Torbay and South Devon NHS
NHS Foundation Trust

Mortality Review Policy

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Document Information

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Mortality Surveillance Group		29 September 2017	
Links or overlaps with other policies:			
· Duty of Candour and Being Open Policy · Incident Reporting Policy · Investigation SOP · Inquest Policy · Complaints Policy			
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Amendment History

Issue	Status	Date	Reason for Change	Authorised
1	Ratified	September 2017	New document	Mortality Surveillance Group
1	Ratified	10 November 2017	Uploaded to ICON	Mortality Surveillance Group
2	Ratified	15 December 2017	Appendix 1 amended	Patient Safety Lead
2		26 January 2018	Review date extended from 2 years to 3 years	

CONTENTS

1. Introduction and Background

1.1. There is an increased drive for the Trust Board to be assured that deaths are adequately reviewed and an assessment made of the quality of care and potential for avoiding death. Where necessary, appropriate learning and changes should be made to ensure future patients are at less risk. This in part has been as a result of scrutiny over mortality rates and recently with high-profile investigations into NHS hospital failings.

1.2. These concerns were highlighted by the CQC in December 2016 with the publishing of their report– Learning, Candour and Accountability. The report concluded that carers and families experienced the NHS as not being as open and transparent as it could be, with many opportunities to learn from deaths, that may have been avoided, not being made.

1.3. In May 2017 the National Guidance was published by the National Quality Board detailing the standardised approach expected from providers.

1.4. The National Guidance includes a clear process for review, including a peer review processes that incorporated analysis of mortality and morbidity (M&M) with the aim of improving patient safety. By utilizing the specialty M&M meetings, established to review deaths as part of professional learning, there is the potential to help provide assurance that patients are not dying as a consequence of unsafe clinical practices.

1.5. Concentrating attention on the factors that cause deaths will impact positively on all patients, reducing complications, length of stay and readmission rates through improving pathways of care, reducing variability of care delivery, and early recognition and escalation of the deteriorating patient.

1.6. Retrospective case note reviews help to identify examples where processes can be improved and enhance understanding of the care delivered to those whose death is expected and inevitable to ensure they receive optimal end of life care.

1.7. In summary, systematic, routine, multidisciplinary, mortality reviews can improve accountability of mortality data, support quality improvement programmes and give assurance to hospital boards that patient deaths are not as a consequence of unsafe clinical practices (Higginson et al 2012).

2. Aims & Scope

2.1. The aims of the mortality review process are to:

- Identify and minimise ‘avoidable' deaths in all Trust hospital sites
- Review the quality of end of life care
- Ensure a consistency in the quality of reviews by using the Royal College of Physicians - Structure Judgement Review (SJR)
- Create clear reporting mechanisms through to the Medical Director where any areas of concern can be raised
- Ensure that patients’ wishes have been identified and met wherever possible
- Improve the experience of patients’ families and carers through better opportunities for involvement in communication, investigation and review
- Identify and minimise avoidable admissions or late presentation
- Enable informed reporting , both internal and external, with a recognised and transparent methodology

- Promote organisational learning and patient safety improvement
- Align our internal processes with the standardised approach recommended in the published national guidance
- Publish public monthly mortality data in an easy to understand format

2.2. This Policy relates to all staff groups who may be involved in the mortality review process and includes, but is not exclusive to:

- Medical Staff
- Senior Nursing Staff
- Clinical Coding Staff
- Allied Health Professionals
- Clinical Audit & Effectiveness Staff
- Performance Analysts and Information Team
- Quality Improvement Staff
- Governance Staff

2.3. The mortality review process is *applicable* to:

- All in-hospital deaths in all specialties
- Diagnosis groups identified by CQC/Imperial College Dr Foster Unit
- Diagnosis groups identified by the Mortality Review Committee
- Where necessary any patient/client receiving care from our Trust

2.4. A Trustwide mortality peer review group, the Mortality Surveillance Group (MSG), has been created to ensure:

- Up to 40 randomly selected deaths per month are reviewed centrally (out of approximately 80-120 deaths per month, please see section 8) to ensure trust wide coverage
- Deaths reviews related to inquests, incidents, complaints, physician concerns, or any other relevant source, i.e. RCP score 3 or less, are being undertaken
- Any diagnostic groups that are alerting in the Dr Foster reporting database are reviewed
- Any deaths of individuals with Learning Disabilities, identified Mental Health needs, Infant and child death, Stillbirth or Maternal death are reviewed. This may also be in addition to the speciality M&M review

