

Guideline Development within Maternity Services

Issue Date	Review Date	Version
December 2018	December 2023	1

Purpose

The purpose of this Standard Operating Procedure is to provide all staff within Maternity Services a framework for consistent and effective clinical guideline management. It will provide consistency in the delivery of care that is required standard across the maternity services.

Who should read this document?

All midwives and medical staff working within Maternity Services.

Core accountabilities

Owner	Ceri Staples
Review	Clinical Effectiveness Committee
Ratification	Director of Midwifery
Dissemination (Raising Awareness)	Obstetric and Maternity staff
Compliance	Director of Midwifery

Links to other policies and procedures

Policy for the development and management of Trust wide policies and procedural documents

Version History

1	December 2018	Approved by the Clinical Effectiveness Committee
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The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available in G Drive – Document Library – UHPT Trust Documents. Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

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Standard Operating Procedure (SOP)

Guideline Development within maternity services

1 Introduction

The Maternity Guideline Group oversees the review, development and approval process for guidelines on behalf of the Trust Executives and Trust Board. The terms of reference for the group are shown in appendix 1.

This document will provide a framework for consistent and effective clinical guideline management. It should be read in conjunction with the 'Policy for the development and management of Trust-wide policies and procedural documents'.

2 Definitions

Clinical guidelines recommend how healthcare professionals should care for people with specific conditions. They can cover any aspect of a condition and may include recommendations about providing information and advice, prevention, diagnosis, treatment and longer-term management.

Guidelines assist healthcare professionals in decision making about appropriate care and effective treatment but they do not replace knowledge or skills: however they ensure consistency and agreed standards of care that can be audited. The guideline outlines the expected best practice for a particular issue or principles to be followed.

Guidelines can be generated as a result of new evidence, clinical incidents, advice and direction from relevant authoritative bodies such as the National Confidential Enquiries and royal Colleges as well as from individuals who identify gaps in information.

It is the responsibility of the authors together with the Maternity Guideline Group to agree the development, approval, dissemination and review of all guidelines

3 The Maternity Guideline Group

The Maternity Guideline Group will advise regarding the consultation process required for each guideline, as this will depend on the content and impact on the service. The consultation process must be comprehensive and robust and include all stakeholders. The author is responsible for steering the policy through the consultation process. Each guideline will have a lead committee / author for consultation. The author will assure the Maternity Guideline Group and the Clinical Effectiveness Committee that there has been appropriate consultation. Documentation of the consultation process and ratification will be in accordance with Trust policy and a record of the process will be maintained (see appendices 2 & 3).

The Maternity Guidelines Group will consist of:

- Maternity Matron

- Minimum of 2 Consultant obstetricians
- Senior midwives

Additional input will be requested from clinicians and/or senior midwives subject to the individual guideline under development/review.

All approved guidelines will be updated to include the date of ratification, date of next review, version number and changes from previous guideline.

4 Process for guideline development

- When the need for a new clinical guideline has been identified, the authors and co-writers are identified and the first draft is produced.
- All guidelines should follow the Trust guideline template (Appendix 2). The first draft guideline is then circulated to the Maternity Guideline Committee and other relevant parties if indicated for timely comment/review.
- The author then produces a completed draft which is circulated to members of the Maternity Guideline Committee to agree the title of the document to ensure consistency and that it can be easily identified by all staff, to ensure all standards are addressed, and to identify if an audit is required.
- The final guideline is then submitted to the Guideline & Audit lead Midwife to be circulated to the committee attendees at least 2 weeks before the next scheduled Clinical Effectiveness Committee meeting for ratification. In addition any training programme necessary for implementation of the guideline should also be submitted for ratification.
- Once agreed by the Clinical Effectiveness Committee, the Guideline & Audit lead midwife will arrange for the guideline to be placed on the G Drive (G:\DocumentLibrary\UHPT Clinical Guidelines). Copies of all guidelines are stored on the G drive (G:\maternity\auditandguidelines\guidelines) and will be publicly available on the hospital website.
- All guidelines must contain a document control box at the end that contains author, work address, version, changes, date ratified and review date.

5 Document Ratification Process

- The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.
- This document will be reviewed by the Maternity Guideline Group and ratified by the Maternity Clinical Effectiveness Committee.
- Non-significant amendments to this document may be made by the nominated author. These must be ratified by the Clinical Effectiveness Committee.

6 Dissemination and Implementation

- Following approval and ratification, this procedural document will be published in the Trust's formal clinical documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter, the maternity newsletter and via email.
- Document control arrangements will be in accordance with The Development and Management of Formal Documents.
- The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Clinical Effectiveness Committee and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

7 Monitoring and Assurance

Audit

- Each guideline will have a section that outlines its minimum auditable standards, monitoring and compliance arrangements together with frequency of audit and responsible person.
- Results of audits are reported to the Clinical Effectiveness Committee, which is responsible for review of audits and monitoring the implementation of action plans; – please refer to Maternity Risk Management Framework.
- A minimum of 75% compliance for every guideline audit is required; however, in all cases 100% compliance should be the ultimate goal. If the audit achieves < 100%, evidence must be provided that recommendations and action plans have been developed and implemented designed to achieve 100% compliance. The implementation of changes will be subject to subsequent audit.

Compliance of each guideline with this document will be monitored using the audit tool shown in appendix 2.

8 Review of policies/guidelines

The maximum review term for a guideline/policy is five years. It is the responsibility of the Maternity Guideline Group in conjunction with the guideline & audit lead midwife and the maternity risk manager to ensure that reviews are arranged in line with changing legislation, evidence or as a result of learning from experience, including through incident reporting and risk management.

FLOWCHART SUMMARISING PROCESS FOR GUIDELINE REVIEW, DEVELOPMENT & MANAGEMENT

REVIEW & DEVELOPMENT

Identify need to develop or update an existing guideline.
Identify key author and agree consultation process



WRITING GUIDELINE

Review current evidence through literature search
Ensure compliance with National Guidelines and Standards
Use Trust Policy for correct formatting



CONSULTATION

Draft guideline circulated to the Maternity Guideline Group for comment
Revisions to be made by key author
Submit to Maternity Guideline Group for final development – provide evidence of consultation or gather evidence from e-mail of final versions



RATIFICATION

Maternity Guideline Group review to provide uniform agreement that due process has been followed and appropriate national guidance has been incorporated.
Formal ratification provided by the **Clinical Effectiveness Committee**



MONITORING & AUDIT

Audit tools for each guideline will be designed and located within the Maternity drive. This can be accessed via the Risk Management team.
Each guideline will contain a section identifying lead person responsible for carrying out audit, the frequency of audit.
Audits will be submitted to **Clinical Effectiveness Committee** (responsibility for implementation of recommendations from audits rests with this committee).



GOVERNANCE

Clinical Risk Management team will provide assurance of adhering to governance arrangements through the **Clinical Effectiveness Committee**

