SESLHD HANDBOOK
COVER SHEET

Health
South Eastern Sydney
Local Health District

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FUNCTIONAL GROUP(S)	Corporate Governance Clinical Governance
KEY TERMS	Policy, procedure, guideline, business rule, corporate governance
SUMMARY	This document outlines the principles and processes for the development and management of policies, procedures, guidelines, business rules and other policy documents in SESLHD.

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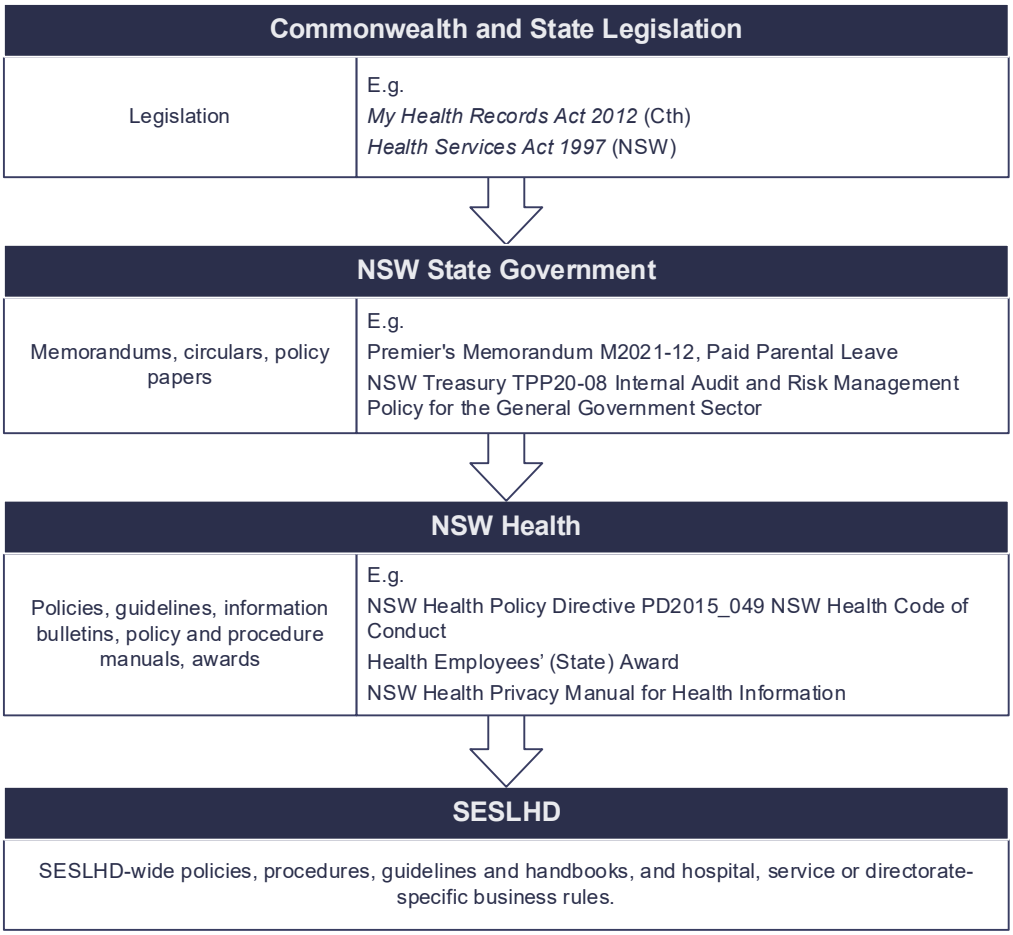
1 Introduction

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 policy 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 *NSW Health Policy Directive PD2015_049 NSW Health Code of Conduct*, 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 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. When required or where appropriate, this Framework applies principles from *NSW Health Policy Directive PD2022_047 NSW Health Policies and Other Policy Documents* and the *Corporate Governance and Accountability Compendium for NSW Health.*

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 related to policy documents. 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, handbooks, frameworks and business rules 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 other definitions and acronyms used in this Framework can be found at **Section 12.**

