Royal College of Physicians | Patient Safety

Experience of structured judgement review in clinical practice

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Foreword

Dr John Dean, RCP clinical director for quality improvement and patient safety

Mortality case review has been a source of learning in healthcare from the time of the Crimean War, and National Mortality Review programmes have been commissioned by the NHS since 1954. Morbidity and mortality case reviews have been common practice by clinical teams but can lack structure, follow-up actions, and therefore potential impact.

A renewed focus on 'Learning from Deaths' has been in place in the NHS in England for the last 2 years.[1] In most NHS trusts this has incorporated the use of the Structured Judgement Review (SJR) approach, which has underpinned the National Mortality Case Record Review (NMCRR) programme. The NMCRR programme was commissioned by the Health Quality Improvement Partnership (HQIP) on behalf of the NHS in England and Scotland shortly before the Learning from Deaths policy for England was agreed. Over the 3 years of the programme around 800 clinicians have been trained in this approach and most acute NHS trusts have integrated SJR into their governance and learning systems.

In our 2018 NMCRR annual report we were able to illustrate not only how trusts, boards and teams were using this approach systematically, but most importantly how they had developed or refocused improvement programmes based on the learning from this approach – and were beginning to see improved care processes and outcomes.

The NMCRR programme was commissioned in response to the Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* in December 2016.[2] The CQC's follow-up publication: *Learning from Deaths: a review of the first year of NHS trusts implementing the national guidance*[3] in March 2019 notes that while the use of structured approaches to mortality case review is now in place in hospitals in the NHS in England, the translation of learning into improvement practice, the underpinning learning culture, and the resulting outcomes will take some time to embed and adapt.

Our review with other national mortality programmes also identified our four core themes and called on clinicians and healthcare organisations to act. These are: improving recognition and management of sepsis, early detection and appropriate escalation of patients who are deteriorating, denying life-saving therapies on the grounds of being older, pregnant or having a learning disability, and communication, both within and between organisations and healthcare agencies.

This year's report describes examples from healthcare organisations and systems on how they have structured their approach to learning from mortality case record review, and explicitly developed improvement programmes. The approach is naturally contextual to the organisation or system. We have also focused learning from the national database on people who may have died from sepsis. All of this shows the potential of both a national and local approach to learning and improving in this context.

While the commissioned NMCRR programme has come to an end in England, the RCP's Patient Safety Team is ready, willing and able to work with trusts, boards, teams and systems across the UK and internationally to support safety learning and improvement actions. The introduction of medical examiners in England and Wales will influence the work of healthcare organisations.

We will continue to work closely with the national medical examiners, NHS Improvement, other national mortality programmes, and other patient safety programmes to bring collective but context specific wisdom, guidance and peer support to organisations as they mature their practice and deliver benefits to patients, families and staff. This work has already begun and will be shared at our National Mortality Conference.

References

1 National Quality Board. *National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care.* London: NQB, 2017.

2 Care Quality Commission. *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England.* London: CQC, 2016.

3 Care Quality Commission. *Learning from deaths: a review of the first year of NHS trusts implementing the national guidance.* London: CQC, 2019.

Case studies

It has been pleasing over the past year to see positive outcomes from structured judgement review (SJR) emerging from trusts outside of our early adopters of the methodology. Following a call for abstracts, a selection of the submissions received have been translated into case studies which are illustrated in this section.

The themes identified in these case studies include work on:

> reducing pneumonia mortality rates

> the impact of the medical examiner system

> the impact of SJR in the emergency department

> reducing mortality in stroke patients

> using SJR to improve hip fracture care.

Barking Havering and Redbridge University Hospitals NHS Trust

Reducing pneumonia mortality rates

History of **higher than expected** pneumonia mortality rates in the trust

Undertaken **two cycles** of mortality reviews

First cycle

Identified significant proportion of patients wrongly coded with pneumonia as a cause of death. (High volume of frail elderly patients from nursing homes were being transferred to hospital in the late stages of life.)

Structured judgement review on 27 patients, focused on quality of care.

