National Mortality Case Record Review Programme

Frequently Asked Questions

May 2017

Sections

Foreword:

This document is a non-exhaustive list of frequently asked questions about the National Case Record Review programme and the Structured Judgement Review Methodology. Various sources have been used to compile this list including information from our pilot sites. This document is to be used as an aid to support the training of reviewers. It is subject to amendments as we gain further experience and gather more feedback during the course of the programme.

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1. The Structured Judgement Review (SJR) Methodology

1.1 Is this methodology validated and reliable?

This method has been shown to be valid[1] and is used extensively in several healthcare systems in England. Case study reviews from our pilot sites and the work done in Yorkshire & Humber shows that consensus agreement can occur more than 95% of the time.

1.2 Why is this method being used rather than other methodologies e.g. Prism2?

The methodology has many aspects in common with other retrospective methodologies used for case notes reviews. This method has been used extensively in England and validated on a large cohort of cases. It was chosen to be the standardised mortality review tool by NHS Improvement.

1.3 Why do we need both scores and judgement comments?

This is covered in some detail in the Royal College of Physicians' Reviewer Guide[2]. The data provides different forms of information that can be used for individual cases and for groups of cases. Contrasting judgement comments and care scores can also assist reviewers in their decision making in each phase of care.

1.4 How much of the scoring is subjective and how much is objective?

Many decisions in health care have elements of both in the final formulation, and these decisions, of course, vary from case to case and between situations. These processes also apply to Structured Judgement Review.

1.5 There could be a large variation in subjectivity in the judgement; Doves & Hawks.

This can be so, but work on training cases suggests this is not as great as one might expect and, of course, it has always been present with mortality reviews, whatever the method used. Quality assurance of the reviews via the governance process should help to identify cases where additional training is required.

1.6 Why has a Likert scale been chosen?

The scale was chosen so that clinicians could give their clinical explicit judgement about the overall quality of care received by the patient. There is no validated categorical scale that can be used in these circumstances. All of the large epidemiological studies on mortality rates have used this approach.

1.7 Is there a matrix available to judge what is good and what is not so good care?

No. Experience shows that in all but the poorest of care, the judgement on the range of care is much more subtle. And even in poor care there is often some good 'rescue' work. This is why explicit judgements form the basis of the reviews, rather than use a criterion based approach.

1.8 How do I make a judgement on a colleagues' work?

This is a governance question and local processes will be in place to manage this.

1.9 Do the issues/comments carry different weightings when giving a phase score?

Yes, they do, but not as 'mini scores', because the weight of a particular component of a phase of care may carry most importance in making a decision. If everything else is adequate and one item is poor this could take the care score down. The reverse could happen if one element was excellent.

1.10 Do we name the care giver (e.g. Doctor /Nurse) when writing the judgement comment?

No. Care giver names are not used in the review, although role titles can be used where this is thought relevant.

1.11 How long, on average, does it take for a review to be completed?

This is mainly dependent on the details of the case. But SJR and other structured methods such as PRISM 2 require the reviewer to give attention to the detail of the case throughout the care episode so by definition some of these reviews can take significant amounts of time, up to and sometimes even over one hour.

1.12 If the care prior to arrival to hospital is relevant, should I record that in the review? If so, should it be in the admission phase?

Yes. But this is background and should not form part of the material on which a judgement is made, since the review process only looks at the care provided within the hospital.

1.13 What should we record as 'procedures'? Should cannula insertions be recorded?

The reviewer needs to make a judgement here. Where procedures carry some risk, and some cannulations do so, then these should be included in procedures.

1.14 Do Not Attempt Cardio Pulmonary Resuscitation decisions; should it be recorded in the end of life phase even if completed in the first 24hrs?

Activities and care that occur in the first 24 hrs should be recorded there, even if these are decisions that refer to end of life care. They should be referred to again in the EOL section, with the 'hindsight' on whether this was appropriate at the early stage of care.

1.15 Should a surgical procedure be recorded in the 'care during a procedure' phase or in the perioperative phase?

Surgical procedures can be recorded in either phase provided they are recorded at least once in the review and care scores given appropriately.

1.16 For surgical procedures performed within the first 24 hours, should we record this is in the 'initial first 24-hour phase of care'?

Similarly, the data should be recorded at least once in the review and scored accordingly.

1.15 What is the inter-rater variability in terms of scoring?

There are no inter-rater comparisons available from SJR training or recent practice. Initial inter-rater comparisons from the supporting research were similar to other assessments. That is, agreement of about 60-70% between 2 reviewers separately examining the same set of case notes.

1.16 Why is there variability in scores during training?

Variability at this stage is to be expected because of known inter-rater variability between reviewers and because the training session is the first time that many people have used this new methodology.