2 Principles

The following principles apply to all policy documents across SESLHD:

a. Policy documents 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 or duplicate 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; where necessary to facilitate local implementation of a NSW Health document; or where legislative or state guidance does not exist and there is no other suitable external guidance. (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, style and referencing standards, and use language appropriate to the purpose and audience. (See **Section 7**)

g. Policy documents will include a risk rating of the topic or process addressed by the document, in line with the risk matrix set out by NSW Health and SESLHD risk guidance. (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 version history section of the document or within the records management system. (See **Section 3**)

i. Strategies will be put in place to implement policy documents, monitor compliance with appropriate requirements and evaluate the effectiveness of policy documents and the processes they address. (See **Section 8 and 9**)

j. Policy documents will be assigned a review date aligned with its risk rating, with a maximum review period of five years, in line with the requirement in the Corporate Governance and Accountability Compendium for NSW Health. (See **Section 6**)

k. SESLHD-wide policy documents will be accessible from a single internet page. Each hospital, service or directorate will make their business rules available from an appropriate intranet or internet 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 the organisation, which are outlined below.

3.1 SESLHD-wide policy documents

SESLHD is required to have a system in place to ensure that its policy documents are approved by the Board or Chief Executive and are readily accessible to staff, in line with *Corporate Governance and Accountability Compendium for NSW Health*, section 2.3.1.

SESLHD-wide policy documents are coordinated by the Governance and Policy team, part of the Clinical Governance and Medical 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 approved by one of the SESLHD executive committees, prior to submission to the Chief Executive for final approval.

The SESLHD executive committees that review and approve SESLHD policy documents are:

- District Patient Safety and Quality Committee
- SESLHD Executive Meeting.

The Governance and Policy team maintains records of SESLHD-wide policy documents and monitors the status of these documents to enable document authors and coordinators to maintain document currency. Regular reports and information are 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 communicate and record evidence of 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 that supports the governance of policy documents across the organisation and provides a forum for information-sharing. The committee's membership includes representatives from hospitals, services and directorates across SESLHD.

3.2 Hospital, service or directorate policy documents

Hospitals, services and directorates across SESLHD 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 policy 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

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

Policy documents are registered in SESLHD's electronic records management system, Content Manager, and managed closely to ensure that version control is maintained.

Staff involved in overseeing policy governance processes across SESLHD are responsible for contributing to and ensuring good record keeping practices. *SESLHDHB/022 - SESLHD Corporate Records Management Framework* 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.

Use of external content in policy documents

Staff involved in developing policy documents in SESLHD must maintain good practices in consideration of intellectual property, through referencing and seeking permission for reproduction of content as required, in line with the *Copyright Act 1968* (Cth).

This may include seeking permission for use of images, diagrams or content from organisations external to SESLHD. Permission must be sought directly from the authoring organisation. Permissions granted under the *Copyright Act 1968* (Cth) cannot be transferred to a third party.

Requests for use of SESLHD policy document content

SESLHD policy documents are the intellectual property of SESLHD and cannot be duplicated without permission. The SESLHD Governance and Policy team reviews and considers written requests for use of content from SESLHD policy documents, and grants permission where appropriate, in line with agreed internal processes and the *Copyright Act 1968* (Cth).

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 or review 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, subject matter experts and stakeholder groups.
- Developing a plan that addresses the implementation, communication, monitoring, compliance with, evaluation of the policy document.
- Completing the relevant forms required under the policy development process and seeking Executive Sponsor approval of the final draft policy document.
- Supporting implementation of the policy document, including communication to relevant staff and ensuring mechanisms are in place to support ongoing monitoring and compliance.
- Undertaking evaluations of the policy document.
- Reviewing the policy document prior to its review date, 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, giving consideration to the most suitable document type for the purpose of the document and the risk being addressed by development of the document.
- Overseeing the development process, approving versions of the policy document at relevant stages, and presenting the policy document to relevant committees for approval.
- Ensuring that strategies for implementation, monitoring, compliance and evaluation are developed for new policy documents or following review of existing policy documents, and that the policy document and associated implementation strategies are communicated to the hospitals, services and directorates that are required to implement the policy document.
- Ensuring that policy documents within their portfolio remain current and accurate, and are reviewed in a timely manner, prior to the policy 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 are encouraged to participate in policy development and review by providing feedback on policy documents during consultation periods or on existing published policy documents when ideas or issues arise.
- 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.