Second cycle

Number of actions were undertaken:

- renewed focus delivering the sepsis 6 bundle
- assessment of compliance with curb 65 and sepsis 6 delivery
- ensuring compliance with community acquired pneumonia care bundle
- objective: teach junior doctors differences between lower respiratory tract infection (LRTI) and pneumonia and how to diagnose pneumonia
- mandatory e-learning course for managing pneumonia.

The **summary** of the reviews identified:

- 15 people (**55.55%**) out of 27 died of pneumonia, whereas 12 people (**44.45%**) died from other causes.
- Only six patients out of 15 with pneumonia had documented CURB65 score (**40%**).
- Only seven patients out of 18 patients had sepsis 6 bundle completed and followed (**38.88%**)

Bradford Teaching Hospitals
NHS Foundation Trust

Approach to mortality review

Adult deaths are captured centrally and shared weekly with mortality leads, in order to select cases for structured judgement review (SJR)

If care is assessed as **inadequate or poor**, a second independent review is initiated

Identified problems in care go to serious incident investigation, or referral to the coroner

Learning points are included in the trust-wide mortality outcome report, along with recommended improvements

Two mortality reports are produced quarterly and shared with all teams, to identify themes and learning

Learning from SJRs is used to inform and drive quality improvement initiatives, eg Deteriorating Patient Collaborative Improvement Programme

Learning is fed back to staff using established clinical governance structure

Bradford Teaching Hospitals
NHS Foundation Trust

Learning disability mortality review process

Deaths of all patients with a learning disability reviewed by the LD Mortality Review Group

Collaborative working with Learning Disabilities Community Liaison Team improves identification of learning disability and mental health deaths in hospital

If structured judgement review finds **inadequate or poor care**, then a second independent review is initiated

Problems in care are **recorded on Datix** and dealt with via internal investigation systems

Key learning and recommended improvements included in the trust-wide mortality outcome report

Some of the **key learning points** identified and receiving focus include:

- the importance of recognising end of life, and involving the palliative care team
- the need for staff to initiate nil by mouth conversations with patients and relevant multi-professionals to agree patient management plan
- documentation of 'typical function when well' by making a walk/talk/read/feed assessment

Buckinghamshire Healthcare NHS Trust (BHT) and Oxford Academic Health Science Network (AHSN)

The impact of a medical examiner service in improving patient safety and quality of care

Regional approach to learning from deaths via the Oxford Patient Safety Collaborative, Oxford AHSN

- Group includes community, ambulance and CCG to improve cross-system structured judgement reviews (SJR)
- Four out of five acute trusts have now implemented a medical examiner, with the 5th planned for March 2020.
- The group has created a safe environment with peer support for:
  - sharing feedback from national events and emerging national guidance
  - development of regional terminology
  - practical processes, eg rotas
  - sharing themes
  - how to integrate into current governance processes and learning from deaths framework.

What did we learn/change?

- Feedback from relatives is overwhelmingly positive – examples of outstanding practice is fed back to ward teams.
- Care of the deteriorating patient is focused on vital signs monitoring, early senior medical review with NEWS2 and electronic observations implementation.
- Enhanced focus on care of learning disability patients including best practice guidance, health passports and communication aids.
- Increased awareness of timely DNACPR decisions and treatment escalation plans (TEP), with BHT moving to universal TEP adoption.

Results within one year of launching the medical examiner system

- **99.8%** compliance for medical examiner screening for adult deaths
- Annual mean selection for SJR is **12%**
- Increased accuracy in death certification and improved support for junior doctors (validated by staff survey)
- Local agreement with the coroner, leading to **32%** reduction in referrals

The future

BHT works with the local authority, coroner's office and registrar (linked with the CCG) to disseminate learning to primary care – ensuring the patient journey is improved in the community as well as in hospital.

Cambridge University Hospitals NHS Foundation Trust (CHU)

The Learning from Deaths Programme in an Emergency Department (ED)

(review of progress 12 months post implementation)

Examples of learning

- Anti-coagulation advice changed: information about the significance of increasing headache after head injury following the death of a patient with a minor head injury.
- End-of-life medications should be prescribed for all patients recognised as dying, regardless of their clinical and conscious state on initial assessment.
- Further work is required to ensure consistency across all reviewers and true learning.

