Dorset County Hospital NHS
NHS Foundation Trust

Policy Title	Mortality Review Policy and Process		
Policy Number	**1595**	**Version number**	**1**
Applicable to	All staff within the Trust		
Date first issued	April 2017		
Date current version issued	August 2017		
Next review due date	September 2020 (unless further guidance or Legislation is issued)		
Author's name and title	Mandy Ford Head of Risk Management Neal Cleaver Deputy D.O.N and Quality Becky Protopsaltis Patient and Public Engagement Lead		
Development group/committee	(Previous) Hospital Mortality Surveillance Committee (Current) Hospital Mortality Surveillance Group		
Stakeholders	Medical Director Director of Nursing/Quality Divisional Director Divisional Head of Nursing/Quality Consultants Non-medical Clinicians Risk and Legal department Patient Experience team		
Approved by (committee name)	Hospital Mortality Surveillance Group		
Date approved	July 16th 2017		
Ratified by (committee name)	Quality Committee		
Ratified on	August 22nd 2017 (with minor amendments)		
Keywords	Mortality, morbidity, death, review,		

Document Management Section (if applicable)			
Previous policy number		**Previous version number**	
Changes requested or dictated by			
Description of changes since last version			

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Executive Summary

Policy title	Mortality and Morbidity Review Policy and Process
Purpose	To enable learning from deaths as part of quality improvements by setting out the process to ensure a consistent and coordinated approach for the review of all deaths in hospital.
Applicable to	All clinical staff within the Trust and staff related to risk management and patient and public engagement.
Aim of policy	The aim of this policy is to ensure: • a consistency of approach to the review of patient mortality within the Trust; and for that approach to be multi-disciplinary as appropriate • the families and relatives to be involved in determining the terms of reference for the review if they choose to do so. • the outputs of any such reviews are clearly documented, fed in to the appropriate committees and archived for future audit. • clear reporting mechanisms are in place, to escalate areas of concern identified by Hospital Mortality Surveillance Group (HMG) meetings so that the Trust is aware and can take appropriate action.
Main features	Provides information on the review process for deaths that occur whilst in Hospital.
Policy lead	Paul Lear, Medical Director
Development group	Hospital Mortality Surveillance Group (previous committee)

1 Introduction

1.1. Concern about patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures that have taken place over the last few years. There is an increased drive for NHS Trust boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

1.2. The Care Quality Commission (CQC) published its review Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. (2016). The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

1.3. The National Quality Board issued National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts in Identifying, Reporting, Investigating and Learning from Deaths in Care in March 2017. The guidance aims to ensure that nationally health care organisations endeavour to identify degrees that a death is avoidable and to embed learning from consistent structured reviews of the events which led to death.

1.4. The standards expect providers to have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken. This is detailed in this policy and supplemented by Clinical Guideline number 1376 Policy and procedure following the death of a service user.

1.5. The Board should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This will allow them to identify any areas of learning for clinical care and ensure the delivery of safe care. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership, quarterly mortality reporting to the Board at the public section of the meeting with data suitably anonymised, and outputs of the mortality governance process including investigations of deaths being communicated to frontline clinical staff and reported in the annual Quality Accounts.

1.6. The Trust has had in place a mortality review process for a number of years. The need to take account of trends highlighted by hospital mortality indicators is included in this policy. The notes of every patient who dies at the hospital will be examined to establish if there were any aspects of their care that could have been better (this process is described in section 2.6). They are also being checked to ensure information about the patient's care and underlying medical condition are clearly and accurately recorded.

1.7 There are a number of specialties undertaking Mortality and Morbidity Reviews Meetings (M&M meetings) across the Trust; the aim of this policy is to ensure a consistent approach for undertaking and learning from M&M meetings.

1.8 The National Guidance indicates that deaths must be investigated where:

- The patient is recorded as having learning disabilities.
- The patient is recorded as having mental health issues (guidance states anyone deemed as not having capacity).
- All cases where death was unexpected.
- All cases in which there is an alert of high Summary Hospital Mortality Indicator (SHMI): this will be an on-going variable.
- There has been a Serious Untoward Incident (SUI) during the spell of care.
- Issues have been identified with a service from information provided or gathered by the Care Quality Commission, NHS England or Healthcare Intelligence and Quality Improvement (CHKS).
- Where bereaved relatives and carers, or staff, have raised a significant concern, formally or informally, about the quality of care provision.
- A sample of deaths (1 in 4) that fit into none of the above categories.

