The Royal College of Pathologists
Pathology: the science behind the cure

National Medical Examiner's Good Practice Series No. 16

Deaths after delays in care and treatment

August 2024

Author: Dr Alan Fletcher, National Medical Examiner

The Royal College of Pathologists
6 Alie Street
London E1 8QT
T: 020 7451 6700
F: 020 7451 6701
www.rcpath.org
Registered charity in England and Wales, no. 261035

Contents

About the National Medical Examiner's Good Practice Series **3**

Introduction **4**

Recommendations for medical examiners **4**

Context and background **5**

Deaths relating to access to acute and emergency care 5

Defining time standards for providing care **6**

Investigating and reporting delays **7**

Scrutinising deaths after delays in care and treatment **7**

What constitutes a delay? 7

Consideration of delays **8**

1. Was there a delay? 8

2. Did the delay contribute to death? 8

3. Was the delay reasonable? 9

Does the Coroner decide to investigate? 9

Conclusion **10**

Find out more **11**

References **13**

Appendix A **Patient rights** **15**

Appendix B **Concerns reported by medical examiner offices** **17**

Acknowledgements **19**

About the National Medical Examiner's Good Practice Series

Medical examiners are senior doctors providing independent scrutiny of non-coronial deaths in England and Wales – a relatively recent development.

While there is extensive guidance available on a wide range of topics for NHS and public sector staff, the National Medical Examiner's Good Practice Series highlights how medical examiners and medical examiner officers can better meet the needs of local communities and work more effectively with colleagues and partners.

The Good Practice Series is a topical collection of focused summary documents, designed to be easily read and digested by busy frontline staff, with links to further reading, guidance and support.

Introduction

Delays are often avoidable and are of concern as they can lead to preventable deaths.

The question of what constitutes a delay is complicated, as a delay could be a matter of weeks, hours, or even minutes depending on context. The word 'delay' contains a negative implication, but there is necessarily an elapse of time between any 2 events.

Delays may be due to individual error, such as failing to make a diagnosis, or forgetting to send a referral or they may be due to system failures, such as capacity issues. Most reporting of delays refers to those that arise from capacity issues.

Delays in care and treatment are increasing[1] and are attracting interest and concern from a range of groups.

Medical examiners have a unique position in being able to provide independent scrutiny to help identify where delays may have contributed to a death.

Recommendations for medical examiners

Medical examiners have a unique position in being able to provide independent scrutiny to help identify where delays may have contributed to a death as well as considering when delays in treatment and care may not have necessarily caused the death but are still important to examine (**Appendix B**). These deaths should be reported to local, system wide and national governance processes.

Medical examiners should:

1. determine whether there was a significant delay
2. decide whether relevant standards were met
3. consider whether the quality of care before death was appropriate
4. report concerns to local Clinical Governance for investigation
5. consider the distress any delay may have caused bereaved relatives and any concerns they may express.

Context and background

This guidance paper focuses on deaths after delays in care and treatment and the medical examiners' role in relation to them.

Medical examiners can play a key role identifying positive examples of good treatment as well as providing feedback, and detecting when care could have been better, so that healthcare providers can prevent recurrence for future patients.

Most deaths in the UK are expected (i.e., attributable to a known problem or problems). However, some deaths are not expected and may require more understanding of circumstances. Medical examiners should also consider the National Medical Examiner's Good Practice Series papers on Post-Mortem Examinations[2] and Palliative and End of Life Care.[3]

Bereaved people are often very positive about the quality of care of the deceased and the support the family received, and there are many examples of excellent care which can be fed back to treating teams. However, there can be problem areas in a minority of deaths.

The sections below set out some specific areas to consider but are not exhaustive. It should also be recognised there are important differences between expected deaths in hospitals and in the community.

Deaths relating to access to acute and emergency care

Deaths after delays in care and treatment can be due to multiple factors and can be a multi-agency issue. An increasing demand for ambulance services has caused challenges for patients arriving at hospitals as well as delays in handovers to emergency care that have system-wide causes.