3. Definitions

3.1. **Mortality rate**: The mortality rate (or death rate) is a measure of the number of deaths that occurred during a particular time period divided by the total size of the population during the same time frame. It is typically expressed in units of deaths per 1,000 individuals per year. The trust will use its own unadjusted mortality data as well as Dr Fosters Hospital Standardised Mortality Ratio (HSMR) and the Department of Health's Hospital Standardised Mortality Index (SHMI)

3.2. **Mortality peer review process**: A structured methodology for retrospective case note review following a patient's death to establish whether the clinical care the patient received was appropriate, provide assurance on the quality of care, and identify learning, plans for improvement and pathway redesign where appropriate.

3.3. **Structured Judgement Review (SJR):** The Structured Judgement Review is an evidence based methodology, created by the Royal College of Physicians, for reviewing the quality of care provided to those patients who die in hospital. A programme of training on this methodology will be delivered by the Royal College of Physicians.

3.4. **Mortality and Morbidity (M&M) Meeting:** A multidisciplinary meeting where mortality (death) and morbidity (the incidence of disease and or complications following treatment) of patients' clinical outcomes are discussed for learning and sharing purposes.

3.5. **LeDeR:** The Learning Disabilities Mortality Review programme will receive notification of all deaths of people with learning disability aged 4 to 74 years of age. The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities. All deaths of people with learning difficulties are notified to the programme.

3.6. **Full case review:**
The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.

4. Roles and responsibilities

4.1. The overall responsibility for the mortality peer review process resides with the Medical Director who will report through the Quality Assurance Committee to the Trust Board.

4.2. **Mortality Surveillance Group (MSG)**

The Mortality Surveillance Group will be responsible for:

- Providing assurance to the Trust Board directly or via the Quality Assurance Committee, on patient mortality, based on review of care received by those who have died
- Agreeing and approving the mortality review proforma (Appendix One)
- Reviewing relevant M&M outcomes, audit data and action plans as necessary
- Receiving and reviewing mortality presentations on cases scoring 3 or below on the RCP SFR metric
- Identifying areas of high risk and agreeing and monitoring improvement plans
- Ensuring that feedback and learning points are shared with the relevant staff within the SDUs and specialties
- Ensuring the mortality governance is maintained and meets the requirements of the recommended evidence based practice.
- Agree the monthly Board Mortality Dashboard (BMD) (see Appendix Two) and the bi-monthly Mortality Score Card (MSC Template – Appendix Three)

Medical Director (MD) or nominated Deputy

The Medical Director will be responsible for:

- Overall oversight and regular review of the mortality peer review process
- Identifying the relevant Clinical Directors, Governance Leads or Directors, to ensure completion of the individual mortality peer review or mortality alert reviews as required, or where coding issues are identified

- Oversight of the reporting dashboard sent monthly to the Trusts' public facing website
- Identify the relevant clinicians for such training as LeDeR, RCP (SFJ), Serious Incident (SI) training

Senior Medical Staff

Nominated Senior Medical Staff (by MD) will be responsible for:

- Ensuring all relevant deaths are reviewed using the mortality review proforma available or the review tools recommended for the specialty patient criteria
- Identifying clinicians to complete the mortality peer reviews and recording findings on the mortality review proforma and enter the RCP score on the mortality database or sent the proforma to the Patient Safety Office
- Ensuring that patients' families and carers are given an opportunity to be engaged with the review process, at an appropriate time and including feedback on the outcomes of the review as appropriate and in line with the Duty of Candour and being Open policy ref 0898
- Ensuring that all pertinent cases and findings from mortality peer reviews are presented by the appropriate clinical leads at specialty Mortality & Morbidity (M&M) meetings and or at the MSG
- Ensuring that outcomes and learning from M&M meetings are recorded and action plans for improvement are developed where required
- Ensuring that findings are evaluated and reported to specialty and SDU governance meetings to promote learning
- Overseeing progress on the implementation of action plans and keeping governance informed
- Feeding back findings from mortality peer reviews and M&M meetings to the MSG
- Ensure any RCP scores of 3 or below are presented at the Mortality Surveillance group and have been subject to a full case review

