TERMS OF REFERENCE

MATERNITY SERVICES QUALITY & SAFETY PROGRAMME (MQSP) FORUM

PURPOSE

- To support the service, Hauora Tairāwhiti Clinical Governance Committee and multidisciplinary clinical teams to monitor and manage standards of clinical care to ensure they are of a high quality and safe
- To require, support and facilitate formal clinical governance and clinical practice improvement processes in Hauora Tairāwhiti
- To monitor and review systems, standards, indicators and outcomes which reflect the quality of clinical care provided within the service
- To monitor and oversee regional and local activities associated with:
    - The National Maternity Quality and Safety Programme
    - The National Maternity Standards
    - Maternity Service Specifications
    - Section 88 (Referral Guidelines)
- To provide a forum in which decision making and responsibilities for the quality of care are shared between clinicians, managers and consumer leaders
- To report these activities to the Clinical Governance Committee
- To manage the risks of care

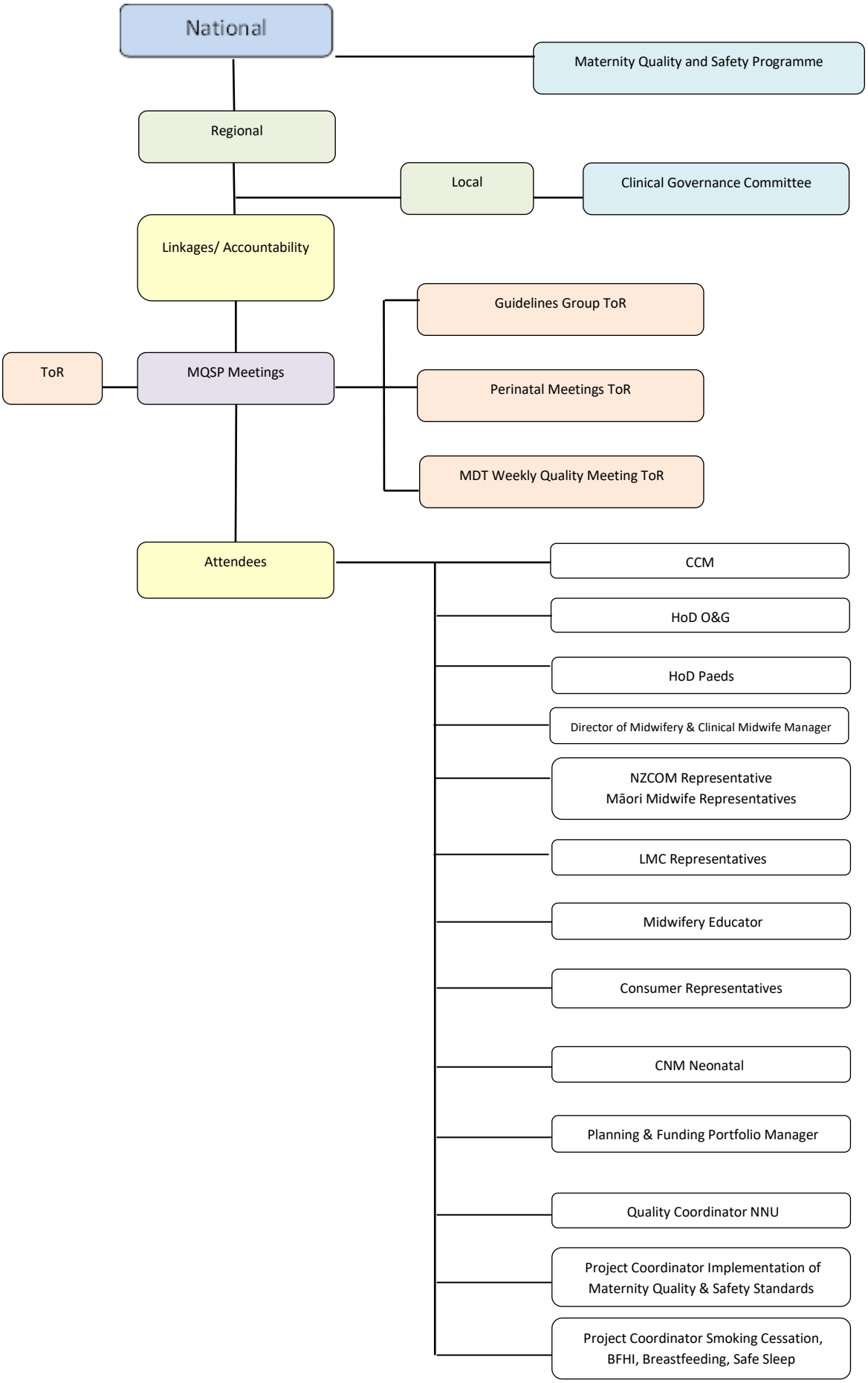
CONSTRAINTS

- The Forum must act to support Organisational and Service goals
- The Forum must uphold compliance with legislative and standards requirements as well as contractual obligations.
- Legislative responsibilities for action may lie outside the delegated authority of the Forum and its members. Issues of this regard must be clearly documented in communication to those who hold the responsibility to act*
- Forums will escalate issues beyond their authority to Hauora Tairāwhiti Clinical Governance or relevant Clinical Care Manager (CCM) or Clinical Director (CD) of Women Child & Youth (WCY) in the first instance
- Forum activities must support the Organisational and Service Risk plan

CHAIRPERSON

- CCM/DOM

STRUCTURE of MQSP



REPORTS

- Annual Report submitted to Hauora Tairāwhiti Clinical Governance annually.
- Reports of Clinical Governance and Quality Improvement activities conducted by Service multidisciplinary clinical teams will be reviewed by the MQSP Forum. These activities may include but are not limited to:
    - Serious Event Reviews
    - Morbidity and Mortality reviews (Perinatal reviews)
    - Clinical Audit
    - Peer Review and Appraisal
    - Clinical Practice Improvement activities
    - Protected Quality Assurance Activities (PQAAs) – e.g. (Case review from Adverse event)
    - Incidents and Complaints
    - Clinical Indicator Review
    - Retrospective Clinical Record Review
    - Development and achievement of Service Risk plans

- Midwifery Educator and Quality Coordinator will provide reports to the Forum on service incidents, complaints, Serious Event Reviews, Health and Disability Commissioner's (HDC) reports, Accident Compensation Corporation (ACC) reports, Occupational Health and Safety (OH&S) issues and consumer satisfaction surveys
- Recommendations and actions from the MQSP Forum will be actioned by relevant forum members
- Appropriate items will be escalated to the Clinical Governance committee and the CCM/CD in the form of a risk plan for their consideration
