Health
Sydney
Local Health District

SLHD Policy Compliance Procedure

Governance and Development of Policy, Procedures and Guidelines	
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Governance and Development of Policy, Procedures and Guidelines

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Governance and Development of Policy, Procedures and Guidelines

1. Introduction

This policy compliance procedure (PCP) describes the processes to ensure the development, review and management of quality policy, procedure and guidelines at Sydney Local Health District (SLHD) within a robust governance framework. This framework will ensure that high-quality, standardised documents are available and accessible to all staff in SLHD.

This PCP has been developed to operationalise the requirements of the Ministry of Health (MoH) *Policy Directives and Other Policy Documents* (PD2022_047), and Standard 1.7 of the National Safety and Quality Standards in Health Care.

In this PCP, the term 'Policy Document' will be used to refer to any policy, procedure or guideline within SLHD, its facilities and services. Refer to the Definitions for information and description of the different document types.

2. Risk Statement

SLHD Enterprise Risk Management System (ERMS) Risk # 01 – Deviation from Standards of Clinical Care.

- Deviations may result in adverse events, harm to patients, medical negligence claims or unfavourable media attention.

3. Scope

Applies to all SLHD staff who have responsibility for the commissioning, implementation and development of policy documents, including current policy document owners and authors.

4. Implementation

- A dedicated SLHD Policy Management Project Plan was endorsed in October 2020, and will be evaluated by the SLHD Policy Committee. The Plan sets out actions and deadlines to implement the requirements of this PCP.
- It is the responsibility of the SLHD Policy Manager/s to lead the implementation of this PCP and the SLHD Policy Management Project Plan, in collaboration with Facility Policy Coordinators, to ensure the service measures are achieved.
- A memo from the SLHD Chief Executive was distributed in October 2020 to highlight the key elements of the Plan that served as the basis for this revised PCP.
- This PCP will be available for all staff on the SLHD intranet under "Policies and Guidelines".

5. Key Performance Indicators and Service Measures

- All SLHD, service and facility policy documents must have an implementation section and high risk policies (with High or Extreme risk rating) must have a dedicated implementation plan. An implementation guide and sample plan can be found in Appendix A.
- New and amended policies will be stored in TRIM under the dedicated Policy Management folder.
- 100% of Policy Managers/Coordinators are trained in managing the upload, archive and reporting features in the dedicated policy maintenance site.

- 100% of policy documents pending publication in the policy maintenance site are acknowledged and/or approved by the Policy Managers within three working days of receipt of intention to publish.
- Policy Managers/Coordinators will develop a revision plan with the respective owners and authors of all out-of-date policy documents.
- Policy Managers/Coordinators must attend 80% of the District and Facility policy committee meetings.
- Service Measures will be reported quarterly at the SLHD and Facility Policy Committee meetings and to their respective Clinical Quality Councils or Governance Committees.

6. Framework

Policy documents that meet the criteria in Appendix B are submitted to the SLHD Policy Manager/Coordinators and administered under the system and processes as described in this document.

Policy documents submitted to a Policy Committee will follow the flowchart process in Appendix C prior to publication.

6.1 Accountability and Responsibility

- The **SLHD Chief Executive** and **Executive Director of Medical Services, Clinical Governance and Risk** have the authority to request the review and revision of any policy document.
  - This authority will be exercised for any policy documents that give rise to potential risks, are significantly overdue, no longer comply with MoH policy or relevant legislation, or requiring amendment/revision following recommendations arising from incident investigations.
  - If the review and revision of a policy document is requested, it is expected the review or revision is completed within the timeframes advised by the District Clinical Governance Unit.
- **SLHD Policy Manager/s** are responsible for the management of SLHD policy documents and maintenance of the SLHD Policy webpage.
- **Facility Policy Coordinators** are responsible for the management of policy documents within their facilities.
- **Policy Owners** are responsible for overseeing the development, review, revision, implementation and evaluation of policy documents. In most cases, this will be a Tier 2 Executive (for SLHD policy documents), Clinical Director/Manager, General Manager (GM) or other executive sponsor.
- **Policy Authors** are responsible for leading the development, review and revision of policy documents, and they can be any staff member who is determined by the Policy Owner to have the skills and knowledge to undertake the task. Policy Authors work in collaboration with the Policy Owners in the implementation and evaluation of policy documents, and ensuring the currency of the information contained within the policy document.
  - If a policy author leaves either SLHD or the role with responsibility for the policy, it is their responsibility to hand-over the development or revision of relevant policy documents to new staff. If the position remains vacant, it is the responsibility of the **policy owner** to allocate to a new author.
  - When developing policy documents, policy authors should be mindful that these may be published online and available to the general public in line with our organisational obligations under the Government Information (Public Access) Act 2009 (GIPA Act).