Senior Nursing Staff/Allied Health professionals/Relevant others

Senior Nursing Staff/Allied Health professionals/Relevant others will be responsible for:

- Participating in mortality peer reviews wherever possible, either in person or by nominated staff being available for advice on nursing or professional practice issues

Clinical Coding Staff

Clinical Coding staff will be responsible for:

- Participating in mortality peer reviews as necessary
- Where coding issues have been identified, rectified and resend the information to the Clinicians involved as well as to the Secondary User Services (SUS)
- Routinely reviewing alerting diagnosis groups in Dr Foster from patient lists provided by the Patient Safety Lead each month
- Provide any feedback relating to any Clinical Coding issues

Performance Analysts

The Performance Analysts will be responsible for:

- Collating the Mortality reporting dashboard monthly for submission on behalf of the Trust
- Ensure the morality reporting dashboard is presented to the Trust Board monthly

Director of Patient Safety & Patient Safety Lead in conjunction with the Patient Experience Team, Litigation Team and embedded Clinical Governance Teams

Director of Patient Safety & Patient Safety Lead will be responsible for:

- Recording known incidents, complaints, inquests and post mortems on the mortality database and any other relevant system e.g. STEIS
- Identify these cases to the relevant specialty leads for mortality review
- Identify with Clinical Coding any Dr Foster alerts and arrange review with relevant specialty teams
- Ensure the reports are fed back into the MSG
- Monitor identified learning outcomes and associated action plans via the Trust Risk Management System
- Ensure there is a process for reporting the death to other organisations who may have an interest
- Ensure the Duty of Candour has been addressed and a Specific Point of Contact (SPOC) has been assigned to a case, where necessary
- Support the families through the process where necessary

Clinical Audit & Effectiveness Team

The Clinical Audit & Effectiveness Team will be responsible for:

- Assisting where necessary in clinical audits concerning mortality

5. Mortality & Morbidity meetings (M&M)

5.1. Participation in mortality and morbidity (M&M) meetings should be considered a core activity for **all** clinicians. Whilst it is recognised that different departments will have different requirements and aims in relation to M&M meetings, the main principles are that they should be a forum for discussion of deaths and other clinical adverse events.

5.2. At these meetings there should be a culture of psychological safety so that there is adequate challenge to clinicians in the care

5.3. The overall aim is to learn lessons from clinical outcomes and drive improvements in service delivery. The M&M meeting has a central function in supporting services to achieve and maintain high standards of care.

6. Clinical coding

6.1. Accurate clinical coding is essential in order that the correct information is collected in terms of activity and outcomes.

6.2. Clinicians and coders need to work as a team to understand how each team understand the data and that the recorded data is in synergy with the coded outcome.

6.3. This is supported as part of the mortality peer review process through clinical coding staff involvement in the individual reviews and mortality alert reviews, guidance for clinical staff on the Trust intranet and other clinical coding training sessions.

7. Process for carrying out mortality reviews

7.1. The process for the conduct of mortality reviews is outlined as below:

Identification of patient deaths requiring review

- Patient deaths are notified through the Bereavement Support Office and/or Patient Safety Team, including post-mortem information where known – these are recorded on the mortality database available via the intranet
- Checks are made by the Governance Team against any incidents recorded on DATIX and these are noted
- At the end of each month, data of all in-hospital deaths that occurred together with incident and post mortem information is forwarded to the Medical Director, Director of Patient Safety, Clinical Directors and Governance Leads via the mortality database
- Local M&M coordinators & relevant others will also collate any relevant deaths for review
- Where concerns have been raised about a patient's care and treatment, i.e. through a Coroners request, incident report or complaint, the mortality review should be carried out as directed by the MSG and used to inform any formal serious incident investigation
- If there is an identified duty of candour issue the mortality reviewers should act according to the guidance in the relevant Trust policy
- Any unexpected death should be notified and reviewed whether or not it is considered an incident

Mortality reviews via M&M

- The relevant M&M coordinators or relevant other should nominate peer reviewers to carry out the mortality reviews
- The reviews should be completed by the nominated peer reviewers and relevant senior nurse who should work together and carry out a holistic review of medical and nursing care
- The findings of the mortality peer reviews should be recorded on the mortality review proforma and entered onto the mortality dashboard directly or by the Patient safety team
- All RCP scores of 3 or less will need a full case note review and presentation to the MSG
- The peer reviewer(s) should ensure that the patients' family and/or carers have been contacted and given an opportunity to be engaged in the review, if necessary, via the single point of contact if the death is subject to any investigation, complaint etc