In January 2024 there were 5,009 life threatening calls to the ambulance service, which account to around 13.9% of all calls, the third highest month on record. 48.8% of life-threatening calls received an emergency response within 8 minutes.[4]

During the Winter of 2024, NHS England weekly winter figures show improvements to delays in ambulance handovers which dropped to 18,799 hours in the week ending February 25, down from 23,494 the previous week, despite more patients being taken to hospitals by ambulance, with a 17% rise from the same time last year.[5]

In January 2023, the Royal College of Emergency Medicine (RCEM) estimated there were at least 300-500 excess deaths occurring across the United Kingdom associated with crowding and extremely long waiting times in Emergency departments.[6]

A scientific study published in the Emergency Medicine Journal estimated for every 72 patients waiting between 8 and 12-hours from their time of arrival in the Emergency Department there is 1 patient death because of the delay.[7]

The RCEM report, "Long waits and excess deaths", states that in 2022 NHS England reported that 347,703 patients waited 12 hours from **decision to admit**, which calculates to 1,656,206 people waited 12 hours or more from their time of arrival at an emergency department: "… we [RCEM] estimate that 23,003 patients potentially died in 2022, equalling 446 patients a week".[8]

Defining time standards for providing care

In 2017, NHS England implemented new ambulance standards across the country and introduced 4 categories of call which should be responded to within certain time limits.[9]

The NHS Constitution sets out a series of time standards against which patients with certain conditions should be treated (**Appendix A**).

In addition, NICE and professional bodies set out time standards for treatment, e.g., thrombectomy within 6 hours of a stroke[10] and Primary PCI within 12 hours of myocardial infarction[11].

Changes to the GP Contract 23/24 make clear that patients should be offered an assessment of need, or signposted to an appropriate service, at first contact with the practice.[12]

The NHS England Quality and Outcomes Framework guidance for 2023/24 provides additional guidance on the interpretation and verification of the QOF indicators for 2023/24 in England for GPs.

Consideration should be given to the wider issues that may present delays such as winter pressures or events such as the COVID-19 pandemic.

Investigating and reporting delays

Where identified, local Clinical Governance processes may investigate deaths that may have been contributed to by a delay in care or treatment.

Coroners may investigate deaths where they consider that delay has had a sufficient level of impact to be contributory to a death. Feedback from medical examiner offices suggests that thresholds for investigation vary across coronial jurisdictions.

Maternal deaths, child deaths and deaths of those with learning disability or autism have a national framework for investigation and reporting.[13,14, 15] These all consider the impact of delays to some extent.

NHS England's Learn from Patient Safety Events Service[16] is being rolled out and may provide lessons to be learnt from deaths caused by delays.

Scrutinising deaths after delays in care and treatment

What constitutes a delay?

As part of the independent scrutiny process, medical examiners should consider how they quantify a 'delay', for example, if a patient should have been seen in a maximum of 6 weeks but was seen after 10 weeks, is the 'delay' equal to all 10 weeks, or only the 'excess' 4 weeks? The latter may seem more appropriate but becomes harder to apply when there is no set time limit to compare against. (**Appendix A** details maximum waiting times according to the NHS Constitution.[17])

The decision of whether a delay contributed to death is complicated. If a delay occurred during the deceased's care or treatment, it does not automatically mean there is relevance to the cause of death. The circumstances of the delay must be considered, so it may help to decide separately firstly whether there was a delay, secondly whether the delay contributed to death, and thirdly whether the delay was reasonable.

Consideration should be given to the perspectives of bereaved people as their input into discussions is important. Medical examiners can help explain, but not excuse delays, and should consider how expectations can be managed, including through directing bereaved people to the appropriate complaints process.

Consideration of delays

1. Was there a delay?

There could be a delay in any aspect of the patient's care, for example from a referral from primary care to secondary care (days, weeks), waiting time for an appointment (weeks, months), a diagnostic delay (weeks, months) or in administration of a drug (minutes, hours).

A delay can be defined as any period between the need for an action or decision and its occurrence which is greater than would be expected according to commonly accepted reasonable practice or standards.

As far as possible, the facts should be considered objectively without reference to opinion, levels of experience, or surrounding circumstances. For example, if an inexperienced clinician referred a patient as routine when on review their symptoms indicated an urgent referral, that potentially leads to a delay measured relative to the standard for urgent cases not for routine cases. The clinician's inexperience does not alter the fact that there was an avoidable delay.

