# Metapolicy

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| First Produced: | 02/05/2016 | Authorisation: | Council |
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| Past Revisions: | | Officer | |
| Review Cycle: | 3 years | Responsible: | Director, Governance & Strategy |
| Applies From: | Immediately | | |

*This policy replaces the policy on policies introduced in 2009 and revised March 2012 to include embedding of sound principles regarding policy process for improved policy outcomes as well as the practical requirements in terms of creating a policy and the framework on which they are created, reviewed and disseminated. The content of this policy and procedure will be reviewed according to the review cycle detailed above.*

# 1 Introduction

## 1.1 Purpose

A metapolicy - otherwise known as a 'policy on policies' – is a mechanism for embedding sound principles regarding policy process for improved policy outcomes. It provides a framework that sets out to define the range of compliance documents (e.g. regulations, policies, procedures, protocols) and establish a classification system which groups them (e.g. academic, financial, facilities management). In addition, it identifies and describes the processes by which the compliance documents are developed, reviewed and made available to the organisation and its stakeholders.

## 1.2 Scope and Application

Provides a process for the development and management of policies, outlines protocol for liaison with policy owners to determine and facilitate approval pathways, determines consistent documentation presentation and alignment with delegated legislation, document control, and facilitating approval. Outlines the policy repository and policy review cycle.

## 1.3 Formal Delegations

a To the Ara Council authorisation/approval of:

- i Section 1.16 Protected Disclosures
- ii Section 2.03c Academic Board Membership
- iii Section 3.05 Fraud
- iv Section 6.01 CE Delegations
- v Section 6.02 CE Leave
- vi Section 6.03 CE Performance Review
- vii Section 6.04 CE Remuneration Review
- viii Section 6.05 CE Travel

b To the Academic Board and its subcommittees authorisation/approval of:

- i All other Academic Policies

c To the Ara Council and Te Kāhui Manukura authorisation/approval of:

i Section 1.01 Relationships with the News Media and Other External Agencies

ii Section 1.02 Disclosures and Management of Conflicts of Interest

iii Section 1.07 Brand Standards, Promotional and Non Promotional Communication

iv Section 2.05 Council/Staff Discounted fees

d To the Ara Council endorsement of:

i Section 3.04 Discretionary Expenditure

e To Te Kāhui Manukura authorisation/approval of:

i All other Corporate Policies

## 1.4 Definitions

a **Approval Authority** - The person(s) within the Institute who has the delegated authority to approve:

i the development of a new compliance document;

ii a major review of an existing compliance document; and/or

iii amendments to an existing compliance document's content that changes its original intent.

The Approval Authority generally does not conduct the review of a document. This is completed by the Officer responsible. If the Officer responsible identifies major amendments to the document (i.e. a significant proportion of the wording needs to be changed and/or the intention of whole or part of the document has changed), then the Approval Authority will need to read those changes and approve them.

Approval Authorities shall take new or substantially revised compliance documents awaiting approval to Te Kāhui Manukura for consultation and general visibility.

Any breaches of a compliance document will, in the first instance, be brought to the attention of the Approval Authority.

b **Codes (e.g. Code of Practice, Code of Conduct, Code of Ethics) –** These set out minimum expectations and best practice guidelines that it is expected will be adhered to.

c **Compliance Document -** A compliance document is a collective term that refers to any document that is accessed through the QMS that the Institute requires staff, students and visitors to comply with. Compliance documents may be:

i Codes of Conduct or Practice

ii Forms

iii Frameworks

iv Guidelines

v Instructions

vi Plans

vii Policies

viii Principles

ix Procedures

x Regulations

xi Statutes

xii Strategies

d **Document History and Version Control** - Document history and version control are used to record detail of minor and major amendments (reviews) to Institute documentation over time. It allows anyone accessing the document to know if it is the most current version; when it was last amended; what was changed from the previous version; and who approved the document, including any amendments made to it.

e **Governance and Strategy Unit**– The unit within the Institution responsible for the official repository of compliance documents.

f **Guidelines / Procedures** - Standard, step-by-step, methods of operating in line with best practice or safe practice. They generally relate back to a policy statement and may offer advice or set expectations about how a policy or regulation should be implemented or how an activity is carried out. Compliance is expected, and where a decision is taken to depart from the guidelines, actions may need to be explained and/or justified.

g **Legislation** - Laws approved by Parliament and enforceable by the government of the country.