6.2 Committees

Policy Committees are responsible for maintaining oversight of the relevant facility/SLHD policy system and to ensure all policy documents are:

- Kept up-to-date and reviewed in a timely manner;
- Developed in accordance with best evidence based practice;
- Reviewed by a multidisciplinary team of experts;
- Suitable for use within SLHD and its Facilities;
- Compliant with relevant MoH and SLHD policies, legislation and regulations.

SLHD and its facilities are required to develop a policy framework that is approved by a Tier 2 Executive or facility GM. Policy Committees must develop a Terms of Reference and should report to the Clinical Council or relevant Executive Council.

6.3 Consultation

Consultation with a multidisciplinary team is essential and should at a minimum include representation from subject experts, managers, end users and consumers. Consultation promotes staff engagement, a sense of ownership/responsibility and encourages compliance. The Policy Manager/Coordinators, Clinical Directors and Clinical Managers, Enterprise Risk Management System Coordinator and the Centre for Education and Workforce Development (SLHD-CEWD@health.nsw.gov.au) should always be included in the consultation process. Documents will not be tabled to the District Policy Committee without evidence of this consultation.

The consultation of SLHD policy documents with all Clinical Directors, Clinical Managers and General Managers will be initiated by the Policy Manager to ensure a timely and coordinated process. This consultation will be recorded in the organisation's document management system (TRIM).

The Policy Manager/Coordinator is able to advice on the relevant staff who may be consulted.

6.4 Approval and Endorsement

New or revised policy documents must be presented to, and approved by, a dedicated Policy Committee. To be considered at SLHD Policy Committee, documents must have the endorsement of the relevant Tier 2 Executive or Clinical Director.

Following approval by a Policy Committee, SLHD policy documents with cross-stream or district wide impact are submitted to the Clinical Quality Council for endorsement and Facility policy documents are submitted to their respective General Managers for endorsement. Once endorsed, these policy documents can be published on the intranet by the Policy Manager/ Coordinator.

Out of session approval by a Policy Committee may be considered for urgent policy documents or during a public health emergency (e.g. COVID-19 pandemic). Chief Executive, Tier 2 Executive or Facility General Manager approval is still required prior to publication.

6.5 Policy Hierarchy

Policy hierarchy is the relationship between policy documents (Appendix D). Policy documents must comply with those that exist at a higher legislative, policy or organisational level. For example, SLHD policy documents must comply with MoH Policy Directives. In addition, MoH policies may require Local Health Districts to develop local procedures to operationalise a particular MoH policy. However, as a general rule, if a policy document exists at a higher

organisational level, it should not be duplicated at a lower level unless there is a clear practice need. When hyperlinking to policy documents external to SLHD, authors should create a link to the policy document's landing page to ensure access to the most up to date version.

Departments may develop unit specific documents to guide practice that is unique to their specialty however, it is important to avoid using the titles Policy, Procedure or Guideline as this may imply that the document has been approved by the SLHD or Facility Clinical Quality Council. Appendix E outlines the minimum standards for unit specific documents.

Facilities should also avoid "coversheet policies" as the sole purpose of these short documents is to link and refer directly to a MoH, SLHD, Clinical Excellence Commission (CEC), Agency for Clinical Innovation (ACI) or National Health and Medical Research Council (NHMRC) policy document, without additional content for operationalization within the local facility or department. Coversheet policies do not support compliance and creates unnecessary work both for the staff searching for a policy document or the staff who ensures they are up to date. The SLHD Policy Manager/s can be requested to upload a link on the intranet to high level policy documents as necessary.

6.6 Aboriginal Health Impact

Policy documents where there are specific needs for Aboriginal people are required to acknowledge this and the impact of any disparity, and include guidance for staff on specific considerations when working with Aboriginal people. The Aboriginal Health Unit and/or Aboriginal Workforce Officer should be consulted who may be able to assist with developing the Aboriginal Health Impact Statement (AHIS) and guidance on any specific considerations.