1.9 Deaths in hospital of patients under the age of 18 years and maternal deaths are excluded from this process document because they are reviewed under other established Trust processes but learning and outcomes of these reviews are fed through to the HMG. The Terms of Reference is attached for information as Appendix D.

1.10 The HMG will meet on a bi-monthly basis and will review the findings of the clinical reviews undertaken and identify any learning. A register of attendance will be maintained. The learning will be disseminated at Divisional Governance meetings. The HMG will include Divisional Directors and Division Heads of Nursing as members. The HMG will report to the Quality Committee and the Trust Board.

1.11 Regular review of the Trust's mortality review process will be carried out to ensure the effectiveness of the process, that any patterns and changes in mortality data are investigated and reported appropriately and to meet the need to continuously improve the review processes to maximise learning and improve care to patients.

1.12 From 01.10.2017 reviews will include all unexpected patient deaths within 30 days of discharge or contact with hospital services where admission was deemed unnecessary.

2 Aim and Objectives of This Policy

2.1 The aim of this policy is to ensure:

- a consistency of approach to the review of patient mortality within the Trust; and for that approach to be multi-disciplinary as appropriate
- that families and relatives are included in determining the terms of reference for the review if they choose to do so.
- the outputs of any such reviews are clearly documented, fed in to the appropriate committees and archived for future audit.
- clear reporting mechanisms are in place, to escalate any areas of concern identified by HMG meetings so that the Trust is aware and can take appropriate action.
- The policy applies trustwide but mortality reviews are operational at division level.

2.2 This policy describes the process to ensure a consistent and coordinated approach for the review of all deaths in hospital. Changes to governance structures that support this process have been included in this document.

2.3 This policy recognises the need to consider mortality rates and national mortality indicators, available at diagnosis and individual patient level, to ensure that deaths are reviewed and patients are safe.

2.4 The aim of this process is to identify any areas of practice, both specific to the individual case and beyond that where care could be improved, based upon peer group review. Any areas of good practice will also be identified and shared across the Divisions.

2.5 The process will ensure that there are clear reporting mechanisms in place, in order that areas of concerns can be identified and escalated, so that the Trust is aware and can take appropriate action.

2.6 **Mortality Review Process**

- There will be 2 reviewers per death (1 X Doctor and 1 Non-Medical Clinical Professional)
- Additional pool of clinicians to give specialist opinions as required (e.g. Surgeons, respiratory, gastroenterology etc.)
- Access to external reviewers as required
- Use Royal College of Physicians Structured Judgemental Review form **https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources**
- Reviews should be completed within 2 weeks of death
- Where there is significant disparity between reviewer's outcomes, a third review may be required

Please note: if the death forms part of a Serious Incident, there may also be a need to complete a Route Cause Analysis in line with the existing Trust processes. This may include reporting to external agencies.

If the death is deemed avoidable, the case will be heard at the Trust Learning from Incidents Panel.

