, Allied Health, SESLHD
11	Director, Clinical Governance and Medical Services, SESLHD
12	Director, Corporate and Legal Services, SESLHD
13	Director, Finance, SESLHD
14	Director, Internal Audit, SESLHD
15	Director, Nursing and Midwifery Services, SESLHD
16	Director, People and Culture, SESLHD
17	Director, Population and Community Health, SESLHD
18	Director, Research, SESLHD
19	Director, Strategy, Innovation and Improvement, SESLHD
20	Executive Director, Operations, SESLHD
21	General Manager, Mental Health Service, SESLHD
22	General Manager, Organ and Tissue Donation Service
23	General Manager, Prince of Wales Hospital and Sydney/Sydney Eye Hospital
25	General Manager, Royal Hospital for Women
26	General Manager, St George Hospital
27	General Manager, Sutherland Hospital and Garrawarra Centre
28	Manager, Media and Communications, SESLHD
29	Manager, Office of the Chief Executive, SESLHD

5 Document Categories and Status

5.1 Document categories covered by the Framework

The policy governance process outlined by this Framework is for important and high-level document categories that require strict and tightly-governed management.

The following table summarises the policy document categories that are managed under the governance process outlined by this Framework.

Table 3

Policy			
Document scope	**Purpose**	**Compliance**	**Access**
SESLHD-wide	Outlines SESLHD's position towards a topic area or discipline and contains principles that mandate actions	Compliance is mandatory	SESLHD Policy internet page
Procedure			
Document scope	**Purpose**	**Compliance**	**Access**
SESLHD-wide	Outlines how a policy or a process is to be implemented and provides more detailed and specific instructions than a policy	Compliance is mandatory	SESLHD Policy internet page
Handbook			
Document scope	**Purpose**	**Compliance**	**Access**
SESLHD-wide	Provides the structure, context and standard practices of the organisation on a topic area or discipline	Compliance is mandatory	SESLHD Policy internet page
Guideline			
Document scope	**Purpose**	**Compliance**	**Access**
SESLHD-wide	Outlines best practice and recommended processes	Compliance is not mandatory, but sound reasons must exist for departing from it.	SESLHD Policy internet page
Business rule			
Document scope	**Purpose**	**Compliance**	**Access**
Hospital, service or directorate-wide Or to one department of a hospital, service or directorate	Outlines a local process or rules for an activity or topic area Business rules may be assigned sub-categories, such as clinical, or corporate	Compliance is mandatory	Central business rule intranet or internet page for the hospital, service or directorate

It is noted that use of the above document categories and definitions will require some transition of existing categorisation and document use within SESLHD.

5.2 Document categories not covered by the Framework

Not all documents that are developed in SESLHD are required to be managed under this Framework, or are applicable to be managed under this Framework. Other documents types may also be managed under separate governance arrangements.

These document categories include:

- Strategies and plans
- Position descriptions
- Work instructions or task lists for a position or department
- Orientation manuals for a position or department
- Instruction manuals for software or equipment
- Safe operating procedures for equipment or devices.

Consideration should be given during document creation as to whether the category of document requires management under policy governance processes.

Documents in SESLHD not managed under the policy governance processes described in this Framework should not be titled ‘policy’, ‘procedure’, ‘guideline’, ‘handbook’ or ‘business rule’, to avoid misinterpretation.

5.3 Document status

SESLHD uses the following definitions for the status of policy documents for the purposes of reporting and communicating the currency of policy documents.

- **Current**
  Documents are current when they have been approved and published, and are within the period before the next review date.
  Documents that are under review but are within the review date are still defined as current.

- **Overdue**
  Documents are overdue when the review date has passed. This is defined as the first day of the next month after the assigned review date.
  For example, a document due for review in January 2022 will become overdue on 1 February 2022.
  Documents that are under review but have passed their review date are still defined as overdue.

- **Obsolete**
  Documents are obsolete when they are no longer published as a document under the policy governance process. This may be due to the document no longer being relevant and removed from publication. This may also be due to a document being converted to a document type that is not covered by the policy governance process (See **Section 5.2** above).

