The Shrewsbury and Telford Hospital NHS Trust

Guideline Development Framework – Maternity (Including Standard Operating Procedures)

Version 10

Lead Persons	:	Steph Chatham, Guideline Midwife Head of Midwifery
Division	:	Women and Children's
First implemented	:	June 2004
This version implemented	:	21st June 2024
Planned review	:	31st July 2027
Keywords	:	Guidelines (development of),
Revisions by	:	Steph Chatham, Guideline Midwife
Written by	:	Jacqui Bolton and Paula Pryce
Consultation	:	Kimberly Williams, Head of Midwifery. Lauren Taylor, Deputy Head of Midwifery
Comments	:	References to SaTH Guidelines/Protocols in the text pertain to the latest version of the guideline/protocol on the intranet. Printed copies may not be the most up to date version.

Version	Implementation date	History	Ratified by	Full review date
1	June 2004	New guideline		2007
2	December 2006	Revised		2009
3	November 2008	Revised	Maternity Guidelines Group	2011
4	June 2010	Rewritten	MGG 11.6.10	June 2013
5	July 2010	Minor changes from CNST feedback	MGG	July 2013
6	28th June 2011	Changes to guideline template, ratification and monitoring and audit forms	MGG Maternity Governance	June 2014
7	9th August 2011	Small procedural change on advice of CNST	MGG Maternity Governance	August 2014
7.1	13th February 2012	Clarification of process	GC Authorisation	February 2015
7.2	20th June 2014	Definition of Standard Operating Procedure added	GC Authorisation	February 2015
8	10th December 2015	Full Version Review	MGG Maternity Governance	December 2018
8.1	2nd November 2016	Routine review dates changes to 5 years in line with SaTH Policy for Policies.	MGG Maternity Governance	December 2018
9	18th July 2019	Full version review	MGG Maternity	July 2024

Version	Implementation date	History	Ratified by	Full review date
			Governance	
10	21st June 2024	Full version review. Review dates adjusted to 3 yearly.	Maternity Governance	July 2027

1.0 Introduction

1.1 To ensure that guidelines, policies, and standard operating procedures (SOPs) are developed, written, ratified according to this framework.

1.2 A Maternity Guidelines Group (MGG) is in place to ensure the development, oversight, and dissemination of up-to-date guidance **(see Appendix 1**).

1.3 The Guideline Midwife will be responsible for the systematic review of guidelines, policies, and SOPs, ensuring development, distribution and archiving in accordance with Trust policies. Any resulting training needs will be implemented by the Clinical Education Midwife.

2.0 Aim

2.1 To have evidence-based guidelines, policies and SOPs for management and practice that are fully reviewed every three years, unless changes in practice, national guidance or clinical risk issues necessitate earlier or later review.

2.2 SATH NHS Trust Maternity Services provide up-to-date, evidence-based care aimed at positively influencing patient outcomes, developed, and supported by recognised professional and national advice. This is an evolving process, interlinked with training, education and in response to clinical incidents.

2.3 To include the MNVP in the process of updating guidance wherever possible.

3.0 Objectives

3.1 Guidelines, and policies will be written in accordance with the Maternity Guidelines Template (Appendix 2) SOPs will be written in accordance with the Trust SOP template (Appendix 3).

3.2 Guidelines, policies and SOPs will be evidence-based and where possible supported by local and national guidance.

3.3 Guidelines, policies and SOPs will be reviewed and updated following notification from Audit that planned review is due or new guidance has been issued, or notification from Governance, or any group identified in the Women's Risk Management Strategy.

3.4 Relevant parties for each document will be consulted during the development or updating process.

3.5 Guidelines, policies and SOPs will be subject to a two week wider consultation period before being presented to the relevant governance committees for ratification.

3.6 Training needs will be addressed through inclusion in the Training Needs Analysis following consultation with the Clinical Education Midwife, and through the Maternity Governance structure as outlined in the Women's Risk Management Strategy.

3.7 New documents will be substituted for outdated documents and this information will be disseminated to all relevant parties.