Assigning a single Executive Sponsor to a policy document is recommended as best practice for governance and accountability.

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

The list of Executive Sponsors for SESLHD-wide policy documents is available on the SESLHD Policy intranet page. SESLHD-wide policy documents are to have one Executive Sponsor only.

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 recommended level of Executive Sponsor for policy documents in SESLHD.

Table 1

Policy 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 approved list
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 recommended 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 is to 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 policy documents, the Governance and Policy team should be notified once the transfer has been agreed.

5 Policy 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 2

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	Business rule intranet or internet page for the hospital, service or directorate

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

5.2 Policy documents with a clinical focus

The principles of this Framework relate to all policy documents, however additional considerations may be required for policy documents on a clinical topic.

In line with the National Safety and Quality Health Service Standards, clinical and clinical support staff need ready access to best-practice guidance and decision support tools that are contemporary and reliable. Clinical and clinical support staff may access information in a number of ways. As noted in the *Corporate Governance and Accountability Compendium for NSW Health* section 4.1, information is readily accessible from a range of sources including professional associations such as colleges, registration authorities, training bodies and universities.

As such it is acknowledged that policy documents developed by SESLHD are not the most suitable or accessible format for some types of clinical information.

SESLHD policy documents should not be developed to set out or duplicate requirements for clinical care where this information is readily accessible via another appropriate source, such as national or state-level guidance or other accepted external reference.

5.3 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 document types may also be managed under separate governance arrangements.

Examples of other document categories include:

- Consumer health information and brochures
- Forms and templates
- Instruction manuals for software or equipment
- Models of care
- Orientation manuals for a position or department
- Position descriptions
- Safe operating procedures for equipment or devices
- Strategies and plans
- Work instructions or task lists for a position or department.

Consideration should be given during the early stages of document creation as to whether the category of document requires management under policy governance processes. It is recommended to seek advice early from the relevant policy governance contact when considering developing a policy document, to determine whether it is the appropriate document type.

The Governance and Policy team provides general advice on governance of non-policy document types and a guidance document is available to assist staff to manage these documents.

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.

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

- **Overdue**
  Policy documents are overdue for review 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 policy document due for review in January 2025 will become overdue for review on 1 February 2025.
  Policy documents that are under review but have passed their review date are still defined as overdue for review.

- **Obsolete**
  Policy 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 policy document being converted to a document type that is not covered by the policy governance process (See **Section 5.3** above).
  The term 'rescind' may be used to describe the process of making a policy document obsolete. In terms of processes under this framework, obsolete and rescinded have the same meaning.

6 Risk Management Approach

Development of policy documents is one part of managing risks inherent within SESLHD. In the development and implementation of new or revised policy documents, consideration of risk is important. Action 1.7 of the National Safety and Quality Health Service Standards requires health organisations to use a risk management approach for the development, review and monitoring of policy documents.

Risk ratings

Policy documents, both SESLHD-wide and local, include a risk rating in line with the risk matrix set out by *NSW Health Policy Directive PD2022_023 Enterprise-wide Risk Management* and in line with the framework of *SESLHDPR/304 Enterprise Risk Management.*

The risk rating is made of the topic or process addressed in the policy document. The risk rating is to be the current risk, considering the current controls in place, including those set out by the policy document once implemented, and their effectiveness to mitigate or control the risk. The risk rating of a policy document should not be the initial or inherent risk without existing controls in place.

Using the NSW Health risk matrix, the risk rating is determined by considering the potential consequences related to the topic or process addressed in the policy document, and the likelihood or frequency of this outcome occurring. Consequences 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 policy 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.

SESLHD has adapted the NSW Health risk matrix into a SESLHD Risk Matrix which provides further guidance to support determination of risk and may assist in the assessment of policy documents.

SESLHD-wide policy documents assessed to have a risk rating of high or extreme should be related to an identified risk in the organisation's risk register and should form part of the broader mitigation strategy to address the risk.

Review period

The risk rating of a policy document determines the maximum review period, to ensure that accuracy and best practice is maintained for topics with a higher level of risk, as in **Table 3** below. The maximum review period for SESLHD policy documents is five years, in line with the maximum period set by the Ministry of Health as in *NSW Health Policy Directive PD2022_047 Policies and Other Policy Documents*.

