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Monitoring, Reviewing, Investigating and Learning from Mortality Policy

NGH-PO-1109

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POLICY

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1	July 2017	Associate Medical Director	Ratified	Procedural Documents Group

SUMMARY

This policy describes the Trust's approach to monitoring, reviewing, investigating and learning from the circumstances around the deaths of those patients who have died whilst under the care of the Northampton General Hospital. The aim of the policy is to improve patient care and reduce avoidable mortality. The policy sets out the roles and responsibilities of staff members and groups and also the governance arrangements for escalating concerns identified during mortality reviews.

1. INTRODUCTION

This policy describes the Trust's approach to monitoring, reviewing, investigating and learning from the circumstances around the deaths of those patients who have died whilst under the care of the Northampton General Hospital. It supports the delivery of Domain 5 of the NHS Outcomes Framework "Treating and caring for people in a safe environment and protecting them from avoidable harm" (Department of Health, 2016).

Concerns about patient safety and scrutiny of hospital mortality rates have increased over the last few years, particularly following high profile inquiries such as the Francis Report (The Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013), the Keogh Review into 14 acute Trusts (NHS England, 2013), the Morecambe Bay investigation (Department of Health, 2015), and the Mazars- independent review – Southern Health NHS Foundation Trust (NHS England, 2015).

The Care Quality Commission (2016) published a review "Learning, Candour and Accountability: a review of the way NHS Trusts review and investigate deaths of patients in England" and in response to this the Secretary of State for Health (2016) made a range of commitments to improve how the NHS learns from reviewing the care provided to patients who die. These commitments are addressed in this policy.

A key part of learning lessons and subsequently improving care is through involving clinical staff and families /carers in the process of monitoring, reviewing, investigating and learning. A well-functioning and supported Specialty morbidity and mortality meeting is the cornerstone of engaging clinical staff. Relatives and carers can offer a valuable perspective on the care received and must be given the opportunity to express any concerns they have had. National Guidance on Learning from Deaths published by The National Quality Board in 2017 states that

"*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 death to an investigation report and its lessons learned and actions taken."*

2. PURPOSE

The overarching aim is to improve the quality of patient care by reviewing the care received by patients who have died whilst under the care of the hospital, and use lessons learnt from these reviews to inform the quality improvement actions necessary to improve care, improve services, and reduce avoidable mortality.

The objectives of this policy are to:

- Confirm the process for monitoring, reviewing and investigating all adult deaths in the Trust to ensure a consistent approach.
- Demonstrate how areas of both poor and good practice are identified, shared and used to drive quality improvement within the Trust.
- To outline the involvement of families/ carers in the process.
- To clarify the governance arrangements of the process of monitoring, reviewing, investigating and learning

3. SCOPE

This policy applies to all adult patients who have died at NGH NHS Trust. It does not include patients under the age of 18 or Maternity patients. This policy applies to all clinical staff involved in the mortality review process in all clinical Specialties.

4. COMPLIANCE STATEMENTS

Equality & Diversity
This document has been designed to support the Trust's effort to promote Equality, Diversity and Human Rights in the work place in line with the Trust's Equality and Human Rights Strategy. It has also been analysed to ensure that as part of the Public Sector Equality Duty the Trust has demonstrated that it has given 'due regard' to its equality duty and that, as far as is practicable, this document is free from having a potential discriminatory or adverse/negative impact on people or groups of people who have relevant protected characteristics, as defined in the Equality Act of 2010.

NHS Constitution
The contents of this document incorporates the NHS Constitution and sets out the rights, to which, where applicable, patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with the responsibilities which, where applicable, public, patients and staff owe to one another. The foundation of this document is based on the Principles and Values of the NHS along with the Vision and Values of Northampton General Hospital NHS Trust.

5. DEFINITIONS

Avoidable/preventable	These terms can be used interchangeably to describe when something could have been done to change the outcome.
Serious Incident	Serious Incidents are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death.
Morbidity	Any condition which has a negative impact on the patient's wellbeing.
Mortality	Death, specifically in relation to this policy whilst an in- patient.
Hospital Standardised Mortality Rate (HSMR)	Hospital Standardised Mortality Rate measures whether the number of deaths observed in a hospital is higher or lower than expected based on a statistical calculation looking at 56 diagnostic groups which account for 80% of deaths. Hospital Episode statistics data is used for the calculation, as well as other factors including the patient's age, severity of illness, deprivation and comorbidities, to provide an expectation as to whether a patient is expected to survive or not. Confidence intervals are used to determine if the Trust is a significant outlier.
Summary Hospital-level Mortality Indicator (SHMI)	Similar to HSMR but includes data on the number of deaths within 30 days post discharge, and covers 100% of deaths in hospital. The statistical analysis does not take into account palliative care coding.
Reviewing Mortality as defined by National Guidance on Learning from Deaths, 2017	The application of a case note review to determine whether there were any problems in care provided to the patient who died in order to learn from what happened (for example Structured Judgement Review).
Structured Judgement Review (SJR)	Standardised review method developed by the Royal College of Physicians and the Improvement Academy of Yorkshire and Humber Academic Heath Science Network requiring reviewers to make explicit safety and quality judgements using information in the case notes, to identify strengths and weaknesses in care provision and to provide information about what can be learnt. https://www.rcplondon.ac.uk/file/5067/download?token=M_FqXpcm
Investigating Mortality as defined by National Guidance on Learning from Deaths, 2017	A systematic analysis of what happened, how it happened and why. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.
M&M	Mortality & Morbidity

6. ROLES & RESPONSIBILITIES

ROLE	RESPONSIBILITY
Chief Executive and the Trust Board	• Responsible for oversight of the review process.
Mortality review group (MRG)	• Review National Mortality Indicators, crude mortality rates and national clinical audits • Oversee the process for responding to mortality alerts • Oversee the Directorate/ Specialty M&M process • Identify Trustwide themes • Oversee learning and actions as a result of mortality reviews. For Terms of Reference for MRG please see Appendix 1
Review of Harm Group (RoHG)	• To receive referrals following screening or reviewing mortality where concern has been raised about the quality of care. • To investigate mortality • To involve families/ carers in investigations • To feedback the findings of subsequent investigations to the MRG.
Medical Director (MD)	• Takes overall responsibility for reviewing and learning from care received by patients who have died • Assures the Trust Board that the mortality review process is functioning correctly, reports mortality information to the Board including the avoidable mortality rate • Supports and quality assures the review process, and provides executive leadership through chairing the MRG
Associate Medical Director (AMD)	• Oversees implementation of this policy and adherence to it • Provides regular mortality reports to CQEG • Quality assures screening, reviewing and

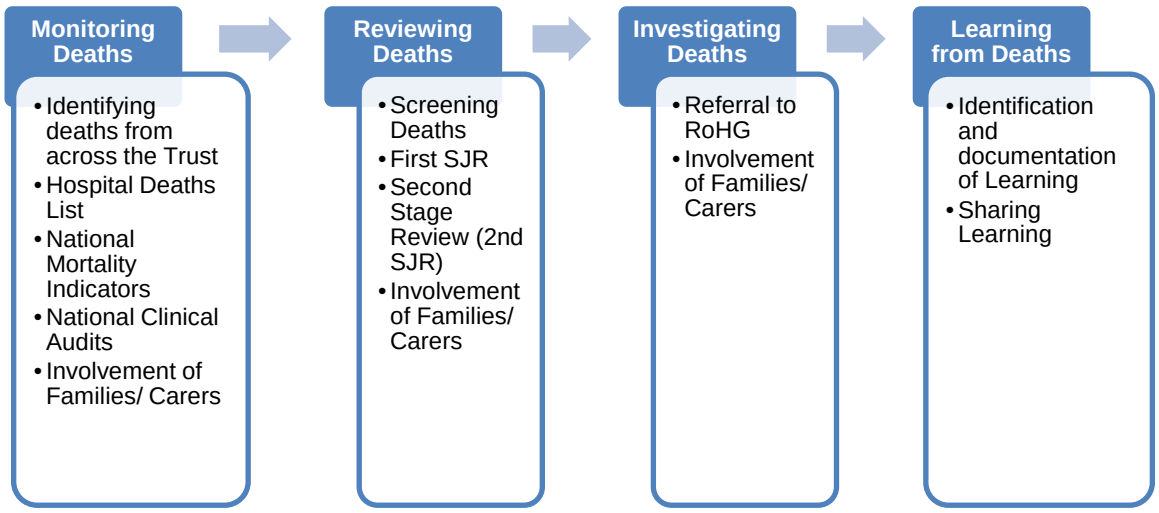
	investigating mortality • Acts as link between MRG and divisions • Acts as a link between MRG and RoHG • Oversees dissemination of learning and actions
Specialty Doctor	• Supports the Associate Medical Director and Medical Director • Oversees the tracking of cases through screening, reviewing and investigating (Appendix 2) • Cascades training for the use of the SJR tool • Provides monthly reports to MRG on progress of the introduction of the NMCRR • Collates data from screening and reviews to identify themes for learning • Support M&M leads to provide annual M&M reports for presentation to MRG • Co-ordinates second stage reviews • Supports NGH contribution to Countywide shared learning events • Ensure that all Learning Disability deaths are reported to the LeDeR (National Learning Disability Mortality Review)
Senior Clinical Audit and Effectiveness Coordinator	• Interrogates National casemix-adjusted mortality data monthly to identify new alerts/significant variation in performance. • Supports the AMD in review of new alerts and regular monthly/quarterly monitoring for overall mortality indicators and previous areas of concern. • Documents review for discussion with MD/MRG. • Reports mortality indicators and crude mortality rates monthly via Corporate and Division/Directorate scorecards. • Provides regular and ad-hoc reports on areas of concern to clinical leads. • Uses Dr Foster tools to monitor the impact on clinical outcomes following implementation of action plans.
Clinical Directors	• Have oversight of mortality indicators relevant to their Directorate. • Appoint Directorate/ Specialty M&M leads and ensure that meetings are taking place at appropriate intervals (in accordance with M&M Terms of