6 Risk Management Approach

Consideration of risk is an important step in the development and implementation of new or revised policy documents. The National Safety and Quality Health Service Standards require health organisations to use a risk management approach to the development, review and monitoring of policies, procedures, guidelines and business rules.

Risk ratings

All policy documents, both organisation-wide and local, include a risk rating of the topic addressed by the document in line with the risk matrix set out by NSW Health Policy Directive *PD2015_043 - Risk Enterprise-Wide Risk Management Framework.*

Using the NSW Health risk matrix, the risk rating is determined by considering the potential consequences of non-compliance with the document, and the likelihood or frequency of this outcome occurring. Consequences of non-compliance with a document may include impacts on patients, visitors, staff or SESLHD as an organisation.

The risk rating categories are Extreme, High, Medium and Low. Risk ratings are assigned during document development, and reassessed as part of the review process. Risk ratings may change over time, such as when new systems or processes are put in place that reduce the likelihood of an adverse outcome occurring.

Review period

The risk rating included in a document determines the maximum review period, to ensure that accuracy and best practice is maintained for topics with a higher level of risk (See **Table 4**). The maximum review period for all SESLHD documents is five years. Documents can be reviewed more frequently than the allocated review period, if a need arises, such as when there is a change in legislation or standard practice.

Table 4

Category	Review period
Extreme Risk	Within 1 year or more frequently
High Risk	Within 2 years or more frequently
Medium Risk	Within 3 years or more frequently
Low Risk	Within 5 years or more frequently

7 Development

Staff across SESLHD are responsible for identifying opportunities or requirements for policy documents to be developed in SESLHD.

Policy documents should only be developed by SESLHD:

- When there is a legislative requirement for a policy document to be developed;
- When there is a requirement under a NSW Health policy directive for a policy document to be developed;
- To document a process or standard practice in an area covered by legislation or a NSW Health policy directive, where clarity is required on local implementation; or,
- To document a process or standard practice in an area that is significant to the operations of SESLHD and where legislative or state guidance does not exist.

Hospital, service or directorate business rules should only be developed:

- To document a process or standard practice in an area of responsibility covered by legislation, a NSW Health policy directive or SESLHD policy document, where clarity is required on local implementation that is specific to the hospital, service or directorate; or,
- To document a process or standard practice in an area of responsibility that is significant to the operations of the organisation, and where legislative, state or SESLHD-wide guidance does not exist, and where development of a SESLHD-wide document would not address the need.

7.1 Development process

There are seven key steps in the policy development process:

Step 1 – Identification and approval to develop a policy document

Step 2 – Document creation

Step 3 – Consultation

Step 4 – Draft for Comments

Step 5 – Document finalisation and Executive Sponsor approval

Step 6 – Executive committee approval

Step 7 – Publication

Information is provided below on the requirements of each step, with particular reference to the process for SESLHD-wide documents. It is acknowledged that the policy development process may be lengthy, depending on the level of research, consultation and approval required.

Step 1 – Identification and approval to develop a policy document

The first step of the process is to identify an opportunity or requirement for a policy document to be created, in line with the principles of **Section 7** above.

Considerations for the creation of a new policy document
- What is the aim of the new document? - What other strategies might help achieve this? - Would a new document duplicate a NSW Health or higher-level governance document? - Is there a similar document authored by NSW Health, or another site in SESLHD that covers this topic? How has this been implemented? Can it be amended to cover the issue at hand? - Who is the target audience? How will they be consulted to ensure that the 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 changes in practice be communicated? - How will compliance and effectiveness be monitored?

Following consideration, if a new policy document is proposed, the document category (see **Section 5**) and the appropriate Executive Sponsor should be identified (See **Section 4.2**).

Approval is to be sought from the Executive Sponsor for the policy document to be developed. This step requires a preliminary assessment of any resource requirements, implementation responsibilities and how the document will be monitored for compliance and effectiveness.

Considerations to guide the Executive Sponsor’s approval to develop a document
- The strength and practicality of the document and its implementation - 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.

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

Step 2 - Document creation

Once approval for has been received from the Executive Sponsor for a document to be developed, drafting of the document can commence, using the required template according to the document category.