6.7 Rescission

Policy documents that are no longer relevant, needed or is replaced by a MoH or district policy document may be rescinded with the approval of the policy owner/author, relevant Policy Committee or Tier 2 Executive/GM. The approval is to be documented via email record and saved in TRIM. The relevant Policy Manager/Coordinator will ensure that the SLHD Policy webpage is up-to-date.

Policies may be rescinded or made obsolete because:

- It is replaced by a district or MoH policy document;
- The issues or risks that the policy was mitigating no longer exist;
- Another policy or risk solution has been implemented.

Rescinded policy documents are archived electronically through TRIM and therefore are available on request and for medico-legal purposes.

7. Principles

- Before developing or revising a facility or service policy document, the author should search the intranet for a similar policy document developed by SLHD or other facilities. The next steps are:
  - Consider if the policy document under development or revision can be applied to at least one other facility;
  - The author must communicate with peers across SLHD to collaborate in the development of a district wide policy document.
- To ensure policy documents within SLHD and its facilities are developed and administered in alignment with good governance, all policy documents are to be developed and reviewed within the framework as set out in this PCP. All policy documents must:

- Be reviewed and revised every five (5) years. A review may be conducted earlier by the owner and author if deemed necessary, and by the Chief Executive, Tier 2 Executive, GM or by the Executive Director Clinical Governance and Risk Unit.
- Be written and reviewed with evidence-based best practice.
- Incorporate and include any relevant legislation, regulation or MoH guideline-policy directive-information bulletin.
- Be developed with adequate support for implementation and in consultation with a multidisciplinary team comprising key stakeholders and subject matter experts.
- Describe how the policy document will be implemented (see Appendix A).
- Use the policy template as published on the SLHD Policy intranet page.
- Referenced using a recognised referencing style such as Harvard Referencing Style, APA 6th Style Referencing or Vancouver Referencing Style.

- Facility or Service policy documents (current or due for review) that are identified for conversion to a district policy document:
  - The current Policy Owner/Author will lead the revision/conversion in collaboration with stakeholders across SLHD;
  - The Facility Policy Coordinator will continue to manage the revision/conversion until submission for approval by the SLHD Policy Committee;
  - The Policy Manager/s can provide guidance with regards to identification of subject matter experts for consultation and Tier 2 for sign-off.

8. Definitions

Policy Directive (PD)	A set of principles that reflect the SLHD/Facility mission and values, compliance with which is mandatory.
Policy Compliance Procedure (PCP)	A document developed by SLHD/Facility to implement a significant MoH Policy or Guideline, or other significant NSW Government interagency document, to which the MoH is a party. Compliance is Mandatory.
Procedure	A set of actions or processes that must be followed. Compliance is mandatory.
Guideline	Systematically developed statements to assist effective decision making and to support staff in undertaking their duties. Compliance is not mandatory, however they are based on best practice and should be implemented as described.
Policy document	The collective noun for all policies, procedures and guidelines of SLHD and its health facilities and services.
Coversheet policies	Approved and published facility policy documents where the sole purpose is to provide a link to a MoH, SLHD, CEC, ACI, NHMRC or professional body policy document.
Standard Operating Procedures (SOP)-Protocols-Practice Points-Flowcharts-Tip Sheet	A set of service level processes assisting clinical and non-clinical staff with day-to-day work. These documents are usually derived from a MoH, SLHD, CEC, NHMRC or professional body policy documents and are quite specific to a local procedure and focused on a single service. Minimum standards for the creation of SOPs can be found in Appendix E.
Minor Amendment	A change made to a policy document that does not modify it in a way that changes the intent or significantly affects the content or application of the policy. It includes where there is a need to: correct or update a title, name, formatting, web link and references to law or other policy documents; spelling, grammar, or clarity of language.

