Clinical Guideline Development in Maternity

Summary statement: How does the document support patient care?	The purpose of this document is to provide guidance for the development and quality monitoring of clinical guidelines within maternity services to ensure care is provided according to national best practice standards.
Staff/stakeholders involved in development:	Clinical Governance Lead Clinical Effectiveness Team
Division:	Women and Children's
Department:	Maternity
Responsible Person:	Chief of Service
Author:	Clinical Effectiveness Team
For use by:	All staff involved in the development and quality monitoring of clinical guidelines in Maternity.
Purpose:	To provide clear guidance on the standards for development & monitoring of clinical guidelines for Maternity.
This document supports:	UH Sussex Clinical Guidelines CQC Fundamental Standards
Key related documents:	uhstw001-policy-for-the-development-and-management-of-trust-policies.pdf
Approved by:	Joint Obstetric guideline Group
Approval date:	20th December 2023 Date uploaded: 20th December 2023
Ratified by Board of Directors/ Committee of the Board of Directors	Not Applicable – Divisional Ratification only required
Ratification Date:	Not Applicable – Divisional Ratification only required
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If you require this document in another format such as Braille, large print, audio or another language please contact the Trusts Communications Team	
Reference Number:	UHS-CG-0021-2023

Version	Date	Author	Status	Comment
1.0	Dec JOGG	CE Team	LIVE	New Trust wide guideline replacing: • MP081 Guideline for producing protocols (Legacy East) • CG15026 Maternity Clinical Guideline Development Legacy West)

Contents

Maternity Clinical Guideline Development

1.0 Introduction

This document provides guidance on the development, review and update of clinical guidelines. Policies, SOPs and patient information documents in University Hospitals Sussex.

This document applies to all staff involved in the development, review and monitoring of clinical guidelines and patient information within UH Sussex West Maternity department and should be read in conjunction with the current UH Sussex uhstw001-policy-for-the-development-and-management-of-trust-policies.pdf

1.1 Abbreviations used within this guideline

UH Sussex - University Hospitals Sussex	**JOGG -** Joint Obstetric Gynaecological Guideline Group
NICE - National Institute of clinical Excellence	**RCOG -** Royal College of Obstetricians and Gynecologists
SOP- Standard Operating Procedure	**TMC -** Trust Management Committee
ICB - Integrated Care Board	

2.0 Roles and responsibilities

The key roles with responsibility for Clinical Guideline and Patient Information Development and Quality Monitoring within Maternity are as follows:

Chief of Service - The Chief of Service has overall responsibility for fostering a climate in which quality and safety is recognised as an integral part of Maternity and for ensuring that the Clinical Guideline Development is completed as per the agreed departmental plan, with actions and recommendations acted upon and for communicating these to the Trust Board and Executive Committee.

Maternity Clinical Governance Lead, Head of Midwifery and Obstetric Clinical Director - These roles have an overarching responsibility for monitoring the progress of Maternity Clinical Guideline Development, -for supporting the implementation of agreed action plans resulting from findings and for reporting progress on a regular basis to the Chief of Service.

Joint Obstetric Gynaecological Guideline Group (JOGG) - has responsibility for ensuring that clinical guidelines and patient information reflect local and national best practice recommendations (including recommendations from local and national patient safety, complaints and claims) are developed, regularly reviewed and updated as required as per uhstw001-policy-for-the-development-and-management-of-trust-policies.pdf. JOGG is also responsible for the overall management of the guideline, policy and SOP development and for the guideline status monthly to the Safety and Quality meeting.

Trust Management Committee has overall responsibility for the Divisional ratification of policies.

Medicines Governance Committee - has responsibility for approving guidelines that contain medicines for the Trust and report to UH Sussex Clinical Outcome and Effectiveness Group, and the Patient Safety Group.

3.0 Process for development, review and update of clinical guidelines and patient information documents

Pre-existing guidelines, policies, SOPs and patient information documentation require review and update every three years and a database of expiry dates is maintained and managed within the JOGG meeting to identify those due for update six months prior to date of expiry.

This nominated reviewer has responsibility for management, development and reviewing against NICE guidance and other national recommendations, therefore learning or new best practice information which require early update of a clinical guideline or patient information document can be readily identified and actioned.

Where review or development of new guidance is identified from new national or local guidance or learning, or where guidelines or patient information documents have reached their three yearly review period, the previous document author or reviewer or other key stakeholder is contacted and requested to undertake review and update/develop the guideline or patient information document.

The Library Service staff can assist with literature searching on request at KnowledgeShare.

References should be cited using the Harvard referencing style, for example:

Pears, R. and Shields, G. (2019) *Cite them right: The essential referencing guide.* 11th edn. London: MacMillan.