While preliminary research will have been undertaken in Step 1 to determine any overlap with existing documents, further research should be undertaken during the document drafting process to inform the content. This research may include literature reviews to assess recent advances in the relevant topic area, review of legislation and other guiding documents, and review of internal resources and information within SESLHD.

Policy documents are to be written using clear and consistent language, with appropriate referencing of source documents.

As part of the process for drafting the document, the risk rating and review period of the document are to be determined. (See **Section 5**)

Further considerations for the document development process are outlined in **Section 7.2**.

Step 3 – Consultation

The author, in consultation with the Executive Sponsor, is responsible for ensuring that adequate consultation with key stakeholders occurs during the policy document development process.

Where appropriate, policy documents should be developed by, or in consultation with, a multidisciplinary group, which includes subject matter experts. Adequate consultation with the staff expected to implement and abide by the document is important to ensure current and accurate information, ensure feasibility, and to assist with the document's implementation.

Broad consideration should be given as to what expert or advisory groups are to be consulted during the development process, in such areas as work health safety, infection prevention and control, pharmacy or industrial relations.

Standard 2 of the National Safety and Quality Health Service Standards requires health service organisations to involve consumers and carers in the planning, delivery and evaluation of services. (Australian Commission on Safety and Quality in Health Care, 2017) Consumer and carer engagement and consultation should be considered as part of the development and consultation process for policy documents that directly impact consumer or carer experience.

Step 4 – Draft for Comments

As part of the development process for new policy documents or as part of a major review, documents are posted on a Draft for Comments page on the SESLHD intranet.

The purpose of the Draft for Comments period is to seek input from staff members to whom the policy document will apply. It is expected that consultation with experts and other key staff has occurred earlier in the development process.

For any SESLHD-wide documents that are relevant to all, or the majority of, staff members in SESLHD, or where there is an identified need for an extended consultation period, the standard Draft for Comments period is four weeks.

For SESLHD-wide documents on a specialty subject area that is not directly relevant to the majority of staff members in SESLHD, the standard Draft for Comments period is two weeks.

Authors are provided a feedback form to record feedback received during the Draft for Comments period.

If a policy document has not been progressed and finalised within six months of the completion of the Draft for Comments period, a re-review including an updated review tool, Executive Sponsor approval and consultation period is required, to ensure currency of the document.

Hospitals, services and directorates may set their own timeframes and processes for seeking comments on policy documents from staff, but are encouraged to apply the above principles.

Step 5 – Document finalisation and Executive Sponsor approval

Following the Draft for Comments period, any feedback received through consultation should be considered, and if appropriate, included in the final draft version of the policy document. The implementation plan may also need to be updated to reflect the feedback received.

The final draft policy document and the implementation plan is then submitted to the Executive Sponsor for approval.

Considerations to guide the Executive Sponsor's endorsement
- Does the document duplicate or contradict any existing policy or reference document?
- Has the document been developed by the appropriate author or group?
- Have the correct individuals / groups been consulted about the document?
- What feedback has been received about the document?
- How has feedback 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?

For SESLHD-wide documents, once approved by the Executive Sponsor, the final draft version of the policy document and supporting documents, along with evidence of Executive Sponsor approval, is sent to the Governance and Policy team for progression.

Step 5a – Approval of medication-related policy documents

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.

For SESLHD-wide documents, the relevant committee is the SESLHD Quality Use of Medicines Committee.

The Quality Use of Medicines Committee will review and approve medication-related policy documents. The Quality Use of Medicines Committee may also provide guidance on the appropriate review period and risk rating.

For medication-related policy documents, it is expected that input has been sought during the development process from a pharmacist with relevant subject matter expertise.

All policy documents that reference medication are tabled at the Quality Use of Medicines Committee, and progress as outlined below.

- Policy documents that involve medication that have undergone a minor review are submitted to the Quality Use of Medicines Committee, and proceed to be published once approval from the Committee is received.
- Policy documents that are new, or undergoing a major review will be submitted for Quality Use of Medicines Committee approval, and if approved, then proceed to the Clinical and Quality Council for approval, as outlined in Step 6 below.