h **Officer Responsible –** The person within the Institute who is responsible for a document when it is due for a major review or, when it requires an amendment that is not part of the Governance and Strategy Units responsibility. Will be the person within the Institute with the responsibility for ensuring adherence of the document's content and would be best placed to answer any questions with regards to the interpretation of the document or its implementation.

i **Policy** - Formal expectations of staff and students on specified Institute matters. Policies are formally documented and approved by Council or the bearer of Council's delegated authority. Boundaries are defined and a framework provided within which operating procedures may be developed including the set of principles on which they are based and associated procedures (See also the Policy template, Section 1.19a). Compliance is expected and non-compliance may result in censure, penalties or disciplinary action.

j **Principles** - Statements of the fundamental values and circumstances that form the basis of procedures and good practice guidelines.

k **Procedures** – A statement that provides information or step-by-step instructions to implement a Policy; a process.

l **Review Date** – A date (month and year) nominated by the Officer Responsible when the document should next be reviewed. The standard review periods will be between one year and three years. The nominated review date does not prohibit updates more regularly if necessary.

m **Te Kāhui Manukura (TKM) –** Committee that advises the Chief Executive on the strategic direction, management, and operation of Ara Institute of Canterbury.

n **Statute** - Rules that determine:

i the standards for each qualification offered by the Institute

ii the formal expectations of the Institute with regard to other general matters pertaining to its function e.g. Discipline

Statutes are approved by Council, are mandatory, and failure to comply with them will normally result in penalties.

Note: can also be referred to as Regulations.

- **Quality Management System (QMS)** – A central electronic repository accessed via Infoweb. It houses all Institution-wide strategy, planning and compliance documents.

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| **Related Ara Procedures**(indicate if attached to policy or where they can be found)<br>• Policy Template (available on Infoweb/ www.ara.ac.nz; Ara's websites or from the Governance and Strategy or Academic Offices in Executive<br>• Policy review cycle | **Related Ara Policies**<br>• |
| **Related Legislation or Other Documentation**<br>• | **Good Practice Guidelines**(indicate if attached to policy or where they can be found)<br>• |
| **References**<br>▪ NZQA Quality Assurance framework | |
| **Notes** | |

# 2 Principles

2.1 Ara policies will comprise of statements of principle that articulate and align with legislative, regulatory or organisational requirements.

2.2 Ara policies and any associated procedures and good practice guidelines will enact the values and vision, supporting the mission, goals and strategies of the Institute as they are expressed in the Strategic Plan.

2.3 Stakeholder consultation will be part of the processes for developing new policies and reviewing existing policies.

2.4 Policies will meet or exceed legislative and regulatory requirements.

2.5 The authority of a policy is established when it is formally approved by Ara Council, the Academic Board or Te Kāhui Manukura.

2.6 Policies will be kept current through a review cycle.

2.7 In the event of any change which will substantively affect the policy, it must be reviewed, and submitted to the authorising authority as soon as possible after the substantive change has occurred e.g. changes in legislation.

2.8 Each policy will have a designated Officer Responsible who, unless specified otherwise, will be a member of Te Kāhui Manukura.

2.9 Policies will be available to all staff and students.

# 3 Associated Procedures for Ara Academic & Corporate Policy on: Policies

**Contents:**


3.1 Application of Compliance Documents
3.2 Compliance Document Lifecycle
3.3 Review Existing Compliance Documents
3.4 Rescinding or Merging of Compliance Documents
3.5 Quality Management System Library
3.6 Governance and Strategy Unit Responsibilities and Functions


**All policies on Ara's InfoWeb are the current version. Please check date of this hard copy before proceeding.**

## 3.1 Application of Compliance Documents

The QMS is the official electronic repository for Ara compliance documents. These are held separately to departmental compliance documents, by virtue of having Institute-wide application. Where there are inconsistencies between departmental compliance documents and Ara compliance documents, the latter override the former.

Compliance with documents housed in the QMS is expected from staff, students and visitors. For staff and students, this expectation is encapsulated in employment and enrolment contracts. For contractors, there is an induction process that is required to be completed prior to starting work for Health and Safety. For visitors, Institute signage sets expectations in common areas. For any areas that are staff only, the staff member accompanying the visitor should ensure compliance, or if unaccompanied, the visitor should sign in at Facilities Management or the Security office.