1.17 Can nurses review a surgical procedure?

Just as with the whole spectrum of professional reviewers, specialist nurses with the appropriate skills can contribute to a surgical case review.

1.18 How do we accommodate reviewers' specialist skill sets or reviews needing specialist information? Can we review what is not within our speciality?

In general, reviewers will work within their broad areas of expertise or will occasionally undertake joint reviews. Where specialist information is required then colleague support should be arranged through the review programme.

1.19 Is it a problem when reviewers' specialist knowledge guides their focus when doing reviews?

Reviewers will often bring specialist knowledge to bear when undertaking reviews. But reviewers will recognise that many of the quality issues they find are about the organisation and delivery of care and are thus generic.

1.20 Can trainees be reviewers?

Doctors in the later stages of training often make very perceptive reviewers. After review training they would work in within the governance process, as would all other reviewers.

1.21 Can we use SJR for other reviews other than deaths?

Yes. SJR is a quality and safety review process and works well for cases where there is not a death. This is, of course, outside of the framework of the national mortality review programme.

1.22 Can this review method be used on near miss/random samples as part of quality improvement work?

Yes, it works well in these circumstances, providing rich information for themed reviews.

2. The Mortality Review Process

2.1 How do we select the cases for review?

Each Trust will publish an account of the rationale for choosing case notes for review but a minimum list has been described by NHS Improvement and Clinical Quality Commission in the Framework for Learning from Deaths[3].

2.2 Who can train to be a reviewer?

Usually reviewers are consultants, senior trainees or senior nursing staff but in principle anyone can train to be a reviewer as long as the quality of their reviews is good and consistent and they have the appropriate clinical skills to assess the appropriateness of the care provision.

2.3 Can the second review be done by a team?

Yes, provided all the members have also reviewed the notes. Good governance processes suggest there should be a lead reviewer who takes responsibility for the decisions.

2.4 Why is there an issue with consultants reviewing their own cases?

The issues are around the need for review objectivity. The 2017 NHS guidance 'Learning from Deaths', Section 20,[3] sets out the expectations.

2.5 How does SJR fit into our governance processes?

All mortality review processes need to be part of the hospital governance process. The strengthening of good governance processes during 2017 will provide extra support for reviews and reviewers.

2.6 What happens if we identify a problem in care?

The Duty of Candour and National Framework legislation will apply to this process and each Trust should have a system in place to act on such problems in care.

2.7 How do we avoid duplication of reviews with mortality & morbidity reviews and/or other national audits?

Correlation rather than duplication is required here. Mortality and Governance committees should be able to provide guidance here.

2.8 How do we integrate this process with Serious Untoward Incidents investigations & Root Cause Analysis?

For this to happen, the mortality review programme needs to be firmly embedded in the hospital governance programme.

2.9 How does this process correlate with Coroners' cases?

There is currently no evidence of this with any review programme, although some research evidence may be available in future.

2.10 On average, what proportion of cases at first review end up with an overall phase score of 1 or 2 and need escalating?

This proportion varies greatly between types of cases and selection methods, but experience shows that one might expect around 5-10% of cases going to second review

2.11 Should we review elective palliative radiological interventions?

It would be wise to do so if there was a concern that the intervention may have played a part in the death of a patient.

2.12 Can we review paediatric deaths?

Though the SJR method can be applied to the review of child deaths, this programme is concerned with the deaths of adults [18 years and over] who die in acute hospitals. There may be instances where children aged 16yrs and 17yrs die in an acute hospital, for example in the intensive care unit. Special processes will be in place in the hospital to manage reviews under these circumstances.

2.13 How does the review programme work when there is pressure to review all deaths?

There is now much clearer national guidance[3] on the cases for inclusion in the review process. There is no suggestion that all deaths in hospital require a full review.

2.14 Within how many days should a review be done?

There is no set time for reviews to be done although it is likely that the hospital will have developed a policy on this. It makes sense to try to get the reviews done without due delay since there is always a chance that an unexpected issue is found that will require disclose. This is better done sooner rather than later.

2.15 How do I do a timely review when there are delays in getting the case notes?

This is a problem faced by many reviewers, who will need the support of the hospital governance process to recognise the requirement to improve the timeliness of access.

2.16 I am a busy consultant, how do I find time to do reviews?

This is a frequent problem, being addressed now in many hospitals through a more structured approach to undertaking reviews and managing the information from those reviews. Delay is after all a governance issue and is now explicitly addressed in the 'Learning from Deaths' NHS plan[3].

2.17 As a trust, how do we assess our cohort of reviewers?

This is the role of the hospital governance process. Continuous quality improvement assessment approaches assess the quality and appropriateness of the reviews in the hospital programme. This can be done, for example, by exploring the quality of qualitative data being provided and matching judgements against scores given.