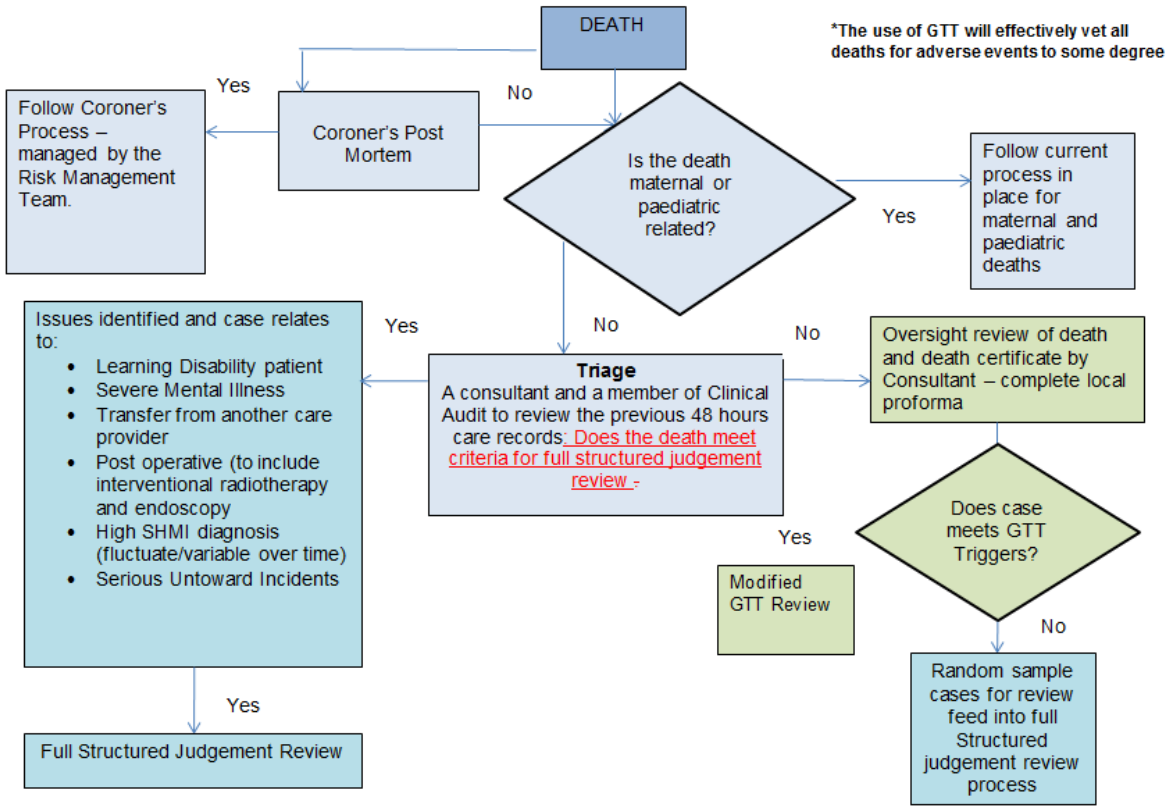
Triage Process

- Case notes reviewed by a consultant and clinical audit or Senior Nurse within 48 hours of death
- All reviewers to be trained in the use of Structured Judgement Review
- Death certificates to routinely be added to patient records
- All cases will be triaged

Alternatives to Global Trigger Tool (GTT)

- Use locally agreed components of GTT (hybrid DCH GTT)
- Random selection of case notes following death for those that do not meet the criteria

Flowchart for Mortality Review Process



2.7 The following deaths should be reviewed:

- All in-hospital deaths will undergo initial triage by a doctor and nurse/AHP on the next working day.
- All deaths as per National Guidance (vide supra 1.8 and 1.12).
- All in-hospital complications, misadventures as identified via the clinician or via the Datix reporting system.
- All deaths in electively admitted patients (except in cancer and haematology).

- All deaths in 'Low Risk Mortality Diagnosis Groups' as per Dr Foster Mortality data.
- All other deaths as per terms of reference for each M&M meeting.
- Emergency Department Deaths, with the exclusion of those patients who are dead on arrival (DOA) – unless they have had recent (within 30 days) contact with our services.
- Cases subject to inquest, where the Trust is likely to be at fault.
- All children (see 2.10).
- All maternal deaths automatically undergo a full Route cause Analysis style investigation.

2.8 The following should also be considered by HMG:

- Any related feedback from inquests.
- Any internal or external peer review of cases or benchmarking data.
- Any other issues attendees wish to raise, and themes identified and any learning.

2.9 Mortality review in neonates and children:
Since 1st April 2008, Local Safeguarding Children's Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such responsibility is enshrined in the Children's Act 2004 and applies to all children under 18 years of age. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children, and to prevent future deaths.

3 Who This Policy is For

3.1 This policy applies to anyone engaged in the mortality review process under the authorisation of the Trust, including locums, agency, students and staff.