Step 6 – Peak Executive Committee approval

New SESLHD-wide policy documents or policy documents that have undergone a major review receive approval from Chief Executive via one of the SESLHD Peak Executive Committees, as the final approval prior to publication and implementation:

- **SESLHD Clinical and Quality Council**
  Policy documents with a clinical focus.

- **SESLHD Corporate Executive Council**
  Policy documents with a corporate focus.

- **SESLHD Executive Council**
  Policy documents with an operational or strategic focus.

For SESLHD-wide policy documents, the Governance and Policy team organises for the document to be tabled at the relevant committee meeting and will advise the author of the outcome.

Step 7 – Publication

Once advice is received that the committee has approved a policy document, the document is published.

SESLHD-wide policy documents are published on the SESLHD public internet page. Hospital, service and directorate business rules are published on their local intranet page.

The author is advised once the document is approved and published, and is responsible for progressing the implementation process, as outlined in **Section 8**.

7.2 Considerations for the development process

The following areas should be considered as part of the policy document development process. For SESLHD-wide documents, these considerations are essential, and are included in the policy development forms that must be submitted for all new SESLHD-wide policy documents.

Aboriginal Health Impact Statements

NSW 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. Authors will complete an Aboriginal Health Impact Statement Declaration, and the related checklist if applicable, for each new SESLHD-wide policy document.

Legislative Requirements

To fulfil its statutory obligations, SESLHD is required to have a governance structure to manage legislative compliance. The overarching framework*, SESLHDHB/025 - SESLHD Framework for Legislative Compliance,* outlines the requirements for incorporating legislation into policy documents.

The policy document development phase is the appropriate stage at which to identify if a policy document should reference legislation and/or if it contains legislative reporting obligations. A national standards and legislative declaration form is completed for each new SESLHD-wide document.

National Safety and Quality Health Service Standards

The National Safety and Quality Health Service Standards developed by the Australian Commission on Safety and Quality in Health Care provide nationally consistent statements about the level of care consumers can expect from health services.

All policy documents, where relevant, must align with the National Safety and Quality Health Service Standards.

Clinical Care Standards

As part of the National Safety and Quality Health Service Standards, health service organisations are expected to support clinicians to use the best available evidence, including the Clinical Care Standards developed by the Australian Commission on Safety and Quality in Health Care.

Policy documents developed by SESLHD on topics covered by the Clinical Care Standard should reference the relevant Clinical Care Standards, where appropriate.

8 Implementation

Implementation of policy documents relates to the series of activities undertaken to achieve the goals and objectives of the policy document (Van Meter & Van Horn, 1975). It is an integral part of policy development, and requires thoughtful planning and consultation throughout the development process.

The National Safety and Quality Health Service Standards require organisations to support effective implementation of a policy system by ensuring that staff have:

- Ready access to relevant policies and procedures; and,
- Position descriptions, contracts or other mechanisms that require staff to comply with organisational policies and procedures. (Australian Commission on Safety and Quality in Health Care, 2019)

To achieve this requirement, all SESLHD-wide policy documents require an implementation plan to be completed during its development or when undergoing a major review. It is recommended that a multidisciplinary panel, including staff who will use the policy document, are involved in development of the implementation plan. A successful implementation plan will include identification of potential facilitators and barriers to compliance, and strategies to support implementation in the context of the current SESLHD environment, including consideration of resource implications.

Examples of implementation strategies that can be effective in a healthcare setting are in the **Table 5** below. It is acknowledged that that simple dissemination of policy documents is unlikely to result in effective implementation (Oxman, Thomson, Davis, & Haynes, 1995).

Table 5

Implementation Strategy	Comments and Examples
Dissemination of policy	Unlikely to result in effective implementation if this is the only strategy used.
Use multiple strategies	Effective implementation plans include multiple strategies to target different barriers.
Integrating policy document recommendations into organisational processes	For example, automated reminders, clinical decision support systems, or restructuring patient records. Strategies that are nearer the end user and integrated into the process of care delivery are more likely to be effective
Reminders	Reminders can significantly improve practice. Examples include prompts as part of patient records.
Education	Education should be interactive or combined with other interventions: - Presentations and passive dissemination may lead to small changes in practice - Interactive such as role playing or practising skills are more likely to be effective - Education combined with other strategies is more likely to be effective.
Resources	Additional tools such as quick reference cards attached to identification cards, consumer information and handouts, or point of care reminders may assist in effective implementation.
Audit and feedback	Audit and feedback is most effective when there is a large difference between the baseline and the recommended practice; and when it is personalised and repeated over time. Existing data monitoring systems can provide data for audit and feedback.