	Reference) and with the appropriate administrative support, • Monitor the outcomes of M&M and report these to the divisional governance meetings, • To facilitate structured judgment reviews and second stage reviews when required • Disseminate learning throughout the Directorate and ensure that actions are completed
Divisional Directors	• Have oversight of mortality indicators relevant to their division • Ensure that Directorates/ Specialties are participating in mortality reviews • Ensure that outcomes from M&M and other mortality reviews are reported and discussed at divisional governance meetings • Report outcomes (learning and quality improvements) to CQEG and escalate concerns.
Directorate/ Specialty Mortality and Morbidity Meetings (M&M)	• Receive and discuss the results of SJR • Identify learning and take actions necessary to improve care • Disseminate learning from SJR • Investigate Specialty mortality alerts • Report to the divisional governance meeting monthly/ quarterly • Provide an annual report to MRG. (Appendix 3) For Terms of Reference for Directorate/ Specialty M&M meetings please see Appendix 4
Mortality and Morbidity leads	• Fulfil duties of M&M lead job description (Appendix 5) • Chair Specialty M&M meetings and ensure appropriate content and recording of meetings • Ensure timely structured judgement review • Escalate learning and actions where appropriate to clinical director • Collaborate with second stage reviews when required
Mortality Screener	• Screens the case notes of all adult patient deaths using a standardised screening form to identify any

	concerns in care or potential learning / opportunity for improvement • Completes part 5 of the cremation form (including contacting consultant in charge of the patient and nursing staff to ask if they have concerns regarding care) • Refers relevant cases to the Specialty M&M lead for SJR • Refers relevant cases to AMD for consideration for discussion at RoHG • Feeds back and documents learning identified from screening
Medical staff	• Attend M&M meetings • Participate in M&M reviews and contribute to quality improvement initiatives • Encourage junior staff and medical students to attend
Bereavement team	• Share the list of deaths with the Mortality Administrator • Alert Mortality Screener if the family/ carers have expressed concerns or an appointment has been made for a follow up visit with a consultant or the family/ carers have expressed a wish to make a complaint • Inform the family/ carer that all deaths are routinely reviewed
Coding Department	• Review coding of cases as requested by the Senior Clinical Audit and Effectiveness Officer.
Clinical Quality and Effectiveness Group (CQEG)	• Receives regular mortality report from the Associate Medical Director • Receives quarterly M&M report from Divisional Directors • Discusses Trustwide issues with mortality and develops action plans appropriately
Mortality Administrator	• Updates and maintains the Excel spreadsheet tracking all deaths in the Trust • Highlights and follows up outstanding screening and reviews

	• Retrieves notes for second stage reviews • Supports AMD, Specialty Doctor and Senior Clinical Audit and Effectiveness Coordinator
All Trust Employees	Have a responsibility to: • Support the Trust to achieve its Vision • Act at all times in accordance with the Trust values • Follow duties and expectations of staff as detailed in the NHS Constitution – Staff Responsibilities

7. SUBSTANTIVE CONTENT



7.1. Monitoring Deaths

7.1.1 Identifying deaths from across the Trust

Prompt identification of patients who have died in the Trust is achieved in one of the following ways:

- Case notes of the majority of patients who have died during an admission to the Trust are delivered to the Bereavement Suite (excluding deaths in Critical Care).
- In the Emergency Department (ED), it may not possible to issue a death certificate and the notes will therefore not go to the Bereavement Suite. In this instance the case notes are delivered to the mortuary.
- Death certificates for patients who die in Critical Care are completed by the Critical Care Team and the case notes are delivered to the Mortuary.

The Mortality Administrator will liaise with these 3 sources regularly to obtain a list of deaths. All notes then go to the Mortuary and the list can be cross checked for omissions at this stage.

7.1.2 Hospital Death List

This is produced monthly (approx 2 weeks after the end of a month) by the Information Team and gives details of every death in the Trust including those in ED. It serves the following purposes:

- Monitoring of overall numbers of deaths per month and trends over time.
- Allows Specialty/ Directorate M&M leads to cross check patients who have died in their care to ensure no relevant deaths have been overlooked for review.
- Allows Specialties, teams and individual consultants to verify attribution of deaths.

7.1.3 National Mortality Indicators

National Mortality Indicators look at death rates in diagnosis groups/ Specialties and they identify variances and outliers. They provide an early warning system of potential quality and safety problems within a hospital and compare performance with other hospitals. They can be used to identify possible trends, provide a starting point for further investigation and identify areas of potential improvement. However, they do not provide information about the quality of care received by individual patients, nor is there any evidence that the “excess” deaths identified by these statistics correlate with the number of avoidable deaths.

At Northampton General Hospital, mortality is monitored using HSMR and SHMI.
Dr Foster intelligence provides the Trust with monthly HSMR data relating to in- hospital mortality indicators by diagnosis group and 30 day in hospital mortality following procedures.

Deaths in low risk groups are also reviewed monthly and deaths in 7 high-risk groups are monitored quarterly (pneumonia, stroke, congestive heart failure, acute kidney injury, sepsis, acute myocardial infarction, fractured neck of femur).

New alerts (by diagnosis group or procedure) and significantly raised mortality over the rolling year are reviewed monthly by the AMD and the Senior Clinical Effectiveness and Audit Officer. Alerts are considered in context (including changes in activity, coding practice, patient comorbidity scores, triangulation with other data eg known SIs, National Clinical Audits or inquests) and any subsequent action planned: including further monitoring arrangements, commissioning a Trustwide or Specialty case notes review. (Appendix 6)

AMD reports details of key mortality indicators (HSMR, SHMI), alerts and actions planned to the Medical Director and MRG for consideration for further investigation.

7.1.4 National Clinical Audits

National clinical audits that publish hospital or consultant specific mortality outcome measures are presented to MRG.

7.1.5 Involvement of Families/ Carers

Families/ carers are supported by the Bereavement Suite and given an information booklet “What happens now?”. The next reprint of this booklet will include a statement which explains the Trust routinely reviews the care of patients who have died. This will also be explained by the Bereavement Suite Staff.

Staff in the Bereavement Suite are experienced in supporting families/ carers at this difficult time. If necessary they will arrange a follow up meeting with the relevant consultant or explain how to pursue a complaint. If families/ carers raise concerns while in the Bereavement Suite this information will be passed to the Mortality Screener and will help inform the decision about the need for review.

7.1.6 Documentation of Monitoring

The demographics of each patient identified during monitoring will be entered onto an Excel Spreadsheet (stored on a Trust shared drive) by the Mortality Administrator.

7.2. Reviewing Deaths

7.2.1 Screening Deaths

The Mortality Screener reviews the case notes of all adult deaths within 4 days of death using the locally designed screening tool. This identifies those deaths which require review using the Structured Judgement Review (SJR) tool (Appendix 7).

All deaths on Critical Care are screened by the M&M lead and discussed fortnightly with a multidisciplinary team to identify those deaths which require review using the SJR tool.

If there is immediate cause for concern raised by the screening process a Datix is completed and the case is discussed with the AMD (Clinical Governance) for consideration for escalation to RoHG.

An automatic Structured Judgement Review will occur in the following situations:

- The patient died during an elective admission
- The patient died within 30 days of an operative procedure
- The patient died within 30 days of chemotherapy
- The patient had a learning disability
- The patient was admitted from a mental health trust
- The patient died in ED

7.2.2 First Structured Judgement Review (SJR)

Following screening, those case notes identified as requiring first SJR (Appendix 8) are passed to the lead for the relevant Directorate/ Specialty M&M who oversees completion of the SJR tool within 4 weeks. The case must be presented and discussed at the next

Directorate/ Specialty M&M within 12 weeks and learning and subsequent actions documented.

Some Directorate/ Specialty M&M's may elect to review all deaths using the SJR tool even if they have not been picked out by screening. In these Directorates/ Specialties the number of deaths per month will be a manageable number (<10).

If there is immediate cause for concern raised by the first SJR a Datix will be completed and the case should be discussed with the AMD (Clinical Governance) for consideration for escalation to RoHG.

7.2.3 Second Stage Review (2nd SJR)

A second stage review is carried out:

- For all cases where care has been rated as poor or very poor following the first SJR.
- In all patients with a learning disability. This will be undertaken by a member of the LD M&M team. The death will also be reported to The National Learning Disability Mortality Review.
- When an investigation is required following an alert arising from National Mortality Indicators, National Clinical Audits or other external bodies.

Second stage review will be completed by an independent group of clinicians, who will provide a second assessment of the quality of care and determine the potential avoidability of death.

7.2.4 Involvement of Families/ Carers

The outcome of any follow up meetings between families/ carers and consultants or details of any complaints should feed into the review process and may help inform the decision about the need for investigation.

7.2.5 Documentation of Results of Reviews

Following review the spreadsheet is updated to record:

- The outcome of the screening process
- The outcome of first SJR if applicable
- The outcome of second stage review if applicable

7.3. Investigating Deaths

7.3.1 Referral of deaths to RoHG.

At any stage during the process of screening and reviewing deaths there may be sufficient cause for concern to warrant the completion of a Datix and discussion with the AMD (Clinical Governance). This has the advantage of identifying potential need for investigations as early in the process as possible.

Deaths judged to be:

- Grade 1 (definitely avoidable)
- Grade 2 (Strong evidence of avoidability)
- Grade 3 (probably avoidable)
- Grade 4 (possibly avoidable but not very likely)
- Grade 5 (Slight evidence of avoidability)
- Grade 6 (definitely not avoidable)

Following the 2nd SJR, a Datix Incident Report is completed for all deaths graded as 1,2 or 3 and such cases are presented to RoHG by the AMD (Clinical Governance).

7.3.2 Involvement of Families/ Carers

The families/ carers are offered the opportunity to contribute to the investigation when contacted by the Governance team. Please refer to the Duty of Candour Policy (Being Open With Patients, Relatives and Carers following an Incident, Claim or Complaint) NGH-PO-254.

7.3.3. Documentation of Results of Investigations

Following investigation through RoHG the outcomes will be:

- Included in the Excel spreadsheet by the mortality administrator
- Reported at the next MRG meeting

7.4. Learning from Deaths

7.4.1 Identification and documentation of learning

Learning may be identified and documented at any stage of the process:

- During screening.

- At Directorate/ Specialty level during M&M meetings following use of the SJR tool.
- At Trustwide level during second stage review.
- Following investigations by RoHG.

7.4.2 Sharing Learning

- The Mortality Review Group will receive the collated results of screening, reviews and investigations and will use this forum to share Trustwide learning with representatives from the Divisions.
- Divisions are responsible for disseminating learning across their Directorates/ Specialties and identifying any quality improvement actions necessary.
- Outcomes from Serious Investigations are disseminated across the Trust by the Trust Governance team at a biannual Trustwide meeting (Dare to Share).
- Dissemination of learning occurs across the county at the biannual Countywide Mortality and Morbidity meeting – held jointly with Northampton General Hospital, Kettering General Hospital and Northamptonshire Healthcare Foundation Trust.