Most common learning point: the need to address inadequate end-of-life planning

Care was '**excellent**' or 'good' in **84.5%** of cases

Most patients were **elderly** with multiple comorbidities or were living with life-threatening chronic illness

71 patients died in the ED in year 1

CUH conducts structured judgement reviews (SJR) on all ED deaths

Timeliness of SJR completion improved with resource allocation

41mins

Average time for SJR was **41 minutes**

The Christie NHS Foundation Trust

Implementing structured judgement reviews (SJR

Specific examples of improvements in cancer care:

- Reductions in risk of nephrotoxic chemotherapy
- Extended pneumocystis prophylaxis to other treatment groups
- Improvements to pre- and post-procedural care
- Awareness of earlier opportunities to discuss clinical plans when a patient's outlook has changed

What we have learned?

- Action plans are made after clinical incidents
- Feedback letter to consultant after every SJR and linked to appraisal
- Regular updates in trust-wide grand rounds and 'Learning for Improvement' bulletins
- Reports to Patient Safety and Board Quality Assurance committees
- 6-month themed analysis of all reviews, including comments and low level concerns
- Top themes are highlighted to clinical directors and matrons
- Findings shared with relevant QI groups
- Discussed at doctors' teaching sessions
- Comparative analysis loop every 6 months

How

- SJR embedded and undertaken for **40%** of deaths
- 33 reviewers – SJRs are completed by doctor and nurse pairs
- Discussions at Mortality Surveillance Group
- Outcomes and learning points agreed, or cases are further escalated

Royal Cornwall Hospital (RCHT)

Stroke Team use of structured judgement review (SJR)

SJR now used to review all stroke deaths – results presented at monthly operational stroke meeting. Issues are identified to inform changes

Best news is:
stroke mortality is consistently reducing

Still working on:
improving atrial fibrillation detection and management, and increasing stroke consultant staff

Achievements to date:
new CT scanner in ED, 60% of stroke patients are admitted to stroke unit within 4 hours of arrival, increased nurse staff levels, six bedded HASU, admission of all strokes, centralised 7-day TIA clinic and monthly coding meetings

After the Cornish Stroke Pathway Review the following recommendations were added:
increased capacity of hyper-acute stroke unit (HASU) and timely admission of all stroke patients, ringfencing stroke beds, increased nursing and consultant staffing levels, admission of minor strokes and centralisation of TIA clinic service

SJR is now used to review deaths

Main issues identified:
incorrect coding, upgrade of CT scanner needed, better management of atrial fibrillation in community, faster access to stroke unit

In 2016/17 RCHT was an outlier for mortality in stroke patients. There were **212 deaths**, in comparison with 145 expected

Leeds Teaching Hospitals NHS Trust

Implementing the 'Learning from Deaths' guidance

The trust has implemented an electronic mortality screening tool – currently **93%** deaths are screened.

If **mandatory criteria are triggered** a structured judgement review (SJR) is completed.

We have **trained** approximately 400 consultants, senior trainees and senior nursing staff in SJR methodology.

Learning from SJRs is shared quarterly in the Mortality Improvement Group.

The trust involves bereaved families and carers in mortality review. A letter signposts to further support and how to contact the Patient Advice and Liaison Team if necessary. This has been well-received and the feedback is overwhelmingly positive.

There have been many **improvements to patient care** as a result of the programme, including:

- clarifying the treatment pathway for patients with intracranial injury who are not for surgical intervention
- ensuring that anticoagulation is reversed appropriately
- implementing sepsis screening within the Children's Hospital

Lewisham and Greenwich NHS Trust

Structured judgement review (SJR) implementation

Key findings and learnings from the reviews are established, and have led to implementing:

Monthly reporting of trends and learning to the Trust Mortality Review Committee

Increased collaboration with the coding department to implement an escalation process for any deaths recorded against low-risk diagnosis groups.