Outcomes

- Where concerns have been identified but no incident has previously been reported, the appropriate Clinical Governance Coordinator should be informed by the nominated peer reviewer and an incident report with brief details should be raised on DATIX and follow normal process
- In addition, if there are found to be concerns about the standard of care, i.e. RCP score 3 or below, then the case should be reviewed in-depth and presented at the MSG

- Discussions, outcomes and learning from the M&M meetings, including conclusions about outstanding care and sub-optimal care, should be formally recorded and reported to the MSG
- Mortality reviews and in-depth reviews from M&M meetings should be used to inform any subsequent investigations, complaint or legal claim
- Outcomes from the mortality review should be fed-back to the patient's family and/or carers if that is their wish via the SPOC
- If there are concerns about mortality in any particular patient group, (e.g. CQC alert, Dr Foster Unit at Imperial College, elevated SMR for a particular diagnostic group, or global high weekend mortality) it will be necessary to undertake an in-depth case note review

Approval of full case note review

- The need for a full case note review should be approved by the MSG if not already done so at the M&M level. The group should also identify appropriate consultant(s) to undertake the review and the cohort of patients whose care and treatment require review

Dr Foster alerts

Where Dr Foster has flagged a mortality alert and/or once agreed by MSG:

- An appropriate multi-disciplinary group should carry out the review, together with a lead with overall responsibility for the review and writing up the result
- Assessment of clinical coding should be part of the case note review, but the primary focus should be to provide assurance on the quality of care
- The care for each case should be recorded on the Trust mortality review proforma and the score entered onto the mortality database

Reporting findings from full case note review and Dr Foster alerts

- A report should be constructed demonstrating methodology, findings, learning and recommendations
- The identified lead for the review should add appropriate narrative and finalise the report, liaising with the Medical Director/Deputy Medical Director or relevant other for action planning and present the report to MSG
- For Dr Foster alerts a report for the Care Quality Commission will be collated from the findings of the clinical peer review and submitted to the CQC where necessary
- Any subsequent action plans from a CQC report will be approved by the MSG and monitored through to completion by the committee

8. Monthly case note review

8.1. As an assurance mechanism and in place of reviewing all deaths up to 40 randomly selected case notes from Medical patients will be chosen and reviewed over a given month by a bespoke team

8.2. These peer reviews will feedback any findings to the relevant clinicians, M&M meetings and follow the same procedures as previously discussed

8.3. The RCP scores will also be entered onto the mortality dashboard and RCP scores of 3 or below will require a full case note review and presentation at the MSG

9. Feedback to the frontline

9.1. It is recognised that clinicians need to be kept informed of the outcomes of their work if they are to learn and improve. It is therefore essential that there is a mechanism for the outputs of the mortality governance process to be fed back to clinical staff including plans for improvement, lessons learnt and pathway redesign. Each Service Delivery unit must have a system of dissemination of the learning.

9.2. Dashboards showing outcomes at individual / team / ward / department level will be developed and form part of the mortality review reports to SDUs and the Mortality Surveillance Group

10. Mortality Database

10.1. An active database will be maintained on a daily basis. The Bereavement office will enter the detail off the death certificate, into Datix and this is uploaded into the data warehouse. The information from here creates a database of all hospital deaths. The database allows entry of the RCP score and any relevant information.

11. Sharing with other Organisations

11.1. The Trust will implement a process whereby the outcome of any reviews, where significant outcomes are notified to the GPs concerned. Where necessary, the Trust will request a cross-system review which will involve the GP, neighbouring Trusts or ambulance Trust

12. End of Life Care

12.1. Any patient that falls into the specified category that requires a clinical peer review will have the review undertaken whether they are a patient being cared for by the End of Life Care /Palliative Care teams

12.2. The End of life team will be involved with the clinical peer review if relevant

12.3. The results of any review will be shared with the End of Life Care Steering Group

13. References

- NHS England, Mortality Governance Guide
- Morbidity & Mortality Meetings: A guide to good practice, Royal College of Surgeons (2015)
- Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England
- Higginson J, Walters R, Fulop N, *BMJ Qual Saf (2012)*, Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?

