National Medical Examiner update

September 2021

Welcome

It is now some weeks since we asked all NHS organisations in England to start preparing the ground for medical examiners to provide scrutiny of all non-coronial deaths. In Wales there was a similar request to accelerate and extend implementation. I would like to thank medical examiners and officers, and healthcare providers, for the work taking place. Feedback from bereaved families demonstrates that they appreciate and benefit from medical examiners' work. Medical examiners are also facilitating improvements in care by identifying issues and deaths that need further investigation, and helping resolve concerns at an early stage.

I appreciate this is a complex task and will take time. We avoided prescribing a deadline because some areas are at different stages of readiness compared to others, so timings will vary. Given medical examiners' pivotal role in improving healthcare and safeguarding for patients and their families, my priority is to ensure we get this right, and that the national model, set out in my good practice guidelines, is embedded. Of course we must consider when the forthcoming statutory system will be enabled. However, fully implementing the guidelines, and all the elements of medical examiner scrutiny, will put medical examiners and healthcare providers in the best position when the statutory system comes into effect.

For GPs, I wish to reiterate there is no expectation that they should examine the body as part of the medical examiner process, nor do I envisage such a requirement in the statutory system beyond the requirements for MCCD completion. There is also no need for non-acute doctors to provide a report to the medical examiner – sharing records or a relevant summary is sufficient. We have previously mentioned that where there is local agreement, as part of extending scrutiny to non-coronial deaths in non-acute settings, medical examiner offices can assist GPs and other healthcare providers with coroner referrals.

I would encourage MEs to share their thoughts with coroners on cases that are notified. I received feedback this is especially helpful for coroners when considering the issues. I am fully supportive of this being provided in writing, if not in the notification, then through a supplementary communication.

Dr Alan Fletcher, National Medical Examiner

What's included in this update

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- GPs discuss the benefits of the medical examiner system
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Health and Care Bill

The Government introduced the Health and Care Bill on 6 July 2021, reinforcing the Government's commitment to introduce a statutory medical examiner system. Subject to parliamentary process we do not expect the statutory system to be introduced before Summer 2022. We continue to support the non-statutory system of medical examiners to scrutinise all non-coronial deaths in all settings. We will keep you informed of progress.

GPs discuss the benefits of the medical examiner system

Two GPs who are medical examiners have kindly shared their experience of the medical examiner system, including the benefits for GPs, in this video. We would encourage medical examiners and officers to share this, as part of their engagement with GP practices. We are grateful to Dr Jonathan Cope, GP and lead medical examiner in Plymouth, and Dr Robert Coleman, GP and lead medical examiner in Suffolk for taking the time to speak about medical examiners from a GP's point of view.

Good Practice Series

The Royal College of Pathologists has published two further good practice papers for medical examiners, *How medical examiners can facilitate urgent release of a body*, and *Learning disability and autism*. We are grateful to all those who have participated in discussions and contributed to drafting these papers. We plan further papers on Child Death Reviews, Mental Health, and Anti-Microbial Resistance in coming months.

Resources for extending medical examiner scrutiny to all non-coronial deaths – England

We have received a number of questions about resources for extending medical examiner scrutiny in England. In our communications we have emphasised that we should use the flexibility of the non-statutory period to facilitate this work. For example, as additional staff are recruited in readiness for scrutiny of deaths in the community, they can initially be deployed to facilitate setting up processes and agreements with other providers, before scrutiny of those deaths begins. This can either be through working on these elements themselves, or releasing more experienced staff to establish agreements and processes.

Many medical examiner offices have registered for the online resource for medical examiners to assist community rollout in England, and we invite those that have not done so yet, to contact nme@nhs.net.

Implementation in Wales

Our aim is that all four regional hubs will be able to operate flexibly across the whole of Wales, using our digital system to share cases. Work is also underway to directly connect to the wider NHS Wales patient safety system so that medical examiners and officers can load demographic information and process referrals automatically.

Feedback from care providers and coroners is highlighting that the service is identifying and passing on cases that would otherwise have gone undetected, with medical examiner discussions with the bereaved playing a significant role in identifying these cases. Output-and-outcome dashboards have been developed and will be further refined over coming months.

The second round of recruitment is underway to facilitate increased activity as we move towards ensuring that all non-coronial deaths are scrutinised in Wales from 1 April 2022. The Wales national team is working with acute and primary/community care providers to ensure a whole-system approach to mortality reviews.

Both the lead medical examiner and lead medical examiner officer for Wales continue to provide significant input into national teaching/learning programmes.

Quarterly reporting and funding – England

Most medical examiner offices in England should have received funding confirmation letters setting out agreed reimbursement for activity from 1 April 2021 to 31 March 2022. These will have been sent to the lead medical examiner and medical director. Please contact funding.nme@nhs.net for further information.

We are grateful that medical examiner offices have completed their Quarter 1 2021/22 submission. This will help us to process reimbursement payments and also provides positive information about the progress medical examiners are making, and the impact they are having for bereaved people and for improving healthcare.

The 2021/22 Quarter 2 submission is due via the online portal between 1 October 2021 and 22 October 2021. Please find here information on how to access the portal, and feel free to contact reporting.nme@nhs.net if you have queries. Medical examiner offices that require further support completing submissions should contact their regional medical examiner officer.

Patient safety insight in England

After some recent questions from medical examiners, we thought it would be useful to provide some information about England's patient safety insight team.

The NHS England and NHS Improvement national patient safety team review data from a range of sources to identify new, emerging or under recognised risks to patient safety. Sources include the *National Reporting and Learning System* (NRLS), now being replaced by the *Learning from Patient Safety Events System* (LFPSE), the *Strategic Executive Information System* (StEIS) as well as reports from patients and public, and HM Coroner (*Prevention of Future Death* reports).

Where an issue or risk has been identified, patient safety clinical teams explore further to examine if there are any underlying associated themes. Responses to identified risks include action through national networks, and work with partners, such as the Medicines and Healthcare products Regulatory Agency and NHS Digital. The team works with royal colleges or national professional associations when the issue relates to a speciality. Ultimately, the team may produce a National Patient Safety Alert to mandate specific action.

Medical examiners have a key role in identifying new or under-recognised patient safety issues. Recently the team reviewed a report arising from medical examiner scrutiny,

regarding airway protection during a bilateral sphenopalatine artery embolisation and are discussing next steps with the Royal College of Radiologists.

More information about the national patient safety team's insight team can be found in their review and response reports.

Training and events

Currently, 1,263 senior doctors have completed medical examiner training, and 285 staff have completed medical examiner officer training. Further sessions are planned and will continue to be held virtually via zoom for the foreseeable future.

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.