



NMCRR statement for stakeholders

RCP's National Mortality Case Record Review programme leaves a lasting legacy in patient safety

After three successful years, the Royal College of Physicians' National Mortality Case Record Review (NMCRR) programme will close on 30 June 2019, leaving a long lasting legacy in patient safety. The RCP will continue to support mortality reviews with new work streams helping NHS trusts to support clinical governance systems, identifying areas for improvement and collaboration, and preparation for CQC visits.

The RCP's National Mortality Case Record Review Programme (NMCRR), funded by NHS Improvement and the Scottish Government and commissioned by the Healthcare Quality Improvement Partnership, developed the Structured Judgement Review (SJR) process to effectively review care received by patients who have died. SJR was developed to replace the variable local systems with a standardised, national, evidence-based method.

In just three years, the SJR process has been implemented in over 120 acute NHS trusts in England and also in a number of Scottish hospitals. The NMCRR team has trained around 600 healthcare professionals across England and Scotland, who in turn have shared their training with thousands of clinicians throughout the NHS in England and Scotland.

The NMCRR's 2018 annual report highlighted a number of case studies where the SJR has made positive contributions to improving healthcare for patients and demonstrated that quality improvements are possible as a result of implementing SJR.

For example, Buckinghamshire Healthcare NHS Trust introduced medical examiners and the SJR process to screen all deaths in 2017. Within just 6 months 97% of deaths were screened and 12% of all cases used the SJR process. Subsequent (or related) improvement work resulted in:

- improvements in end-of-life (EOL) care including promoting patient choice
- increased use of personalised care plans in the hospital and the community
- improved sepsis recognition and treatment
- increased awareness of timely DNACPR (do not attempt CPR) decisions and treatment escalation plans (TEP).

Dr Andrew Gibson, consultant neurologist and clinical lead for the NMCRR programme, said:

This pioneering NMCRR programme set out to implement a validated, standardised way of reviewing the case records of adults who died in hospitals across England and Scotland to improve patient care and safety, and we have made huge strides to achieve that. It has been a privilege to be part of such a ground breaking programme which demonstrated that through using a standardised review approach NHS trusts can successfully improve quality in patient care and safety.



It also highlights the significant efforts required to implement the programme nationally and the enthusiasm from those involved to work collaboratively. This is by no means the end as we will continue to widen the scope of this important work by offering trusts bespoke packages to ensure mortality reviews and other quality improvement initiatives continue to be fully embedded across all NHS Trusts.

To maintain the success of mortality reviews and other quality improvement initiatives, the second phase of the RCP mortality work will offer NHS trusts bespoke packages such as assessments of clinical governance systems, identifying areas for improvement and collaboration. These packages will also assist with the rollout of the Medical Examiner system and will help more comprehensive preparation for CQC visits.



The Royal College of Physicians

The Royal College of Physicians (RCP) plays a leading role in the delivery of high-quality patient care by setting standards of medical practice and promoting clinical excellence. The RCP provides physicians in over 30 medical specialties with education, training and support throughout their careers. As an independent charity representing over 35,000 fellows and members worldwide, the RCP advises and works with government, patients, allied healthcare professionals and the public to improve health and healthcare.

NMCRR Programme

The National Mortality Case Record Review (NMCRR) Programme contract was awarded to the Royal College of Physicians (RCP) in February 2016 and is funded by NHS Improvement and commissioned by the Healthcare Quality Improvement partnership (HQIP). The RCP collaborates with two partners to deliver the NMCRR Programme: the Yorkshire and Humber Improvement Academy (IA) in Bradford and Datix UK. The programme aims to develop and implement a standardised methodology for reviewing the case records of adults who have died in acute hospitals across England and Scotland. The programme also aims to improve understanding and learning about problems and processes in healthcare that are associated with mortality, and to share best practice.

Buckinghamshire Healthcare NHS Trust (BHT)

Buckinghamshire Healthcare NHS Trust provides a wide range of high quality acute and community services from two acute hospital sites in Stoke Mandeville and Wycombe, five community hospitals at Amersham, Buckingham, Chalfonts and Gerrards Cross, Marlow and Thame, and a number of community sites across the county, as well as in patients' own homes.

Around 6,000 staff serve residents across Buckinghamshire, Thame (Oxfordshire), Tring (Hertfordshire) and Leighton Buzzard (Bedfordshire) - a combined population of 500,000. It serves a much larger population, 1.5m, for burns and plastic services and 14m for spinal injuries.

Further details can be found at:

<http://www.buckshealthcare.nhs.uk/For%20patients%20and%20visitors/hospitals-and-community-facilities.htm>