4 Definitions, Legislation and Guidelines

4.1 Definitions:

Avoidable/Preventable	These terms are used interchangeably in the NHS and for the purpose of this policy 'preventable' or 'unpreventable' will be used with reference to whether anything could have been done differently to change the outcome.
Complication	An additional problem that arises following a procedure, treatment or illness and is secondary to it/ complicates the situation.
Dr Foster Intelligence	Dr Foster works with healthcare organisations to achieve sustainable improvements in their performance through better use of data.
Death certification	Deaths by natural causes are certified by the attending doctor. Trainee doctors are encouraged to discuss the cause of death and

	the certification details with their consultant prior to completing the certificate. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. The report should be made via email on the linked form available on the intranet.
Global Trigger Tool (GTT)	A chart review process which involves looking for triggers; stop medication order /abnormal laboratory result which may indicate an adverse clinical event.
Healthcare Intelligence and Quality Improvement (CHKS)	CHKS is a leading provider of healthcare intelligence and quality improvement services.
LeDeR	An established and well-tested methodology for reviewing the deaths of people with learning disabilities. All deaths of people with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer. The LeDeR programme currently operates independently of, but communicates and cooperates with, other review and investigatory processes.
Mortality	For the purpose of M&M meetings, mortality relates to any deaths within 30 days of procedure within a surgical specialty or any in hospital unexpected death for non-surgical specialties.
Mortality & Morbidity Meetings (M&Ms)	A multi-disciplinary group who review and discuss clinical cases, outcome data (clinician and patient reported) and related information (e.g. SIRI, complaints, and any other benchmarking data). For the purpose of this policy this includes Radiology Discrepancy. Joint M&M/ Audit meetings may be held as audit plays an important part in the M&M process. If these are separate meetings, there will need to be an agreed process for ensuring the findings from both are shared across the Divisions and services and that any actions identified are suitably co-ordinated.

Misadventure	Any injury or adverse reaction resulting from any medical treatment. Some examples are medication errors, IV infection, surgical mistakes and postoperative septicaemia.
Mortality review	A process in which the circumstances surrounding the care of a patient who died during hospitalisation are systematically examined.
Serious Incident Requiring Investigation (SIRI)	An accident occurring on NHS premises that resulted in serious injury, and or permanent harm, unexpected or avoidable death.
Structured Case Record Reviews	A weekly list of all deaths in the Trust is produced by the Information Department 4 weeks after the week in which the patient died. This allows time for the records to go for coding and to be scanned onto the electronic patient management system.
Summary Hospital Mortality Indicator (SHMI)	Reports on mortality rates at individual trust level across the NHS in England using a standard and transparent methodology. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

4.2 Legislation and Guidelines

National Guidance on Learning from Deaths	National Quality Board March 2017
Using the structured judgement review method	Royal College of Physicians 2016
Learning, candour and accountability	Care Quality Commission December 2016
INQUEST's report on the CQC Family Listening Day	INQUEST (Truth, Justice and Accountability) October 2016
Incident Reporting Policy	Trust Policy August 2017
The Coroners (investigation) Regulations 2013	Statutory Instrument 2013 No 1629
Serious Incident Framework	NHS England March 2013

5 Equality Impact Assessment

5.1 The completed assessment for the policy is attached as Appendix A.

6 Privacy Impact Assessment

6.1 The PIA Screening Questionnaire is attached as Appendix B.

7 Stakeholders and Consultation

7.1 Staff from Divisions A and B and the staff that sit on the Mortality Review Group.

8 Roles and Responsibilities

The Trust Board has the overall responsibility for gaining assurance that the National Guidance on Learning from deaths is in place, delegating the implementation to the Chief Executive. The designated Non-Executive Director will ensure there is understanding of the processes, champion quality improvement through any required actions and ensure scrutiny and publication of associated information. The Chief Executive has designated the Medical Director as the Executive Director lead.

8.1 The Medical Director will:

- assure the Board that the mortality review process is functioning correctly
- be responsible for ensuring the implementation of the M & M review process and for providing an overarching framework for the Trust Board
- ensure that arrangements are in place so that all clinical staff as appropriate are aware of their responsibilities to contribute to the process.
- review external mortality data sources and coordinating rapid mortality reviews.
- ensure Bimonthly Hospital Mortality Surveillance Group (previous committee) mortality review meetings are held to corporately review lessons learnt
- offer advice to colleagues involved with the mortality review process
- chair the Trust HMG
- arrange for the cases graded as a concern by the first multi-disciplinary review (based on the grading system provided on the RCP structured judgement review forms) to be referred for discussion at the HMG
- raise any identified risk onto the Trust Risk Register where it will be reviewed as part of the risk management process
- ensure that external mortality alerts are investigated and any associated concerns are resolved
- ensure that any actions identified in relation to mortality review are recorded, progressed and monitored appropriately
- feedback learning points identified from the mortality review process.