2.18 Are the review forms disclosable to families/carers if they have a complaint?

Yes, just as all of the other patient records are available.

3.The National Mortality Case Record Review (NMCRR) programme.

3.1 The programme is only being implemented in England and Scotland, what is happening to other parts of the UK?

The current contract covers England and Scotland; if other parts of the UK wish to participate they should contact HQIP.

3.2 Which sites were involved in the pilot phase of the NMCRR programme?

NHS Highlands (Scotland), South Manchester NHS FT, Harrogate and District NHS FT, York Teaching Hospital NHS FT, St George's University Hospitals NHS FT, West of England Academic Health Science Network (including Bristol, Bath, Swindon).

3.3 What are the implications for the NMCRR programme once it becomes part of the wider mortality Framework?

The NMCRR was commissioned as an independent programme from the Framework and will continue to be so for its lifetime.

3.4 Where can we find the programme support materials?

They are available via the RCP mortality programme webpages[4]. They will also be available via the on-line portal once it is in place.

3.5 What is the NMCRR programme portal and when will it be available?

The portal will be an on-line tool, free to use and there for all clinicians involved in the NMCRR process. Our aim is that it will hold all programme guidance materials, offer a feedback mechanism directly to the NMCRR programme team, facilitate a forum, will be a sharing platform for example to display case studies, and will also facilitate annual renewals for reviewers to test their knowledge and assure themselves and their employers of their knowledge and skill as an SJR reviewer. We are currently working with software companies and hope to have the portal on-line by Autumn 2017.

3.6 Who can be a Tier One trainer?

Tier One trainers can be recruited from clinical and non-clinical backgrounds but must have educational and training competencies. Usually Tier One trainers come from senior educationalists, consultant staff or senior allied health disciplines including nursing and physiotherapy.

3.7 We have a different methodology in my Trust, does this matter?

The Framework specifies that where needed the SJR methods should be used for case record review but it is not mandated completely and some flexibility exists. The CQC and NHSI[3] would need to be reassured that the system in place in your Trust is validated and reproducible.

3.8 Will anything else happen to the information we input? Will it be reported nationally?

Individual hospitals will only be able to see and analyse their own information. However, the Royal College of Physicians and the Yorkshire & Humber Improvement Academy will have access to all anonymised information nationally. The NMCRR programme will report this anonymised information nationally and regionally, for example, on the identification of themes; good practice and learning points. This information will not take the form of league tables.

3.9 Is the programme going to publish data around avoidable mortality and will comparison league tables be created?

No, the NMCRR contract specifically states that the work is not designed to generate data for comparison of Trust/hospital performance or to contribute to a national measure of the number of deaths due to problems in care. The data generated from this programme is primarily for use by Trusts/hospitals to support their own learning and improvement.

3.10 How will the national programme ensure that the quality of reviews in hospitals is maintained?

The programme will not be responsible for ensuring the quality of trust reviews but will have a role in assessing the quality of training provision by Tier One trainers.
The core project team have developed a quality assurance strategy which will be deployed when the Tier One trainers become fully engaged in the implementation and roll out of the programme.

3.11 What happens to the programme at the end of the 3 year contract?

The decision whether or not to renew the contract will be taken during Year 2. As the SJR process has become part of the wider Department of Health mortality structure it is likely that SJR will continue as a lead mortality review process even if the contract is renewed.

3.12 What is the current situation with DATIX and the platform?

The platform is currently in the final stages of building and will shortly be hardened/security tested. Once that is completed the platform will be tested by the pilot sites prior to being rolled out nationally in England and Scotland.

3.13 How much will the DATIX platform cost my Trust?

The platform will be free for hospitals/Trusts to use and training will be provided by DATIX UK. Hospitals/Trusts that do not currently use DATIX systems will still be able to use the mortality platform.

3.14 Why are we not able to input the date and time for admissions and deaths of patients on the DATIX platform?

Doing so would make the patient more likely to be identified. The platform only allows the input of non-identifiable data.

3.15 How will the DATIX platform help us to understand our mortality reviews?

Clinicians will input their mortality reviews onto the platform, as the numbers of reviews build the platform will support with the ability to perform thematic analysis to identify areas of concern and also good practice. It will be possible to analyse data looking at days or specific wards so that locally mortality can be better understood. An analysis package and associated analysis guidance will accompany the DATIX roll-out.

References

1. 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; 22:1032–1040. DOI: 10.1136/bmjqs-2013-001839.

2. Royal College of Physicians. *Using the structured judgement review method – a guide for reviewers*. London: RCP, 2016.

3. National Quality Board. *National Guidance on Learning from Deaths*. March 2017

4. Royal College of Physicians. www.rcplondon.ac.uk/mortality .London: RCP, 2017.