- Information and direction will be communicated to multidisciplinary clinical teams through relevant members of the Maternity Quality and Safety Forum
- New Born Hearing Screening report presented quarterly

OBJECTIVES AND PRIORITIES

The broad objectives for the MQSP Forum are to:

- Oversee all quality improvement, quality assurance and risk management activities within the Maternity Services
- Oversee the Service Risk Plan and the strategies to achieve the deliverables in this plan
- Priorities for the forum as determined by the Clinical Governance committee will be:
    - Serious Event Reviews
    - Clinical Indicator Reviews
    - Review of other Incidents and Complaints
    - The National Maternity Quality and Safety Programme
    - The National Maternity Standards
    - Maternity Service Specifications

Specific objectives of the MQSP Forums will include the following:

Consumer involvement

- To encourage consumer participation and engagement in order to maintain and improve the quality of care provided by the Service. Consumer representatives will disseminate to key consumer representative groups in the community as agreed by Forum.
- To be involved with the annual consumer satisfaction survey and present results at MQSP Forum.
- To receive information on complaints, consumer satisfaction surveys, ACC and HDC reports
- To feedback on these reports to multidisciplinary teams through clinical quality forums

Clinical Quality Evaluation and Improvement

- To review outcomes of Serious Event Reviews and Root Cause Analysis (RCAs). To endorse and monitor implementation of Serious Event Review panel recommendations. To table RCA recommendations and actions.
- To monitor and analyse trends from incident reporting and make recommendations to reduce recurrence of incidents (corrective action)
- Ensure that all clinical policies, procedures and guidelines of the facilities regarding the provision of maternity and neonatal services are developed, reviewed or updated through multidisciplinary consultation within prescribed time frames.
- Review quarterly women's compliments and comments, and Consumer Satisfaction Surveys, face to face or phone feedback and suggestions, and propose changes/ implement actions as necessary/appropriate.
- To review outcomes and recommendations from Morbidity and Mortality reviews and to endorse and monitor implementation of these recommendations
- To set audit priorities and schedules. To review audit outcomes. To endorse and monitor implementation of audit recommendations
- To monitor Peer Review and Appraisal
- To monitor Clinical Practice Improvement activities
- To monitor Retrospective Clinical Record Reviews
- To monitor and review national reports e.g. National Maternity Monitoring group with Clinical Indicator and PMMRC reports
- To review the key areas for improvement and make recommendations for change through clinical quality forums
- To monitor service specific requirements issued by the Ministry of Health

