Policy, Procedures and Guidelines: Governance

Scope (Staff)	All Staff
Scope (Areas)	All Areas

Contents

Introduction and Background

Well developed, evidence based, and easily available policy, procedure and guideline documents are a foundation element of any system in which individuals and units are held accountable for adherence to expected standards. They help reinforce and clarify the standards expected of employees and management, promote consistency of clinical care, and ensure compliance with laws and regulations. SLHD is committed to the delivery of effective and evidence based healthcare, and recognises the importance of high quality, consistent, and well implemented policies, procedures and guidelines in achieving this objective.

This policy compliance procedure, which describes the management processes for policies, procedures and guidelines at SLHD, has been developed to operationalise the requirements of the MoH PD NSW Health Policy Directives and Other Policy Documents (PD2016_049), and standards 1.7 and 1.17 of the National Safety and Quality Standards in Health Care,

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

Aim

This document provides structured governance and processes to ensure the development, review, and management of quality policy, procedure, and guideline documents at SLHD. This includes ensuring that high-quality, standardised documents are available and accessible to all staff at SLHD.

Risk Statement

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

Aboriginal Health Impact

SLHD is committed to ensuring that policies and programs strive to achieve equity for Aboriginal people. 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. More information on this section can be found in Policy, Procedures and Guidelines: Development, and Policy, Procedures and Guidelines: Writing and Style Guide (both in development)

Scope

Any document which meets either of the following criteria must be administered under the Policy, Procedure and Guideline System (the system and processes described in this document) at SLHD:

1. Any document which concerns any aspect of providing clinical care to a patient - including Clinical Practice Guidelines, Clinical Pathways, and Protocols
2. Any document which staff are expected to follow and refer to in the course of their work, especially if non-compliance with the procedures described in that document could result in disciplinary action for any employee

Definitions

Policy	A set of principles that reflect the SLHD mission and values, compliance with which is mandatory
Policy Compliance Procedure (PCP)	A document developed by SLHD to implement a significant MoH Policy or Guideline, or other significant NSW Government interagency document, to which NSW Heath is a party. Compliance is mandatory
Procedure	A set of 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 there should be a good reason as to why they have not been implemented as described.
Policy document	The collective noun for all policies, procedures, and guidelines of SLHD and its health facilities and services
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 are noted at the policy committee
Major Amendment	All changes made to a policy document other than a minor amendment. These amendments must be approved by the policy committee
Endorsement	The official statement indicating that the document, and its content, is accepted as correct. This is granted by the policy, procedure and guideline committee
Approval	The process of making the document officially valid for use within the area of the organisation to which the endorsement applies. This is granted by the SLHD Clinical Quality Council for SLHD documents, or the facility General Manager

Review	A formal examination of an enacted policy, which usually occurs at the end of a mandatory review period (5 years at SLHD), but may happen within this period for significant changes. Reviewed policies are allocated a new document number and assigned a new review period
Rescission	The act by which a policy is withdrawn from use.

Principles

So that policies at SLHD are developed and administered in alignment with good governance, all policy documents at SLHD must:

- be reviewed at least once every five (5) years. A review may be conducted earlier if deemed necessary.
- be written and reviewed with evidence-based best practice
- incorporate relevant legislation, regulation, NSW Health guidelines, policy directives and information bulletins, and professional standards where appropriate.
- be developed in consultation with key stakeholders, with adequate support for implementation
- be formatted in a standardised template, and be published and accessible to staff via the SLHD Policy intranet page
- be referenced using the Vancouver Style

Detailed guidance on policy document development and review processes is outlined in Policy, Procedures and Guidelines: Development

Accountability and Responsibility

Accountability and responsibility for policy development, review and management has been delegated to specific key positions and organisational committees. These are the same across all facilities of SLHD.

Document Owner

The document owner is the person responsible for overseeing the development, review, revision, implementation and evaluation of a particular policy document, and for providing endorsement of the final document before it is submitted to the Policy committee for endorsement. In most cases, this will be a Tier 2 Director, Clinical Manager/ Director or other executive sponsor.

Once the document has been approved, the document owner is responsible for monitoring the implementation, effectiveness, and use of the document, and is responsible for ensuring currency of the information contained within the document; however they may delegate this role to the document author as appropriate.

Document Author

The person who is delegated responsibility for leading the policy development team, generally a senior subject matter expert. This can be anyone determined by the document owner to have the necessary skills and knowledge to undertake a review or develop a policy document. They are the key liaison point for any issues with a document.

Where relevant, document evaluation is also led by the document author, in consultation with the document owner, the SLHD Policy Committee, and the Manager, SLHD Policy

SLHD Policy Manager

The SLHD Policy Manager has operational responsibility to manage the policy governance framework and monitor its implementation. The SLHD Policy Manager is responsible for supporting document owners and authors in reviewing and developing district-wide policy documents, and providing periodic reports to document owners and the SLHD Policy Committee as to the review status of relevant policies.

The SLHD Policy Manager also maintains oversight of facility/ local service policies, and may make recommendations that facilities collaborate to consolidate their policy holdings and develop district-wide documents.