7.5. Governance Arrangements

7.5.1 Mortality Review Group

Mortality Review group provides the following reports:

- Regular report to CQEG - detailing mortality metrics HSMR and SHMI, new alerts from Dr Foster, deaths in low risk groups, weekday vs weekend mortality, and outcomes of investigations from previous alerts.
- Quarterly report as part of the Medical Directors report to Quality Governance Committee (QGC) - detailing themes identified from second stage reviews. This report will also include a dashboard giving the following information:
    - Total number of deaths per month
    - Number of deaths undergoing SJR
    - Number of deaths identified with an overall care score of 1 or 2 (very poor or poor care)
    - Number of deaths categorised as possibly avoidable following second stage review (Avoidability of death judgement score 1,2 or 3)
    - Number of deaths referred to RoHG

7.5.2 Directorate/ Specialty M&M

Directorate/ Specialty M&M leads provides the following reports:

- Template from Directorate/ Specialty M&M meetings to divisional governance meetings detailing learning points (Appendix 9)
- Annual report to MRG - detailing process of M&M meetings, the number of meetings held, number of cases discussed and learning points identified, details of cases referred for second stage review and their outcomes (Appendix 10).

7.5.3 Divisional Directors Reports

Divisional Directors will report M&M activity in their Division quarterly to CQEG. This includes the identification of learning points relevant across the division and planned actions to address the learning points.

7.5.4 Quality Assurance and Key Performance Indicators

The following quality assurance measures are in place:

- Review a percentage of “no concern” screening cases at MRG every 6 months – to ensure that correct cases are being investigated.
- Compare the outcomes of duplicated first SJR (eg death reviewed by Vascular Surgery and Critical Care) to ensure consistency and determine if the quality of the investigation is acceptable and rigorous enough.
- Compare the outcomes of the first SJR and second stage review to ensure consistency and determine if the quality of the investigation is acceptable and rigorous enough.
- Assess the quality of the M&M meetings when M&M lead presents annual summary to MRG.

8. IMPLEMENTATION & TRAINING

Training for Mortality Screeners and for those staff undertaking structured judgement reviews is be cascaded down from the AMD and Specialty Doctor who have attended regional training on the use of the National Structured Judgement Review Tool.

9. MONITORING & REVIEW

Minimum policy requirement to be monitored	Process for monitoring	Responsible individual/ group/ committee	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
70% notes to be screened within 2 days	Dashboard completed by mortality administrator	Mortality Screener	quarterly	MRG	AMD	MRG
90% SJR to be completed within 4 weeks	Dashboard completed by mortality administrator	Specialty M&M lead	quarterly	MRG	Directorate Governance lead	MRG
90% SJR to be discussed at Specialty M&M within 12 weeks	Dashboard completed by mortality administrator	Specialty M&M lead	quarterly	MRG	Directorate Governance lead	MRG
90% relatives/carers given opportunity to be involved	Dashboard completed by mortality administrator	Mortality Screener and Bereavement centre	quarterly	MRG	AMD	MRG
Quarterly divisional reports to include lessons learnt and action plans	Divisional quarterly report to CQEG	Divisional Governance lead	annually	CQEG	Divisional Governance lead	MRG

10. REFERENCES & ASSOCIATED DOCUMENTATION

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APPENDICES

Appendix 1	**Using the structured judgement review method A clinical governance guide to mortality case record reviews**
Appendix 2	**NGH Mortality Review Group Terms of Reference**
Appendix 3	**NGH Flowchart for Review of All Deaths**
Appendix 4	**NGH Directorate/ Specialty Morbidity & Mortality Meetings Terms of Reference**
Appendix 5	**Mortality Screening Tool**
Appendix 6	**Structured Judgement Review Tool**
Appendix 7	**Mortality Alert Flowchart**
Appendix 8	**Template for Recording Directorate/Specialty M&M Meetings**
Appendix 9	**Template for Directorate/Specialty Annual Report to MRG**

Royal College of Physicians

National Mortality Case Record Review Programme

Using the structured judgement review method

A clinical governance guide to mortality case record reviews

Supported by:

Improvement Academy
Part of the Yorkshire & Humber AHSN

Datix®
Software for patient safety

Commissioned by:

HQIP
Healthcare Quality Improvement Partnership

Dr Andrew Gibson

The National Mortality Case Record Review Programme and clinical governance

Introduction

The National Mortality Case Record Review (NMCRR) Programme is a national collaborative project led by the Royal College of Physicians (RCP) in partnership with Yorkshire and Humber Academic Health Science Network's (AHSN's) Improvement Academy and Datix. It is commissioned by the Health Quality Improvement Partnership (HQIP).

The aim of the 3-year programme is to introduce a standardised methodology for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland. The primary goal is to improve healthcare quality through qualitative analysis of mortality data using a standardised, validated approach linked to quality improvement activity. The work will not cover deaths that occur in other settings.

Around 50% of all deaths occur in hospital and most of these are inevitable, but around 3–5% of acute hospital deaths are thought to be potentially preventable.[1]

The structured judgement review (SJR) review methodology has been validated[2] and used in practice within a large NHS region. It is based upon the principle that trained clinicians use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible. This method is described in detail in the accompanying documentation: *A guide for reviewers* by Dr Allen Hutchinson.

What is the modified SJR?

SJR relies upon trained reviewers looking at the medical record in a critical manner and commenting on specific phases of clinical care. The NMCRR Programme has developed a slightly modified version of the original approach that features some of the elements used in the PRISM2 study.[1] The approach can be used for any patient pathway that has a defined endpoint or characteristic, eg death or a fall. Therefore, while in this programme it is being used to learn from mortality within hospitals, it could be applied to a number of pathways. This makes it an attractive and versatile tool for acute organisations to use once they have a cohort of trained reviewers.

Clinical governance and the SJR method

Any process that can potentially reveal harm must include parallel governance processes. The overarching principles that should be considered when using the SJR reflect the possibilities of outcomes, including:

- problems within healthcare processes in the organisation (eg management of deteriorating patients or high-risk medications)

- identification of aspects of poor care delivered by individual clinicians (eg substandard clinical practice or careless and reckless behaviour).

Process failures are much more common than issues related to the practice of individual clinicians but both will require management by a robust and transparent governance process.

The overarching principles to consider are:

- The hospital can describe and demonstrate the success of the process by which poor outcomes are managed.
- The hospital has an executive-level officer who is responsible for mortality reviews.
- The hospital can demonstrate how individual reviews are managed within mortality and morbidity (M&M) meetings and describe how poor outcomes are reviewed.
- The hospital can describe both a robust governance strategy and the key individuals who are responsible for its delivery.
- The hospital has a Hospital Mortality Committee or a Mortality Governance Group that is executive led and contains appropriate membership.
- Where there is a medical examiner presence (in England) the hospital can demonstrate synergy and commonality of purpose.

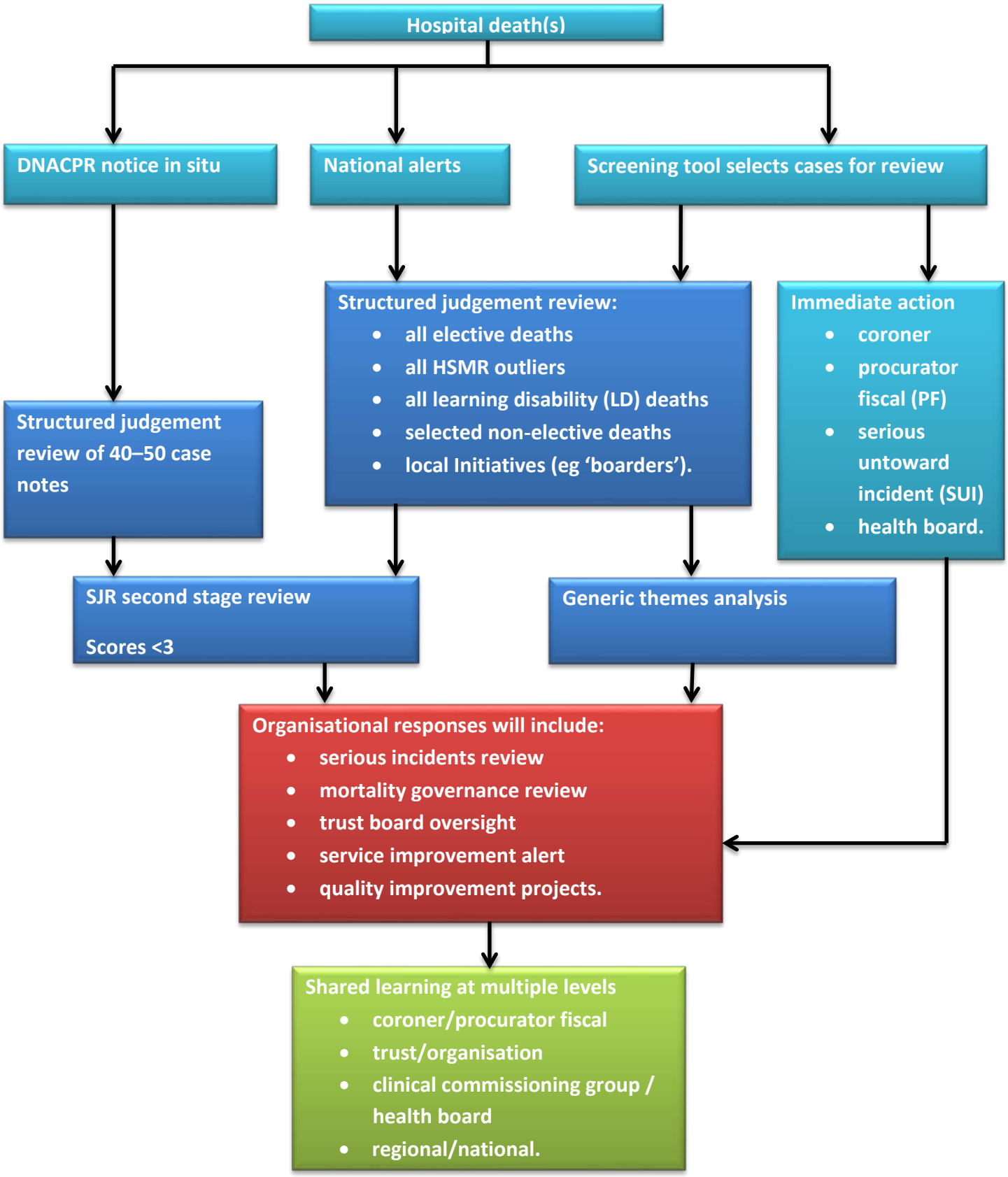
This process is described schematically in Fig 2. The use of a screening tool within the hospital will ensure that immediate concerns are addressed without the need to use the SJR. The screening tool that is used is not mandated within the SJR methodology.