The introduction of a treatment escalation plan – checking completion of the document forms (part of the SJR process)

A more detailed end-of-life framework added to the SJR process, in collaboration with the palliative care service

The expansion of **SJR-trained staff** to include members of resuscitation services

SJRs with care scores of 1–3 (very poor, poor, or adequate care) are checked against the trust's incident reporting system.

United Lincolnshire Hospitals NHS Trust

Developing a system-wide mortality learning and action group for Lincolnshire

The trust introduced a multi-agency meeting to monitor deaths, agree actions, share learning and escalate issues to the Lincolnshire Mortality Summit for action against system-wide workstreams.

The first Lincolnshire Mortality Collaborative meeting took place in **February 2017**. Cases with system-wide failings and identified workstreams are discussed and assurance is provided to the collaborative meeting.

The collaborative meets every **6 weeks**.

The meeting has reviewed **197 deaths** to date, referred from both primary and secondary care.

The meeting reviews cases from a system-wide perspective: reviewing the case from secondary care, ambulance to acute care. The meeting reviews SystmOne notes and acute care case notes.

The **full pathway** of the patient is also reviewed.

Good practice is recognised and discussed with individuals or teams where appropriate.

Learning and themes that have emerged include:

1. Inappropriate admissions from nursing homes to acute care:

- During January 2018 – December 2018, 11 % of admissions were from nursing homes; 48 % of these cases should not have been admitted.
- Workstream with neighbourhood team and CCGs, initiated in line with national Enhanced Health in Care Home Framework.

2. Late recognition of end-of-life and advance care planning

3. Advance care planning communications with GPs and care homes:

- Acute care discharge documentation has been changed to reflect advance care plan options.
- Follow up by GPs on advance care plans.

4. System-wide patient safety briefings circulated:

- ReSPECT roll out
- End-of-life communication through the system

Sherwood Forest Hospitals NHS Foundation Trust

Working in partnership to implement a medical examiner (ME) service

Aim

- To use a QI approach to pilot a new ME service
- Engagement, information and real-time support are especially important, especially for junior staff
- PDSA cycles to test communication, scrutiny and documentation. We established a feedback process from staff, the bereaved and coroners

Outcomes

1. The accuracy of cause of death certification significantly improved
2. Improved reporting and liaison with the coroner
3. Positive feedback from the bereaved. The service helped to address their concerns, and offer early bereavement support and signposting
4. No added delays; sometimes quicker death certification
5. The new service detected and reported the important cases where there were potential problems in care

Learning

1. Setting up an ME service takes time and requires leadership, training and organisational support

2. There are huge benefits to the service – it is an enhancement and not a hindrance to current clinical governance

3. Some consultants found the new independent scrutiny a challenge and required further explanation and support

St George's Hospital, London

Using structured judgement review (SJR) to improve hip fracture care

Approach =
SJR + NICE guidance + national hip fracture audit

2016

National Hip Fracture Database (NHFD) mortality alert – SJR for all cases, with focus on best practice criteria for hip fracture.

1 Care generally good but:

- some **delays identified in time** to operation
- some **delays in patient mobilisation** post op
- **high proportion** of inpatient falls in 2016
- **high proportion of mortality** from pneumonia in comorbid patients

2 Led to improvements:

- in data submission to NHFD
- improved patient care
- board to ward involvement
- reduction in mortality

3 Board to ward improvement programme included:

- Emphasis on **correct coding** to NHFD
- **Early operative intervention** within 36 hours: 74.9% (2016), 83.8% (2018)
- **Management flexibility** – increase capacity to match demand
- Medical care **led by orthogeriatrics** / daily review
- Appointment of falls coordinator dramatically reduced inpatient falls resulting in fractures
- **7-day physiotherapy service** – physio within 24hr post-op: 85.7% (2016), 100% (2018)

4 Continue with SJR for hip fracture patients who die, mortality reviews include best practice criteria. Monthly review meeting of all best practice breaches.

