National Medical Examiner update

# December 2022

Welcome

As the end of the year is upon us, it is a good opportunity to reflect how far the programme has come this year, and to consider the challenges ahead.

Medical examiner offices have made excellent progress towards recruiting the full workforce required for the statutory medical examiner system. We passed an important milestone in extending the medical examiner system in England, with medical examiners offering independent scrutiny for more than 10% of expected deaths in other healthcare settings, with similar progress being made in Wales. I recognise the hard work, planning, and engagement with other healthcare providers that underpins this work.

However, we must not lose sight of the significance of the coming weeks and months. Together, we are all contributing to some of the most significant changes to death certification in decades; the government expressed its commitment to [work towards commencing statutory implementation plans from April 2023](https://questions-statements.parliament.uk/written-statements/detail/2022-06-09/hcws85). This development will deliver, for the first time, consistent surveillance of the quality of care leading up to all non-coronial deaths, and great opportunities for learning and improving, at local, regional and national level. While recognising the commitment and achievements thus far, there is some distance before a universal system is in place, and it is important all healthcare providers and medical examiner offices increase the pace of implementation.

I recognise the significant pressures faced by the NHS, especially during the coming winter. I am continuing to monitor progress closely, and – with the national teams in England and Wales – I am ready to provide further support if required.

With my best wishes for the festive period and the New Year.

**Dr Alan Fletcher, National Medical Examiner**

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Good Practice Series – antimicrobial resistance and out-of-hours

We are pleased to announce that the Royal College of Pathologists has published the latest of the National Medical Examiner’s good practice series. This latest paper includes information and recommendations for medical examiners regarding [antimicrobial resistance](https://www.rcpath.org/resourceLibrary/good-practice-series-recording-antimicrobial-resistance-on-the-medical-certificate-of-cause-of-death.html).

The previous paper published by the Royal College of Pathologists set out principles which medical examiner offices should consider regarding [out-of-hours services](https://www.rcpath.org/uploads/assets/8411492d-f1e4-4c85-86200ccbb3e253eb/Good-Practice-Series-Out-of-hours-arrangementsFor-publication.pdf). It is important that these arrangements, and the needs of the local community, are considered in coming weeks. Medical examiner offices in England should liaise with their regional medical examiner regarding out-of-hours services before the end of January 2023.

Reviewing GP patient records

Medical examiner offices are making good progress in extending scrutiny to deaths in non-hospital settings. There can be practical challenges to arranging sharing of electronic patient records, but it should be remembered that many deaths in the community are expected or palliated, and therefore a proportionate review of the patient record may be less extensive than it is for more complex cases. The online resource for medical examiners includes information and case studies about some options being used in England.

While the optimum solution may be for medical examiner offices to have access to other healthcare providers’ electronic records for deceased patients, local systems may not be available to support this, or other arrangements may prove more practical for the present. For example, one medical examiner office in England agreed with GP practices that secure sharing of a summary is the most practical solution. As the GP practice systems include a one-click PDF summary function which administrative staff can produce, there is little or no workload implication. In the minority of cases where medical examiners require more information, they can often obtain this direct from their host organisation’s systems, if the patient was previously admitted or treated, or they can request other information from the GP practice staff.

Records from GP practices do not in the majority of cases need to be extensive, but should include entries for at least 3 months, including previous medical or medicines history, and any hospital correspondence. Of course, other information the GP practice staff believe relevant can be included.

Medical Indemnity

As a reminder, we have advised medical examiners previously that you should inform your medical indemnity provider that you have started working as a medical examiner. Medical examiners should ensure the information held by their indemnity provider is up to date. When we started implementing the medical examiner system, NHS England also confirmed with NHS Resolution that NHS trusts (and medical examiners employed by trusts) will be covered for legal liabilities arising from their medical examiner activity through membership of the Liabilities to Third Parties Scheme (LTPS).

Template information for members of the public

As rollout of the medical examiner system to other parts of the healthcare system continues, information for members of the public, including bereaved people, is increasingly important. We must bear in mind that the medical examiner system will be new to both members of the public, and to staff in other healthcare organisations. Medical examiner officers lead rollout locally, so are best placed to decide how and when to inform people that medical examiner scrutiny is starting.

The national team developed template information that medical examiner offices can adapt for local use, available in the online resource for medical examiners, along with translated versions. We encourage medical examiner offices to adapt this for local use, and share it with their partner healthcare providers. This can help staff in other healthcare organisations to understand medical examiners, and provides them with information to give to bereaved people about medical examiners, and can avoid valuable time and resource being diverted to responding to queries.

