Royal College of Physicians

RCP National Mortality Case Record Review Programme

Supporting information for responses to media queries/FOI requests

The National Mortality Case Record Review (NMCRR) Programme is supporting the implementation of the Structured Judgement Review (SJR), a standardised methodology for reviewing the case records of adults who have died in acute hospitals across England and Scotland. The programme aims to improve understanding and learning about problems and processes in healthcare that are associated with mortality, and to share best practice. The contract to deliver the NMCRR programme was awarded to the Royal College of Physicians (RCP) in February 2016.

Over the life of the programme the RCP has continually advised NHS Improvement, the Healthcare Quality Improvement Partnership and the Department of Health of the lack of a validated methodology to calculate avoidable deaths. The Hogan et al paper (BMJ2015;351:h3239) on avoidable deaths in hospitals demonstrated the great difficulty in ascertaining if deaths were avoidable in many cases of frail elderly patients with multiple conditions.

The guidance to Trusts to report avoidable deaths was included within the National Quality Board publication Learning from Deaths in March 2017 and is not linked to the NMCRR programme or the RCP.

Within Learning from Deaths is a template dashboard to guide Trusts to report quarterly information, it is important to note that the NMCRR programme SJR methodology does not allow the calculation of whether a death has a greater than 50% probability of being avoidable.

The NMCRR programme, supported by the RCP, does not endorse the comparison of data from the SJR between trusts. There are a variety of selection techniques in use to identify cases for mortality review by Trusts that have implemented the NMCRR programme SJR methodology.

The development of a “league table” of avoidable deaths using statistics generated from a range of approaches would not be appropriate. This was acknowledged during a speech by Jeremy Hunt, Secretary of State for Health and Social Care on December 14 2017. For example, Trusts choosing to review large numbers of deaths could appear to have higher numbers of deaths where there were potential problems in care than those reviewing fewer cases.

Link to the RCP NMCRR programme webpages National Mortality Case Record Review Programme | RCP London

Link to the National Quality Board – National Guidance on Learning from Deaths

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