The review period follows on from the risk rating. The risk rating is not to be determined based on the preferred review period.

Policy documents can be reviewed more frequently than the allocated maximum review period if a need arises, such as when there is a change in legislation or standard practice.

Table 3

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.

Development of policy documents by SESLHD must meet the principles of the *Corporate Governance and Accountability Compendium for NSW Health*, which requires in section 4.2.3 that:

- SESLHD policy documents may only be developed to clarify location implementation issues where there is no other guidance or where there is a gap in local guidance.
- NSW Health policy documents must not be redrafted or re-badged to incorporate local procedures.
- SESLHD policy documents are to reference NSW Health policy documents, with appropriate links included to facilitate access.

In line with these requirements, policy documents should only be developed by SESLHD where there is a clear and justified need for a tightly governed document in one of the following circumstances:

- 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 and there is no other suitable external guidance.

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, SESLHD-wide, or appropriate external guidance does not exist, and where development of a SESLHD-wide policy 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 – Policy document creation

Step 3 – Consultation

Step 4 – Draft for comments

Step 5 – Policy 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 policy 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 policy document? - What is the issue or risk being addressed? - Is a policy document the most effective format for the purpose and objectives? Is there a more suitable way for staff to access this information? - Would a new policy document duplicate a NSW Health or higher-level governance document? - Has research been undertaken to determine whether there are any external guidance or reference documents that would remove the need for SESLHD to develop a new policy document? - Are there other policy documents at SESLHD-level or hospital/service/directorate-level that could be consolidated as part of the development of a new policy document? - Does the policy document support the aim of reducing clinical or corporate variation across the organisation? - What are the workforce, financial or other resource implications related to the proposed policy document? - What are the ongoing resource implications of implementing, monitoring and measuring compliance with the policy document? - What committees or working groups will need to contribute to the development of the policy document? - Who are the target audience and end users of the policy document? How will they be consulted to ensure that the policy document is practical and realistic? - How will the policy document be communicated and implemented? - How will the impact and outcomes of the policy document be evaluated?

Adapted from NSW Health Policy Directive PD2022_047 NSW Health Policies and Other Policy Documents

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 the suitability of the policy document to achieve the required objectives, any resource requirements, implementation responsibilities and how the policy document will be monitored for compliance and effectiveness.

Considerations to guide Executive Sponsor approval to develop a policy document
- What is the issue or risk that is being addressed by the proposed policy document? - What is the risk rating of the topic or process to be addressed by the proposed policy document? - Is a policy document the most effective format for the purpose and objectives? Is there a clear and justified need for the document to exist as a policy document? - What are the workforce, financial or other resource implications related to the proposed policy document? - What are the ongoing resource implications of implementing, monitoring and measuring compliance with the policy document? - Does the policy document support the aim of reducing clinical or corporate variation across the organisation?

Adapted from NSW Health Policy Directive PD2022_047 NSW Health Policies and Other Policy Documents

For SESLHD policy documents, further information on the purpose and rationale for the policy document may be requested from authors and Executive Sponsors prior to the policy document being progressed, to ensure that the document meets the requirements of this Framework.

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

Step 2 – Policy document creation

Once approval for has been received from the Executive Sponsor for a policy 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 policy 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 policy document, the risk rating and review period of the document are to be determined. (See **Section 5**)

Further considerations for the policy 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 policy 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 which 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, new SESLHD-wide policy documents or those undergoing a major review are posted on a Draft for Comments page on the SESLHD intranet. Policy documents may also be posted on the Draft for Comments page when undergoing a minor review that would benefit from broad staff consultation, or when the scope of the review has not yet been determined.

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

For any SESLHD-wide policy 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 policy 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 back to the Governance and Policy team for processing within six months of the completion of the Draft for Comments period, a re-review including an updated Policy Submission Form, Executive Sponsor approval and consultation period may be required, to ensure currency of the document content.

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 – Policy document finalisation and Executive Sponsor approval

Following the Draft for Comments period, any feedback received through consultation is considered, and if appropriate, included in the final draft version of the policy document. Implementation strategies 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 Executive Sponsor approval of a policy document
- What is the issue or risk that is being addressed by the policy document? - Is a policy document the most effective format for the purpose and objectives? - Is the risk rating of the policy document appropriate? - Has the document been developed by the appropriate author or group? - Have the appropriate individuals, groups or committees been consulted on the policy document? - Has feedback been sought and incorporated as appropriate? - Have implementation strategies been developed? - Have processes been developed to monitor compliance with the policy document? - Have the resource implications of implementing, monitoring and measuring compliance with the policy document been considered?