The choice of which case records to review ultimately rests with the hospital in question. A few organisations may wish to review all deaths that are identified internally following the application of a brief screening process. However, there are some groups of patients where serious consideration must be given to reviewing all deaths including (but not exclusive): elective deaths, learning disability deaths, unexpected deaths, deaths in younger patients, deaths following procedures or surgery, deaths following emergency admissions and deaths flagged to be part of an outlier statistic either internally or externally.

Organisations should, independently, be able to describe how they respond to external flags and alerts in respect of high case fatality disorders such as stroke and fractured neck of femur. These alerts can take the form of HSMR statistics or national audits using Hospital Episode Statistics (HES) data sets in England or Scotland. However, and in addition, hospitals may also wish to further modify the suggested list and the way in which non-elective patients or cases are selected for review to reflect unique local circumstances. For example the SJR might be used to analyse in detail the care of a specific cohort of patients such as those that are ‘outliers’ or ‘boarders’.

After the review has taken place, the organisation’s governance process and quality improvement process will dictate further responses. Dealing with poor care, if identified, must be well rehearsed within organisations prior to undertaking the reviews. An example of a possible case note review process is shown on the next page.

Fig 1 SJR governance flow chart



The drive to learn from unintended events is a cornerstone of high performing organisations and safety conscious industries. Many patients who die have received good care, and many who receive poor quality care do not die, so reviewing the records of the small percentage of patients who die in hospitals will not tell us everything about the quality of care in that organisation. However there are legitimate public expectations that we will seek to detect potentially avoidable deaths in hospitals and a professional obligation to understand and learn from failures in care.

An open and transparent culture and a desire to change through acceptance and ownership of the data obtained from case note reviews are crucial to learning.

Most hospitals in England and Scotland have some form of mortality review process but these vary widely and few use a recognised, validated approach. Outputs from reviews are also used in a variety of ways but current evidence suggests that learning from analysis of mortality is not the norm and, historically, mortality reviews have led to recrimination rather than learning.

All methodologies have their strengths and weaknesses but SJR has been developed and validated in the UK and is currently used in 12 hospitals in Yorkshire and Humberside. A number of other sites in England and Scotland have been enrolled as pilot sites.

Work from Sheffield Teaching Hospitals NHS Foundation Trust compared information from a review of 49 surgical deaths using the Modified Mortality Review Tool (MMRT) with information obtained from the review of 80 cardiac arrests using the SJR.[3] The SJR is superior on a number of levels but in addition this comparison showed that the MMRT uses 'implied criticism' rather than 'explicit judgement'. This difference led to the failure of reviewers using the MMRT to commit to a judgement on the care provided in over 20% of cases, an effect that was not evident with SJR. The clarity of explicit judgements when properly executed allows reproducible assessment of the quality of patient care from which learning flows and, with appropriate quality improvement processes applied, improvement follows.

Cascading training of in-house reviewers is relatively quick and easy, and it rapidly results in a cohort of trained reviewers. These reviewers can be used for both mortality reviews or for analysis of other harm events such as cardiac arrests, falls or pressure area care.

Learning from the outcomes of the SJR: clinical governance in action

As discussed already, there are two potential areas of learning that can be obtained from this method. The detail captured can identify both poor practice and good practice of individual clinicians. When multiple reviews are undertaken within a clinical area or hospital, a thematic analysis can be performed that may highlight process or systemic issues.

Using the SJR to review cardiac arrests produced data that generated nine themes as well as areas of individual concern associated with a low overall phase scores of less than three.

The nine themes generated by this work (see Box 1) were used to create improvement cycles which then resulted in a reduction of cardiac arrest rates as demonstrated in Fig 2.

Box 1 Analysing the SJR to generate themes

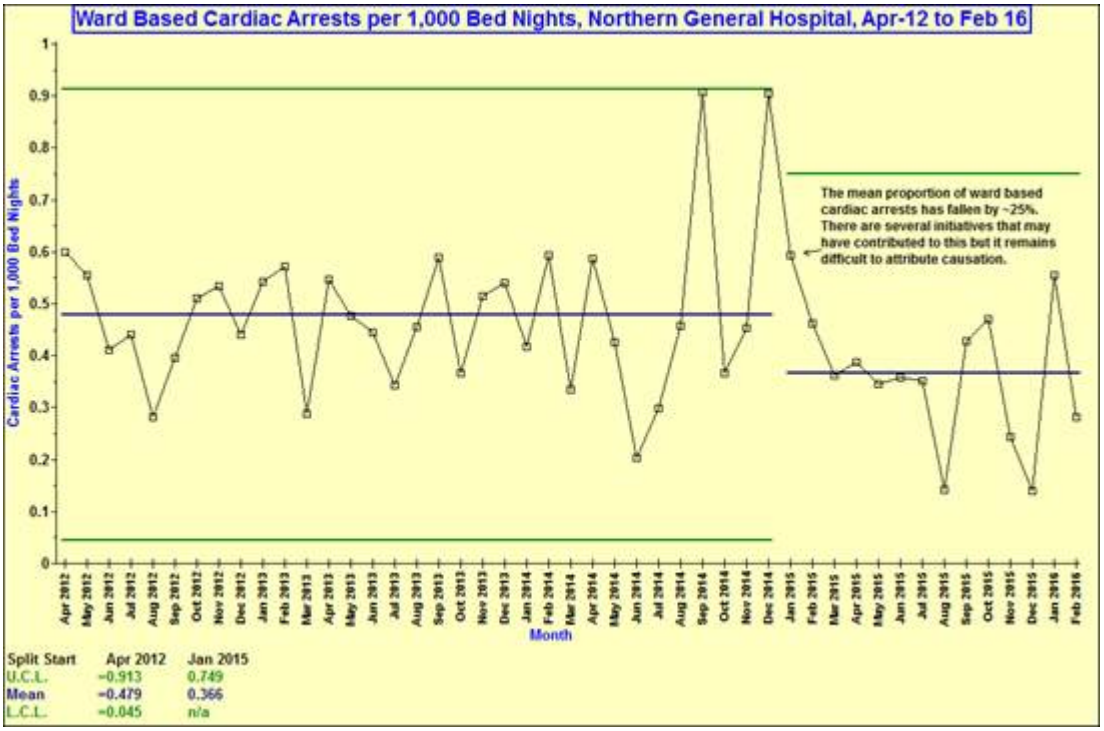
The SJR produces two types of data:

1. a score from 1 to 5 identifies very poor to excellent care respectively in a number of phases of care
2. qualitative data in the form of explicit statements about care using free text.

These outputs allow the identification of those cases with poor care, very poor care or excellent care. The use of qualitative research methods and word detection software then allows identification of recurrent themes. A sample of 50 case notes generates adequate information to direct further study and learning.

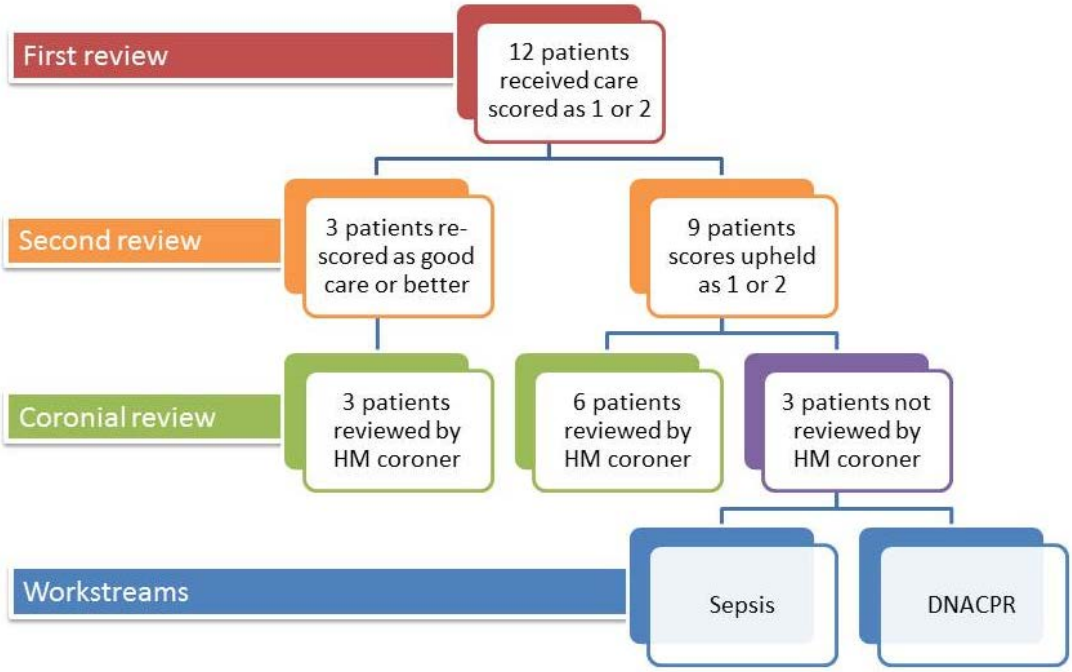
For example, in the cardiac arrest study, it became clear that a recurrent theme was the delay in identifying patient deterioration. This led to a review of the early warning score (EWS) charts, with subsequent modification to include temperature and increased sensitivity of detection of deteriorating patients.

Fig 2 SPC chart showing changes in rates of cardiac arrests 2012–2016



In addition, 12 patients had received scores that required second-stage review. These reviews confirmed that 75% of the scores were correct and 25% were rescored. The flow chart at Fig 3 describes the first- and second-stage reviews and the actions taken, which included the involvement of HM coroner (HMC) and the realisation of the need for further analysis with the incorporation of the learning into new areas of work.

Fig 3 First- and second-stage reviews with subsequent actions



This included a DNACPR workstream, which highlighted a number of other issues leading to further learning and continued analysis. A number of other examples, derived from local and regional analysis, can be found on the Improvement Academy website: www.improvementacademy.org.

