Roll-out of the UHL Medical Examiner service beyond UHL

June 8th 2021

NHS England has today sent a letter to all healthcare providers setting out the expectation that a medical examiner service will be implemented to scrutinise all deaths not investigated by a coroner.

The text of that letter is available at https://www.england.nhs.uk/publication/system-letter-extending-medical-examiner-scrutiny-to-non-acute-settings/

Medical examiner services have been piloted in a number of sites across England and Wales over several years, mainly but not exclusively in secondary care. The identified advantages include:

- A reduction in unnecessary referrals to the coroner
- Improved accuracy of recorded causes of death
- Near elimination of death certificates rejected by the Registrar
- Support and education for all doctors
- Benefits in quality improvement and safety across all care pathways and boundaries

And arguably the biggest benefit of all:

- Help to bereaved relatives in understanding what has happened to their loved one and why, and in providing constructive feedback (positive or negative) to the NHS.

A good medical examiner service should not delay issuing the necessary forms and registering a death; in some cases the process is quicker. Systems exist to expedite urgent release of the body for religious or other reasons.

It is anticipated that essentially all deaths in secondary care and 90% of all deaths outside secondary care should be covered by such a service by April 2022.

When this has been achieved the intention is to make this a statutory requirement, so that registration of a death will not be possible unless the agreement of a Coroner or a Medical Examiner has been documented. At that point the intention is to abolish the current system of 'cremation forms' and all deaths will be scrutinised proportionately to their circumstances but irrespective of the type of funeral.

It is anticipated that this will be achieved by extending the medical examiner services that have already been established in secondary care throughout England and Wales.

GPs are being encouraged to become part-time medical examiners, looking at both acute and community deaths.

This document summarises the history of this project and sets out a proposal to achieve this target in Leicester, Leicestershire and Rutland.

A Brief History

The concept of Medical Examiners (of the cause of death) was introduced in Dame Janet Smith's report on her inquiry into the crimes of Harold Shipman. She noted that the risk of allowing a single unsupervised medical practitioner to complete a death certificate had been identified many years earlier, but nothing had been done to address that risk until Dr Shipman used the loophole in the law to certify his own murders as being deaths due to natural causes.

A mechanism to introduce a medical examiner service, which would review all deaths not investigated by a coroner, was included in the Coroners and Justice Act 2009. However, the provisions in that legislation were never implemented, at least partly because the Act had been drafted with the assumption that the law, and hence required practice, would change on a specific date across all of England and Wales. This proved difficult to organise.

Subsequently a number of medical scandals gained considerable media attention, with a common thread being that the relatives of those who died complained that no-one had listened to their concerns. Foremost amongst these was the Francis report into poor care at the Mid-Staffordshire Hospital. The Francis report includes a whole chapter on death certification, medical examiners and the coroner and bemoans the fact that medical examiners had not been introduced, as they would have been ideally placed to 'blow the whistle' much sooner on poor practice at that hospital.

While Jeremy Hunt was Secretary of State for Health he became very interested in the concept of counting 'avoidable deaths' in the NHS as a surrogate measure of quality of care. One of the requirements within the Trust Development Authority's (TDA) Annual Operating Plan between 2014/15 and 2017/18 was that *All (in-hospital) deaths of patients are reviewed using a screening template or equivalent to identify any evidence of suboptimal care* whilst the 16/17 NHS Mandate NHS included a requirement to *publish avoidable deaths per trust annually* (using retrospective case record reviews to determine whether deaths were avoidable or not). It gradually became clear that the term 'avoidable' was difficult to define in this context, so counting such deaths would be subject to large inter-observer variation. However, while this work was ongoing there was a growing realisation that medical examiners would be well placed to identify deaths that justify closer review as part of the 2017 'Learning from Deaths' programme that was developing in NHS England.

A small number of NHS acute Trusts (including Leicester in 2016) had already established local medical examiner services with the aim of improving the quality of death certification, improving the relevance of referrals to the coroner and identifying cases where the 'Learning from Deaths' programme might find useful material. This led to the realisation that a medical examiner programme need not be introduced throughout the country on the same day. NHS England / NHS Improvement and DHSC therefore developed a policy of encouraging secondary care Trusts to implement local medical examiner systems on a voluntary basis, with no change in the law, funded in part by the cremation form fees generated by medical examiners scrutinising deaths in hospital. A National Medical Examiner was appointed and a national programme for training medical examiners was made available.

