National Medical Examiner update

February 2022

Welcome

Medical examiners and medical examiner officers, along with the rest of the NHS in England and Wales, will have experienced considerable pressures over recent months. I fully understand that Omicron, along with winter pressures, have made it a particularly challenging time.

However I am encouraged and grateful for the remarkable progress that medical examiner offices have continued to make. Medical examiners scrutinised more than 50,000 deaths in the quarter ending December 2021. I know that some medical examiner offices have been recruiting additional staff, and started to develop processes with GPs and other healthcare providers. This process will need to continue and accelerate in coming months. I intend to provide guidance on out-of-hours provision in the near future.

As you will see in this update, the Health and Care Bill continues to progress through parliament, bringing us closer to the advent of the statutory medical examiner system. There are many other areas of significant work to take forward, including our ambition to provide a national means of accessing GP records in England. We have also been working hard to provide updated guidance about the death certification, registration and cremation provisions after the Coronavirus Act expires, and DHSC, the Ministry of Justice, and the General Register Office recently agreed the update which is being published.

There is much to do, but as ever I am grateful to all for your hard work and dedication.

Dr Alan Fletcher, National Medical Examiner

What's included in this update

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Coronavirus Act: easements for death certification and registration

The Coronavirus Act 2020 was time-limited legislation which introduced a range of emergency measures in response to the coronavirus pandemic, including easements for Medical Certificates of Cause of Death (MCCDs), and registration of deaths. These easements proved extremely helpful.

The Ministry of Justice and General Register Office (Home Office) have recently confirmed that the provision extending the requirement for having seen a deceased patient to 28 days, rather than 14 days prior to death, is made permanent through a change to regulations, and that it is the government's intention that Cremation Form 5 will not be re-introduced. However the provision for any medical practitioner to complete the MCCD, introduced as an emergency measure by the Coronavirus Act, is discontinued from 24 March 2022. Official guidance from the Ministry of Justice for cremation forms, and General Register Office/Office for National Statistics for MCCDs, will be updated to reflect changes from 25 March. NHS England and NHS Improvement and Welsh Government will circulate information for doctors through established communication updates.

Health and Care Bill update

The Health and Care Bill completed House of Lords Committee stage on 10 February 2022 and report stage in the House of Lords is planned to start 1 March 2022. The Health and Care Bill will amend the Coroners and Justice Act 2009 to allow NHS bodies to appoint

medical examiners instead of Local Authorities in England, and Welsh NHS bodies instead of only Local Health Boards in Wales. Subject to parliamentary process we do not expect the statutory medical examiner system to be introduced before Summer 2022.

MCCD digitisation

DHSC has commissioned NHS Business Services Authority to develop a digitised Medical Certificate of Cause of Death (MCCD). DHSC is working with relevant stakeholders including all relevant government departments and Welsh Government. It is anticipated that the digitised MCCD will be introduced not prior to Summer 2022. If your role involves completing MCCDs and you are interested in supporting the user research please contact nhsbsa.researchops@nhs.net

Medical examiner case management system

DHSC has commissioned NHS Business Services Authority (NHSBSA) to develop a national case management system for medical examiners and medical examiner officers in England, 'Medical Examiner Service - Manage My Caseload'. NHSBSA are building the system based on requirements from DHSC, the National Medical Examiner and medical examiner offices. The system is currently being tested with a number of medical examiner offices in NHS acute trusts, with the feedback from these settings informing system improvements. NHSBSA have been upscaling the roll out of the digital system gradually from January 2022 and are keen to receive and respond to user feedback as the roll out progresses at Nhsbsa.meofficesupport@nhs.net. The roll out will be coordinated through regional medical examiners.

Extending medical examiner scrutiny to other healthcare providers

In the September 2021 bulletin we mentioned that two GPs who are also medical examiners kindly shared their experience of the medical examiner system and the benefits for GPs in this video. There is also a web page for GPs, and we have recently added a web page for other healthcare providers such as community and mental health

trusts. This information can be shared to provide information about medical examiner implementation.

A number of medical examiner officers asked about practical arrangements for sharing patient records. We recognise this is a complex area, and are working with DHSC, NHSX and NHS Digital. We hope it will be possible to provide a national mechanism for sharing electronic patient records. Regional medical examiners and regional medical examiner officers can provide examples of arrangements that medical examiner offices have used.

Deaths after discharge from hospital

Learning from Deaths guidance in England asks trusts where processes are established to carry out case record reviews of former inpatients who died within 30 days of leaving hospital. It can be difficult for trusts to identify such deaths. As medical examiners start to scrutinise more deaths in the care of other providers, it is likely more cases will be identified, and can be referred for trust case record review in line with Learning from Deaths guidance.

LeDeR reviews for autistic people with no learning disability

The NHS England and NHS Improvement Autism Programme has focused attention on the need for reliable data on health inequalities faced by autistic people. Following changes to LeDeR policy, as of 1 January 2022 deaths in England of autistic people with no learning disability can be reported at www.leder.nhs.uk. This information can be shared with all healthcare providers.

Implementation in Wales

Wales continues to develop its service in line with the National Medical Examiner's Good Practice Guidance and the revised legislative timescale. The number of deaths scrutinised is increasing month on month, from both acute and non-acute settings, and it is worth noting that non-acute deaths now make up over 12% of cases scrutinised.

The service is continuing to develop relationships with key stakeholders and, in addition to holding joint Continuing Professional Development sessions with members of Coroner's teams, it has been further developing links with care providers' patient safety and clinical

quality systems. This is allowing details of activity, compiled and aggregated from within the single, all Wales Medical Examiner System, to be analysed and shared more widely across the health and care system. It is facilitating the identification of both general trends and specific areas where lessons can be learned, and improvements made within care provider organisations.

The ability to move cases between medical examiners and medical examiner officers in the four regional hubs, using the single, all Wales system, is also continuing to ensure that capacity can be maximised to meet fluctuations in local demand, and to ensure that the scrutiny process is completed within the required timeframe to allow death to be registered appropriately.

Feedback from the bereaved continues to confirm the value of a scrutiny service that is independent of the care provider, as well as the benefits of trained staff able to take the time to listen to concerns, explain the circumstances surrounding the death, and respond to any specific questions as required.

Training and events

Currently, over 1,500 senior doctors have completed medical examiner training, and over 350 staff have completed medical examiner officer training. Further sessions are planned and will continue to be held virtually via zoom for the foreseeable future. Two of the joint virtual training for coroners and medical examiners have now taken place and were very collaborative and constructive days, helping us all gain a greater understanding of each other's roles and how we can best work together to support bereaved families.

The second annual NME conference will be held virtually on 18 May 2022 – registration details will be published at a later date.

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.

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 webpage.

NHS Wales Shared Services Partnership also has a web page for the medical examiner system in Wales.