3.8 Guidelines, policies and SOPs will be dated and securely archived.

4.0 Definitions

4.1 **Policy:** A formal document adopted by the Trust setting out the boundaries within which action will take place and reflecting the philosophy of the department. It provides a prescribed plan for staff to follow, which should not be deviated from.

4.3 **Guideline:** A systematically developed, evidence-based document to assist clinicians and service users to make decisions about appropriate treatments or actions for specific circumstances. They allow deviation from a prescribed pathway according to individual circumstances and where reason can be clearly demonstrated and documented.

4.4 **Standard Operating Procedure (SOP)** A written instruction describing a standardised process on a procedure including responsibility of individuals to achieve uniformity of the performance of a specific process.

4.5 **Website officer:** This is usually the Guidelines administrator but can be a member of the Trust Clinical Audit team in the absence of the Guidelines Administrator.

5.0 Process

5.1 Style and Format

Guidelines, policies, and SOPs will be written in accordance with the Maternity Guidelines Templates (see Appendix 2).

5.2 Review

- Guidelines, policies, and SOP's will be reviewed every three years, unless changes in practice, national guidance, or if clinical risk issues (Including serious incidents and Audit) necessitate earlier review.
- When new national guidance is issued the Guideline midwife will work alongside the audit team and will be responsible for benchmarking Maternity guidelines alongside guidance i.e. NICE or RCOG and identify any variations and changes to practice.
- The planned review date will be incorporated on to the front sheet of each document.
- In cases where the scheduled review identifies that no change is required, the Guideline midwife will present the document to the Maternity Guidelines Group (MGG) with the recommendation that the document does not require updating at that time, if the committee is agreement, then the guideline will be presented to Maternity Governance for formal ratification.
- In some circumstances it may be necessary to extend the full review date due to pending publication of National guidance. This will be reviewed and approved by the Head of Midwifery/Guideline midwife, Administrator MGG and Guideline Lead.
- Where changes are required to wording, format and/or layout there is no need to re-ratify the document **if the changes do not change practice.** However, these changes should be presented at the Maternity Governance Committee meeting as 'information only', for full transparency and oversight.
    - In these circumstances a newer version will be disseminated with the appropriate version numbering to reflect this. i.e. version 3 with no change to practice will be known as version 3.1 and so on
    - When changes are then made which do show a change in practice this version 3.1 will become version 4 after ratification.

5.3 Documentation and References

- Guidelines, policies, and SOPs will be evidence-based and where possible supported by local and national guidance (e.g. NICE/RCOG/RCM). Up to date references will be included.
- The overarching guidelines list is updated throughout the process and guideline position status is presented to Maternity Governance monthly.