Medical Examiner scrutiny involves 5 main steps:

1. Collation of background information taken from electronic patient systems such as NerveCentre, ICE, Datix, Ambulance Records to prepare a summary of relevant clinical summary highlighting any particular areas that may require more detailed discussion with the certifying doctor, bereaved relatives or scrutiny of case notes
2. A conversation with the next of kin or other member of the family, to check that the cause of death is understood; to answer any questions (if possible, and to flag sources of further information if not); and to request feedback, good or bad, on the quality of care provided. Decisions on coroner referral and certification may be revisited, if appropriate, in the light of this conversation, although the relatives cannot dictate what causes go on a death certificate.
3. A discussion with a doctor who knows and has attended the patient around whether coroner referral is needed; if not, how best to complete an MCCD; and whether any aspects of care should have been done better
4. A brief or 'proportionate' review of relevant medical records to check the conclusions of that conversation

5. ‘Signoff’ of the case. When the system is on a statutory basis this will involve the medical examiner informing the Registrar’s Office that registration can go ahead.

Other than the last, the sequence of these steps is not prescribed and the best sequence may vary between cases. All steps other than the review of medical records and final signoff may be delegated by the ME to a Medical Examiner’s Officer, if appropriate in the individual case.

We have now reached the stage where most hospitals in England and Wales have a medical examiner system. Reactions from all involved (notably doctors, relatives, Registry officers, coroners and bereavement office staff) have, after some initial reservations, been very positive:

The next step in NHS England’s plan is to ‘roll out’ the medical examiner service from secondary care Trusts to cover deaths in care homes all other hospitals (including psychiatric and private hospitals) and in primary care. NHSE has started to implement arrangements to fund the system so that it is not dependent on existing budgets.

As soon as this system is deemed to be sufficiently mature, the law will be changed to make it mandatory for the certification of all deaths to be scrutinised either by a coroner (in accordance with current criteria) or by a medical examiner. A date for this changeover has not yet been defined and plans have been delayed by the pressures caused by the Covid pandemic.

Finance

The 2009 Coroners and Justice Act set out the expectation that the current system of cremation form fees (dating from 1904) would be abolished but would be replaced by a single certification fee to cover all deaths not investigated by a coroner. The resultant income would fund the medical examiner service. This proved controversial and has not yet been implemented. So far, the service has been funded by direct support from NHSE and by using cremation form fees paid where the forms have been completed by a medical examiner. The future funding model is not yet known but it has been made clear that this should not represent a financial burden on the Trusts that provide the service. At the NME Conference on 27th April 2021 it was indicated that the final position will probably be a service funded on the basis of a flat fee per death scrutinised, as was originally planned in the 2009 Act.

Developments in Leicester

A Medical Examiner service was established in 2016 at the University Hospitals of Leicester, one of the first hospitals in the country to do this. The was driven principally by the Medical Director’s recognition that to undertake a full ‘structured judgement review’ of all deaths, as was then being required by DHSC, would be time consuming and inefficient; the Trust needed a mechanism to identify those deaths where the effort of a more detailed review would be worthwhile in the context of the Learning from Deaths programme.

After initial doubts by some members of staff the service has been very well received. Referrals to the Coroner have reduced, MCCD rejections by the Registrar have almost ceased. Doctors, especially junior doctors, are pleased to have support in an area where they receive relatively little training. But perhaps the most positive response has come from bereaved relatives, almost all of whom are pleased to be contacted, to have the option to ask questions about the cause of death and to be invited to express opinions on the quality of care given. The vast majority of those comments have been complimentary, but we have identified several areas where work to improve care quality is indicated and is now ongoing.

Leicester’s approach has been to ask medically qualified MEs to do much of the work, with less delegation to non-medical Medical Examiner’s Officers than is recommended by current national guidance. This of course implies additional cost, but to date the response of UHL’s Executive and Trust Boards has been to agree that such extra expense is justified by the considerable benefits obtained.

The UHL medical examiner service currently scrutinises all deaths occurring in UHL that are not investigated by the coroner, plus a few deaths in the community where the deceased was recently an in-patient (typically about 3,000 adult deaths p.a.). The service has coped with the increased number of deaths caused by the Covid pandemic with limited extra resources and a brief period where completion of screening of deaths at GH and LGH was delayed. Medical Examiners have also undertaken additional work to assist UHL in compliance with NHSE requirements around reporting of Covid-related deaths. There has also been a gradual increase in the number of child and neonatal deaths discussed with the Medical Examiner although full scrutiny is not carried out as all these deaths will be subject to full mortality reviews as per national requirements.