Box 2 Case study: setting up mortality reviews in the hospital setting using the SJR

You will need:

- a safety orientated culture with executive engagement
- identified champions and clinical leaders who are enthusiastic about mortality reviews and have adequate time allocated to do the work
- an active faculty or hospital committee with senior clinicians and medical director representation that regularly meets and creates the hospital's vision about mortality reviews
- a training programme and trainers, who should also be members of the faculty
- widespread advertising of the process and multiple training sessions
- faculty oversight of how the process is embedded
- an explicit description and acknowledgement of what happens if poor care is identified
- an ability to analyse complex quantitative and qualitative data using a variety of means (eg cumulative sum (CUSUM) and SPC charts).

Quality improvement and the SJR methodology

The methodology described thus far does not of itself lead to changes in the quality of the delivery of healthcare. The analysis of the outcomes of reviews simply describes either themes for exploration or individual areas of care. Transforming the results of the reviews into healthcare reform requires hospitals to act on the outcome of the analysis.

This means that there is only likely to be quality improvement when the results of the SJR are transformed into meaningful and tangible actions that impact on the delivery of patient care.

What about clinical governance and other national initiatives?

In parallel with the NMCRR, a number of other initiatives are being developed which will provide consistent information and instruction to hospitals. Hospitals will need to be aware of the moves to standardisation and learning, and prepare for them accordingly. The clinical governance associated with these changes will require modification from time to time.

For example, the delivery of a national M&M strategy in Scotland is a key interdependent, which will be delivered in tandem with the role out of the NMCRR.[4]

A parallel in England is the desire to see consistency of approach to both hospital mortality and the development of executive-led hospital mortality committees or mortality governance committees. These groups will oversee both the analysis of SJR and the associated governance of M&M. It is envisaged that these groups will have a strategic role within hospitals. This will ensure that appropriate governance exists alongside robust mortality review that supports learning and quality improvement in healthcare.

It is also envisaged that the Care Quality Commission will visit English acute trusts to further investigate the relationship between mortality and quality improvement.

In addition, the medical examiner system that will hopefully emerge from the extended national pilot schemes in England will also affect this process. One possibility is that there is a single review process common to both the hospitals in England and the medical examiner review. It would be mutually helpful if this were the SJR, as this would allow a true integration of the two processes. This would allow each to support the other and, in doing so, reduce the magnitude of the task that each has in attempting to review all hospital deaths.

Summary

The use of the SJR methodology should be preceded by a clear description of the organisation's clinical governance process. The clinical governance guidance in this document is purposely non-prescriptive, as it is acknowledged that most hospitals already have robust governance arrangements. However the guidance also allows, where appropriate, modification of those processes in order to further promote best practice.

A number of examples are presented to describe the use of the SJR with associated learning and clinical governance responses.

The key to the delivery of quality improvements associated with the use of the SJR methodology is the prior existence of robust and timely interventions that reflect a hospital's effective clinical governance processes.

Editorial note

Please note that this guide is subject to change following conclusion of the pilot phase of the programme.

References

1. Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239.
2. Hutchinson A, Coster JE, Cooper KL, Pearson M, McIntosh A, Bath PA. A structured judgement method to enhance mortality case note review: development and evaluation. *BMJ Quality and Safety* 2013 doi:10.1136/bmjqs-2013-001839.
3. Gibson A. Regional Mortality Conference Yorkshire and Humber Improvement Academy Leeds 2014.
4. Manoj Kumar, Health Improvement Scotland. Personal communication, 2016.

NGH Mortality Review Group

TERMS OF REFERENCE

Membership	• Medical Director (Chair)
	• Associate Medical Director (Clinical Governance)
	• Non-Executive Director
	• Specialty Doctor (Medical Directors Office)
	• Senior Clinical Effectiveness and Audit Co-ordinator
	• Director of Nursing or Deputy
	• Doctors (Consultants)
	  o Anaesthetist / Intensivist
	  o General Surgeon
	  o T&O surgeon
	  o Acute Physician
	  o Care of the elderly
	  o Respiratory/ cardiology
	  o Accident and Emergency
	  o Oncologist
	  o Palliative Medicine
	• Junior Doctor
	• Information Department Representative
	• Head of Clinical Coding
	• Assistant Director Patient Safety & Quality Improvement
	• Governance Representative
	• Dr Foster Representative

Quorum	A minimum of 5 members of the group must be present and must include either the Chair or the Deputy Chair, one nurse and two doctors and a member of the Mortality Review Team.
In Attendance	In order to fulfil its remit, the Group may obtain any professional advice it requires and invite, if necessary, external experts and relevant staff representatives to attend meetings.
Frequency of Meetings	• Monthly
Accountability and Reporting	• Report monthly via the Associate Medical Director (Clinical Governance) to CQEG
Date of Approval	• 31/03/2017
Review Date	• 31/03/2018

NGH Mortality Review Group

Terms of Reference

1. Constitution

The Clinical Quality and Effectiveness Committee (CQEG) hereby establish a sub -group known as the Mortality Review Group.

Its principle aims are

- Assurance - To provide assurance to the Trust Board on patient mortality
- Quality Improvement – To provide a forum for discussion of reviews, support action planning and identify opportunities to share learning

.

2. Purpose

To act as the central group for monitoring, reviewing, investigating and learning from mortality, chaired by the Medical Director.

The Mortality Review Group will escalate any concerns that may arise to CQEG and will support the Trust strategy of '*Best Possible Care'* for patients.

- **Operational Duties**

1. To review on a monthly basis the benchmarked mortality rates of the Trust
2. To consider the mortality data in conjunction with other qualitative clinical data and identify areas for further investigation
3. To investigate alerts received from the CQC or identified by Dr Foster
4. To ensure that local Trust mortality processes are carried out in a timely manner according to nationally recognised best practice
5. To improve the accuracy of consultant attribution of cases to enhance the general M&M process and the use of this information for consultant appraisal and revalidation
6. To ensure Trustwide ownership of the issues raised by mortality monitoring
7. To assign clinical leads to address raised mortality in particular clinical areas. The leads will support a detailed case note review and will be required to report their findings and recommendations back to the group in an agreed timeframe
8. To monitor and consider the information from electronic review of all hospital deaths
9. To oversee directorate/ specialty M&M processes and receive key findings
10. To highlight issues of data quality that influence mortality metrics or the investigation of mortality issues
11. To highlight changes in coding practice or rules that influence mortality metrics or the investigation of mortality issues

- **Strategic Duties**

1. To act as the strategic hospital mortality overview group with senior leadership
2. To support the reduction of avoidable deaths
3. To sign off all regulatory mortality responses
4. To report on mortality performance to the Trust Board

3. Membership

- Medical Director (Chair)
- Associate Medical Director (Clinical Governance)
- Non-Executive Director
- Specialty Doctor (Medical Directors Office)
- Senior Clinical Effectiveness and Audit Co-ordinator
- Director of Nursing or Deputy
- Doctors (Consultants)
    - Anaesthetist / Intensivist
    - General Surgeon
    - T&O surgeon
    - Acute Physician
    - Care of the elderly
    - Respiratory/ cardiology
    - Accident and Emergency
    - Oncologist
    - Palliative Medicine
- Junior Doctor
- Information Department Representative
- Head of Clinical Coding
- Assistant Director Patient Safety & Quality Improvement
- Governance Representative
- Dr Foster Representative

4. Quorum, Frequency of meetings and required frequency of attendance

A quorum must include the chair or nominated deputy. No business shall be transacted unless 5 members are present one of whom must be the chair. In the event of the chair being unavailable the meeting will be chaired by Associated Medical Director (Clinical Governance) who is the nominated deputy. There must also be one nurse, two doctors and a member of the Mortality Review Team.

The (chair) will monitor compliance with the Terms of Reference and will bring any non-compliance to the attention of the CQEG

Members of are required to attend a minimum of 10 of the meetings held each financial year.

An attendance list will be kept and circulated to the membership with the minutes. If members are unable to attend they may nominate a deputy to attend on their behalf.

5. In attendance

In order to fulfil its remit, the Group may obtain any professional advice it requires and invite, if necessary, external experts and relevant staff representatives to attend meetings.

6. Authority

The Mortality Review Group is authorised by CQEG through the Chair to investigate and develop any activity within its terms of reference. The Mortality Review Group shall make recommendations to CQEG through the Chair if it deems appropriate on any area within its terms of reference where action or improvement is required.

7. Accountability and Reporting arrangements

The Mortality Review Group will report to CQEG quarterly and shall draw to the attention of CQEG to any issues that require escalation to Quality Governance Group / Board disclosure to the Board through the Chair of CQEG. In parallel key issues/concerns and associated actions will be reported to HMT via the Divisional Director / Divisional Manager.

The Minutes of the meeting shall be formally recorded by the Specialty Doctor. Copies of the minutes of the meeting shall be available to all members of the Mortality Review Group and made available for staff to see.

8. Sub-committees and reporting arrangements

The Mortality Review Group shall have the authority to establish sub-groups/task and finish groups for the purpose of addressing specific tasks or areas of responsibility. The terms of reference, including the reporting procedures of any subgroups must be approved by the Mortality Review Group and be regularly reviewed.

Compliance and Effectiveness

The Mortality Review Group will support the CQEG and the Board of Directors in discharging their responsibilities by providing objective assurance that processes are in place across the Trust to ensure that high quality, safe effective services are being provided that meet the terms of the contract that is in place. This information will be integrated through in the quarterly report to CQEG

9. Requirement for review

These terms of reference will be formally reviewed by The Mortality Review Group no less than annually, and may be amended in consultation with CQEG to reflect changes in circumstances which may arise.

