Learning from deaths and improving patient care

Aim: Using the clinically co-produced iteration of Structured Judgement Review methodology to enable tens of thousands of reviews to be carried out each year across the UK, helping NHS Trusts to learn from deaths and improve patient care.

Background

The Keogh review described the use of hospital mortality indices to quantify actual numbers of avoidable deaths as “clinically meaningless and academically reckless.” On the basis of this report and views from clinicians, a better approach to learn from deaths was needed.

The systematic case record review was universally recognised to deliver the most comprehensive assessment but had never been undertaken at the scale and timeliness required to produce real learning and improvement. Professor Allen Hutchinson (University of Sheffield) developed a case note review methodology which provided the basis of the Structured Judgement Review (SJR); which has now become the primary method for mortality review across the UK. Moving beyond judgements of the avoidability of death, the **SJR methodology helps clinicians and families understand the holistic care received by individuals to identify areas of good practice and areas where improvements may be needed**.

How our ARC is helping

The SJR method was developed by the Yorkshire and Humber ARC's Implementation arm, the Improvement Academy, in collaboration with clinicians, as a means to learn from deaths in a timely, useful, and consistent manner. Researchers worked with the Royal College of Physicians to create a guide for the roll out of the methodology across England and Wales, as part of the National Mortality Case Record Review Programme. Following this, the SJR method was recommended in the NHS England National Guidance on Learning from Deaths.

The Improvement Academy developed and deliver training to organisations in the SJR methodology, which has now been **implemented across England, Scotland, Wales, and Northern Ireland**. The approach has been modified to meet the needs of mental health and community trusts, and hospices.

Our impact on the safety of patients in hospitals

- **Tens of thousands of mortality reviews are conducted by trained clinicians across the UK and beyond every year** (approximately 10% of deaths and 250,000 in-hospital deaths a year).
- These result in a growing portfolio of improvement work at both a local and system level and in key priority areas such as stroke care, palliative medicine, and managing deteriorating patients.
- NHS Trusts have benefitted from having a structured methodology and guidance to support them in **learning from deaths and improving patient care**.
- Future patients and families will benefit from the learning implemented via the improvement projects identified from conducting the reviews.