2. Did the delay contribute to death?

This is a factual judgement to be made initially by the attending practitioner and medical examiner, or if a notifiable death by the coroner, and inevitably attracts a range of opinion. A delay hypothetically contributing to the death does not necessarily mean it should be considered as a cause of death. For example, many patients present with cancer only when the tumour is already well advanced – this delay in presenting and subsequent treatment is not considered a cause of death.

To consider the delay as potentially contributing to death, it is necessary for the attending practitioner and medical examiner to have reason to suspect that death would, likely, have not occurred at that time but for the effects of the observed delay. For example, a deceased person may have survived an acute myocardial infarction if an ambulance had arrived within the target time. The attending practitioner and medical examiner are not in a position to provide definitive expert opinions, which is for further investigation to consider.

There may be circumstances where Clinical Governance referral is appropriate, even if the delay did not contribute to the death, and some cases may be a need to escalating further.

3. Was the delay reasonable?

The delay between referral and treatment may have been caused by the patient's own actions, such as cancelling an appointment. It will be important to consider whether the patient had been properly informed of the importance of attending.

The delay between clinical indication and administration of treatment was for a commonly accepted reason, such as waiting for test results that might show the intended treatment was contraindicated, provided this is in line with relevant treatment protocols.

A delay would never be acceptable because of staff absences, workloads, lack of training, malfunctioning of computer systems or winter pressures.

Does the Coroner decide to investigate?

If the attending practitioner and medical examiner reach the conclusion that a delay did occur, there is reasons to suspect the delay did contribute to death, **they must refer to the coroner as death was not caused solely by the natural consequences of the disease**.

If the coroner decides not to investigate, that would seem to indicate that the delay did not contribute materially to death and/or was not sufficiently close to the chain of events leading to death to be considered causal. Therefore, it would be appropriate to consider the case under clinical governance processes as there may be lessons to learn, but **a delay in treatment should not be recorded as part of the cause of death on the MCCD**.

Conclusion

It is not always clear whether or a delay may have contributed to a death, but this should be considered and examined during medical examiner scrutiny and investigation.

Deaths after delays may highlight the ‘symptoms’ of a system under pressure if there have been communication or administration failures or a failure to identify or act on warning signs.

Delays in care and treatment can cause extreme distress for patients and bereaved people, particularly those caused by system pressures, for example a lack of beds available or an extended wait in an Emergency Department, and medical examiners should offer the opportunity for concerns to be raised following a bereavement.

Find out more

- Emergency Medical Journal: Data & Statistics | RCEM & Association between delays to patient admission from the emergency department and all-cause 30-day mortality
- Care Quality Commission: A different ending, addressing inequalities in end-of-life care
- General Medical Council: Treatment and care towards the end-of-life
- Kings College London: Learning from Lives and Deaths: People with a Learning Disability and Autistic People, LeDeR Annual Report
- Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK)
- National Audit of Care at the End of Life (NACEL)
- National Child Mortality Database
- National Institute for Health and Care Excellence (NICE). *Stroke and transient ischaemic attack in over 16s: diagnosis and initial management*. Published May 2019. Available at: www.nice.org.uk/guidance/ng128/chapter/Recommendations#thrombectomy-for-people-with-acute-ischaemic-stroke
- NHS England. *Ambulance Quality Indicators Data 2024–25*. Accessed July 2024. Available at: www.england.nhs.uk/statistics/statistical-work-areas/ambulance-quality-indicators/ambulance-quality-indicators-data-2024-25/
- NHS England. *Changes to the GP Contract in 2023/24*. Published 6 March 2023. Available at: www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2023-24/
- NHS England. *Guide to NHS waiting times in England*. Accessed July 2024. Available at: www.nhs.uk/nhs-services/hospitals/guide-to-nhs-waiting-times-in-england/
- NHS England. *Learn from patient safety events (LFPSE) service*. Accessed July 2024. Available at: www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/

