<table>
<thead>
<tr>
<th><strong>NAME OF COMMITTEE</strong></th>
<th>New Interventions Assessment Committee</th>
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<tbody>
<tr>
<td><strong>TYPE OF COMMITTEE</strong></td>
<td>Operational Committee</td>
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<tr>
<td>Governance, Management, Working Group</td>
<td></td>
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<tr>
<td><strong>DOCUMENT NUMBER</strong></td>
<td>D09/59231</td>
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<tr>
<td><strong>DATE OF PUBLICATION</strong></td>
<td>January 2010</td>
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<tr>
<td><strong>RELATED DOCUMENTS</strong></td>
<td>SESIAHS Policy - Safe Introduction of Interventional Procedures into Clinical Practice (PD_007)</td>
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<td>New Interventions Assessment Committee Application (F008)</td>
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<tr>
<td></td>
<td>Safe Introduction New Interventional Procedures into Clinical Practice – Progress Report (F010)</td>
</tr>
<tr>
<td><strong>REVIEW DATE</strong></td>
<td>Documents are to be reviewed a maximum of five years from date of issue</td>
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<tr>
<td><strong>CHAIR/CO-CHAIR</strong></td>
<td>Director Clinical Governance (Chair)</td>
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<td></td>
<td>Medical Executive Director (Co-Chair)</td>
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<td><strong>SECRETARIAT</strong></td>
<td>Executive Officer, Clinical Governance Unit</td>
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<tr>
<td><strong>AUTHOR</strong></td>
<td>Director Clinical Governance</td>
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<td><strong>SUMMARY</strong></td>
<td>The role of this committee is to assist clinicians to introduce new interventional procedures so that patients, clinicians and managers may be confident that all new interventional procedures introduced into SESLHD facilities are supported by evidence of efficacy, safety, effective resource utilisation and assurance of an agreed process for monitoring outcomes.</td>
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1. AUTHORITY
The South Eastern Sydney Local Health District (SESLHD) Hospital Board is responsible for the overall governance of the SESLHD New Interventions Assessment Committee (NIAC), delegated responsibility for NIAC sits with the Chief Executive (CE) of SESLHD.

To ensure effective governance in an efficient manner, the SESLHD Hospital Board and Chief Executive will establish relevant committees and councils to undertake various governance functions. The New Interventions Assessment Committee will report to the SESLHD Hospital Board and Chief Executive on committee work, as required.

The SESLHD Clinical & Quality Council (CQC) is the peak patient safety and clinical quality committee within SESLHD. The New Intervention Assessment Committee (NIAC) has delegated responsibility from CQC. All new procedures to be performed within SESLHD must first be approved by NIAC.

The Executive Sponsor of the New Interventions Assessment Committee will be the Director of Clinical Governance.

2. PURPOSE
NIAC is responsible for ensuring, through appropriate consultation, that all new interventions introduced to facilities within the District are supported by evidence of safety, clinical effectiveness, and finance efficiency.

NSW Health defines a new intervention as “A procedure not previously performed within a Local Health District Facility or one that is performed in the District and for which approval is sought for its performance at another facility. This will include variations to an existing procedure or treatment or when a new medication or device is introduced.” If it is unclear whether a procedure should be considered a new procedure at a Facility, clarification should be sought from the Chair of NIAC.

3. RESPONSIBILITY AND SCOPE OF ACTIVITIES
The key functions of NIAC

The Committee is responsible for providing recommendations to the CQC for endorsement with regards to the following scope of activities:

- Support and monitor compliance, as required, within the NSW Health Framework (Clinical Practice – Model Policy for Safe Introductions of New Interventional Procedures PD2005_333) for introduction of new interventional procedures;
- Ensure that clinical context and appropriateness, scientific evidence, clinical ethics, resource implications, credentialing and training aspects are all integrated in decisions relating to the introduction of new interventional procedures;
- Ensure that new interventional procedures reviewed by the Committee fit within SESLHD’s future directions and facility role delineations;
• Evaluate the science and ethics relating to applications for introduction of new interventional procedures and clinical practice innovations, in conjunction with the SESLHD: Research Ethics Committee and the District Clinical Ethics Committee, as deemed relevant;
• Assess the risk and benefits to the Local Health District and patients of proposed new interventional procedures;
• Understand and define requirements regarding the training and credentialing requirements of those wishing to undertake the procedure, and of other clinical staff (medical, nursing, allied health) who may be involved in peri-procedural care, ensuring that linkages with the Medical and Dental Appointments Advisory Committee and other SESLHD professional standards committees are maintained;
• Integrate information concerning the science, ethical acceptability, resource implications, credentialing and scope of practice and training to determine the overall acceptability of the proposed and any limitations to be placed;
• Define ongoing monitoring and reporting requirements;
• Monitor regular evaluation of individual approved procedures;
• Ensure safe transition between new interventions and routine clinical practice;
• Provide an environment that encourages innovation in clinical practice.
• To ensure appropriate ethics approval is obtained for new interventions being conducted in a research setting.