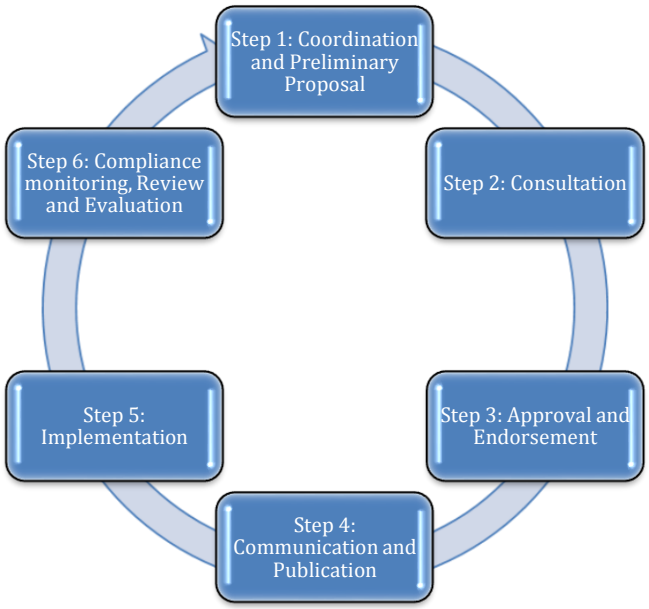
These documents are compliant with NZ legislation and in many instances, provide the institute application or interpretation of legislation. A good example is the Privacy Policy; developed to ensure compliance with the Privacy Act 1993.

Ara compliance documents may also be informed by national and international standards published by Standards New Zealand, together with other authorities that define minimum requirements and best practice guidelines.

## 3.2 Compliance Document Lifecycle

### a Policy Cycle

The policy cycle is as follows:




A description of each step is provided in Appendix A.

## b Creating New Compliance Documents

The need for a new compliance document may be driven by a number of factors, both external and internal, including but not limited to:

i new or changed government requirements;

ii new or amended regulations;

iii new strategic direction of the Institute;

iv restructuring;

v identification of a gap in current 'suite' of compliance documents;

vi emerging operational issues;

vii identification of risks or inconsistencies in behaviour by staff and/or students;

viii review/consolidation of older compliance documents;

ix external pressures, from, for example, the media; and

x events

Once a need is identified, relevant persons or groups should contact the Governance and Strategy Unit who will guide them through the process of drafting a compliance document using the policy template. The draft should be informed by research, benchmarking and appropriate consultation. A checklist is appended to this Metapolicy to assist with the drafting process.

Prior to seeking approval of the identified Approval Authority, the draft must be brought to the attention of the Governance and Strategy Unit who will conduct a quality assurance check of the document's content and format. Following this step, the document approval process should then be followed by the Approval Authority, including presenting the draft compliance document at TKM for consultation.

Compliance documents will not be uploaded to the QMS until both the Governance and Strategy Unit and the Approval Authority have respectively consulted and approved the compliance document, and the Officer Responsible has taken the document to TKM for discussion.

Once approved, the Governance and Strategy Unit will publish the compliance document in the QMS. It is then the joint responsibility of the Officer Responsible and the Governance and Strategy Unit to ensure that the new compliance document is advertised on Infoweb and its existence widely promulgated to interested parties (the Officer Responsible should do this).

Policies must be:

i Presented in a common/standard format (using template provided);

ii Written concisely, in plain English (assistance with translation of policies may be provided to employees and students, if required);

iii Developed in consultation with appropriate stakeholders;

iv Formally approved by the appropriately delegated body;

v Maintained centrally;

vi Kept up-to-date;

vii Applicable Ara-wide, unless otherwise stated;

viii Contained under Academic or Corporate Policies & Procedures on Infoweb and on www.ara.ac.nz, Ara's website repositories (other Ara documents should not be referred to as policies).

c **Format of Compliance Documents**

Compliance documents published in the QMS are developed on a standard template to ensure that specific, key information is captured and is standardised across all documents. While there may be variations within the body of the compliance documents in terms of, for example, sub-headings, all should include core information which will assist with classification, the review cycle, and retrieval.

Core information includes:

i Unique ID: Each compliance document in the QMS is assigned a unique ID that stays with the document through its lifecycle and is never reassigned. This information is displayed on the top left hand side of each page of the document and can be used as a reference for checking the history of a document, particularly if it has undergone name changes.

ii Last modified: This is the month and year when the compliance document was created or the last amendment/review was approved (whichever is the most recent).

iii Review date: This is the month and year when it is recommended that the compliance document is next formally reviewed.

iv Staff only documents: A limited number of compliance documents within the QMS are accessible to staff only. This is generally because they contain commercially sensitive information.

v Footer information: The compliance document title, page number, and controlled version notification are documented in the footer of each page of all compliance documents in the QMS.

