The Royal Wolverhampton NHS
NHS Trust

Health Scrutiny Panel

7Th November 2019

Report title	Development of the Medical Examiner Role and on site Registrar
Report of:	Dr Jonathan Odum, Medical Director Dr Mike Norell, Lead Medical Examiner
Portfolio	Public Health and Wellbeing

Recommendation(s) for action or decision:

The Health Scrutiny Panel is recommended to:

Note the report

Introduction

1.1 The Royal Wolverhampton NHS Trust (RWT) has a clear strategy to learn from deaths that occur whilst the patient is under the care of the organisation. A key part of this system is the development of the Medical Examiner office with its close links with the coroner's office and the commitment to provide the opportunity to hear the experience of bereaved families.

Alongside this development came the provision of a new capital development, the Bereavement Centre, and this provided the opportunity for the registrar to be on site to work alongside RWT's bereavement team.

This report provides an update on the impact of these initiatives so far.

2.0 Background

2.1 RWT developed a Bereavement Centre in a vacant area of the Urgent and Emergency Care Centre and this opened in January 2019. The Bereavement centre is staffed by administrative officers, medical examiners, a bereavement nurse and the city council Registrar. The new centre allows bereaved families to attend, pick up the death certificate, speak with a medical/nursing member of staff if they want to and register the death at the same appointment.

2.2 In January 2019 the Trust was one of the first organisations in the country to introduce the role of the Medical Examiner (ME). The introduction of this role is a key part of the regime set out in the Coroners and Justice Act 2009 covering all deaths within England and Wales. In April 2019 a national Medical Examiner was appointed and the expectation then was that the position of Trust based medical examiners would be rolled-out albeit via a non-statutory scheme. It is envisaged that the scheme will cover all hospitals by the end of March 2020 and that there will be a move by the Government towards placing the scheme on a statutory footing, and then a further development of the statutory scheme to cover deaths within hospitals and within the community by the end of March 2021. RWT has been at the forefront of the scheme development, sharing experience with other organisations as they develop and has been involved in the selection and appointment of regional Medical Examiners

2.3 Medical Examiners are senior doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification.

The purpose of the medical examiner system is to:

- Provide greater safeguards for the public by ensuring proper scrutiny of all non-coronial deaths
- Ensure the appropriate direction of deaths to the coroner
- Provide a better service for the bereaved and an opportunity for them to raise any concerns to a doctor not involved in the care of the deceased

- Improve the quality of death certification

2.4 **Scrutiny**: The introduction of the Medical Examiners role now means that cases where the death occurred within the hospital can be scrutinised by an independent medical colleague within days of the death. From a starting position of 29%, approximately 60% of cases are now scrutinised each month. Whilst progress has been made, the Trust's aim is to achieve over 90%. There are currently issues that require resolution to reach this target and these include the ability to provide support for those deaths that occur in the Emergency Department, often out of day time hours and an improvement in the capability to cover for each ME at times of annual leave. This may require the appointment of Medical Officers to support the MEs and improve capacity.

Month	% of total deaths scrutinised by Medical Examiners	% of total deaths referred for further review (from July 19 to Mortality Reviewers)
January	29%	17%
February	46%	17%
March	58%	14%
April	55%	20%
May	60%	22%
June	64%	23%
July	62%	21%
August	52%	16%

The Trust's policy, in line with national guidance, is that where potential areas of concern with care are picked up at scrutiny, the Medical Examiners will refer cases on for more detailed review. From July '19 this is to a team of Mortality Reviewers in the Trust. This includes cases where relatives have raised issues as well as a group of conditions were mandatory referral is required i.e. patients who die following an elective procedure, children, patients with specific mental health conditions and those with learning disabilities.

These reviews allow the organisation to record good and poor practice. The governance system in place then mandates that individual results are shared with directorate teams and thematic presentations shared at Divisional and Trust Board level. Note that these learning points do not necessarily mean that the care provided (or omitted) has contributed to the death, but that there are areas where care can be improved to enhance overall experience.

Examples of learning that have been picked up include areas of good and less good practice around End of life care, omissions of communication and delays in recognising deterioration.

2.5 Direction of Deaths to the Coroner: As part of the process, the Notification of Deaths Regulations 2019 came into force on 1st October. The Regulations state that a registered medical practitioner must notify the relevant senior coroner of a person's death in certain types of cases. Hitherto there have been no regulations and circumstances of reporting have varied across coroner areas. The presence of a team of Medical Examiners with expertise in the appropriateness of referral ensures that the Trust's medical teams are guided to make the referrals where necessary.