Clinical Risk

- To review clinical risks as defined in the Service Risk Plan
- To oversee Protected Quality Assurance Activities for the service and ensure bi-annual reports are made to the Ministry of Health
- To identify appropriate methods to correct, eliminate or reduce identified risks '
- Maternity Quality and Safety Forum members are to disseminate recommendations to clinical quality forums

Professional development and management

- To promote opportunities for professional development which support excellence in clinical care
- To monitor professional development and the maintenance of professional standards
- The MQSP Forum will ensure that an annual Continuing Education and Quality Plan is available for all Maternity and Neonatal Practitioners. An annual report of education will be available to the MQSP Forum by the end of January.

FREQUENCY OF MEETINGS

- Monthly unless agreed by the Forum except over the winter period.

MEMBERSHIP

The membership of the Forum must be multidisciplinary and have sufficient authority to require change within the service when required.

Core members:

- Clinical Care Manager Women, Child & Youth (Chair)
- *Director of Midwifery (Vice Chair)
- *Clinical Director Obstetrics
- *Clinical Director Paediatrics
- *Clinical Nurse Manager NNU
- NZCOM representative
- *Lead Maternity Carer (LMC) representative
- Midwifery Educator
- *Consumer Representatives
- *Core Midwife
- Māori Midwife representative
- Quality Co-ordinator NNU
- Project Coordinator: BFHI, Smoking Cessation, Safe Sleep

*Denotes members that must provide a delegate if not available to attend.

Members for minutes/occasional attendance as possible:

- Consultant Obstetricians
- Consultant Paediatricians
- Te Puia Springs Midwives
- Clinical Director Anaesthetics
- GP Liaison
- Audiologist and New Born Hearing Screening Coordinator

QUORUM

Not less than 50% of the core membership plus the Chair or Vice Chair (13 core members) = minimum of 5 plus chair/vice chair. If a quorum is not achieved, the meeting may go ahead but decisions and recommendations will be emailed to all members for agreement, progression and action prior to next meeting.

The committee has the power to co-opt relevant individuals as identified as necessary for decision making by the committee. The committee may invite other individuals for a specific meeting/s, or part thereof, where it is considered necessary for decision-making.

REVIEW DATE

- Forum role and terms of reference to be reviewed annually
- Subsequent review date to be determined on this date.

RESOURCES

- Forum Secretariat services are to be provided by an administrator from within the service.
- The Service Quality Coordinator or designated role (DHB specific) will be responsible for coordination of standing and ad hoc reports and analysis of these (as outlined in Section 5. of these Terms of Reference) and facilitating follow up on action points, as directed by the Forum.

FOOTNOTE:

"Where the Forum considers a clinical activity which is covered by regulation or legislation, the responsibility for actions may lie outside the Forum members. Such responsibility shall be clearly identified in Forum minutes and / or communication to the relevant Hauora Tairāwhiti manager or staff member. Note that the Forums act on the basis of their advocacy and the delegations implicit in their membership but when they are confronted with issues of significance which cannot be resolved through implicit delegations, they will escalate to the relevant management of DHB. Recommendations arising from legislative and/or external compliance reviews are particular examples of requirements that may exceed delegations."

"MQSP Forum members shall be aware of confidentiality issues. When a sensitive item is being discussed, the Chair shall identify it as an 'in committee item', on the agenda and the issue should not be discussed outside of the meeting unless released at the meeting by way of resolution."

Authorised By
Maternity Services Quality & Safety Forum Chair

Authorised By
Director of Midwifery

Terms of Reference Drafted: **July 2018**
Terms of Reference Reviewed **November 2018**
Terms of Reference to be reviewed: **3 yearly**