## 3.3 Reviewing Existing Compliance Documents

When a document held in the QMS is due for review, a review cycle workflow will be generated and an email will be sent to the Officer Responsible three months (90 days) before the listed Review Date by the Governance and Strategy Unit. It is the responsibility of the Officer Responsible to ensure that the review is conducted and the Approval Authority is engaged within the 90 day timeframe and that appropriate consultation occurs to inform the review.

Where any major review is undertaken, the Officer Responsible must consult the Governance and Strategy Unit, and the Officer Responsible must present the policy for consultation at TKM.

*Note:* a compliance document may be reviewed at any time to address necessary amendments to content that occur outside the stated review period.

The Governance and Strategy Unit will assist with the process of uploading the revised version of the compliance document to the QMS.

Throughout the lifecycle of a compliance document, continuous monitoring should occur to confirm accessibility, relevance, and compliance within the Institute and with wider NZ legislative requirements. This function is the responsibility of the Governance and Strategy Unit, with input from the wider Institute when issues are identified.

## 3.4 Rescinding or Merging of Compliance Documents

As the QMS develops over time, it may become necessary to either rescind certain compliance documents or merge them with others. In order to do so, the Governance and Strategy Unit must seek written approval from the appropriate Approval Authority. The Officer Responsible should notify TKM of the intention to rescind the document. Once this has occurred and approval has been granted by the Approval Authority, the Governance and Strategy Unit will remove the compliance document from the QMS and notify appropriate stakeholders.

Officers Responsible seeking to have a compliance document that they manage rescinded or merged should liaise with the Governance and Strategy Unit in the first instance.

a Stakeholder consultation processes may vary but should include some, or all, of the following:

  i Formative discussion, involving initial discussion of the policy by the relevant working party or committee;

  ii Dissemination to a wider audience of stakeholders (this may be a particular group, or the wider Ara community) for broader consultation for a set period of time;

  iii Determination, by the relevant committee, of the decision to endorse the policy, prior to it being forwarded to the appropriate approval authority.

b Where applicable, the Officer Responsible for the policy prepares procedures and guidelines to accompany the policy. The procedures/guidelines should provide succinct and expert advice on good practice in relation to the policy. The Officer Responsible determines the level of consultation required, if any, in developing the procedures/guidelines. Once approved, the Officer Responsible will modify any procedures/guidelines as required and report the changes to the appropriate bodies, including Te Kāhui Manukura, for information, and to the Governance and Strategy Unit for uploading to the websites as required.

c All policies must first be reviewed and signed off by the Governance and Strategy Unit before being submitted to the delegated approval authority.

d Policies that have become obsolete will be formally disestablished by the delegated approval authority or after periodic review and recommendations to the approval authority from the Chief Executive and the Directors, Academic, Human Resources, Corporate Services and Governance and Strategy.

e When a new or revised policy is approved or a policy is disestablished, the approval authority notifies the Governance and Strategy Unit who will inform the Ara community via global email as part of the process of removal (See 3.3f), and remove the policy from the websites.

f The new/revised policy is posted to the appropriate Ara website, together with any associated or related procedures/regulations/forms/other documentation; and a disestablished policy and its associated or related procedures are removed by the Governance and Strategy or Academic Division Offices for Corporate Policies and Academic Policies respectively.

g Where applicable, the Officer Responsible will, in consultation with the appropriate Manager, coordinate any training deemed necessary to support the policy.

*Gaps in policies will be identified by the delegated approval authority and/or by periodic review and recommendations to the approval authority by the Chief Executive and the Directors, Academic, Human Resources, Corporate Services and Governance and Strategy.*

## 3.5 Quality Management System Library

The QMS Library was established as an electronic repository for all official compliance documents. It contains all the compliance documents within the QMS, but will also retain all drafts of compliance documents and final versions of documents as displayed through the QMS on Infoweb.

This document repository has been developed in accordance with NZ legislation (Public Records Act 2005); the Ara General Disposal Authority; and Archives NZ's suggested best practice for document retention and storage.

Documents published in the QMS can be viewed and printed as PDFs. While it is possible to save a copy to a personal computer, users are discouraged from doing so as reviews may occur at any time and once printed, a document is considered to be an uncontrolled version and may be out-of-date. If it becomes necessary to print a compliance document because, for example, it is to be included in agenda papers for a committee, then it is recommended that prior to any meeting, a check be made of the version number at the bottom of the page to ensure it aligns with the electronic, controlled version in the QMS.