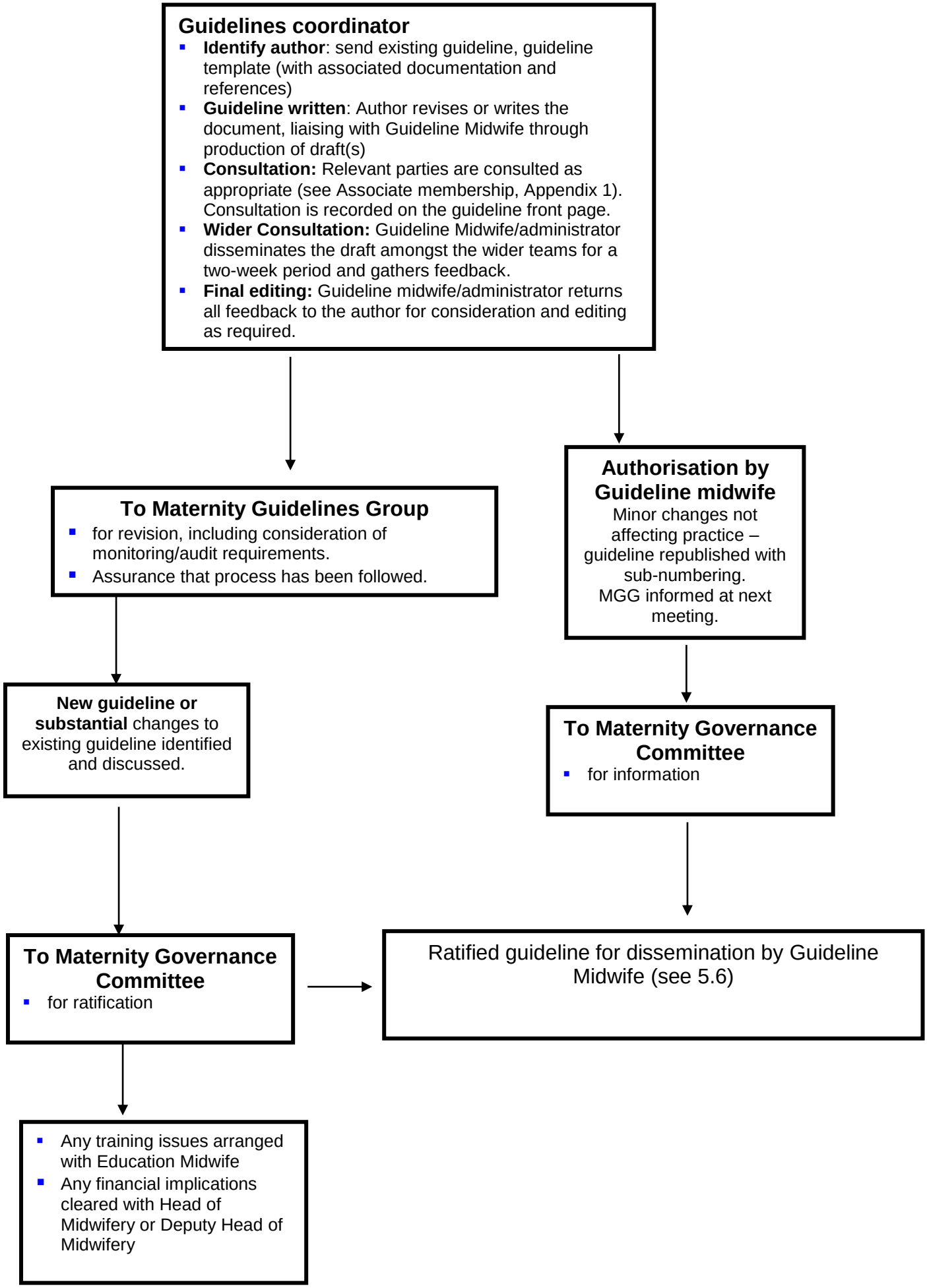
5.4 Maternity Guidelines Group Meeting

Chaired by the guideline midwife, the monthly guideline meeting aims to provide oversight and assurance on the status of guideline reviews and updates. See Appendix 1 for terms of reference and membership details.

5.5 Extraordinary Approval

In circumstances where a guideline need changing urgently, for example where a clinical incident has occurred, the Divisional Director, Clinical Director, or Head of Midwifery (or Deputy) has the authority to approve any guideline changes. Details of consultation and reason for extraordinary approval will be documented on the version control/history box on the front page of each document in addition to an extraordinary approval form (see Appendix 4). These forms will be kept by the guideline administrator.

5.6 Ratification process (including Consultation)



Guideline ratified as in Section 5.5

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Document checked by Guidelines Administrator and Guideline Midwife

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Guideline is uploaded to the Intranet Document Library by Website Officer. Superseded document archived within intranet database system.

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A poster is compiled by the Guideline midwife listing the uploaded guidelines and key updates to note including updates in progress. This poster informs where the guideline can be accessed and the date of implementation.

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The poster is distributed by email to all maternity staff. Staff are also informed via ward safety huddles, notices in ward areas and Mandatory Study days.

6.0 Training

Staff who write or update a document will be assisted to prepare the document according to this guideline by the Guidelines Coordinator.

7.0 Monitoring/Audit

This Guideline is being monitored by the Head of Midwifery.
The guideline midwife is responsible for monitoring and ensuring all policies and guidelines follow the process set out in the framework, with oversight from the Head of Midwifery.

8.0 Reference

SaTH Clinical Guidelines Policy. Shropshire and Telford Hospitals NHS Trust.