Local opinion leaders	Having local “champions”, for example, can influence practice.
Patient-mediated interventions	May be effective as part of an implementation strategy of clinical policy documents. For example, providing patients with education about evidence related to their condition and treatment.

Adapted from Registered Nurses’ Association of Ontario, 2012, Toolkit: Implementation of Best Practice Guidelines.

The Governance and Policy team ensures that SESLHD-wide policy documents are accessible, through publication on the SESLHD Policy internet page, and assist in dissemination through regular policy communications and reporting.

Executive Sponsors are responsible for ensuring that an implementation plan is developed for all new policy documents, identifying relevant stakeholders, and for ensuring that the policy document and the associated implementation plan are communicated to the hospitals, services and directorates that are required to implement the document.

However, responsibility for implementing policy documents does not sit only with Executive Sponsors; hospitals, services, directorates, departments and managers are responsible for considering and progressing strategies to implement policy documents as appropriate.

Managers and other staff members responsible for implementing a policy document should report any issues with implementation to their manager, and escalate to the document author and Executive Sponsor as appropriate.

10 Monitoring and Compliance

The National Safety and Quality Health Service Standards require organisations to monitor and improve adherence to policy documents. (Australian Commission on Safety and Quality in Health Care, 2017) Organisations are expected to review the use and effectiveness of policy documents through clinical audits or performance monitoring.

Compliance with SESLHD policies, procedures, handbooks and business rules is mandatory. SESLHD guidelines aim to inform best practice and while compliance with guidelines is not mandatory, sound reasons must exist for departing from them. SESLHD staff agree to comply with all applicable SESLHD and NSW Health policy documents, through signing the NSW Health Code of Conduct upon appointment.

The Governance and Policy team provide oversight and monitor SESLHD policy documents with regards to currency and provide reminders to Executive Sponsors prior to these documents being overdue.

Authors and Executive Sponsors of policy documents are to consider methods for monitoring compliance and effectiveness of policy documents, and to implement these where appropriate. Monitoring of policy document outcomes through existing data collection methods, such as incident management system data, medical record audits, clinical observation audits or other information, is recommended, where possible.

An audit and feedback process, where performance is measured and then compared to professional standards, or targets, can be effective in changing professional behaviour and improving compliance with policy documents. (Jamtvedt, Flottorp, & Ivers, 2019) (Ivers, et al., 2012). For example, observational hand hygiene audits, with individualised feedback to medical staff, along with ongoing handy hygiene strategies, has been shown to improve compliance with hand hygiene requirements (Smiddy, et al., 2019).

In instances where policy effectiveness and compliance is measured, it is recommended that this information is provided to the end-users of the documents in a constructive, rather than punitive manner, and that these end-users are provided with benchmarks or performance targets, to increase the likelihood of compliance.

12 Review

Executive Sponsors are responsible for ensuring that policy documents within their portfolio remain current and accurate, and are reviewed in a timely manner, prior to the document's review date.

The review date assigned to a policy document indicates the date that the review must be completed by, and not the date when the review process should commence. Executive Sponsors and document authors should plan the review process with sufficient time allowed to ensure it is completed prior to the review date.

Policy documents can be reviewed at any time ahead of their due date, should a need arise. This may be due to the release of a new NSW Health policy document, a change in legislation, or change in best practice.

An initial review and research should be undertaken to determine the extent of review required.

Considerations when reviewing a policy document
- Is the information still relevant and useful? - Does the information consider and reflect current best evidence? - Has the document been effective? Have there been any complaints or incidents related to this document? - Are the links and references throughout the document still accurate? - Does the document refer to, and/or align to legislation or a NSW Health policy directive? If so, has the legislation or policy directive been updated or rescinded? - Is there now a NSW Health policy directive in place that can replace the document? - Do any of the relevant policy governance forms need updating? - Is the document still aligned with the most appropriate Executive Sponsor? - Is the risk rating still appropriate?