Warrington and Halton Hospitals NHS Foundation Trust

Implementing structured judgement reviews (SJR)

Mortality Review Group (MRG) – nine consultant reviewers

MRG supported by **senior team** who ensure delivery of quality improvement

Input from CCG – process has resulted in **changes to practice** and improvements

Regular feedback provided to primary care colleagues via the GP newsletter – informs them of relevant mortality reviews and associated learning points

Undertake SJRs for the coroner as requested

Processes and learning from the MRG presented annually at the joint trust and CCG Clinical Quality Focus Group

Conduct focused reviews: example

- excess number of deaths in patients with alcohol related liver disease.
- No cases of poor care, but poor documentation about patient prognosis and lack of adequate community support on discharge.
- This is being reviewed by the gastroenterologists and the CCG.
- Gastroenterologists now documenting prognosis in all case notes and are in discussion with the CCG regarding improved post-discharge care.
- Focused reviews provide robust evidence of where we need to make changes/improvements

Close links with the safeguarding lead in the trust and the CCG. SJR is done on all learning disability deaths. SJR and outcomes available to the individual – undertaking the full LeDeR review

Collaborative approach has led to wider improvements across the community and is not just focused on secondary care.

Sepsis management – further analysis from the RCP Mortality Review Tool

Introduction

This review expands on the preliminary analysis of cases, first reviewed in 2018, that were identified as having at least a working diagnosis of sepsis of any cause. Within the platform, which now comprises more than 3,000 cases, the term sepsis is the only diagnostic word to emerge from the 50 words most frequently identified by the integrated word analysis search engine. In excess of 600 cases (of 3,000+) now concern the management of sepsis in some way.

As we reported in 2018, clinical staff from the NMCRR programme team were able to access reviews entered by all contributing hospitals, but had no access to any identifiable patient information. Additionally, no data are available to indicate what proportion of any particular hospital's deaths is being included in the dataset. Nor is it possible to determine what the selection criteria were used to select each case entered. Therefore, the results from this analysis cannot be attributed to the work of any particular hospital, 30 of which contributed to the platform.

Review approach

A thematic review of judgement comments was undertaken on a pragmatic sample of 50 review cases selected from the RCP National Mortality Review Tool (online platform) in June 2018. This number of reviews was chosen because we already know that 40–50 mortality reviews of a service or a particular patient journey (such as sepsis) are likely to be sufficient for an organisation – both to praise staff for their care, and to provide a focus for quality improvement initiatives. Further analysis has been undertaken during 2019, benefiting from thematic analyses of other selected datasets from the online platform.

Case selection

Thematic review cases were selected by using the platform word analysis tool to identify a subset of cases within the whole dataset in which the word 'sepsis' was written in the initial management judgement comments. Fifty cases were then selected from the overall 200+ 'sepsis cases' by commencing with a random number and then further selecting every third case.

The difference between a local and a national analysis of the data

There are two key differences. In terms of selecting the review topic, a national level analysis can use any of the available platform criteria to select the topic (and there are likely to be many more cases available for analysis). But an individual hospital is also likely to know how and why each case was selected for review in the first place, as well as holding the original case records.

Secondly, the hospitals know the context in which the care elements were provided. Both of these elements add a richness to the analysis and its meaning that a national analysis cannot provide. Nevertheless, analysis across the whole dataset may be able to identify trends that individual hospitals might wish to explore, in order to determine whether such trends are also to be found at a local level.

As the cases come from multiple hospitals, this thematic analysis is different in principle from that which would be done in an individual organisation. Nevertheless the ensuing themes have subsequently been found to be similar to those that have emerged from other reviews of database material relating to different clinical topics.

Undertaking the review

All of the textual explicit judgement review comments for each case were included in the analysis, from each of the relevant phases of care phases of care. This usually included:

> admission/initial management phase
> ongoing care phase
> end-of-life care phase.

Overall management comments were included with each phase analysis, where appropriate, as were procedure care review comments.

The first stage of the thematic review involved reading each of the 50 SJRs in full across all care phases, so that the analyst could have an understanding of the type of language reviewers were using to describe their views on care. This also assisted exclusions of incorrectly selected cases.

Box 1 shows an example set of case review comments of the type used in the thematic review. (Edited to ensure anonymity.)