- National Quality Board National Guidance on Learning from Deaths

14. Monitoring Compliance with and the Effectiveness of the Policy

Standards/ Key Performance Indicators

14.1. Key performance indicators comprise:

- The number of reported clinical peer reviews per month
- The monthly reported dashboard and RCP score
- The bi monthly Mortality Score Card (MSC)

Process for Implementation and Monitoring Compliance and Effectiveness

The process of clinical peer reviews will be implemented and reported back to the SDUs' M&M Meetings

- All patients in the specialty category, i.e. learning disabilities, identified mental health needs, infant and child deaths and maternal deaths will have a clinical peer review undertaken.
- The monthly reported dashboard will be presented to the Trust Board.
- Any alerting diagnosis groups on the Dr Foster report will have a full clinical peer review undertaken

The process of clinical peer reviews will be implemented and reported back to the SDUs' M&M Meetings

15. Equality Impact Assessment

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age			X	
Disability			X	
Gender			X	
Gender Reassignment			X	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment), marriage and civil partnership			X	
Pregnancy			X	
Maternity and Breastfeeding			X	
Race (ethnic origin)			X	
Religion (or belief)			X	
Sexual Orientation			X	

16. Associated Documentation

- Duty of Candour and Being Open Policy (Ref 2220)
- Incident Reporting Policy (Ref 0848)
- Investigation SOP (Ref 2146)
- Inquest Policy (Ref 0617)
- Complaints Policy (Ref 1473)

Appendix One

M & M Review Proforma

Patient Details Name Age Hosp / NHS number		Lead Consultant: Ward/Area: Date and M&M presented at: Did the patient have a learning disability?	
Admitting diagnosis:		Final diagnosis:	
Date of Admission	Date of death	No of Days in hospital	Ward at time of death:

Using a structured judgement approach please indicate what your **overall** view is of this mortality case was 1. Probably avoidable 2. Possibly avoidable but not very likely 3. Definitely not avoidable	If scores 2 or 3 **no more** information is required. Score ☐ If score is 1, please complete the sections you think are relevant below Score ☐
	Reviewer's name:
	Date of Review :

Score of 1 - Please complete the below sections that are relevant

In the following sections, A - F, and where applicable, please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

If there is any other information that you think is important or relevant then please include.

A	**Phase of care - Admission and initial management with First 24 hours** 1 = very poor 2 = poor care 3 = adequate care 4 = good care 5 = excellent care
B	**Phase of care - On-going** 1 = very poor 2 = poor care 3 = adequate care 4 = good care 5 = excellent care
C	**Phase of care – During a procedure (excluding IV cannulation)** 1 = very poor 2 = poor care 3 = adequate care 4 = good care 5 = excellent care
D	**Phase of care – during perioperative care** 1 = very poor 2 = poor care 3 = adequate care 4 = good care 5 = excellent care
E	**Phase of care –End of Life care** 1 = very poor 2 = poor care 3 = adequate care 4 = good care 5 = excellent care
F	**Phase of care –overall assessment** 1 = very poor 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

v **Assessment of problems, if identified - please tick all that relate to the case**

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1. **Problems in assessment, investigation, diagnosis** Yes o No o
(Including pressure ulcer assessments, falls VTE)
Did the problem lead to harm Yes o Probably o Possibly o No o

2. **Problems with medication/iv fluids/electrolytes/oxygen** Yes o No o
Did the problem lead to harm Yes o Probably o Possibly o No o

3. **Problems in relation to treatment & management plan** Yes o No o
(Including pressure ulcer assessments, falls VTE)
Did the problem lead to harm Yes o Probably o Possibly o No o

4. **Problems with infection control** Yes o No o
Did the problem lead to harm Yes o Probably o Possibly o No o

5. **Problems related to operation / invasive procedure** Yes o No o
Did the problem lead to harm Yes o Probably o Possibly o No o

6. **Problems in clinical monitoring** Yes o No o
Did the problem lead to harm Yes o Probably o Possibly o No o

7. **Problems with resuscitation following an arrest** Yes o No o
Did the problem lead to harm Yes o Probably o Possibly o No o

8. **Any Issues with the TEP form** (Including late TEP) Yes o No o
Did the problem lead to harm Yes o Probably o Possibly o No o

9. **Problems of any other type not fitting the above** Yes o No o
Did the problem lead to harm Yes o Probably o Possibly o No o

Actions – by whom and by when with potential closure date:
1.
2.
3.
4.