- NICE. *Acute coronary syndromes*. Published May 2020. Available at: www.nice.org.uk/guidance/NG185/chapter/recommendations
- NICE. *End-of-life care for adults: service delivery.* Published 16 October 2019. Available at: www.nice.org.uk/guidance/ng142
- NICE. *Quality standard: End of life care for adults*. Published 28 November 2011, updated 2 September 2021. Available at: www.nice.org.uk/guidance/qs13
- Royal College of Emergency Medicine: Excess deaths associated with crowding and corridor
- Royal College of Emergency Medicine: RCEM Explains: Long waits and excess mortality
- Royal College of Pathologists: National Medical Examiner's Good Practice Series
- UK Parliament: NHS Key Statistics: England

References

1. UK Parliament. *NHS Key Statistics: England*. Published March 2024. Available at: commonslibrary.parliament.uk/research-briefings/cbp-7281
2. Royal College of Pathologists. *National Medical Examiner's Good Practice Series No.5 Post-mortem examinations*. Published March 2022. Available at: www.rcpath.org/static/6f3bffc0-f30b-4053-8d50fb2b5df0e57c/Good-Practice-Series-Post-mortem-examinationsFor-Publication.pdf
3. Royal College of Pathologists. *National Medical Examiner's Good Practice Series No.14 Palliative and end-of-life care*. Published March 2024. Available at: www.rcpath.org/static/6fad59c3-535c-4f18-a003e96ccab7d8b7/3d41fcc3-73e9-4961-9a8c6230b764699f/Good-Practice-Series-14-Palliative-and-end-of-life-careFor-Publication.pdf
4. NHS Confederation. *Exceptional winter pressures hamper monumental efforts of NHS staff*. Published 22 February 2024. Available at: www.nhsconfed.org/news/exceptional-winter-pressures-hamper-monumental-efforts-nhs-staff
5. NHS England. *Ambulance handovers improve despite increased demand and ongoing winter pressures*. Published 29 February 2024. Available at: www.england.nhs.uk/2024/02/ambulance-handovers-improve-despite-increased-demand-and-ongoing-winter-pressures/
6. Royal College of Emergency Medicine. *Excess deaths associated with crowding and corridor*. London, UK. Published January 2023. Available at: res.cloudinary.com/studio-republic/images/v1677854299/Excess_deaths_associated_with_crowding_and_corridor_care_13573c9665/Excess_deaths_associated_with_crowding_and_corridor_care_13573c9665.pdf?_i=AA
7. Jones S, Moulton C, Swift S, Molyneux P, Black S, Mason N *et al*. Association between delays to patient admission from the emergency department and all-cause 30-day mortality. *Emergency Medicine Journal* 2022;39:168–173.

8. Royal College of Emergency Medicine. *RCEM Explains: Long waits and excess mortality*. London, UK. Published February 2023. Available at: rcem.ac.uk/wp-content/uploads/2023/02/RCEM_Explains_long_waits_and_excess_mortality.pdf
9. NHS England. *Ambulance Response Programme*. Accessed July 2024. Available at: www.england.nhs.uk/urgent-emergency-care/improving-ambulance-services/arp/
10. NICE. *Stroke and transient ischaemic attack in over 16s: diagnosis and initial management*. Published 1 May 2019, updated 13 April 2022. Available at: www.nice.org.uk/guidance/ng128/chapter/Recommendations
11. NICE. *Acute coronary syndromes*. Published 18 November 2020. Available at: www.nice.org.uk/guidance/NG185
12. NHS England. *Changes to the GP Contract in 2023/24*. Published 6 March 2023. Available at: www.england.nhs.uk/long-read/changes-to-the-gp-contract-in-2023-24/
13. MBRRACE-UK. *Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK*. Published 1 January 2012. Available at: psnet.ahrq.gov/issue/mbrrace-uk-mothers-and-babies-reducing-risk-through-audits-and-confidential-enquiries-across
14. National Child Mortality Database. Available at: www.ncmd.info
15. Kings College London. *Learning from Lives and Deaths – people with a learning disability and autistic people Report 2022 (LeDeR)*. Published November 2023. Available at: www.kcl.ac.uk/research/leder
16. NHS England. *Learn from patient safety events (LFPSE) service*. Published March 2023. Available at: www.england.nhs.uk/patient-safety/patient-safety-insight/learning-from-patient-safety-events/learn-from-patient-safety-events-service/
17. Department of Health & Social Care and Public Health England. *Guidance: Handbook to the NHS Constitution for England*. Published 1 October 2023. Available at: www.gov.uk/government/publications/supplements-to-the-nhs-constitution-for-england/the-handbook-to-the-nhs-constitution-for-england