At present the UHL service has 11 Consultants providing the equivalent of 12.5 PAs of Medical Examiner sessions and we have 1 WTE Medical Examiner Officer /Learning from Death Officers in post with 2 more being recruited – the national expectation is that we would have 3 WTE MEOs for 3,000 deaths and 1 WTE Medical Examiners. The gap in MEOs is currently being covered by other LfD staff working additional hours or bank staff.

Roll-out to primary care and other providers in Leicestershire & Rutland

From the early days of introducing the medical examiner process within UHL, the service has been available for deaths post in the community where UHL clinicians have been asked to provide the death certificate (i.e. deaths in Community Hospitals under the care of UHL Geriatricians).

In 2020 we extended the UHL medical examiner system to the hospice at LOROS, where approximately 200 deaths p.a. occur. This was initially at the invitation of the medical staff at LOROS but it rapidly became clear that there were some similarities to operating the system in primary care – most notably the use of SystmOne for access to medical records, instead of using paper casenotes.

The doctors at LOROS were keen to take advantage of a temporary change in the death certification regulations introduced by the Coronavirus Act 2020, which allows the medical examiner to take over issuing the MCCD and the cremation forms and sending those documents to the Registrar and the funeral director or crematorium. Thus the medical staff at LOROS merely had to send a referral form to the medical examiner system and answer a telephone call from the ME after the ME had viewed the online medical records. They were pleased by this reduction in paperwork despite the loss of income from cremation form fees.

In Autumn 2020 this approach was extended to volunteer GPs at the Fosse Park and Willowbrook practices in Leicester. At this stage the small numbers of additional deaths being scrutinised could be managed without recruiting and training additional medical examiners. The referral process was refined, reducing the referral form to the electronic equivalent of half a side of A4 paper, because most of the information needed could be accessed from SystmOne. However, the GPs were reluctant to ask the ME to complete the MCCD and cremation forms, so after completion of scrutiny the ME re-contacted the GP to agree release of the MCCD. Any feedback from the relatives was passed on by telephone at this point, followed by a written summary of the ME's findings. As in secondary care, almost all the feedback was positive.

All concerned felt that a functional system had been established; one that could deliver the service in a timely manner, even out of office hours.

Unfortunately the second peak of the Covid pandemic then struck the population and GPs were also stressed by the need to deliver the immunisation programme. The pilots at LOROS and in primary care were both suspended.

Now that the Covid pandemic is beginning to subside, we are re-establishing the rollout of an ME service in settings beyond secondary care. This has coincided with NHSE announcing its intention to progress its long-

stated intention to implement a full ME system by sending a letter to all care providers setting out the expectations. **Leicester is therefore well placed to lead the country in responding to this call.**

Extending the service will necessitate the recruitment and training of more part-time medical examiners and additional office space. We anticipate that most or all of the new MEs will be GPs.

Outline proposals for implementing full medical examiner scrutiny in LLR

These proposals have been developed in by a small group convened at the request of Dr Aly Rashid, Medical Director LLR, to run the successful pilot of medical examiners in primary care mentioned above.

Inform, recruit and train GP medical examiners

We intend to start the process by recruiting a small number of GPs to train and work part time alongside UHL's existing medical examiners. In accordance with national policy, GPs recruited as MEs will not specialise in community deaths but will share the scrutiny of all deaths with the current hospital-recruited MEs.

We have an information pack and questionnaire which we propose to send to all GPs and other healthcare providers in LLR including the Partnership Trust, private hospitals etc. after the NHSE letter about implementation is published. The questionnaire includes questions on GP preferences around implementation and potential recruitment and training as medical examiners. This will be supported by webinars and other meetings. Future work will be influenced by the responses to that questionnaire.

As the work expands we will recruit and train more community MEs, at the same time gradually rolling out the service to all care providers who are willing to participate, until we hope that 90% of relevant deaths in LLR will be covered. We will then be in a good position to cope with the stated intention of DHSC to make medical examiner (or coronial) scrutiny mandatory before any death can be registered.

Before implementing these plans we would like to communicate with all GPs in Leicestershire and Rutland, to ascertain their opinions about this development, their willingness to participate in a voluntary pilot scheme prior to statutory implementation and their interest in training to become medical examiners.

To that end we will be grateful to all GPs who are willing to complete a short questionnaire about this development. This is available online at https://forms.office.com/r/wqygsVRwAy **or as a PDF file which can be printed out and posted.**

A series of meetings, Q&A sessions and webinars is also being planned.

Please return questionnaires and send questions to Leicester's Lead Medical Examiner, Professor Peter Furness, at peter.furness@uhl-tr.nhs.uk or by post at the Medical Examiner's Office, Level 1 Sandringham Building, Leicester Royal Infirmary.