Using a structured judgement approach please indicate what your **overall** view is of this mortality case was.

1. Probably avoidable
2. Possibly avoidable but not very likely
3. Definitely not avoidable

Score =	
If score is 1 Date sent to Mortality Group Review	
Reviewer's Name:	

Please send completed M&M proforma to Steve Carr Bowyer Building and to your Mortality Coordinator. The scores will then be included on the mortality database

Appendix Two

Report to	Trust Board
Date	
Lead Director	Medical Director
Report Title	**Mortality Safety Score Card**

Background & Introduction

The indicators for this score card have been collated from a variety of data sources using defined methodology. The sources include Trust data, Department of Health (DH), and Dr Foster, The data in the appendices has in the main been displayed as run charts. The report is generated for various groups and committees including the Board, Quality Improvement Group and Quality Assurance Committee as well as local governance groups.

Data & Graphs – Run Charts

The run charts used are designed to look for *trends* and *shifts* in the data.

Trends: If 5 or more consecutive data points are increasing or 5 or more consecutive points decrease, this is defined as a trend. If a trend is detected it indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of process starting to err.

Shifts: If 6 or more consecutive data points are all above or all below the median this indicates a non-random pattern in the data. This non-random pattern may be a signal of improvement or of a process starting to err.

Information

Dr Foster Hospital Standardised Summary Ration (HSMR) for a full explanation please see the Dr Foster toolkit as below – page 6 gives methodology and explanations.
http://www.drfoster.com/wp-content/uploads/2014/09/HSMR_Toolkit_Version_9_July_2014.pdf

HSMR_Toolkit_Version_9_July_2014.pdf

Department Health: Summary Hospital Mortality Indicator (SHMI): SHMI for a full explanation please see below
https://www.digital.nhs.uk/media/33647/SHMI-FAQs/pdf/SHMI_FAQs

SHMI_FAQs.pdf

Table 1: Torbay & South Devon NHS Foundation Trust Data Sources

Safety Indicator		Data Source	Target	Monthly RAG
Appendix 1 · Hospital Standardised Mortality Rate (HSMR) · Summary Hospital Mortality Index (SHMI)	Mortality	Dr Foster 2015/16 benchmark Month DH SHMI data	Monthly HSMR ≤90	
Appendix 2 · Unadjusted Mortality rate		Trust Data	Yearly Average ≤3%	
Appendix 3 · Dr Foster Patient Safety Dashboard		Dr Foster	All 15 safety indicators positive	

Data Source

The Mortality Score Card (MSC) is based on data from Dr Foster, DH and internal Trust data.

The data is now being expressed for the new Integrated Care Organisation, including all the community hospitals.

Overview – as a guide for possible inclusive data

Appendix 1

This metric looks at the two main standardised mortality tools:
(1A) Hospital Standardised Mortality Rate (HSMR) and
(1B) Summary Hospital Mortality Index (SHMI)
(Data obtained from Dr Foster)

(A) Hospital Standardised Mortality Rate (HSMR) based on the basket of 56 using the 16/17 monthly benchmark

HSMR Measure Aim: to reduce and sustain the quarterly HSMR below a rate of ≤90

A rate above 100 with a ***high relative risk*** may signify a concern and needs to be investigated.

(B) Summary Hospital Mortality Index (SHMI) reporting period xxx

SHMI is derived from Hospital Episode Statistics (HES) data and data from the Office of National Statistics (ONS). SHMI is based upon death up to *30 days* post discharge from hospital and this is the main difference between SHMI and HSMR. The data is released on a **3 monthly basis** and is retrospective; therefore, please note *the following data is from **XXX** data release* and will be different from the dates used on Dr Foster's HSMR.

Appendix 2

Unadjusted death rate as a %
This data looks at the number of deaths in hospitals

This percentage is defined as the monthly unadjusted or 'raw' mortality. It is computed as follows:

Determine the numerator: the total number of in hospital deaths (TD) for the current month (excluding stillbirths and deaths in A & E).
Determine the denominator: the current month's total number of deaths (TD) + live discharges (LD).
Calculate the actual percent monthly-unadjusted mortality by dividing (TD) by (TD + LD) and then multiply by 100.