	Minor amendments must be approved by the document author and owner, and noted by the policy committee.
Major Amendment	All changes made to a policy document other than a minor amendment and all revisions. An amendment that requires additional implementation, change of practice, or education should be considered as major. These amendments would require that a new policy document is issued and must therefore be approved by the policy committee.
Approval	The process by which a policy document is given approval by an individual (CE or Tier 2 Executive) or Committee (District / Service / Facility Policy Committee) and is ready for final endorsement.
Endorsement	The process of making the document officially valid for use and publication within the organisation to which the endorsement applies. • At a SLHD service or facility, this is granted by the service or facility General Manager. • At District-level: ○ For policy documents that have cross-stream or district wide impact, endorsement is granted by the SLHD Clinical Quality Council. ○ For all other documents, final endorsement is by the SLHD Policy Committee.
Review	A formal examination of an enacted policy, which usually occurs at the end of a mandatory review period (5 years in SLHD), but may happen within this period for significant changes. Reviewed policies are allocated a new document number, assigned a new review period, approved by a policy committee and endorsed by the SLHD Clinical Quality Council or service/facility GM.
Rescission	The act by which a policy is made obsolete, withdrawn from use and removed from the SLHD intranet.
Out of Session	The review and approval of policy documents ahead of the next scheduled policy committee meeting.

9. Consultation

Clinical Quality Manager SLHD
Director Patient and Family Experience SLHD
Enterprise Risk Management Coordinator SLHD
Legal Manager SLHD
SLHD Centre for Education and Workforce Development
SLHD Policy Committee

10. References

NSW Health *Policy Directives and Other Policy Documents* (PD2016_049)

11. National Safety and Quality Standard/s, 2nd ed

Clinical Governance Standard

12. Appendices

Appendix A: Policy Document Implementation Guide

The following information is provided to help guide your development of an implementation plan for policy documents.

- Which wards / departments / units is the policy document targeted at?
  - What are the key areas and roles that need to be aware of this new/revised policy document? This may be broad (whole hospital) or narrow (only a few wards/departments/units). How will this new policy document or changes in a policy document be implemented? Who will communicate the publication of the policy document and how will that communication occur?
  - Consider formal structures, for example:
    - Executive, Unit Managers, Educators;
    - Email distribution lists;
    - 'Intranet Bulletin' – coordinated with Strategic and Communications Team for display on the SLHD home page;
    - Education such as unit based in-service, orientation or mandatory training flagged by NSW Health and/or the District; or workshops and forums accessible via My Health Learning; or forums and workshops facilitated by other NSW Health Agencies
    - Development/revision of competency and/or online modules on My Health Learning (coordinated via CEWD).
- How will you review the success of the education and implementation strategy?
  - How will you know your education/implementation strategy has been effective?
  - Are all the necessary staff members aware of the policy document and/or practice changes?
  - Demonstrate accountability with KPIs measuring the policy performance.
  - Consider how you will establish if practice has changed?

Sample Plan:

NSW GOVERNMENT Health
Sydney Local Health District

Policy, Procedure and Guideline Implementation Plan

Title of Policy Document:
Click here to enter text.

Please list significant/main changes to policy document/practice:
Click here to enter text.

Relationship to existing competencies or need to develop new competency:
Click here to enter text.

Education and communication strategy for implementation:
Click here to enter text.

How will you review if the education and implementation plan was successful?
Click here to enter text.

Appendix B: Standards for Policy Documents

1. When creating or revising a policy document, all sections as set out in the policy template are to be completed. The template is available on the policy webpage. Particular attention is given to the following:

a) Scope;
a) Risk Statement;
b) Implementation;
c) KPI / Service Measures (only if relevant);
d) Consultation (comprehensive review by a multidisciplinary team);
e) Ensuring the document has been written with clear structure and is easy to understand.

3. An Implementation Plan is required for new policy documents that have potential significant risks. Revisions to existing policy documents that have potential significant risks may also require an implementation plan and this will be at the direction of the SLHD Policy Manager(s).