The initial review of a policy document will result in one of four outcomes listed below.

1. No changes
2. Minor review
3. Major review
4. Obsolete

All sections and content of a document must be examined in order for it to be considered a review under the policy governance process. Outside of a formal review, some small changes and corrections may be made to documents, as outlined below in **Section 12.2.**

12.1 Review process for SESLHD-wide documents

A summary of the process for each of the four outcomes of the review process for SESLHD-wide policy documents is as follows. Policy documents involving medications may require additional approval processes beyond those outlined below.

1. **No changes**
   If a policy document has had an initial review that has determined that no changes are required to the document, the author will complete the Review Tool, seek approval from the Executive Sponsor, and submit the policy document along with the Review Tool to the Governance and Policy team for processing.

   The policy document will be republished and a new review date will be assigned.

2. **Minor review**
   A review of a policy document is considered minor when amendments or additions are required that do not change the intent, meaning, scope, audience or the fundamental process of the policy document.

   For a minor review, once the changes have been made, the author will complete the Review Tool, seek approval from the Executive Sponsor, and submit the policy document along with the Review Tool to the Governance and Policy team for processing.

   The policy document will be republished and a new review date will be assigned.

3. **Major review**
   A review of a policy document is considered a major review when amendments or additions are required that involve a change to the intent, meaning, scope, audience or the fundamental process of the policy document.

   Major reviews require the policy document to follow the full policy development process from Step 2 in **Section 7** above, including a Draft for Comments period and committee approval.

   For a major review, the author will complete the Review Tool, seek approval from the Executive Sponsor, and submit the policy document along with the Review Tool to the Governance and Policy team for processing.

   The policy document will be republished once the approval process has been completed and a new review date will be assigned.

4. **Obsolete**
   If the initial review determines that the policy document is to be made obsolete, the author will seek approval from the Executive Sponsor for the document to be rescinded.

   This approval, along with information on the reason for the document being made obsolete is to be provided to the Governance and Policy team.

   The policy document will be registered as obsolete and removed from the SESLHD policies and procedures internet page.

   Obsolete documents, and a register of these documents, are kept on record by the Governance and Policy team, and can be provided to staff should a need for a historical document arise.

   See **Section 5.3** for further information on obsolete documents.

12.2 Other changes and corrections to documents

Outside of a formal review, small changes or corrections to documents may occasionally be required.

For SESLHD-wide documents, the following are examples of changes to a document that may be made by the Governance and Policy team upon request by the author. These changes do not require approval from the Executive Sponsor, and do not prompt assignment of a new review date.

- Correction of minor typographical or formatting errors
- Correction of broken links, where there is no change to the document being linked
- Change to information on the cover page of the document, such as Executive Sponsor, author or key words, with the exception of the risk rating.

Policy documents involving medications may require additional approval processes for any changes or corrections.

13 Resources

The following forms and templates are used in the policy development process and can be found on the Templates page of the SESLHD intranet.

Resource name	Reference
Aboriginal Health Impact Statement Declaration Form	Section 7.2
Feedback Form	Section 7.1
Implementation Plan	Section 8
National Standards and Legislation Declaration Form	Section 7.2
Review Tool	Section 12