Appendix 1
Terms of Reference and Membership

Group	Function	Frequency	Required Attendance for Quorum	Required individual attendance	Relevant Attendees
Maternity Guidelines Group	• To provide strategic oversight • To ensure a planned approach to develop, review and approve guidelines. • To review RAG status of Maternity Guidelines. • Receive and action recommendations made for guideline/SOP amendments. • Seek assurance that guidance is benchmarked against national guidance. • To agree actions arisen from Maternity Incident Review Meetings. • To ensure updated and new guidelines and SOPs are communicated to staff. • Monitor compliance of guidelines and SOP's and take measures to address non-compliance. • A formal approach to archiving guidelines and SOP's • To minute all meetings.	Monthly (Min 9 per annum)	The presence of a chair Guideline midwife (chair)/ Deputy Representation from 5 staff members Audit and Information Development Coordinator/ Deputy	50% with nominated deputy for absence	<u>Membership</u>: • Head of Midwifery / Deputy Head of Midwifery • Guidelines Coordinator Midwife • Clinical Education Midwife or deputy/PEF • Maternity Matrons • Ward/MLU managers (at least 2) • Maternity Digital Midwife • Lead Obstetrician for Guidelines • Quality governance representation • Consultant Midwife • Guideline Administrator • Professional Midwifery Advocate • MNVP representative • Guideline/SOP lead <u>Associate Membership</u>: • Clinical Director • Specialist Midwives • . • Pharmacy Link • Trust Librarian Representative • Neonatal Representative • Any other professional as appropriate to individual guidelines

Appendix 2
Guideline Template

The Shrewsbury and Telford Hospital NHS Trust

This document can be used as a template into which you can write/update your guideline or please liaise with guidelines midwife(s) if any queries. This italic text can then be deleted.

Guideline title

VERSION (*Insert version no.*)

Lead Person(s)	**:**	
Division	**:**	Women and Children's
First implemented	**:**	
This version implemented	**:**	
Planned Full Review	**:**	
Keywords	**:**	*Choose words you would use to find document*
Written by	**:**	
Consultation	**:**	
Comments	**:**	References to SaTH Guidelines in the text pertain to the latest version of the Guideline on the intranet. Printed copies may not be the most up to date version.

Version	Implementation Date	History	Ratified By	Review Date
1				
2				
3				
4				

1.0 Introduction

This is the rationale for the document.
Why is it needed?
What local or national drivers are there to its development or updating?
What references need to be given?
Try to do in 3 or 4 points.
1.1
1.2

2.0 Aim(s)

This is the over-arching 'want to achieve'.
Focus on what you want to achieve for women, babies, and providing guidance for midwives for health care professionals.
2.1

3.0 Objectives

These need to be specific, achievable and measurable, so that if someone asks us to prove we are doing this, we can show it.
3.1
3.2

4.0 Definitions and/or objectives

Define any frequently used abbreviations or terms needing explanation.
4.1

5.0 Process

In logical order, as would be followed in practice, describe what is done, when and by whom.
Consider subheading, especially if process is long.
Consider diagrams/flow charts as appendices for clarity and to reduce description.
5.1
5.2

6.0 Training

State how midwives and other relevant staff will be trained to implement the guideline.
6.1

7.0 Monitoring/audit

Audit statement as appropriate.

8.0 References

Appendix 1
Appendix 2

Appendix 3
SOP Template

Standard Operating Procedure (SOP)

SOP Title			
SOP Number			
Division	Women and Children's		
Version Number			
Effective Date		Review Date	
Author			
Approved by			
Approval date			
Distribution			
Location	Maternity Services		

Document Control				
Version	Date	Author	Status	Comments

SOP Objectives	
Scope	
Performance Measures	

Number	Brief	Responsibility

The Shrewsbury and Telford Hospital NHS Trust

Appendix 4

Maternity Guideline Extraordinary Approval

Details of the guideline being changed			
Name of Guideline:			
Ref No		Current version number	
Lead:			
Date of Implementation		Date of Information Poster	
Person giving Extraordinary Approval: (please circle)	Head of Midwifery/ Deputy Head of Midwifery Divisional Director		
Print Name:	Signature:		Date:

Details of changes affecting practise:
Why this is required to be changed? (If known) i.e SI, HRCR, DATIX
Any further comments?

OFFICE USE ONLY	
Job Ref No:	
Further information:	