2.6 Bereaved Families: The role of the ME requires them to make contact with the bereaved family in order to hear their experience and to use this feedback in order to inform the scrutiny process. Alongside the ME, the Trust appointed in June 2019, a Bereavement Nurse who provides a further source of contact for families where necessary and signposts to support services where appropriate.

Thus far, informal feedback from discussions between the ME and the bereaved has been very positive; the family will frequently praise the quality of care and attention received by the patient. Issues that have generated less positive feedback typically include poor communication resulting from the next of kin being provided with differing messages regarding their loved-one's management. Similarly, another typical response has been that the family of a deteriorating patient did not appreciate that he or she was so close to death as turned out to be the case. These occasional concerns are rarely felt to be sufficient to prompt the bereaved to complain through PALS, and they are included often as an afterthought and then only for "completeness". The MEs nevertheless will offer to feedback those comments to the medical teams and this is also much appreciated.

As well as the verbal feedback which informs the scrutiny process, families are also encouraged to provide written feedback on both the Bereavement office processes and care provided to their family member in the last days of life. Feedback from families regarding the process has largely been positive and appreciative of the time made by the Trust to hear their views. Of those who completed the survey 95% of families rated the Bereavement office service good or very good. The data provided on end of life care is reviewed at the End of Life Steering Group and informs the focus of education for nursing and medical staff, including further use of the SWAN suite and the importance of consistent communication between staff and families.

2.7 **Quality of Death Certification**: The new system requires that the death certificate should not be written without the medical team involved in the case discussing the case with the ME. Prior to this it was often a junior member of the medical team alone who completed the death certificate and this is recognised nationally. Lack of experience will undoubtedly have hampered the accuracy of the certificate. One to one discussion with the ME is now required before completion and training in the death certification process from the ME is now included at junior doctor induction. Both of these steps will enhance the accuracy of the data entered on the certificate, which provides both information for individual families and national data bases on cause of death.

2.8 Registration of death should be within 5 days. There is no doubt that delays in completion of certification have contributed to these delays, as has the requirement for families to attend the hospital to collect the certificate and then the civic centre to register. These delays are frustrating and upsetting for families and administrative staff. Wolverhampton has been amongst the poorest performers against the 5 day registration target in the West Midlands, historically only completing 65-75% within the time frame. Since summer 2019 Wolverhampton has begun to achieve 85-95%, undoubtedly influenced by the focus on junior doctors to complete the certificate in a timely fashion and the provision of one stop registrar facilities on site.

2.9 **Future Plans**: These include:

Focus on improving the scrutiny rate of cases by the Medical Examiner from 60% to over 90% of cases.
Engage with other agencies, including Primary Care and WMAS to develop a system of scrutiny which takes a broader view of care provided beyond the hospital site.

3.0 Impact on Health and Wellbeing Strategy Board Priorities

Which of the following top five priorities identified by the Health and Wellbeing Board will this report contribute towards achieving?

Wider Determinants of Health	☐
Alcohol and Drugs	☐
Dementia (early diagnosis)	☐
Mental Health (Diagnosis and Early Intervention)	☐
Urgent Care (Improving and Simplifying)	x

4.0 Decision/Supporting Information (including options)

5.0 Implications

Please detail any known implications in relation to this report:

- Financial implications

  There may be the requirement to employ more Medical Examiner sessions and/or Medical Officers in order to achieve scrutiny in more than 90% of cases.

- Legal implications

There is a statutory obligation to refer certain cases to the Coroner, and the presence of the ME system provides the Trust with the assurance that it has the expertise to identify those cases in a consistent fashion

Whilst the ME system itself is not statutory at the moment there is an expectation that this will become so for hospital sites by March 2020 and for other organisations by March 2021.

Equalities implications

There is the requirement to ensure that where early release for burial or cremation is required, that the case is scrutinised in a timely fashion. The risk of not meeting this timescale but still ensuring scrutiny is higher at weekends.

6.0 Schedule of background papers

6.1 The background papers relating to this report can be inspected by contacting the report writer:

Dr Jonathan Odum
Medical Director
Royal Wolverhampton NHS Trust
Direct line 01902 695898
jonathan.odum@nhs.net

Further information can be found at https://www.england.nhs.uk/wp-content/uploads/2