Adapted from NSW Health Policy Directive PD2022_047 NSW Health Policies and Other Policy Documents

For SESLHD-wide policy 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 Health Policy Directive PD2022_032 Medication Handling requires a Drug and Therapeutics Committee to be responsible for considering all aspects of medicine use, including the development and approval of medication-related policies, protocols and procedures.

For SESLHD, the relevant committee is the SESLHD Drug and Therapeutics Committee.

The Drug and Therapeutics Committee reviews and approves policy documents that contain medication-related information, including all aspects of medication management, and may provide guidance on the appropriate risk rating.

For policy documents that include medication-related information, it is expected that key stakeholders have participated in the development or review of the document, prior to submission to the Drug and Therapeutics Committee. This must include, at a minimum, a pharmacist with relevant subject matter expertise.

Policy documents may be submitted to the Drug and Therapeutics Committee either following Executive Sponsor approval or in final draft format prior to Executive Sponsor approval, to allow the Executive Sponsor to consider any feedback received from the Drug and Therapeutics Committee.

Policy documents that include medication-related information are tabled at the Drug and Therapeutics Committee and progress as outlined below.

- Policy documents that include medication-related information that have undergone a minor review are submitted to the Drug and Therapeutics 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 Drug and Therapeutics approval, and if approved, then proceed to the District Patient Safety and Quality Committee 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 executive committees, as the final approval prior to publication and implementation:

- **District Patient Safety and Quality Committee**
  Policy documents with a clinical focus.

- **SESLHD Executive Meeting**
  Policy documents with a corporate or strategic focus.

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

Step 7 – Publication

Once the required approvals have been received, the policy 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 or internet page.

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

The policy document is considered active and in place from the date of publication, which is noted on the document.

7.2 Considerations for inclusion in policy documents

The following areas should be considered and reflected in policy documents during their development or review where they are relevant.

Aboriginal Health Impact Statements

NSW Health Policy Directive PD2017_034 Aboriginal Health Impact Statement 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.

Delegations of Authority

Policy documents may set or outline approval levels or other delegated responsibilities, including financial and non-financial approvals. It is important that delegations in policy documents match those under *SESLHDHB/027 Delegations of Authority Manual*.

Document authors or coordinators are responsible for checking the Delegations of Authority Manual and for liaising with the SESLHD Finance department on any changes that may be required to ensure alignment.

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 if it contains legislative reporting obligations.

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.

Policy documents, where relevant, must align with the National Safety and Quality Health Service Standards or other service-specific standards that may apply such as the National Safety and Quality Primary and Community Healthcare Standards.

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 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, SESLHD-wide policy documents require that implementation strategies be considered during its development or when undergoing a review.

It is recommended that a multidisciplinary panel, including staff who will use the policy document, are involved in development of the implementation strategies. A successful implementation strategy 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.

Implementation strategies should include consideration of methods to support ongoing compliance with and evaluation of policy documents.

Examples of implementation strategies that can be effective in a healthcare setting are in the **Table 4** below. It is acknowledged that that simple dissemination of policy documents is unlikely to result in effective implementation (Oxman, Thomson, Davis, & Haynes, 1995).

Table 4

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 system modifications. 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 effective implementation strategies are developed for new policy documents and when reviews have been undertaken, 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.

9 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 methods such as 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 of, and monitor SESLHD policy documents with regards to currency and issue regular reports and reminders prior to these documents becoming overdue for review. Overdue SESLHD policy documents are managed and escalated using a risk-based approach. This includes development of risk mitigation plans and escalation to senior executives as appropriate for overdue SESLHD policy documents.

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 policy 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.

10 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. 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 a change in current or recommended practice.