10. FOI Reminder

The minutes (or sub-sections) of the Committee/ Group, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Appendix 1 – Standard Agenda Template

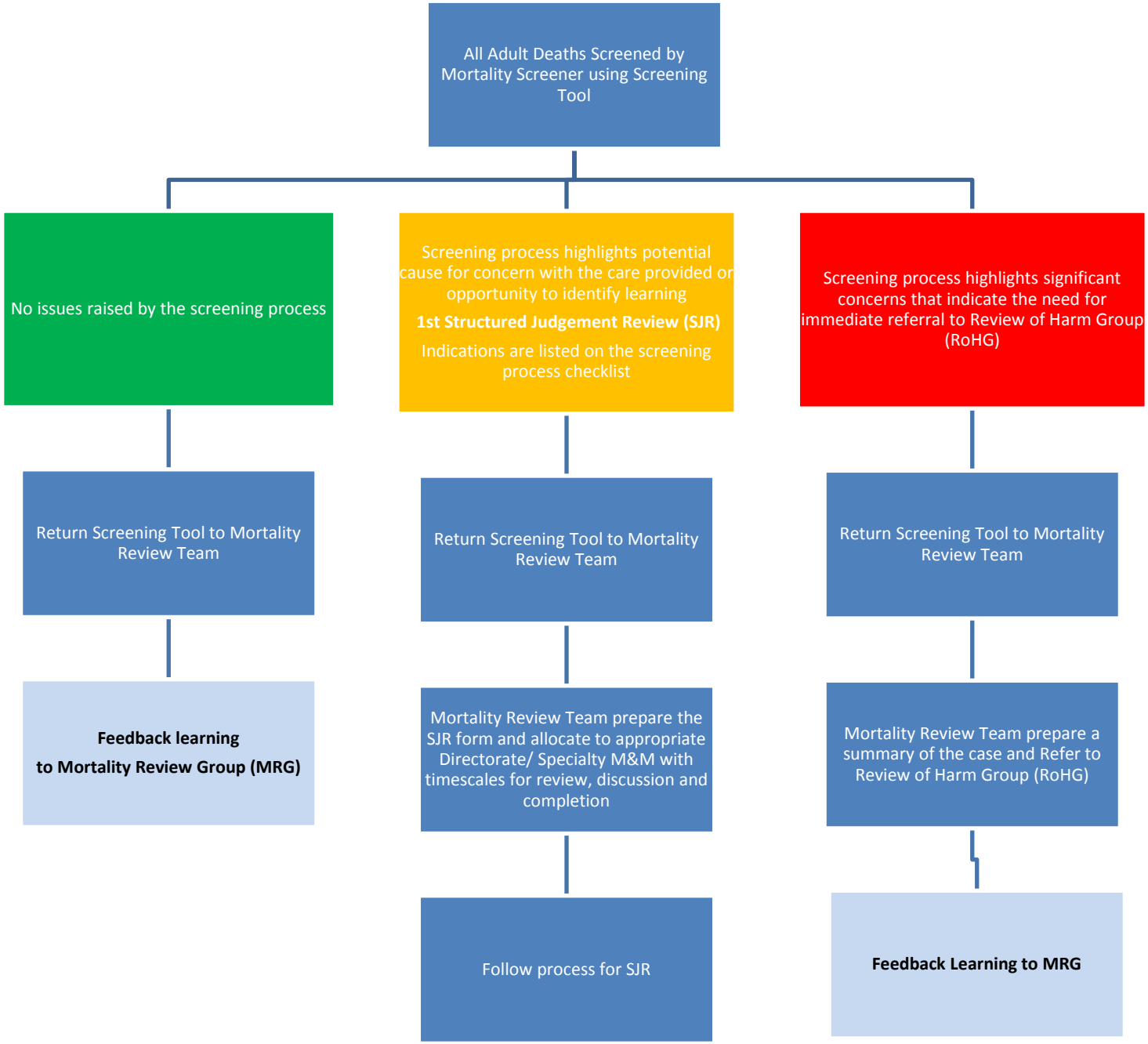
Mortality Review Group - Date

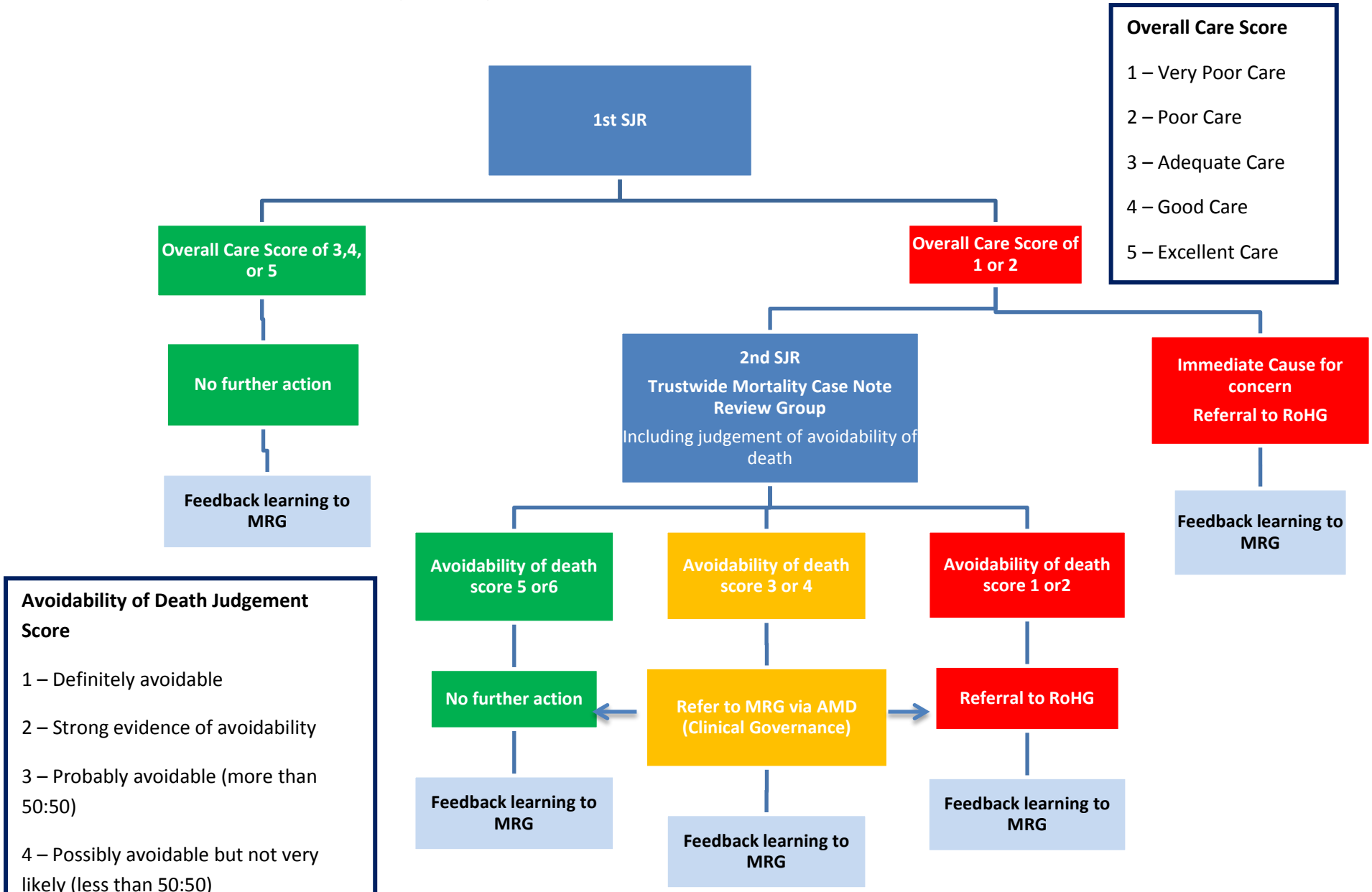
Time and Location

1.	Apologies
2.	Minutes of meeting Action Log
3.	Dr Foster and other Mortality Indicators • General update including crude mortality and SHMI • Investigations and service reviews New Alerts New Alerts Ongoing Investigations Patient Safety Indicator Alert
4.	Imperial/ CQC Mortality Alert
5.	National Clinical Audits
6.	Tracking mortality case note reviews referred for further review
7.	Directorate/ Trustwide M&M
8.	Data Quality Update (SMcG)
9.	Coding Update (BG/CF)
10.	Any Other Business

Next Meeting

NGH Flowchart for Review of All Deaths V3 (Mar 2017)




1st SJR
Overall Care Score of 3,4, or 5
No further action
Feedback learning to MRG
Overall Care Score of 1 or 2
2nd SJR
Trustwide Mortality Case Note Review Group
Including judgement of avoidability of death
Immediate Cause for concern
Referral to RoHG
Feedback learning to MRG
Avoidability of death score 5 or6
Avoidability of death score 3 or 4
Avoidability of death score 1 or2
No further action
Refer to MRG via AMD (Clinical Governance)
Referral to RoHG
Feedback learning to MRG
Feedback learning to MRG
Feedback learning to MRG
Overall Care Score
1 – Very Poor Care
2 – Poor Care
3 – Adequate Care
4 – Good Care
5 – Excellent Care
Avoidability of Death Judgement Score
1 – Definitely avoidable
2 – Strong evidence of avoidability
3 – Probably avoidable (more than 50:50)
4 – Possibly avoidable but not very likely (less than 50:50)
5 – Slight evidence of avoidability
6 – Definitely not avoidable

NGH Directorate/ Specialty Morbidity & Mortality Meetings

TERMS OF REFERENCE

Membership	• M&M Lead (Chair) • Meetings are open to all clinical staff of all disciplines within the directorate/ department • Service Manager • Division Governance and Compliance Co-ordinator
Quorum	• NA
In Attendance	• Administrative support • Other staff may be invited to attend at the discretion of the chair
Frequency of Meetings	• This will depend on the number of deaths to be discussed. 1st Structured Judgement Review should occur within 4 weeks of death to allow early identification of need for further review and escalation via the Mortality Review Team should occur immediately an issue is identified and not wait for the next M&M meeting. It is suggested that directorates/ specialties with more than 5 deaths per month should meet monthly (minimum 10 meetings per year).
Accountability and Reporting	• Report quarterly to CQEG via the Divisional Directors report • Report annually via the M&M lead to the Mortality Review Group
Date of Approval	• 31/03// 2017
Review Date	• 31/03/ 2018

NGH Directorate/ Specialty Morbidity & Mortality Meetings

Terms of Reference

1. Constitution

The Mortality Review Group hereby establishes a sub -group known as the Directorate/ Specialty Morbidity and Mortality Meetings (M&M).

Its principle aims are:

- To support a standardised review process using the Structured Judgement Review (SJR) Tool.
- To provide a forum for discussion of examples of good care and areas where care could have been improved
- To ensure trustwide engagement in mortality casenote review
- To involve a wide range of clinicians of all grades in mortality casenote review
- To inform CQEG via quarterly reports of findings of M&M meetings
- To provide an annual summary to MRG
- To provide a forum for the discussion of "morbidity" where appropriate (some directorates/ specialties will have zero or minimal mortality and therefore the focus will be largely morbidity)
- To act as a forum to feedback Trustwide issues from Trustwide Mortality Casenote Reviews and Dr Foster monitoring

2. Purpose

- To act as the central group for a particular directorate/ specialty - chaired by the M&M lead.
- To escalate any concerns that may arise to Mortality Review Group.
- To support the Trust strategy of '*Best Possible Care'* for patients.
- To provide assurance of the quality of care given to patients who die.