Implementation in Wales

We are delighted to confirm that the funding of the medical examiner service in Wales has now been agreed by DHSC, and will mirror the arrangements in England. Welsh Ministers will make an announcement shortly.

The Medical Examiner Service for Wales is progressing plans to increase the workforce in order to continue to build up the number of deaths scrutinised. Medical examiners and officers will come on stream over the next two months as induction and training programmes are completed. Further recruitment will take place early in 2023 to bring the service up to full establishment.

We are continuing to work with primary and secondary care providers to streamline processes and procedures and to maximise benefits for bereaved people, as well as clinical quality and patient safety systems of care providers. This includes completing scrutiny in a timely manner, no matter the time or day of the week when a death occurs.

With the service expecting to be fully scrutinising 100% of deaths that occur in hospital settings by the end of the year, attention is switching to increasing coverage for deaths that occur in the community. This means working closely with individual GP Practices, and their representative bodies, to ensure that medical examiner scrutiny is an integral part of the wider system of care and review that they provide. The ability of the Service to remotely access notes via practice systems will ensure delays are kept to a minimum and that workload implications for practice staff are minimised.

To support the ongoing development of the service in Wales, we also plan to establish a Stakeholder Reference Group.

Quarterly reporting in England

Feedback from the Quarter 2 reporting 2022/23 submitted by medical examiner offices has again proved overwhelmingly positive and insightful for the programme and showed a positive growth in the scrutiny of deaths in the non-acute sector, rising from 4,009 in quarter 1 to 6,149 in quarter 2.

During quarter 2 -22/2023, we moved over to the new NHS England data collection platform for the [medical examiner office quarterly reporting](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fdatacollections.model.nhs.uk%2F&data=05%7C01%7Chelen.briggs12%40nhs.net%7C5390c52235744d189a6108dacc63574d%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638047024271749719%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=YIpP2QESGb652nObZwd5J%2FPpLCzZHBA4VHNNwVUX5Rw%3D&reserved=0). Presently, the new platform does not have the functionality to upload data via an excel spreadsheet due to a technical problem. Therefore, we encourage Medical Examiner offices to input data directly via the online portal.

The next submission windows for quarterly reporting via the online portal are:

|  |  |
| --- | --- |
| **Reporting period** | **Submission window** |
| Quarter 3 -2022/23 | 1 January – 20 January 2023 |
| Quarter 4 -2022/23 | 1 April – 21 April 2023 |

 Please contact reporting.nme@nhs.net if you have any queries.

Patient Safety Incident Response Framework in England

NHS England published the Patient Safety Incident Response Framework (PSIRF) in August 2022, outlining how providers should respond to patient safety incidents for learning and improvement. The framework will replace the current Serious Incident Framework (SIF) and remove the requirement that all (and only) incidents meeting the criteria of a ‘serious incident’ are investigated. Responses under PSIRF will focus on compassion and involving those affected; system based approaches to learning and improvement; considered and proportionate responses; and supportive oversight. For more information visit: [NHS England » Patient Safety Incident Response Framework](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.england.nhs.uk%2Fpatient-safety%2Fincident-response-framework%2F&data=05%7C01%7Cnickday%40nhs.net%7C680effdff6144bba369e08dac3ec36a2%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638037716529304299%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=FMUXqiHW9z5PO8rh7mb23pW6LQNOPykTTmhjFKNjjko%3D&reserved=0) or contact Patientsafety.enquiries@nhs.net

Training and events

In October 2022, 66 delegates attended the first in person face-to-face training day for medical examiners since the pandemic, bringing the total number of medical examiners trained to 1,721, and 472 staff have completed the medical examiner officer training. Future [sessions](https://www.rcpath.org/profession/conferences/events.html) are arranged.

The Royal College of Pathologists will host the third Medical Examiner Annual Conference on Wednesday 17 May 2023. It is expected this will be an online event. The final programme is still being finalised, and when it is available, registration will open on the college website. We will share the link for registration in a future bulletin.

Contact details

We encourage you to continue to raise queries with us and share your thoughts on the introduction of medical examiners, through the [contacts list.](https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/#national-and-regional-contacts)

The page contains contact details for the national medical examiner’s office, the medical examiner team in Wales, and regional medical examiner contacts in England.

Further information

Further information about the programme, including previous editions of this bulletin, can be found on the [national medical examiner](https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/) webpage.

NHS Wales Shared Services Partnership also has a web page for the [medical examiner system in Wales](http://www.nwssp.wales.nhs.uk/medical-examiner-service).

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