4. Documents are to be provided in word format only.

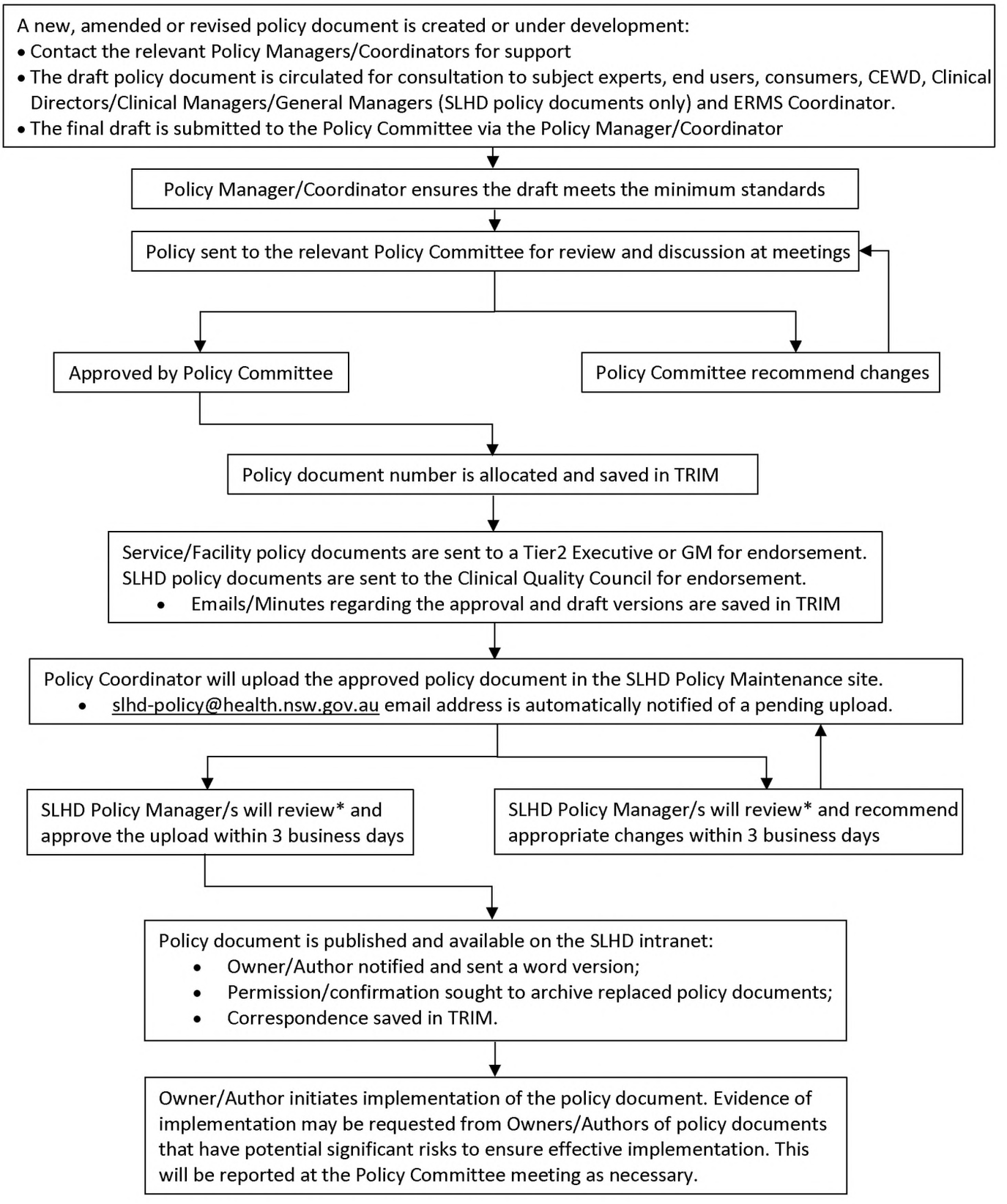
5. Title and keywords must be added in the document's properties tab.