Following a local review, any guideline put forward for approval that identifies the service has deviated either positively or negatively with regards to NICE guidance, will be put forward to the Safety & Quality Meeting and will be monitored via the Risk Register. They will also need to be escalated to the Quality Review Group, chaired by the Integrated Care Board.

The process is as follows:
(See Appendix 1)

3.1 Stage 1a - For update or three yearly review

Using the UH Sussex guideline template of the current guideline or patient information document in Word format, the nominated document author should review the previous document and any new national or local information to identify any amendments or alterations required. Alterations and amendments should be made and highlighted text and the

guideline/patient information version in the footer updated to reflect the new version. Either a DRAFT watermark can be added or the footer marked as DRAFT until the guideline is fully completed before moving to Stage 2.

3.2 Stage 1b - For development of new guidance

The nominated author should review current local and national best practice relevant to the topic in question and other clinical guidelines that may be associated with the new guidance. Using the UH Sussex guideline/patient information template they should write the first version of the guideline/patient information document ensuring that version 1 is identified in the footer and DRAFT watermark added or footer is marked as DRAFT until the guideline is fully completed before moving to Stage 2.

3.3 Stage 1c – Escalation of review

When the author is allocated a guideline/policy/SOP to review, the CE Team will send a draft for the author to review and give a date for it to be completed by.

If the agreed timescale is not achieved and the guideline/policy/SOP expires without satisfactory communication with reasons for why is not received, the Governance Lead will escalate this to the clinicians line manager. The line manager is responsible for following up with the clinician.

Outcomes may be as follows:

- A new timeframe for completion of the protocol is agreed with the Governance Lead.
- If a new timeframe is agreed but not achieved the Governance Lead will escalate this to the Line Manager and the Head of Midwifery and Clinical Director.

3.4 Stage 2 – Consultation and agreement

If specialist trainee is reviewer they must ensure educational supervisor has reviewed before submitting for wider circulation.

Once the new DRAFT document is completed by the author, the author should circulate to relevant stakeholders for comment including any cross speciality guidelines/policies/SOPs eg neonatal, pharmacy. Once comments have been actioned and all questions answered, the final draft should be submitted to JOGG.

This will then be circulated to the JOGG membership ideally two weeks before the JOGG meeting.

3.5 Stage 3 - Additional Approval Process

Guidelines/Policies/SOPs/Patient information that discuss medicines, should be submitted to the Medicines Governance Committee via TRELLO for review and approval by the Trust. If there are significant changes as a result of this, the guideline/policy/SOP may need to return to JOGG.

Joint neonatal and maternity guidelines need to go to the Neonatal and Maternity Guideline Review Meeting (SRH&WH) for neonatal approval.

Any delay with the processes which fall outside of the department should be raised to the appropriate leads within the department concerned i.e. clinical director, chief pharmacist etc

3.6 Stage 3 – Divisional/Board ratification – polices only

Policies that have agreement to proceed for TMC ratification following discussion at JOGG meeting should have any highlighted text changed to black and are forwarded to the next TMC Meeting.

Any guideline put forward for approval that identifies the service has deviated either positively or negatively with regards to NICE guidance, will be put forward to the Safety & Quality Meeting and will be monitored via the Risk Register. They will also need to be escalated to the Quality Review Group, chaired by the Integrated Care Board.

Policies, guidelines or SOPs that require further development following discussion at JOGG or Divisional level should be returned to the nominated author for amendment with comments. The relevant meeting chair will recommend if the document requires a further consultation period or if minor amendments can be made. They will also recommend if the document requires re submission to JOGG, the TMC Meeting or Trust Board if it can be ratified through Chairs Action.

3.7 Stage 4 – Dissemination

Policies, guidelines or SOPs that have completed Stage 3 with agreement and ratification should have DRAFT watermark or Draft in the footer removed. The document will then be converted to PDF format and uploaded to the relevant staff access point eg Trust intranet or OneShare and the previous version of the document archived.

On a monthly basis notify the Clinical Outcomes and Effectiveness Team of amended/new guidelines, policies or SOPs.

4.0 Process for quality monitoring of clinical guidelines and reporting

Guidelines, polices and SOPs are monitored via a rolling programme managed within the framework of the monthly Joint Obstetric Guideline Group.

Guidelines, policies, SOPs and patient information documents are required to conform to up to date best practice standards of care and reflect the recommendations and quality monitoring metrics where available, from national organisations such as NICE - clinical guidelines and quality standards, RCOG green top guidance, etc.

Patient information documents should be reviewed by Maternity Voices Partnership (MVP) and Carer and Patient Information Group (CPIG) for user friendliness.