Box 1. Example case review comments

Initial management
Recognised severe mental health issues
Early recognition pneumonia. Early/timely appropriate Sepsis 6 actions
Timely appropriate antibiotics. Admission assess appropriate
Appropriate escalation decision. Appropriate DNACPR decision.
Timely consultant review
Management plan/ceiling of treatment appropriate
Continuing care
Daily junior doctor review. Appropriate.
No consultant review. poor. Consultant advice had to be sought.
Appropriate observations. Fluid balance monitored. Appropriate
Failure to monitor regularly
Management plan poor
Failure to recognise end of life. EoL decision making poor. Failure to plan EoL care
Failure to recognise need of appropriate symptom relief
End-of-life care
Poor and limited EoL
Lack of timely decision making
Overall care
There was lack of timely clinical re-review on treatment pathway
Failure to recognise lack of response to clinical treatment
Failure to plan for end-of-life care in a more timely manner

Detailed re-reading of each case enabled the analyst to use the textual data to develop some initial thematic review headings (which act as 'clustering words'). Some of the issues, such as recognition and timeliness are clearly highlighted in the review in Box 1. Additionally, the contrasts in a theme are also visible, for example in 'timeliness', with entries such as 'Timely appropriate antibiotics' and 'Timely consultant review', while later in the care process there is a 'Lack of timely decision making'.

Thematic development is not a static process. Where initial theme names may seem appropriate, they will be of limited value if very few comments fall into the category, and should therefore be reviewed or discarded (for example as happened in this review to a theme entitled 'missed opportunities'). In other areas, such as commentaries on therapy, two closely related themes were subsequently brought together where there was deemed to be little loss of information, or there seemed later in the analysis to be an artificial separation. Furthermore, themes are not 'static' within themselves, as they usually contain contrasts, where care is good in one case, or phase of care, and poor in another. The weighting of those contrasts may be important in selecting an area for a quality improvement (QI) focus.

In this analysis the cases come from multiple sources and the 'why' QI questions cannot be addressed in the level of detail that a hospital would be able to bring. Nevertheless, one can still get a sense of the diversity of quality of care, where clusters of judgements of both good and poor care exist under the same theme heading. This is also a feature of some individual reviews, where care in a phase goes well at some points and is judged poor at another time, even within a 24-hour time period. These contrasts are shown in Boxes 2–4.

Sepsis care – thematic review overview results

Overall, in the admission phase, 25 themes emerged, some with only a few items. A few of these initial themes, which contained few comments, were later merged during the analysis.

The 10 themes with the most 'entries' have been chosen for the admission and ongoing phases of care and are shown in the results section below. In most of the judgement comments there is a binary feel to the judgements: either the care is good or it is judged poor. There are relatively few comments at the 'adequate judgement' mid-point.

Many theme types are found in two phases of care, particularly in the admission phases and in ongoing care, although some others (such as sepsis pathway use) are phase specific.

Box 2. Admission / initial management phase (approx first 24 hours)

Ten most common themes with judgement weightings (the ratio of poor to good comments)

Antibiotic management	poor 16	good 23
Recognition of condition or change	poor 6	good 28
Sepsis pathway use	poor 16	good 13
Referral/handover	poor 5	good 21
Management plans	poor 9	good 25
Senior review	poor 7	good 17
Documentation	failure to record	
Sepsis management	poor 4	good 16
Assessment	poor 5	good 16
Escalation	poor 5	good 11

If these results were to be reflected at a local level, the balance of judgements on good and poor care might suggest priorities for further exploration in antibiotic management and sepsis management. However, QI priorities must take account of local issues and challenges. Consequently, what at first seems like the obvious choice for review may obscure other issues that require attention.

In Box 3, which concerns the ongoing care phase, some of the priorities change and some new issues come into contention. For example, challenges around enabling timely senior review, decision-making and appropriate care management may be linked. New priorities such as patient/relative/staff communication emerge, while decision making in the text of the individual reviews in the dataset often relates end-of-life care plans.