Chart 1 - Unadjusted Mortality

Chart 2 - Number of deaths

Chart unadjusted mortality by rolling 12 month periods

Appendix 3

Dr Foster Patient Safety Dashboard

These Patient Safety Indicators are taken from Dr Foster and are adapted from the set of 20 devised by the Agency of Healthcare Research & Quality (AHRQ) in the US. The AHRQ developed its indicators after extensive research and they have the benefit of being based on routinely available data which in turn are based on procedure codes used in the NHS.

Table 1 Dr Foster safety dashboard

Mortality Dashboard – See Page 20

Appendix 3 (Continued)

Torbay and South Devon NHS
NHS Foundation Trust

Currently Test Data below

Torbay and South Devon NHS Foundation Trust: Learning from Moratlity Dashboard June 2017

Department of Health

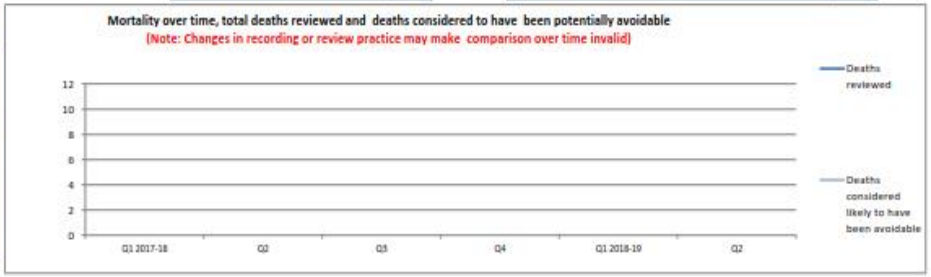
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered to have been potentially avoidable (RCP<=3)	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0	0	0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	0	0	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q2



Total Deaths Reviewed by RCP Methodology Score

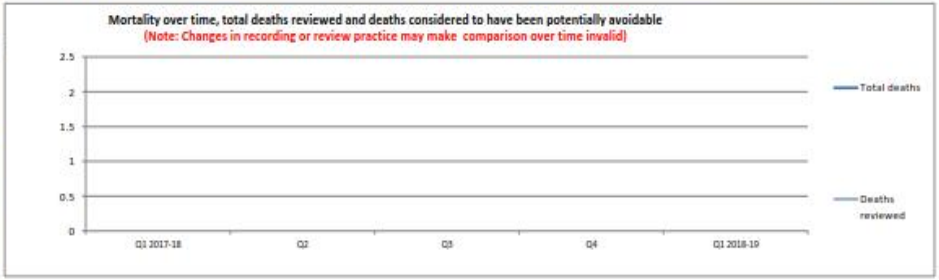
Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	6.7%	This Month	14	93.3%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	4.5%	This Quarter (QTD)	21	95.5%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	4.5%	This Year (YTD)	21	95.5%

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed Avoidable for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered to have been potentially avoidable	
This Month	Last Month	This Month	Last Month	This Month	Last Month
0	0		0	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
0	0	0	0	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
0	0	0	0	0	0

Time Series: Start date 2017-18 Q1 End date 2018-19 Q1



The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

"The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves". (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

NHS South Devon and Torbay Clinical Commissioning Group Torbay and South Devon NHS NHS Foundation Trust

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		**Version and Date**	
Policy Author			

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☐	Other, please state… ☐

Could the policy treat people from protected groups less favorably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐	Sexual Orientation	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐	Religion/Belief (non)	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐	Marriage/ Civil Partnership	Yes ☐ No☐

Is it likely that the policy could affect particular 'Inclusion Health' groups less favorably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Who was consulted when drafting this policy?

Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐
Staff ☐	General Public ☐	Other, please state… ☐

What were the recommendations/suggestions?

Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☐

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION:
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them

Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.

[1] Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
[2] Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
[3] Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
[4] Consider how someone will be aware of (or access) a service if socially or geographically isolated
[5] Language must be relevant and appropriate, for example referring to partners, not husbands or wives
[6] Consider both physical access to services and how information/ communication in available in an accessible format
[7] Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – New Data Protection Regulation (NDPR)

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU New Data Protection Regulation (NDPR) in mind and therefore provides the reader with assurance of effective information governance practice.

NDPR intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy.

Furthermore, NDPR requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data. The most effective way of being open is through data mapping. Data mapping for NDPR was initially undertaken in November 2017 and must be completed on a triannual (every 3 years) basis to maintain compliance. This policy supports the data mapping requirement of the NDPR.

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our GDPR page on ICON.