4. MEMBERSHIP
4.1 Standing
• Director of Clinical Governance
• Medical Executive Director
• Director Research Governance
• Director Medical Services
• Director of Nursing and Midwifery
• Director Clinical Services (one representative from each sector)
• 1 Proceduralist

4.2 Variable
Additional attendees may be coopted to the Committee for various reasons. Examples of additional attendees may include:
• Director of Allied Health,
• Clinician with expertise in the intervention(s) under review (proponent), or
• Relevant professional for intervention(s) under review.

4.3 Appointment of Chair/Co-Chair
The SESLHD Hospital Board through delegated authority to the Chief Executive is to seek advice from the Committee in relation to possible candidates for the Chair /Co-Chair of the Committee. The Chief Executive will give due consideration to the advice of the Committee, but will not be bound to that advice in the appointment of the Chair/co-Chair.
The Chair is appointed for a period, as specified by the Chief Executive must meet the following criteria to be eligible for the appointment:

- Member of the NIAC Committee, and
- Demonstrated attendance of at least 80% of NIAC meetings.
- Appointment no longer than 3 years.

4.4 Appointment of Committee Secretary
The Committee Secretary shall be the responsibility of the Clinical Governance Unit.

4.5 Introduction of New Members
New Committee members are to receive a copy of this Charter and the Code of Conduct and are to meet with the Committee Chair as part of their introduction. Members may seek (with approval by the Chair) any other information they may require in order to be fully brief on their role and responsibilities.

4.6 Ongoing Training
To ensure Committee members’ competency is appropriate, they are given the opportunity to attend technical and professional development courses to help them keep up to date with relevant issues. Any related costs are to be agreed in advance by the Chair, Chief Executive and SESLHD Hospital Board.

5. MEETINGS

5.1 Frequency
The Committee is to meet monthly with dates set 12 months in advance from the first meeting of the New Year. However, there will be the capacity for expedited approval process initiated as deemed necessary by the Committee Chair, the Director of Clinical Governance and the relevant Clinical Stream Director.

5.2 Quorum
A quorum shall consist of a majority consisting of more than 50% of standing members.

5.3 Declaration of Conflict or Duality of Interest
Committee members are responsible for declaring a conflict or duality of interest, whether pecuniary or non-pecuniary. In all cases where a conflict or duality of interest exists, or may be reasonably perceived to exist, the Committee member shall not participate in the decision-making process.

5.4 Agenda
The agenda shall be agreed by the Chair prior to the meeting. The agenda and papers shall be prepared and distributed by the Secretary at least three business days prior to the meeting dates.

5.5 Minutes
All meetings shall be minuted and the minutes distributed to all members of the Committee within a fortnight of the previous meeting. The Chair shall sign the minutes once they have
been endorsed by the Committee at the following meeting.

5.6 Establishment of Subcommittees
The New Interventions Assessment Committee may appoint such sub-committees as it sees fit to carry out further in-depth review of procedures. The Chair of any such subcommittees shall be a member of the New Interventions Assessment Committee. Members of the subcommittees need not be members of the New Interventions Assessment Committee.

6. ASSESSMENT OF COMMITTEE PERFORMANCE
The Committee shall undertake a review of the appropriateness of this Charter annually.

In addition, the Committee shall perform a self-assessment of the effectiveness of the Committee every two years, by way of surveys and interviews with various parties involved in the Committee.

7. REPORTING ARRANGEMENTS
The Committee formally reports to the SESLHD Clinical & Quality Council. The Committee also relates to the District Drug Committee, relevant Human Research Ethics Committees, and the Credentials (Clinical Privileges) Committee.

8. REFERENCES

<table>
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<tr>
<th>Date</th>
<th>Revision No.</th>
<th>Author and Approval</th>
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<tbody>
<tr>
<td>October 2011</td>
<td>3</td>
<td>Prof George Rubin</td>
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