8.2 Divisional Management team under direction of the Divisional Director will**:**

- ensure that all specialties record every death
- ensure that appropriate reviews are undertaken which adhere to the policy and follow the flow chart
- ensure that departments escalate the learning from speciality morbidity and mortality meetings to HMG to facilitate dissemination of learning
- ensure that the findings from mortality review are reported and discussed as part of the Divisional Governance process, to demonstrate compliance with Care Quality Commission (CQC) Regulation 17 'Good Governance'

8.3 Specialty Governance Leads will:

- be responsible for the dissemination of RCP structured mortality review forms for all deaths within the specialty
- ensure that these are completed by nominated consultants. Individuals reviewing cases for which they had sole clinical responsibility should be avoided; ideally, the case should be reviewed by an independent consultant.
- retain a copy of the completed mortality review forms within the specialty.
- ensure that regular specialty mortality meetings are held to review all deaths, keeping a summary of the cases discussed, the findings and the management plan agreed upon. This summary should include the avoidable and unavoidable factors implicated in the death (template is available)
- ensure escalation to HMG of key learning from Speciality mortality meetings
- receive feedback and learning points from the HMG and ensure learning outcomes and action points are included in the specialty governance audit plans as appropriate
- share outcomes within the specialty and at divisional governance meetings
- ensure that the specialty fully investigates mortality alerts as directed by the Medical Director (Chair of HMG) and the HMG.

8.4 Reviewers will:

- review cases **within two weeks of receipt of the case notes** using the Royal College of Physicians Structured Judgemental Review form (https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources)
- the combined review reflects the shared judgement of a doctor and a nurse /AHP.
- grade the management of inpatient care as indicated on the Trust mortality review form based on any concerns highlighted
- return the completed mortality review form to their Governance Lead
- use the Trust incident reporting system (Datix) to report incidents identified during mortality review to enable review as part of the risk management process.

8.5 The Bereavement Team will:

- identify all deaths

- ensure the cause of death is recorded in the case notes of all patients
- ensure that whether a post mortem has been requested or not is recorded in the case notes of all patients
- for deaths referred for post mortem the Bereavement Team will send the case notes to Pathology for post mortem, before the mortality review process begins
- issue a bereavement card to the relatives informing them that the Trust is committed to learning from deaths and as such the records of their relative may be selective for formal review. Should they wish to participate in this review they should contact the PALS department to express this wish and they will be contacted in the case of formal review.

8.6 Clinical Audit will:

- receive a weekly list of in-hospital deaths from Information Services
- receive a weekly list of post mortems from Pathology to link with other mortality data, and request post mortem reports for in-hospital deaths on behalf of the specialty at death to aid completion of the mortality review form
- retain copies of all completed mortality review forms and maintain a log of the forms received and the review result category
- provide updates to specialties, divisions and the HMG on participation rates for mortality review and support in the identification of any gaps
- ensure that any death which has been identified as a concern (based on the grading system on the mortality screening tool form) is recorded centrally and that any in-depth review by the specialty using the 'RCP structured review form' is reported through to HMG
- provide support to clinicians with any questions regarding the process
- provide monthly mortality trend data from Healthcare Evaluation Data (HED) to the HMG
- map monthly patient level data provided by HED mortality indicators against the hospital mortality data and ensure that possible concerns are forwarded to the HMG
- support the Medical Director (Chair of HMG) in the preparation of bi-monthly reports for Trust Board and the Quality Committee.
- provide mortality data and prepare reports to meet the Trust's board, divisional, performance and commissioner reporting requirements.

8.7 The Hospital Mortality Surveillance Group (HMG) will:

- oversee specialty mortality review structure, process and actions
- capture and respond to external and internal mortality trends
- ensure cross divisional learning from mortality review
- ensure the board and executive is informed of mortality outcomes and trends
- discuss cross specialty and cross divisional issues relating to mortality review and develop action plans where appropriate.

8.8 Medical staff:

- All medical staff are required to proactively participate fully in the M&M process, Morbidity and Mortality figures form part of annual appraisal process

- All clinical staff are expected to participate fully in all M&M meetings, including those in other trusts where applicable, that are relevant to their practice. This should be integrated in future appraisal and accreditation processes.