Box 3. Ongoing care

Ten most common themes with judgement weightings

Senior review	poor 12	good 18
Appropriate care and /or management	poor 13	good 14
Management plans	poor 6	good 16
Escalation	poor 6	good 16
Communications with patient and/or relatives	poor 2	good 16
Medication/therapy	poor 7	good 10
Investigations	poor 4	good 10
Review process	poor 7	good 7
Decision-making	poor 5	good 10
Recognition	poor 7	good 5

If these results were to be reflected at a local level, the balance of judgements on good and poor care might suggest priorities for further exploration in: review process, overall care management, perhaps including medication/therapy and recognition (of change).

End-of-life care

In the dataset of 50 cases there are some people who were very ill on admission and died of their acute illness before there was any apparent recognition of their end-of-life needs. Thus there are fewer entries overall in this phase than in the initial management and ongoing care sections. Additionally, there was a tendency among this group of reviewers to provide a briefer commentary on quality of care than was the case in the earlier phases of care. Thus there are only the four themes containing ten or more judgements reported here.

Box 4. End-of-life care

Recognition of end of life	poor 3	good 13
Discussion with patient/relatives	poor 5	good 24
End-of-life care overall	poor 9	good 15
Use of palliative care plan/path	poor 5	good 8

The stand-out issue from the end of life section, reinforced through a further set of reviews not reported in detail here, is that poor care often seems to be related to late referral, or failure to plan for or involve, the palliative care team.

Commentary on the results overall

So far as the quality of the SJR reports are concerned, the great majority available in the dataset are undertaken well and are insightful and explicit. Phrases such as 'timely appropriate antibiotics', 'deterioration well managed', 'failure to recognise end of life' and 'timely end-of-life care plan commenced' are exemplars. Poor quality reviews which tell stories or repeat what is written in the case notes but make no judgements, are few – but do stand out.

The purpose of clustering is, of course, to identify what is going well and where and where does care not go so well – for QI action may be needed to improve a situation where there is a relatively regular issue identified. The hospitals know the where and team information, but the database does not hold this.

There are usually many more examples of good care in the themes than there are of poor care – this represents contrasts in the themes. Yet were these contrasts to be reflected across a single hospital's cases, there are still enough judgements of poor care in some themes to provoke further questions on 'why – what is happening here?' This is the start of the QI cycle.

Some of the judgement comments pick out concerns about the care management or the setting of care, demonstrating how engaged reviewers can become in seeking to improve standards. Examples include adverse judgements, such as the lack of a side ward when a patient is in need of palliative care or when someone has been in the Emergency Department for an extended period of time. An external analysis of reviews can only record this. But the information becomes much richer in context for the individual hospital when it analyses its own reviews.

The value of this thematic review is to demonstrate how to identify ranges of care quality and enable a focus on particular clinical issues or care quality issues (for example, the ability of the institution to respond rapidly, or otherwise, to a person with rapidly deteriorating health).

It is worth emphasising that this is a review of SJRs – no case records are accessible. These reviews from the online platform cannot however demonstrate what is happening in individual hospitals. Only a thematic review of the cases from each hospital, and undertaken by staff in the hospital who know the clinical settings and the available services, can provide for a real exploration of the 'why' questions underlying care variation.

Professor Allen Hutchinson

The future of mortality work at the RCP

Following the huge success of the National Mortality Case Record Review programme, the RCP Patient Safety team is keen to continue working in this important area.

RCP mortality will now sit alongside other important areas of patient safety as we help our members, fellows and healthcare organisations to strive for the very best for their patients and staff.

From 2020 the Patient Safety team plans to offer the NHS a bespoke service based on an organisational health check, followed by a period of support, co-production and collaboration to advance and optimise the patient safety culture.

As a critical friend we will discuss and explore each organisation's needs, and together we will decide the options required to form the framework on which to build an improvement strategy. We will then support delivering training, facilitated discussions and tailored implementation guidance for a mutually agreed period of up to a year. Evaluation will enable adjustments to the plan to ensure we remain on the best possible track to realise each trust's potential and a report will document the journey taken, outcomes and potential next steps.

Fees for this bespoke package will be dependent on the level of input required and the improvement plan timeframe.

Please contact clare.wade@rcplondon.ac.uk to discuss details.

www.rcplondon.ac.uk

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