14 Definitions

14.1 Definitions

Term	Definition
Business rule	Hospital, service or directorate document that outlines a local process or rules for an activity or topic area. Business rules may be assigned sub-categories, such as clinical, or corporate. See Section 5.
Current	Policy documents are current when they have been approved and published, and are within the period before the next review date. See Section 5.
Executive sponsor	The senior manager with portfolio responsibility for the topic area addressed by the policy document.
Guideline	SESLHD-wide document that outlines best practice and recommended processes. See Section 5.
Handbook	SESLHD-wide document that provides the structure, context and standard practices of the organisation on a topic area or discipline. See Section 5.
Hospital, service or directorate	A collective term that refers to the top-level portfolios that make up SESLHD, in line with the SESLHD Executive Structure. A list of the hospitals, services and directorates within SESLHD can be found at Appendix A.
Hospital, service or directorate-wide	A document that applies to across a hospital, service or directorate, or to more than one department within a hospital, service or directorate.
Obsolete	Policy documents are obsolete when they are no longer published as a document under the policy governance process. See Section 5.
Overdue	Policy documents are overdue when the review date has passed. This is defined as the first day of the next month after the assigned review date. See Section 5.
Policy	SESLHD-wide document that outlines SESLHD's position towards a topic area or discipline and contains principles that mandate actions. See Section 5.
Policy document	Policy document is used in this framework as a collective term to refer to policies, procedures, guidelines, handbooks, business rules and other documents types that are managed under the policy governance processes within SESLHD.
Procedure	SESLHD-wide document that outlines how a policy or a process is to be implemented and provides more detailed and specific instructions than a policy.
SESLHD-wide	A policy document that applies to all SESLHD staff or to more than one hospital, directorate or service.
Under review	Policy documents may be described as under review, but this does not affect the definition of the document's status as either current or overdue. See Section 5.This description is used when an author, or person responsible, advises that a policy document is currently being formally reviewed.

14.2 Acronyms

Acronym	Definition
ACSQHC	Australian Commission on Safety and Quality in Healthcare
NSQHS	National Safety and Quality Health Service Standards
NSW	New South Wales
SESLHD	South Eastern Sydney Local Health District

15 References

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16 Revision and Approval History

Version number	Date	Details of changes	Approval
0	June 2009	Developed by Manager, Corporate Governance.	Approved by Chief Executive at Area Executive Team meeting 9/06/2009.
1	June 2012	Feedback from Clinical Governance Unit.	
2	July 2012	Addition of members to DET.	Approved by SESLHD District Executive Team.
3	March 2014	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).	Approved by SESLHD District Executive Team.
3	October 2015	Hyperlink to NSW Health Risk Matrix updated.	
4	July 2016	Document reviewed by Policy and Procedure Sub-Committee.	Approved by SESLHD District Executive Team.
5	November 2018	Minor review. Updated links and reallocated Capital Redesign and Programs and Performance portfolio contents. Replaced Executive Team with District Executive Council.	
6	September 2019	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.	
7	April 2020	Minor review. Update to Risk Ratings as discussed at Policy Governance Committee Meeting.	
8	July 2020	Minor review. Reassigned '*Clinical and corporate provision of Mental Health services*' to Director, Mental Health as incorrectly assigned to Director Health ICT.	
9	August 2020	Minor review. Portfolio contents table updated. Clinical Stream portfolio contents table marked as under review.	
10	October 2021	Major review to reflect new organisational structure, to update the process following realignment of the policy portfolio in SESLHD, and to expand on agreed SESLHD-wide practices.	Final version approved by Executive Sponsor. Approved by SESLHD Executive Council.

Appendices

Appendix A

Hospitals, services and directorates in SESLHD

'Hospital, service or directorate' is used in this Framework as a collective term to refer to the top-level portfolios that make up SESLHD, in line with the SESLHD Executive Structure.

A list of the hospitals, services and directorates within SESLHD is below.

Due to the joint management structure, it is noted that Prince of Wales Hospital and Sydney/Sydney Eye Hospital may be considered either jointly as one 'hospital, service or directorate' or as two individual 'hospitals, services or directorates', as required.

Similarly, due to shared management or resourcing arrangements, St George Hospital, Sutherland Hospital and Garrawarra Centre may be considered either as one 'hospital, service or directorate' or as individual 'hospitals, services or directorates' as required.

No.	Hospital, service or directorate
1	Allied Health
2	Clinical Governance and Medical Services
3	Corporate and Legal Services
4	Finance
5	Mental Health Service
6	Nursing and Midwifery Services
7	Office of the Chief Executive
8	Operations
9	Organ and Tissue Donation Service
10	People and Culture
11	Population and Community Health
12	Prince of Wales Hospital and Sydney/Sydney Eye Hospital
13	Research
14	Royal Hospital for Women
15	St George Hospital
16	Strategy, Innovation and Improvement
17	Sutherland Hospital and Garrawarra Centre