## 3.6 Governance and Strategy Unit Responsibilities and Functions

The Governance and Strategy Unit has overarching responsibility for the accuracy, standardisation, promulgation and efficacy of compliance documents that sit in the QMS. In order for the Institute to minimise risk, the Governance and Strategy Unit must undertake stringent quality assurance on all compliance documents within the QMS.

The unit's responsibilities include:

i support, guidance and direction in the development and review of compliance documents;

ii quality assurance of all compliance documents in the QMS;

iii regular needs/gap analysis;

iv the development and provision of templates, guidelines and style guides;

v the development of "How to.." documents to assist Officers Responsible and Approval Authorities with their roles;

vi ensuring the currency of information;

vii publication of updates about new and revised compliance documents;

viii making minor changes in the QMS (largely style/grammatical) on behalf of the Chief Executive;

ix ensuring the compliance documents meet the requirements of the Public Records Act 2005 and the Ara General Disposal Authority.

## 3.7 Related Documents and Information

i Appendix A: Policy Proposal Approval, Dissemination and Review Process

ii Appendix B: Checklist for Development of New Compliance Document

iii Public Records Act 2005

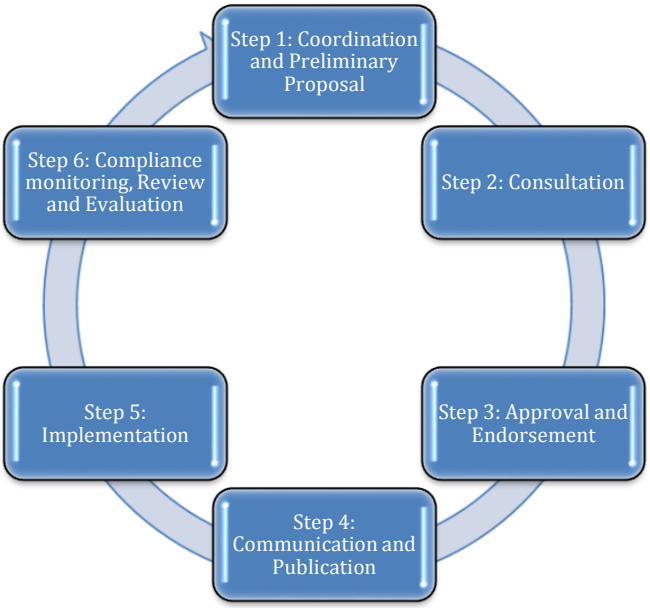
iv Ara General Disposal Authority

v Templates, Examples and "How to …" documents

vi QMS Library

## Appendix A: Policy Proposal, Approval, Dissemination and Review Process

*Note: The diagram depicts the life cycle of **all** Ara statutes, regulations, policies, procedures, guidelines and protocols. For simplicity, only the term 'policy' is used below to describe the process.*




### Step 1 Coordination and Preliminary Proposal

Coordination and intelligence gathering stage. Determining if there is a need.

A new policy may be initiated after identifying that a need exists to address a gap or meet compliance standards. Mitigates against uncoordinated policy proliferation.

The Governance and Strategy Unit should be consulted at this point. All new policies must be created using the approved template.

Preliminary proposal has several components:

1. The new policy is developed by an individual or committee using the Ara template and guidelines and supported by the Governance and Strategy Unit;
2. A draft is widely promulgated amongst relevant persons for comment/input;
3. A quality control checklist should be applied to the draft (see Appendix B of the **Metapolicy**).
4. **Benchmarking:**
   a) The policy is reviewed against other similar policies in other organisations to inform policy and practice through comparative analysis. Identifying points of similarity and points of difference, and making judgements based on these findings. Essentially these judgements relate to the identification of good practice policy provisions and practices for Ara institutional policy requirements.
   b) The policy must be reviewed to ensure that it complies with the Metapolicy and all relevant legislation and regulations and adhere to necessary standards of care.

## Step 2 Consultation

Central to the policy cycle and key to successful policy implementation. The purpose is to improve the quality of policy decisions through access to relevant information and perspectives, including exchange of problem and solution definitions, alternatives and criteria; ensure understanding, acceptance and legitimacy of proposed policies; promote consensus about policy choices; anticipate challenges to the policy process by providing transparency, accountability and opportunities for participation.

A draft new policies and draft policy amendments that are deemed a major change and as such require the approval of the Approval Authority be distributed through the Infoweb alerting staff, unions and students (where applicable) of the availability of the draft and how to respond with suggestions and comments. The duration of the consultation period will be one month from the date it is made available.