References

Department of Health (2005) Promoting Equality and Human Rights in the NHS – a guide for non-executive directors of NHS Boards. Department of Health and Social Care - GOV.UK (www.gov.uk)

NHS Digital (2016). Records Management Code of Practice for Health and Social Care 2016. Home - NHS Digital

Care Quality Commission (Regulations) Care Quality Commission (cqc.org.uk)

Equality Act 2010 Legislation.gov.uk

uhstw001-policy-for-the-development-and-management-of-trust-policies.pdf

Appendix 1: Maternity guideline review & approval responsibilities

Step 1a & b

Clinical Effectiveness (CE) Team -

- CE Team will send a draft for the author to review and give a date for it to be completed by.

Reviewer -

Check national guidance:

- Does the guideline topic already exist in NICE?
- RCOG / RCoA or other professional body (NMC, GMC etc. relevant to topic).
- Think LMS – is there a regional guideline to facilitate standardisation?
- If specialist trainee is reviewer ensure educational supervisor has reviewed before submitting for wider circulation.
- Review relevant patient information and any existing links in the document to ensure they are up to date.
- Circulate draft to relevant stakeholders and ensure all comments and questions are answered prior to sending final draft to Clinical Effectiveness Team.

Is this a guideline that crosses other Dept. or Divisions?

- **If yes**: co-author with other Department (e.g. neonates, pharmacy)
- Ensure it is shared with other Dept/Divisional leads that this guideline crosses (i.e. neonates).
- C&W Pharmacist to be asked to review any guidance that contains medicines.

Step 1c

Clinical Effectiveness (CE) Team -

- If there is no acknowledgement by the author allocated to review the document after three attempts to contact the reviewer by the CE Team, this will be escalated to the Clinical Governance Lead.
- If a document expires without the review being completed this will be escalated to the relevant Lead eg Clinical Governance Lead, Clinical Director, HoM.

Step 2

Reviewer -

- Submit Draft version to Clinical Effectiveness Team, with changes clearly marked.

Clinical Effectiveness (CE) Team -

- CE Team will circulate via email to Joint Obstetric Guideline Group (JOG) members for comments pre-JOGG meeting 2 weeks.
- CE team adds to JOGG agenda for approval.

Reviewer -

- Author presents a summary at JOGG meeting and answers questions from the JOGG members.
- Group decides if changes accepted or whether further amendments required.

Step 3

Clinical Effectiveness (CE) Team -

- Guidelines approved at JOGG will be finalised by the CE Team.
- If indicated, document is taken for further approval eg Neonatal & Maternity Guideline Review meeting or Medicines Governance Committee (MGC) post JOGG.
- List of approved guidelines for each month submitted to Maternity Safety & Quality meeting (this feeds upwards to divisional governance meetings).
- Policies for Divisional ratification post JOGG approval should be submitted to the next TMC Meeting.

Clinical Governance Lead -

- Guidelines that deviate from NICE, should be put on the Risk Register by Safety & Quality Meeting and ICB notified.

Step 4

Clinical Effectiveness (CE) Team -

- CE team completes approval process audit trail and uploads to the relevant staff access point eg Trust intranet or OneShare and ensure the previous version of the document archived.
- Updates can also be shared via staff newsletter, summaries emailed to staff, staff facebook page, safety board and safety huddles.
- CE team to notify Trust Clinical Outcomes and Effectiveness Team of amended/new guideline.

Appendix 2: Due Regard Assessment Tool

To be completed for Polices and placed at the end of the document.

To be used to analyse the effect of your policy or service on the protected groups in equality law, resulting in either:

1. Removing or minimizing disadvantages suffered by people due to their protected group characteristics (i.e. age, race/ethnicity, disability, gender reassignment/identity, sex, sexual orientation, marriage & civil partnership, pregnancy, maternity/paternity, religion/ belief, human rights).
2. Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
3. No further action required.

Click link for due regard assessment tool:

uhstw001-policy-for-the-development-and-management-of-trust-policies.pdf

Appendix 3: Template dissemination, implementation and access plan

The checklist MUST be completed for any Policy. The completed checklist MUST be submitted to the TMC with the final document.

	Dissemination Plan	Comments
1.	**Identify:**	
	• **Which members of staff or staff groups will be affected by this policy?**	
	• **How will you confirm that they have received the policy and understood its implications?**	
	• **How have you linked the dissemination of the policy with induction training, continuous professional development and clinical supervision as appropriate?**	
2.	**How and where will staff access the document (at operational level)?**	

		Yes/No	Comments
3.	**Have you made any plans to remove old versions of the policy or related documents from circulation?**		
4.	**Have you ensured staffare aware the document is logged on the organisation's register?**		