8.9 Nurses, allied health professionals and other clinical staff:

- All healthcare professionals should be involved in M&M reviews, as part of their clinical practice.
- This involvement could range from simply being aware of the outcome of such reviews insofar as they affect their area of practice, to full involvement in the production of data and implementation of recommendations.

8.10 Patient and Public Engagement Lead will:

- ensure that where concerns regarding care have been raised formally or informally (and it is not an incident or Serious Incident (SI), the issues raised by the families/carers/patient representative are fed through to the investigation team and form part of the terms of reference for the review
- act as liaison between the Trust and the person raising the concerns
- ensure that the person raising the concerns receives a response and an opportunity to meet with the Trust if they wish to do so.

8.11 Head of Risk Management and Quality Assurance will:

- ensure that where issues have been identified as a SI or Never Event that a full investigation is completed in line with risk management processes.
- ensure that cases are discussed at the learning for Incidents Panel where the death is deemed avoidable
- liaise with the Coroner's office
- where the death is subject to litigation, that the appropriate processes are adhered to
- ensure that the Duty of Candour process is completed.

9 Dissemination

9.1 This policy document will be approved by the Trust Hospital Mortality Surveillance Group, and all Specialty Governance Leads will be informed that the document has been updated and available to view on the intranet. The policy will be held in the public section of the Trust external website.

9.2 The Clinical Audit Team will co-ordinate the processes covered by this policy, on behalf of the Medical Director (Chair of HMG), and will ensure that all those involved in the process are aware of their responsibilities and the requirements of the policy.

10 Training and implementation

10.1 This policy will be implemented by the Divisional Directors in conjunction with the Medical Director and Clinical Audit, with relevant support and training provided by the Royal College of Physicians in conjunction with NHSI.

10.2 This Mortality and Morbidity Review Policy does not have a mandatory training requirement or any other training needs.

11 Monitoring and Reviewing Arrangements

11.1 Each M & M Group should identify and confirm with the Clinical / Speciality Lead the following:

- Chairperson
- Terms of reference
- Frequency of meetings, ideally should be monthly
- Membership (multi-disciplinary and multi-professional)
- Working arrangements of specialty M&M groups and frequency of joint meetings if applicable
- Reporting arrangements with other Quality / audit groups within the Trust.
- Arrangements for minutes / notation
- Mortality inclusion/exclusion criteria for routine patient case note review
- Morbidity (e.g. complications and misadventures) 'inclusion/exclusion' criteria for routine patient case note review.
- Mortality Review Template to be used
- Completion of M&M review templates and collation of finding, learning points and actions from each meeting
- Storage and retrieval of minutes in line with Information Governance Policies
- Reporting arrangements including the escalation of concerns to the Medical Director. These will be reviewed at a bi-monthly Hospital Mortality Surveillance Group.

11.2 The Executive Medical Director will oversee the monitoring of this policy.

11.3 Key performance indicators will be:

- Each division/speciality will hold M&M meetings, and have agreed terms of reference
- Minutes of meetings will be available for each division/speciality
- All areas of concern will be escalated to the Medical Director.

12.3 Process and timescales for monitoring compliance:

- Each Division will provide an annual report to the Quality Committee summarising the findings of reviews carried out and actions taken as a result of lessons learnt.

12 Policy Content

12.1 The policy details the mortality review process and provides guidance on when and how this will happen.

13 Approval and Ratification

13.1 This policy and process will be ratified at the Quality Committee.

Appendix A

EQUALITY IMPACT AND COMPLIANCE ASSESSMENT

1. General

Title of document	Mortality and Morbidity Review Policy and Process
Purpose of document	This policy recognises the need to consider mortality rates and national mortality indicators, available at diagnosis and individual patient level, to ensure that deaths are reviewed and patients are safe.
Intended scope	To cover patient deaths as indicated within the document.

2. Consultation

Which groups/associations/bodies or individuals were consulted in the formulation of this document?	Patient Experience Clinical Audit
What was the impact of any feedback on the document?	Document amended with feedback
Who was involved in the approval of the final document?	**Hospital Mortality Surveillance Committee Quality Committee**
Any other comments to record?	

3. Equality Impact Assessment

Does the document unfairly affect certain patients, staff or groups of staff? If so, please state how this is justified.	No
What measures are proposed to address any inequity?	Not applicable
Can the document be made available in alternative format or in translation?	If required

4. Compliance Assessment

Does the document comply with relevant employment legislation? **Please specify.**	Yes, as detailed within the document.