Each recommended addition or deletion needs to be considered and a decision made as to whether to reflect them in the final policy. It is good practice to provide feedback to all policy stakeholders that contributed to the consultation process, acknowledging where recommendations were – and were not – adopted.

## Step 3 Approval and Endorsement

Following a rigorous development and consultation stage (Step 1-5), the appropriate Officer Responsible must take the policy to the Approval Authority for endorsement. The Approval Authority must then formally approve the policy, in writing, prior to moving to Step 7. Delegations for approval are identified in Appendix C of the **Metapolicy**.

## Step 4 Communication and Publication

The newly approved policy is then lodged with the Governance and Strategy Unit, who is responsible for its deposit in the QMS Library and notification of its existence on Infoweb.

## Step 5 Implementation

Implementation should be considered early in the development of a proposal and include considerations of the following in the meeting the policy:

1. Specification
2. Conflicting objectives
3. Conflicting directives
4. Required competencies
5. Resourcing requirements
6. Communication requirements
7. Additional guidelines, procedures, templates and forms

## Step 6 Compliance Monitoring, Review and Evaluation

As per the policy template, a review date will be determined and documented; generally triennially but annually or biennially where appropriate. All reviews will be initiated by the Governance and Strategy Unit three months (90 days) before the review date with an email to the Officer Responsible and follow ups as necessary. Ad hoc reviews and amendments may

also occur. It is the responsibility of the Officer Responsible to ensure these are forwarded to the Governance and Strategy Unit.

Review includes review of the policy document and determining its relevance to the current practices as well as what is 'best practice' for the institution.

Internal audit and quality assurance programs will monitor compliance and evaluation efforts. The intention is to embed progressive monitoring and evaluation of policy implementation (see Internal Audit schedule and reporting). Integrating evaluation into policy design and implementation adds rigour, consistent with the idea of carefully considered decisions made by a well-informed, accountable decision maker.

## Appendix B: Checklist for Development of New Compliance Document

Following the consultation phase and before seeking ratification from the Approval Authority, the Officer Responsible should apply the following checklist to the proposed new compliance document. The Governance and Strategy Unit can assist you as required.

| | **Yes** | **No- minor** *(no change necessary)* | **No – major** *(recommended amendments)* |
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| **Compliance Document Format** | | | |
| Have all the following been provided:<br>▪ title<br>▪ last modified<br>▪ review date<br>▪ approved by<br>▪ Officer Responsible? | | | |
| Has the template been applied correctly and the material presented in terms of the specified guidelines? | | | |
| Has the Institute branding been applied consistently throughout the document (including appendices)? | | | |
| **Compliance Document Content** | | | |
| Does the title adequately reflect the purpose and content? | | | |
| Has the document been classified and described appropriately? | | | |
| Is the review date realistic? | | | |
| Has the person with overall responsibility for the compliance document been accurately identified (see approval delegations)? | | | |
| Is the identified Officer Responsible the appropriate person with operational responsibility for the compliance document? | | | |
| Does the introduction clearly identify the purpose? | | | |
| Has the organisational scope been identified and is it acceptable? | | | |
| Are the definitions provided accurate, relevant, and consistent with those used elsewhere? | | | |
| If a policy statement is included, is it actually a policy or is it in fact a procedure, set of guidelines or something else? | | | |
| Are procedures or guidelines clearly identified as such? (NB: these should offer advice and compliance may be expected though not necessarily mandatory.) | | | |
| Is the compliance document comprehensive:<br>▪ issues clearly stated?<br>▪ Institute position or response identified?<br>▪ acceptable minimum standards detailed? | | | |

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| Does the compliance document cover all relevant compliance issues? | | | |
| Have compliance costs, where relevant, been identified? | | | |
| Are appeal processes clearly identified, where appropriate? | | | |
| Have all related compliance documents been identified? | | | |
| Is there any overlap or conflict with other compliance documents in existence? | | | |
| Are the appendices relevant and appropriately presented? | | | |
| Has all relevant background and consultation material been included in the appendices? | | | |
| **General** | | | |
| Is there clear evidence that a robust consultation process has occurred? | Comment: | | |
| Is the Officer Responsible clearly aware of the process for obtaining approval, lodging a copy with the Governance and Strategy Unit for deposit in the QMS Library, and reviewing the compliance document in due course? | Comment: | | |
| Other comments: | | | |