3. Membership

- M&M Lead (Chair)
- Meetings are open to all clinical staff of all disciplines within the directorate/ department
- Service Manager
- Division Governance and Compliance Co-ordinator

4. Quorum, Frequency of meetings and required frequency of attendance

In the event of the chair being unavailable the meeting will be chaired by another nominated consultant.

The chair will monitor compliance with the Terms of Reference and will bring any non-compliance to the attention of the CQEG

An attendance list will be kept and circulated to the membership with the minutes.

In attendance

- Administrator
- Other attendees as requested by the Chair

5. Authority

The Directorate/ Specialty M&M Meeting is authorised by MRG through the Chair to investigate and develop any activity within its terms of reference. The M&M shall make recommendations to CQEG through the Chair if it deems appropriate on any area within its terms of reference where action or improvement is required.

6. Accountability and Reporting arrangements

The Directorate/ Specialty M&M Meeting will report to CQEG quarterly and shall draw to the attention of CQEG to any issues that require escalation to Quality Governance Group / Board disclosure to the Board through the Chair of CQEG. In parallel key issues/concerns and associated actions will be reported to HMT via the Divisional Director / Divisional Manager. The Directorate/ Specialty M&M Meeting will provide an annual summary of activity and learning to MRG.

The Minutes of the meeting shall be formally recorded. Copies of the minutes of the meeting shall be made available for staff to see.

7. Compliance and Effectiveness

The Directorate/ Specialty M&M Meeting will support the CQEG and the Board of Directors in discharging their responsibilities by providing objective assurance that processes are in place across the Trust to ensure that high quality, safe effective services are being provided that meet the terms of the contract that is in place. This information will be integrated through in the quarterly report to CQEG

8. Administration

The Directorate/ Specialty M&M Meeting shall be supported administratively by the Directorate/ Specialty.

9. Requirement for review

These terms of reference will be formally reviewed by The Mortality Review Group no less than annually, and may be amended in consultation with CQEG to reflect changes in circumstances which may arise.

10. FOI Reminder

The minutes (or sub-sections) of the Committee/ Group, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the meeting papers.

Mortality Screening Tool

Patient ID Label:	Date of Death:
	Date of Screening:

On reviewing the whole case, in your opinion was there evidence of the following:		Yes/ No	Supporting comments	Examples of Notable Care
Timeline issues	Delays or omissions in diagnosis, investigations, delivery of care, treatment etc			
Poor communication	To include clinical communications and handovers or communication with the patient or next of kin			
Inadequate monitoring	Failure to recognise or take appropriate action on abnormal observations or investigations			
End of Life issues	DNA/ TEP not considered when appropriate or invalid or not followed. Inadequate palliative care			

On reviewing the whole case, in your opinion was there evidence of the following:		Yes/ No	Supporting comments	Examples of Notable Care
Triggers/ risk factors	• New DVT/ PE • Hospital acquired infection/ wound infection • Cardiac Arrest/ peri arrest • Fall in hospital • Development or worsening of a pressure ulcer • Complication of surgery or treatment • Emergency readmission • Unplanned return to theatre or unplanned admission to ITU post-operatively • INR >6 • Hypoglycaemia • Development of AKI during admission • Use of naloxone or Flumazenil			
Any other concerns	This can relate to any aspect of the patient pathway and can be anything that has caused you concern when reviewing the notes			

Checklist for Mortality Screening Process for ALL ADULT DEATHS

Please confirm that you have completed the following:

1	Reviewed all available documentation and completed the Mortality Screening Tool	
2	Spoken to the junior doctor responsible for the care of the patient and completion of the death certificate if applicable	
3	Spoken to any other relevant members of staff (if applicable)	

Please document the cause of death below for reference:

Ia)
Ib)
Ic)
II(1)
II(2)

Outcome of Screening Process (please choose 1 of the following options)

1	No issues raised by the screening process – No further review required	
2	Screening process has identified the need for 1st Structured Judgement Review	
3	Screening process has highlighted significant concerns that indicate the need for immediate referral to Review of Harm Group (RoHG)	

Signed……..

Name……..

Date……

Indication for 1st Structured Judgement Review If you have selected option 2, please record the indication by ticking the relevant box/ boxes below (there may be more than 1 indication)	
The patient died during an elective admission	
The patient died within 30 days of an operative procedure	
The patient died within 30 days of Chemotherapy	
The patient had a Learning Disability	
The patient was admitted from a Mental Health Trust	
The patient was detained under the Mental Health Act	
The Medical Screener has identified concerns about the quality of care which require further review	
The Medical Screener has spoken to staff members involved in the care of the patient who have identified concerns about the quality of care which require further review	
The Medical Screener has noted that the Next of Kin have identified concerns about the quality of care which require further review	
Any other reason (please specify):	

For use by the Mortality Review Team – Tracking of outcomes of referral for 1st Structured Judgement Review	**Yes/ No/ NA**	**Date Completed**
Screening details entered onto spreadsheet		
Case referred to appropriate Directorate/ Specialty M&M for 1st SJR please document which M&M the case has been referred to:		
Copy of completed 1st SJR returned		
2nd SJR required?		
Date scheduled for presentation at Trustwide Mortality Case Note Review Meeting *(or another group)*		
Referral to RoHG required?		
Feedback from RoHG received		

Structured Judgement Review Tool – 2017 (V4)

M&M: **Audit ID:**

Patient Identifier:		**Date of admission**		**Date of Death**	
Type of admission		**LOS**		**Age**	
Consultant Attribution:					
Ward Transfers:					
Specialty Transfers:					

Brief Summary of Admission:
Co-morbidities/ Past Medical History:

Phase of Care	Comments Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	Please rate the care during this phase 1. Very poor care 2. Poor care 3. Adequate care 4. Good care 5. Excellent Care
Admission and initial management (approximately first 24 hours		
On-going care		

Phase of Care	Comments Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	Please rate the care during this phase 1. Very poor care 2. Poor care 3. Adequate care 4. Good care 5. Excellent Care
Care during a procedure (excluding IV cannulation)		
Perioperative care		

Phase of Care	Comments Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.	Please rate the care during this phase 1. Very poor care 2. Poor care 3. Adequate care 4. Good care 5. Excellent Care
End of Life care		

Overall Assessment Please record your explicit judgements about the quality of care the patient received overall		Please rate the overall care received by the patient

Please rate the quality of the patient record	1. Very poor 2. Poor 3. Adequate 4. Good 5. Excellent	Comments:

Assessment of problems in healthcare

Were there any problems with the care of the patient? If Yes please complete the table below.

Was the problem related to:	**Did the problem occur? Yes/ No**	**Did the problem lead to harm? No/ Possibly/ Yes**
Assessment, investigation or diagnosis (including pressure ulcer risk, VTE risk, history of falls)		
Medication/ IV fluids/ electrolytes/ oxygen (other than anaesthetic)		
Treatment and management plan		
Infection control		
Operation/ invasive procedure (other than infection control)		
Clinical monitoring (including failure to plan, undertake, or to recognise and respond to changes)		
Resuscitation following a cardiac or respiratory arrest (including CPR)		
Any other situation not fitting into the categories above		

Does this case require referral for further review?	**Please tick one option**	***Date referral made***	***Comment***
Overall Care Score 3,4 or 5 - No further review needed			
Overall Care Score 1 or 2 - Referral for Second SJR			
Immediate Cause for Concern - Referral to Review of Harm Group			

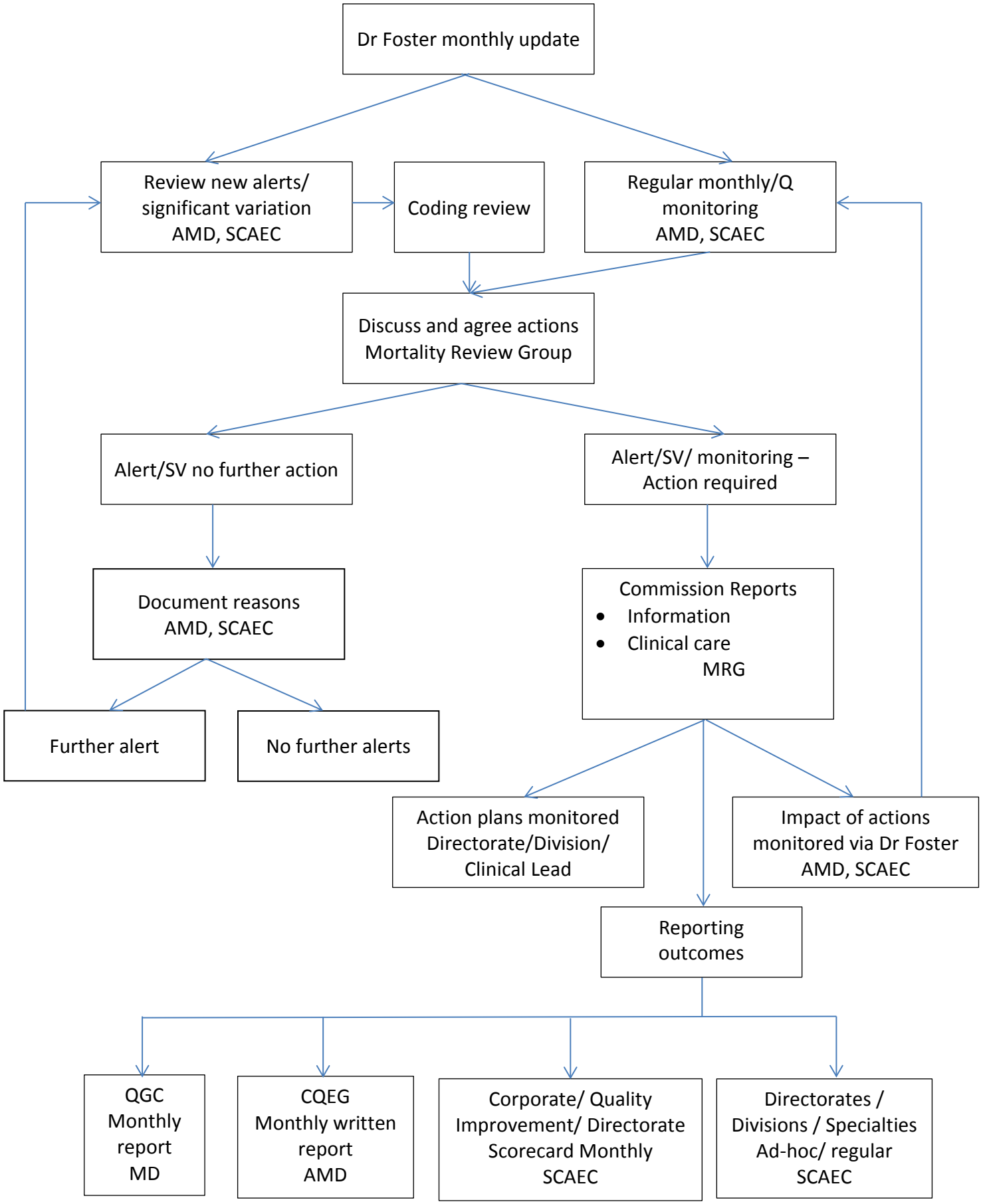
Signed…… *Date……*

……

Avoidability of Death Judgement Score (only complete during 2nd SJR)

