## **Terms of reference template**

*The terms of reference define the purpose and structure of the review team. This template outlines the key components of a terms of reference document, with some sample text included. The terms of reference will be developed by the maternity clinical governance group and should be completed in line with local DHB process and policy.*

### Background

1. The New Zealand Maternity Standards require that district health boards (DHBs) develop and support an ongoing systematic review process, where local multidisciplinary teams work collegially to identify ways to improve services and care.
2. Maternal morbidity reviews are quality improvement initiatives that allow teams to identify ways to improve systems and processes to reduce maternal morbidity. Through reviews, maternity teams learn, share and understand issues to minimise future cases of maternal morbidity.
3. Reviews provide an opportunity to explore how the maternity service responds to women with serious and acute conditions and to identify how to make improvements.
4. Reviews also provide an opportunity to highlight where systems and processes have worked well and have been of high quality. This information enhances learning, creativity, innovation and improved resilience.

### Function

1. The review team’s functions are to:
	1. review selected cases of maternal morbidity to identify the range of factors that may have affected the woman’s care, and either directly or indirectly contributed to the event or the severity of the event
	2. consider whether inequities existed in relation to the maternal morbidity event and identify how these occurred and how they may have impacted the event and the outcomes of the event
	3. develop recommendations to reduce the negative factors that may have contributed to the maternal morbidity event and to promote the positive factors that help to prevent or reduce the severity of the event
	4. seek feedback on the draft findings and recommendations from the woman, her family and whānau, and the clinicians immediately involved in her care, and make any necessary adjustments to the findings and recommendations
	5. report the confirmed findings and recommendations to the maternity clinical governance committee for their endorsement, and delegation of actions.

### Scope

1. The multidisciplinary review team reviews cases of maternal morbidity that have been triggered through the maternity service case review trigger tool or through incident notification (rated Severity Assessment Code (SAC) 3 or 4).

### Composition

1. The review team will comprise:
	1. a hospital midwife
	2. an LMC representative
	3. an obstetrician (may or may not be the clinical director)
	4. a charge midwife
	5. the maternity quality and safety coordinator, who has links to the wider DHB quality and safety team
	6. an experienced maternity consumer
	7. a Māori consumer
	8. representatives of other ethnicities (refer to section 4.4 in *Maternal morbidity review toolkit for maternity services: A foundational document*).
2. The review team should include appropriate cultural representation to help address the physical, social, emotional and spiritual wellbeing of all concerned.
3. Chair and Deputy Chair
	1. The review team will appoint a Chair and a Deputy Chair. The Chair is expected to preside at every meeting of the review team at which they are present unless they deputise their responsibilities to the Deputy Chair.
4. In smaller DHBs there may be times when it is beneficial to involve a member of the review team from a neighbouring DHB to contribute to an objective review.

### Member roles and responsibilities

1. Each member of the review team will:
	1. ensure the security and confidentiality of personal information
	2. read the case summaries (these will be provided in advance of the meeting)
	3. *(for clinical members only)* present a five-minute synopsis of a case at the meeting (this requires time for preparation in advance of the meeting with access to the clinical notes)
	4. discuss care provision and develop a consensus opinion as to what worked well and where there were opportunities to improve systems and processes.
2. Chair and Deputy Chair
	1. The Chair will manage the review discussion, ensure that all members of the team contribute and are heard during the discussion, and assist the review team to come to a consensus. They will ensure that the review team focuses on systems and processes, what worked well and where improvements could be made.
	2. The Chair will confirm with the review team that the draft findings of the review and recommendations are correct by circulating them within two weeks of the meeting.
	3. The Chair will ensure the DHB process is followed to present the draft findings/ recommendations and consider feedback from the woman, her family and whānau, and clinicians directly involved. If any significant changes are required these would need to be confirmed with the review team.
	4. The Chair sends the confirmed findings and recommendations to the maternity clinical governance committee for endorsement and action.

### Meetings

1. *Specify the venue, timing and frequency of the meetings, as well as the meeting format and core principles.* It is anticipated larger DHBs will schedule relatively frequent, regular meetings (eg, monthly), while smaller DHBs may schedule them less often. *Example text is included below:*
2. Meeting will occur once a month, on a date that suits the majority of the review team. Meetings will follow a standard format:
	1. Each review meeting should open and close in a culturally appropriate manner – for example, use of a karakia.
	2. Each case review will begin by reading/listening to a narrative of the woman’s reality when available.
3. The review team will use the tool provided in the maternal morbidity review toolkit, which is a modified version of the expanded London Protocol, and should apply HEAT questions 1–3 to consider whether inequalities existed in the woman’s care.
4. The review meeting will follow these key principles.[[1]](#footnote-1)
	1. Reviews consider the context in which the service was provided, and the focus is on learning and improvement.
	2. Reviews consider the context in which the service was received, and the social determinants of health.
	3. Reviews are based on evidence and knowledge of best practice.
	4. Reviews will be conducted with respect and compassion to the woman, her family and whānau, and the clinicians directly involved in her care.
	5. Reviews and recommendations must be focus on the system, not on individuals.[[2]](#footnote-2) The HEAT questions 4–8 will assist when developing the recommendations and actions.[[3]](#footnote-3)

### Terms and conditions of appointment

*The terms and conditions of appointment are to be decided in line with DHB process and policy.*

### Management of conflicts of interest

*The process to manage conflicts of interest should be developed in line with DHB process and policy. Example text is included below:*

1. Members must perform their functions in good faith, honestly and impartially and avoid situations that might compromise their integrity or otherwise lead to conflicts of interest.
2. When members believe they have a potential conflict of interest on a subject that will prevent them from reaching an impartial decision or undertaking an activity consistent with the review team’s functions, they must declare that conflict of interest and withdraw themselves from the discussion and/or activity.

### Confidentiality to be decided

*The maintenance of confidentiality is crucial to the functioning of a review team.*

*Specific confidentiality requirements must be developed in line with DHB process and policy.*

### Remuneration

1. Members of the review team not employed by DHBs will be paid in line with the Cabinet Office Circular CO (12) 6 (Group 4, level 2).

### Review of the terms of reference

1. The maternity clinical governance committee will review the terms of reference two years from the date at which they are approved by the governance group.
1. Key principles of adverse clinical reviews presentation by Dr J Carthey, human factors and patient safety expert. Unpublished presentation. [↑](#footnote-ref-1)
2. System-focused recommendations are stronger and include identifying how to standardise care and simplify pathways. Person-focused recommendations are weak and include developing guidelines and reminder memos. [↑](#footnote-ref-2)
3. Signal L, Martin J, Cram F, et al. 2008. *The Health Equity Assessment Tool: A user’s guide*. Wellington: Ministry of Health. URL: [www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf](http://www.health.govt.nz/system/files/documents/publications/health-equity-assessment-tool-guide.pdf) (accessed 15 October 2018). [↑](#footnote-ref-3)