6. TRIM number and Author's name are to be included.

7. All new or revised policies are to be saved in TRIM. At a minimum, each folder must contain the following:

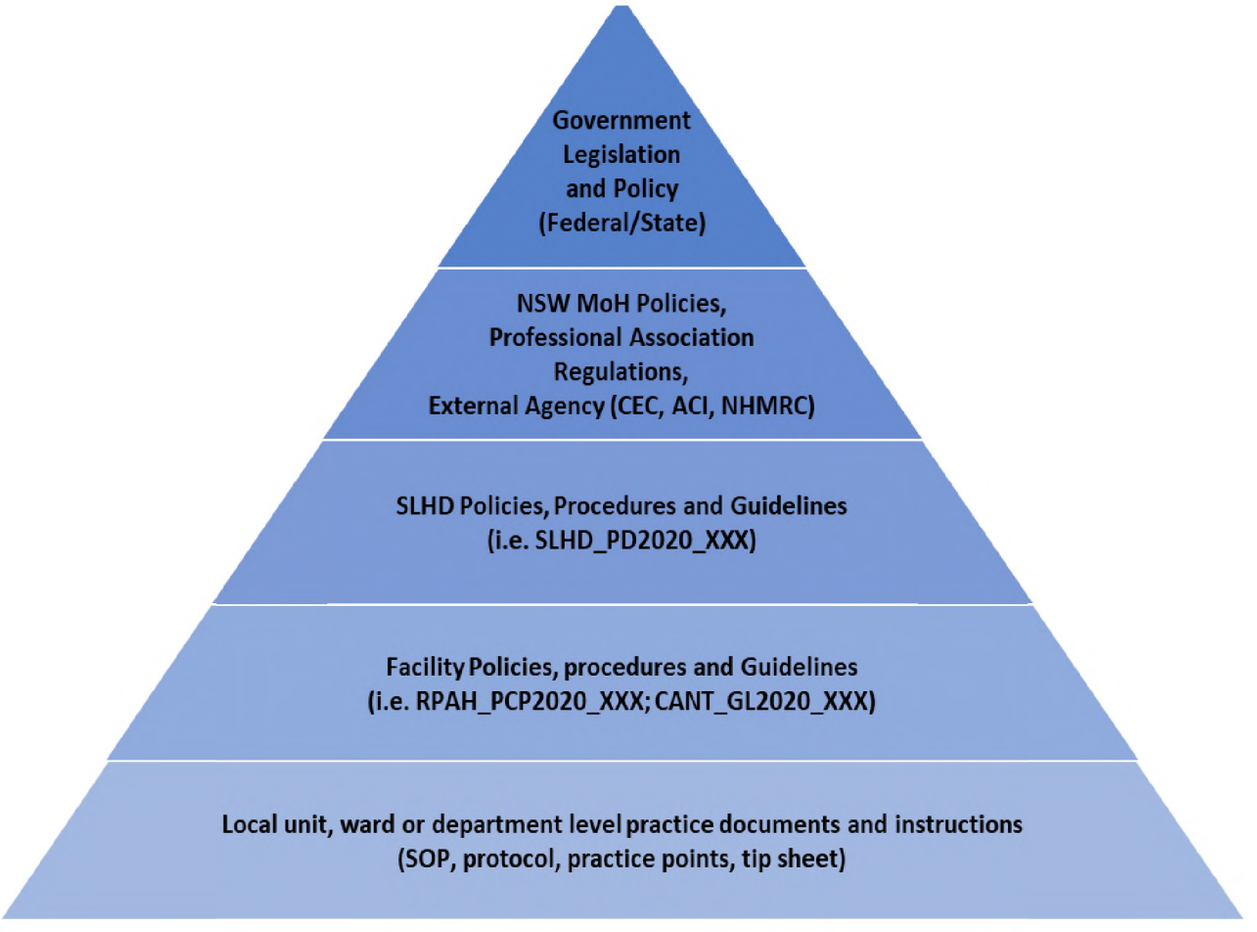
a) Final version in word document;
b) Implementation plan (if required);
c) Email correspondence e.g. feedback, recommendations, endorsements;
d) Tier2 Executive / GM approval to publish or archive (usually email correspondence);
e) Committee meeting minutes (where the policy was endorsed).

Appendix C: Policy Document Development Flowchart



* The SLHD Policy Manager/s will review the policy documents against the standards as set out in Appendix B.

Appendix D: Policy Hierarchy



Appendix E: Minimum Standards for Standard Operating Procedures (SOP) - Protocols - Practice Points - Flowcharts - Tip Sheet

1. Departments may develop unit specific documents to guide practice that is unique to their specialty. If this practice is shared with other departments across the facility or SLHD, then a policy document must be developed and endorsed by the relevant policy committee.

2. Departments are not to use the title Policy, Procedure or Guideline as this implies that the document has been approved by the SLHD, Facility or Service Policy Committee. Suggested titles could be: Protocol, Practice Points, SOP (Standard Operating Procedure).

3. A footnote is to be added with the following information:
- Author: Name and title
- Approved by: Name and title
- Date of approval:
- References: Add the title, policy document number and hyperlinked. It could be a policy document released by NSW Health, SLHD, CEC, College or Professional Association.

4. Protocols, Practice Points and SOPs must be reviewed on a regular basis and revised every 5 years or as necessary. The Head of Department bears the responsibility for all published documents in their websites.

5. Departments must not publish on their websites a pdf version of a NSW Health, SLHD, CEC, College or Professional Association document as version control is not feasible. These could be hyperlinked instead to ensure access to current versions.