Score 1 Definitely avoidable	
Score 2 Strong evidence of avoidability	
Score 3 Probably avoidable (more than 50:50)	
Score 4 Possibly avoidable but not very likely (less than 50:50)	
Score 5 Slight evidence of avoidability	
Score 6 Definitely not avoidable	

Please explain your reasons for your judgement of the level of avoidability of death in this case, including anything particular that you have identified.


Dr Foster monthly update
Review new alerts/ significant variation AMD, SCAEC
Coding review
Regular monthly/Q monitoring AMD, SCAEC
Discuss and agree actions Mortality Review Group
Alert/SV no further action
Alert/SV/ monitoring – Action required
Document reasons AMD, SCAEC
Commission Reports
Information
Clinical care
MRG
Further alert
No further alerts
Action plans monitored Directorate/Division/ Clinical Lead
Impact of actions monitored via Dr Foster AMD, SCAEC
Reporting outcomes
QGC Monthly report MD
CQEG Monthly written report AMD
Corporate/ Quality Improvement/ Directorate Scorecard Monthly SCAEC
Directorates / Divisions / Specialties Ad-hoc/ regular SCAEC

Summary of M&M meeting – Register and Minutes

Date of meeting:	Meeting Co-ordinator:

Medical Staff	
Nursing Staff	
Others	

Patient ID (hospital number)*	Overall Care Score	Learning points	Action	Person responsible

*Add further rows if required

Directorate/ Specialty Annual Report of M&M Meetings to Mortality Review Group			
Directorate/ Specialty			
Date of MRG meeting			
This report covers meetings in the period:			
Dates of Meetings during the period			

Overview of process*			
How are cases selected for Structured Judgement Review (SJR)?			
How many SJR's have been completed in the period?			
Please give details of the Overall Care Scores assigned for all patients who have had an SJR	**Very Poor Care (1)**		
	Poor Care (2)		
	Adequate Care (3)		
	Good Care (4)		
	Excellent Care (5)		
How many cases have been referred for 2nd SJR?			
How many cases have been referred to RoHG?			
For deaths where the care was judged to be poor or very poor – what was the outcome of the 2nd SJR – Avoidability of Death Judgement Score	**1**	**Definitely avoidable**	
	2	**Strong evidence of avoidability**	
	3	**Probably avoidable (more than 50:50)**	
	4	**Possibly avoidable but not very likely (less than 50:50)**	
	5	**Slight evidence of avoidability**	
	6	**Definitely not avoidable**	

*if you need further information to complete this table please email m&m@ngh.nhs.uk

Learning Points

Learning can be identified from examples of notable care or examples of care that could be improved. Please include feedback from RoHG group and 2nd SJRs when available.

Issue Raised*	Learning/ Action taken

*Please add extra rows as required

FORM 1 & 2 - To be completed by document lead

FORM 1a- RATIFICATION FORM - FOR COMPLETION BY DOCUMENT LEAD Note: Delegated ratification groups may use alternative ratification documents approved by the procedural document groups.	
DOCUMENT DETAILS	
Document Name:	Monitoring, Reviewing, Investigating and Learning from Mortality Policy
Is the document new?	Yes / No
If yes a new number will be allocated by Governance	New Number NGH-PO-1109
If No - quote old Document Reference Number	
This Version Number:	1
Date originally ratified:	
Date reviewed:	June 2017
Date of next review: a 3 year date will be given unless you specify different	3 Years
DETAILS OF NOMINATED LEAD	
Full Name:	Dr Louisa Jameson
Job Title:	Speciality Doctor
Directorate:	Clinical Audit
Email Address:	Louisa.jameson@ngh.nhs.uk
Ext No:	3829
DOCUMENT IDENTIFICATION	
Keywords: **please give up to 10 –** to assist a search on intranet	

GROUPS WHO THIS DOCUMENT WILL AFFECT? (please highlight the Directorates below who will need to take note of this updated / new policy)		
Anaesthetics & Critical Care	Gynaecology	Medicine
Child Health	Haematology	Nursing & Patient Services
Corporate Affairs	Head & Neck - inc Ophthalmology	Obstetrics
Diagnostics	Human Resources	Oncology
Facilities	Infection Control	Planning & Development
Finance	Information Governance	Trauma & Orthopaedics
General Surgery		Trustwide

TO BE DISSEMINATED TO: NB – if Trust wide document it should be electronically disseminated to Head Nurses/ Dm's and CD's .List below all additional ways you as document lead intend to implement this policy such as; as presentations at groups, forums, meetings, workshops, The Point, Insight, newsletters, training etc below:

Where	When	Who

FORM 1 & 2 - To be completed by document lead

FORM 1b - EQUALITY ANALYSIS REQUIRED FOR ALL PROCEDURAL DOCUMENTS (I.E. POLICIES, PROCEDURES, PROTOCOLS, GUIDELINES) - FOR COMPLETION BY THE EQUALITY ANALYST	
Is there potential for, or evidence that, this procedural document **will not** promote equality of opportunity for all or promote good relations between different groups?	Yes / No
Is there potential for, or evidence that, this proposed procedural document **will affect** different protected groups/characteristics differently (including possibly discriminating against certain groups/protected characteristics – see below)? • Age • Disability • Gender Reassignment • Marriage and Civil Partnership • Pregnancy and Maternity • Race • Religion or Belief • Sex • Sexual Orientation	Yes / No
If the answer to one or both of the questions above is 'yes' a full Equality Analysis must be undertaken by a trained Equality Analyst using the Trust's Equality Analysis Online Toolkit. The electronic report (PDF) must be submitted with this form for ratification. If the answer to both of the questions above is 'no' the full Equality Analysis process is not required. The Equality Analysis must be logged on the Trust's Equality Analysis Online Toolkit through the completion of the Screen & Sign Off sections by a trained Equality Analyst. The electronic report (PDF) must be submitted with this form for ratification.	

FORM 2 - RATIFICATION FORM to be completed by the document lead

Please Note: Document will not be uploaded onto the intranet without completion of this form

CONSULTATION PROCESS

NB: You MUST request and record a response from those you consult, even if their response requires no changes. Consider Relevant staff groups that the document affects/ will be used by, Directorate Managers, Head of Department ,CDs, Head Nurses , NGH library regarding References made, Staff Side (Unions), HR Others please specify

Name, Committee or Group Consulted	Date Policy Sent for Consultation	Amendments requested?	Amendments Made - Comments
Mortality Review committee			
Directorate M&M Leads			
M&M Bereavement			

Existing document only - FOR COMPLETION BY DOCUMENT LEAD

Have there been any significant changes to this document? *if no you do not need to complete a consultation process*		YES / NO
Sections Amended:	YES / NO	**Specific area amended within this section**
Re-formatted into current Trust format	YES / NO	
Summary/ Introduction/Purpose	YES / NO	
Scope	YES / NO	
Definitions	YES / NO	

FORM 1 & 2 - To be completed by document lead

Roles and responsibilities	YES / NO	
Substantive content	YES / NO	
Monitoring	YES / NO	
Refs & Assoc Docs	YES / NO	
Appendices	YES / NO	

FORM 3- RATIFICATION FORM (FOR PROCEDURAL DOCUMENTS GROUP USE ONLY) **Read in conjunction with FORM 2**			
Document Name:	**Monitoring, Reviewing, Investigating and Learning from Mortality Policy**	**Document No:**	**NGH-PO-1109**
Overall Comments from PDG			

	YES / NO / NA	**Recommendations**	**Recommendations completed**
Consultation Do you feel that a reasonable attempt has been made to ensure relevant expertise has been used?	**YES / NO / NA**		
Title -Is the title clear and unambiguous?	**YES / NO / NA**	Need to complete box on the title page	Completed
Is it clear whether the document is a strategy, policy, protocol, guideline or standard?	**YES / NO / NA**		
Summary Is it brief and to the point?	**YES / NO / NA**		
Introduction Is it brief and to the point?	**YES / NO / NA**		
Purpose Is the purpose for the development of the document clearly stated?	**YES / NO / NA**		
Scope -Is the target audience clear and unambiguous?	**YES / NO / NA**		
Compliance statements – Is it the latest version?	**YES / NO / NA**		
Definitions –is it clear what definitions have been used in the	**YES / NO / NA**	Need to add M&M in Definitions	Completed
Roles & Responsibilities Do the individuals listed understand about their role in managing and implementing the policy?	**YES / NO / NA**		
Substantive Content is the Information presented clear/concise and sufficient?	**YES / NO / NA**	Formatting needs completing	Completed
Implementation & Training – is it clear how this will procedural document will be implemented and what training is required?	**YES / NO / NA**		
Monitoring & Review (policy only) -Are you satisfied that the information given will in fact monitor compliance with the policy?	**YES / NO / NA**		
References & Associated Documentation / **Appendices**- are these up to date and in Harvard Format? Does the information provide provide a clear evidence base?	**YES / NO / NA**	Appendix 4 Title to change to Role Responsibilities	Completed
Are the keywords relevant	**YES / NO / NA**		

Name of Ratification Group: Procedural Documents Group	**Ratified Yes/No:** **Ratified pending minor amendments and Chair Approval**	**Date of Meeting:** **19/07/2017**