5. Document assessed by:

Name	
Post Title/ Position	
Date	

Appendix B

Privacy Impact Assessment Screening Questionnaire

Project/Policy/Procedure Title: Mortality and Morbidity Review Policy and Process

Project Lead: Paul Lear, Medical Director Date: April 2017

	Assessment Question	Yes	No
1	Does the project/policy/procedure use or suggest new or extra technologies that will have a greater impact on privacy?		X
Comments:			
2	Is the justification for the new data-handling unclear or unpublished?		X
Comments:			
3	Does the project/policy/procedure involve an additional use of existing identifier?		X
Comments:			
4	Does the project/policy/procedure involve use of a new identifier for multiple purposes?		X
Comments:			
5	Does the project/policy/procedure involve new or substantially changed identity authentication requirements?		X
Comments:			
6	Will the project/policy/procedure result in handling of significant amount of new data about each person, or significant change in existing data-holdings?		X
Comments:			
7	Will the project/policy/procedure result in the handling of new data about a significant number of people or a significant change in the population coverage?		X
Comments:			
8	Does the project/policy/procedure involve new linkage of personal data with data in other collections, or significant changes in data linkage?		X
Comments:			
9	Does the project/policy/procedure involve new or changed data collection policies or practices that may be unclear or intrusive?		X
Comments:			

10	Does the project/policy/procedure involve new or changed data quality assurance processes and standards?		X
Comments:			
11	Does the project/policy/procedure involve new or changed data security arrangements?		X
Comments:			
12	Does the project/policy/procedure involve new or changed data access or disclosure arrangements?		X
Comments:			
13	Does the project/policy/procedure involve new or changed data retention arrangements?		X
Comments:			
14	Does the project/policy/procedure involve changing the medium of disclosure for publicly available information in such a way that data becomes more readily available than it was before?		X
Comments:			
15	Will the project give rise to new or changed data-handling that is in any way exempt from legislative privacy protections?		X
Comments:			
Does the project/policy/procedure require further privacy impact assessment?			X

If the project/policy/procedure does not require any further Privacy Impact Assessment, this document should be signed by the Project Lead/Policy Author and relevant Information Asset Owner.

The project/policy/procedure should state that it is exempt from a Privacy Impact Assessment, and this questionnaire should be kept with project/policy/procedure documentation.

No further Privacy Impact Assessment need.

Signed _____ Date _____
Project Lead/Policy Author

Signed _____ Date _____
Information Asset Owner

Appendix C

Dorset County Hospital NHS
NHS Foundation Trust

Hospital Mortality Surveillance Group (HMG)

Membership
Medical Director – Chair
Chief Executive
Director of Nursing/Quality
Nurse Consultant – Critical Care
Risk representative
Junior doctor representative
Information Department Representative

Divisional Consultant leads:-
Anaesthetist
Acute Physician
Care of Elderly Physician
Respiratory / cardiology Consultant
Emergency Department Consultant
General Surgeon

Attendees
CCG representative
Clinical Coding representative
Divisional Director
Other ad-hoc attendees are invited as required

Quorum
Chair and 5 members (2 non-medical clinicians (minimum x 1 registered nurse) and 3 medical clinicians (minimum x 2 Consultants)

Frequency of meetings
Alternate months on Wednesday PM 16.00- 17.30

Terms of reference
1. To review all in-hospital deaths (by group members) between meetings. To identify lapses in care which have or could have contributed to premature death. Review to include previous admission/E.D. assessment where relevant. To review all such cases at the bi-monthly review.

2. To review the benchmarked mortality rates of the Trust.

3. To investigate any alerts received from the care Quality Commission (CQC) or identified by the Mortality monitoring information systems: Dr Foster, CHKS.

4. To develop data collection systems to ensure the Trust mortality data is timely, robust and in line with national best practice.

5. To ensure that mortality information is linked to consultant appraisals, is accurate, contextual and engenders a culture of clinical excellence.

6. To develop a mortality clinical coding improvement plan and monitor progress on its implementation.

7. To assign clinical leads to address raised mortality in particular areas (see 3).

8. To review and monitor compliance with hospital policies including DNAR and death certification

Reporting

The Hospital Mortality Surveillance Group will report directly to the Quality Committee and the Trust Board.