Salisbury NHS
NHS Foundation Trust

TERMS OF REFERENCE

Perinatal Mortality & Morbidity Meeting

The Maternity and Neonatal Services recognise the need to review any cases that have resulted in poor or unexpected outcomes for either mother or baby related to the antenatal period and through the postnatal / neonatal period.

It requires close co-ordination between midwives, obstetricians, neonatologists, neonatal nurses and ultrasonographers.

This is achieved through regular multi-disciplinary review meetings to discuss perinatal mortality, morbidity and pathology.

Aims

- To review recent cases focusing on those, which resulted in perinatal mortality or morbidity including near misses (see Maternity Risk Management Reporting Trigger List)

- To provide a forum for multi-disciplinary discussion and learning

- To provide a forum to discuss the recommendations of MBRRACE, other National Confidential Enquiries and relevant national or local documents.

- To develop an increased knowledge and understanding of high risk obstetric and neonatal complications.

- To provide a forum to recognise the need for changes to practice and to forward learning points to the relevant maternity and neonatal governance groups for action.

- To serve as the forum to inform completion of both Stillbirth (MBRRACE)and RCOG 'Each baby counts' and Child Death (CPOD) review paperwork.

Membership

Meetings are multi-disciplinary and open to all interested health care professionals. The meetings will uphold an environment of mutual respect for personal and professional opinions expressed with the aim of interprofessional learning. They are held monthly and representatives from the following disciplines are expected at every meeting.

- Obstetricians
- Paediatricians
- Midwives
- Neonatal Nurses
- Ultra-sonographers (as appropriate to the individual cases)
- Anaesthetists (as appropriate to the individual cases)

A record of attendance will be kept and members will be required to sign the attendance sheet at each meeting.

The meeting with be jointly chaired by a Consultant for both Obstetrics and Paediatrics.
The meeting will be considered quorate when a minimum of 2 consultant obstetricians and 2 consultant paediatricians are present.

It is expected that the consultants will send apologies direct to the chair person when they are unable to attend the meeting.

Meeting format
Meetings will consist of:

(1) Case Reviews
(2) Informal Discussions
(3) Presentations of topics related to Perinatal mortality and/or morbidity
(4) Guest presentations as appropriate
(5) Follow up of cases from previous meetings subsequent to Paediatric or obstetric reviews and assessments

An anonymised record of cases presented and multiprofessional discussions will be kept along with any relevant presentations. Recommendations for changes in practice or guidelines may be presented to the Maternity Governance Forum for ratification.

Unresolved cases
In the rare case where those present cannot reach a clear agreement of appropriateness of care delivery, the case will be reviewed outside the meeting by a panel that includes as a minimum:
Consultant paediatrician - lead for neonates
Consultant obstetrician - labour ward lead
Postnatal and neonatal services manager
Labour ward co-coordinator
Risk Manager

This panel will again review the presentations of the case, if at this stage they cannot agree the appropriateness of care then escalation to the Trusts Risk Manager and the Executive Lead for Risk should be undertaken by the Head of Midwifery or the Maternity Risk Manager.

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