Reviews of policy documents are to be completed in line with the principles outlined in **Section 2** and as such, it is the responsibility of the Executive Sponsor and the document author or coordinator to ensure that:

- appropriate consultation occurs, which may include seeking feedback from subject matter experts, end-users, or representatives of consumers and multidisciplinary teams;
- the policy document remains consistent with, does not duplicate, and appropriately references higher-level governance documents, such as NSW Health Policy Directives or Guidelines;
- the policy document remains reflective of best available evidence;
- the risk rating is reassessed and remains accurate;
- changes are informed by results of compliance and evaluation activities; and
- strategies are put in place to implement the updated policy document.

An initial assessment should be undertaken to determine the extent of review required. A checklist for completing an initial assessment is available on the SESLHD policy intranet page.

Considerations when reviewing a policy document
- Is the issue or risk that the policy document was designed to address still current and relevant? - Does the risk rating need to be updated? - Is the information in the policy document still relevant, accurate and reflective of current best evidence? - Is a policy document still the most effective format for the purpose and objectives of the document? Is it still required? - Has the policy document been evaluated? Has the document been effective in achieving its purpose? - Has there been any feedback, complaints or incidents related to the policy document that may require changes to be made? - Has there been any change to legislation, NSW Health policy or other external sources that relate to the policy document, since the last review? - Are there other policy documents at SESLHD-level or hospital/service/directorate-level that could be consolidated as part of the review? - What are the ongoing resource implications of implementing, monitoring and measuring compliance with the policy document? - How long has it been since the policy document had a major review with broad consultation? - What committees or working groups will need to review the policy document, and how much time needs to be allowed for this process? - What other staff, groups or stakeholders will need input into the review of the policy document, and what methods will be used to seek their input and feedback?

Adapted from NSW Health Policy Directive PD2022_047 NSW Health Policies and Other Policy Documents

The initial assessment of a policy document will result in one of three outcomes:

1. Minor review
2. Major review
3. Obsolete

All sections and content of a policy 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 policy documents, as outlined below in **Section 10.2.**

10.1 Review process for SESLHD-wide policy documents

A summary of the process for each of the three 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. **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, and there is no significant addition or removal of content.

   For a minor review, once the changes have been made, the author will complete the Policy Submission Form, seek approval from the Executive Sponsor of the form and the final version of the policy document, and submit both to the Governance and Policy team for processing.

   The policy document will be republished on the SESLHD policy internet page and a new review date will be assigned.

2. **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, or when there has been a significant addition or removal of content.

   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 Policy Submission Form, seek approval from the Executive Sponsor of the form and the final version of the policy document, and submit both to the Governance and Policy team for processing.

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

3. **Obsolete**
   If the initial assessment or review process determines that the policy document is no longer required, the policy document is to be made obsolete. The author is required to seek approval from the Executive Sponsor for the policy 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 policy internet page.

   Obsolete policy 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 5.4** for further information on obsolete policy documents.

10.2 Other changes and corrections to policy documents

Outside of a formal review, small changes or corrections to SESLHD policy documents may occasionally be required. These can be made via the amendment process.

For an amendment to be made, the following information is requested by the Governance and Policy team:

- Reason for the amendment
- Summary of changes
- Communication plan for advising stakeholders of the change.

Executive Sponsor approval of the above information is required for the amendment to be made. Once approval is received, the changes will be made and the policy document will be republished on the SESLHD policy internet page with a new version number.

The review date for SESLHD policy documents does not change following an amendment.

There are limited circumstances where the Governance and Policy team will make changes to a SESLHD policy document without requiring Executive Sponsor approval, such as correcting minor typographical errors or correcting broken links where there is no change to the document being linked. These changes can be made on the advice of the document author or coordinator. A new version number is assigned to ensure all changes are recorded in the version history.

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

11 Resources

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

Resource name	Reference
Aboriginal Health Impact Statement Declaration Form	**Section 7.2**
Best Practice Guide to Governance of Non-Policy Documents	**Section 5.3**
Feedback Form	**Section 7.1**
Policy Submission Form	**Section 7**, **Section 10**

12 Definitions

12.1 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 policy document that outlines best practice and recommended processes. See **Section 5.**
Handbook	SESLHD-wide policy 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. 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.
Hospital, service or directorate-wide	A policy 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 policy 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 and business rules 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.

12.2 Acronyms

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

13 References

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14 Version 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.
11	September 2024	Major review to reflect updated processes and principles in all sections.	Approved by Executive Sponsor and SESLHD Executive Meeting.