Facility Policy Coordinators

Facility policy coordinators are responsible for ensuring that regular reports concerning the review status of their policies are provided to a suitable governing body at a local level, and for ensuring that their local policies are regularly reviewed. Where there is potential for a facility document to be adopted at the LHD level, the facility policy coordinators are responsible to notify and work with the Manager, SLHD policy to facilitate the development of district-wide policies.

All staff

Under the NSW Health Code of Conduct, all staff agree (as a condition of employment) that they will 'Comply with all applicable NSW Health policies and procedures, and those of the NSW Health agency where they work.' While compliance with guidelines is not mandatory, staff are encouraged to refer to guidelines as best-practice resources in the course of their work.

Staff should be aware that SLHD Policy documents are 'living documents' and may undergo minor changes from time to time – to locate the most up-to-date version of a policy documents, staff should access these through the SLHD policy intranet page. Staff should avoid printing or personally saving electronic copies of SLHD and Facility policy documents, particularly when referring to these documents in the course of clinical care.

Where a policy on the intranet is past its review date, but still live, staff should continue to use this policy until an updated version is released, after which the previous version will be rescinded and archived.

Approval and Endorsement

All documents must be (at a minimum) endorsed by a policy committee prior to being uploaded to the SLHD intranet page. Facility documents also require approval by the Facility General Manage prior to publication. Selected LHD documents require approval by the Clinical Quality Council prior to publication.

Out of session endorsement by the policy committee may be considered for urgent matters.

Committees

SLHD Policy Committee

The SLHD Policy Committee is responsible for maintaining oversight of the policy system within SLHD and the facilities, ensuring that all SLHD policies are:

- developed in accordance with best practice and the principles described in this document,
- have been through an appropriate and rigorous development or review process
- clear in their presentation
- suitable for use within SLHD.

This committee meets monthly. After endorsement by the policy committee, documents may then go for final approval, either by a relevant General Manager, or the SLHD Clinical Quality Council. The SLHD Policy Committee is chaired by the Executive Director, SLHD Clinical Governance.

SLHD Clinical Council and SLHD Clinical Quality Council

The SLHD Clinical Council and Clinical Quality Council provides final approval for SLHD policy documents which are clinical or have cross-stream impact.

Policy Hierarchy

The Policy Hierarchy demonstrates how the levels of policy align within the NSW health system (Appendix 2). To ensure consistency and good governance, every policy document must comply with those which exist at a higher level in the hierarchical structure. For example, SLHD policies must comply with NSW Ministry of Health Policy Directives, and facility policies must comply with SLHD policies. This hierarchy operates to resolve any inconsistencies arising in subordinate policy documents or operational rules that exist outside of this framework

In most cases, if a policy document exists at a higher level it should not be duplicated at a lower level, unless there is a clear operational need.

Policy documents are to be developed in accordance with the following policy hierarchy:

- SLHD-wide documents are to be developed wherever possible and developed/reviewed in collaboration with the SLHD Policy Manager. Specific exceptions to a policy document relating to any of the SLHD facilities should be included in the SLHD policy document.
- Facility specific (ie RPAH, Concord, Balmain-only) documents are only permitted when a SLHD-wide document is not feasible / applicable or when there are directives, requirements or legislation that relates to one site only.
- Department / Area specific policy documents are for use within a single department only and must not duplicate or contradict any MoH, SLHD, or facility policies. The development of department / Area specific policy documents must be done in conjunction with the facility Policy Coordinator. Department/ area specific policies must be administered via the SLHD policies webpage and be presented in the prescribed template.

Relationship between SLHD and MoH Policies

Where a MoH Policy states that Local Health Districts are required to develop local procedures to operationalise a particular policy (or where this is deemed necessary by a relevant executive sponsor), SLHD will develop a policy compliance procedure to outline this.

Where SLHD have resolved to adopt a MoH PD in its entireity, the policy team can (by request) publish a link to the MoH policy landing page on the SLHD policy website.

Staff should note that the SLHD policy website does not contain the full list of MoH policy documents, and that the policies which are on the website have been placed there to assist staff in locating MoH PDs, and that the total holdings (including archived documents) for MoH documents are to be accessed through the MoH website.

Policy documents from other sources

By request, the policy team may publish a link to a policy document that has been developed by an external organisation (such as the Clinical Excellence Commission, the Australian Commission for Safety and Quality, or another government department), if it is the opinion of the relevant subject matter expert within SLHD that the document reflects best available evidence and is suitable for adoption by SLHD staff in its entirety.

If a landing page for the document exists, it is preferable to link to the landing page rather than the document itself, to mitigate the risk that the SLHD policy site will link users to an out-of-date resource or broken link. To avoid linking to out-of-date materials, this hyperlink should always take the user to the publishing site (PDF documents which are saved on internal drives must not be uploaded to the policy site in this way).

Rescission

Documents which are no longer relevant or needed may be rescinded with the approval of the document owner. The approval is to be documented via email record. Document owners are encouraged to proactively contact their policy coordinator (either at the facility or LHD level) to ensure that only the most up-to-date and relevant policies are kept online.

Policies may be rescinded because:

- the issues or risks that the policy was mitigating no longer exist
- the policy no longer effectively manages the issues or risks it was set up to address
- another policy or risk solution has been implemented
- changes to government legislation and policy, or other internal policy, means the policy is no longer required

SLHD maintains an online archive of documents which have been rescinded. Word copies of rescinded documents are available on request and for medicolegal purposes.

National Safety and Quality Standards, 2nd ed.

Clinical Governance Standard

Partnering with Consumers Standard

References

SLHD uses Vancouver numeric referencing. For more information, refer to The University of Sydney's Referencing and Citation Style Guide

1. https://en.oxforddictionaries.com/punctuation/bullet-points

   Curtin Health Academic and Study Guide

Document Control			
Author	Manager, SLHD Policy	**Department:**	Clinical Governance & Risk Unit
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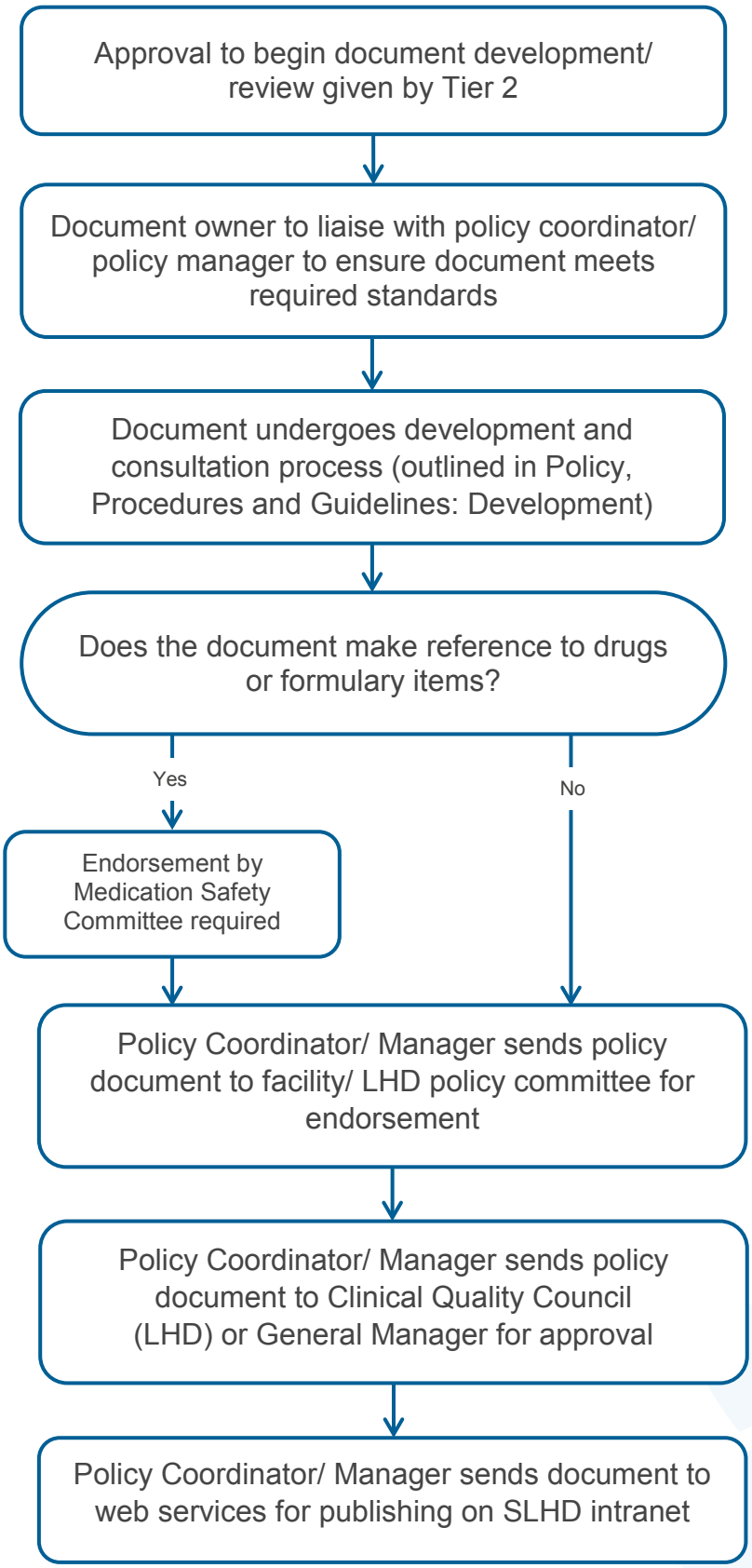
Policy Number	SLHD_PCP2019_001	**Risk Rating**	
Consultation	• SLHD Policy Committee	• Facility Policy Coordinators	
This document is uncontrolled if printed or personally saved. Refer to the SLHD intranet for the most current version.			

Appendix 1: Policy Development and Approval Flowchart



Appendix 2: Policy Hierarchy