Appendix A Patient rights

The NHS Constitution for England sets out rights to which patients are entitled, including: "You have the right to access certain services commissioned by NHS bodies within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. The waiting times are described in the handbook to the NHS Constitution."[17]

You have the right to:

- start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions.
- be seen by a cancer specialist within a maximum of 2 weeks from GP referral for urgent referrals where cancer is suspected.
- a maximum 1 month (31 day) wait from a decision to treat, or earliest clinically appropriate date, to treatment of cancer.
- a maximum 2 month (62 day) wait from receipt of an urgent GP (or other referrer) referral for urgent suspected cancer or breast symptomatic referral, or urgent screening referral, or consultant upgrade, to first definitive treatment of cancer.
- a maximum 28 day wait from receipt of an urgent referral for suspected cancer, receipt of urgent referral from a cancer screening programme, or receipt of urgent referral of any patient with breast symptoms (where cancer not suspected) to the date the patient is informed of a diagnosis or that cancer is ruled out.
- a maximum 4 hour wait in Accident and Emergency from arrival to admission, transfer, or discharge.
- patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral.
- a maximum 7 day wait for follow-up after discharge from psychiatric in-patient care for people under adult mental illness specialties on Care Programme Approach.
- all patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within

28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.

- 75% of people referred to the improving access to psychology therapies (IAPT) programme should begin treatment within 6 weeks of referral and 95% of people referred to the IAPT programme should begin treatment within 18 weeks of referral.
- more than 56% of people experiencing a first episode of psychosis will start treatment within a NICE-recommended package of care with a specialist early intervention in psychosis service within 2 weeks of referral.

Appendix B Concerns reported by medical examiner offices

An informal survey in early 2023 reported 2,813 deaths occurred between Monday 30/01/23 to Sunday 05/02/23 (inclusive) in England and were scrutinized by medical examiners. Medical examiner offices reported the following specific examples of concern, such as cases with identified risks to patient safety or patient care:

- Troponin rise on admission with history of chest pain not followed through
- Unnecessary suffering, patient left in pain despite family requesting pain relief
- Apparent failure to accept relevant referral (stroke)
- Omitted anti-epileptic medication leading to seizure
- No follow-up of DNA for ureteric stent change 4 months earlier, several opportunities missed to recognise and rectify
- Upper gastrointestinal haemorrhage not identified
- Sepsis treatment delayed
- Blood glucose deterioration not acted upon
- Thrombolysis window missed
- Diagnosis of brain tumour
- Referral to community heart failure nurse planned but not actioned, heart failure in a subsequent admission
- Medical outlier patients not receiving timely reviews.

While the sample in the survey is too small for extensive numerical analysis, the following points are noted:

- participating medical examiner offices identified delays in 9.5% of deaths included in this survey
- medical examiner offices reported that:
  - 33.2% of cases with identified delays were referred for clinical governance review

- 17.9% of cases with identified delays were notified to the coroner.

Acknowledgements

This document was drafted following circulation to and input from the following people. The National Medical Examiner is grateful to all for their participation and support:

- Dr Alan Fletcher, National Medical Examiner (Chair)
- Charlotte Benjamin, Chief Medical Officer, North-West London ICS
- Helen Briggs, Office Co-ordinator to the National Medical Examiner Office, NHS England
- Ben Brown, Policy Lead on Medical Examiners, Welsh Government
- Jane Crossley, Team Leader, Death Certification Reform, Department of Health and Social Care
- Nick Day, Policy and Programme Lead, Medical Examiner System, NHS England
- Douglas Findlay, Lay Representative
- Myer Glickman, Head of Methods, Quality and International Health Analysis and Life Events Division, Office for National Statistics
- Natalie Harris, Healthcare Standards and Governance Lead, Welsh Government
- Cathryn James, Clinical Lead, Association of Ambulance Chief Executives
- Dr Suzy Lishman CBE, Royal College of Pathologists
- Michael Marsh, Regional Medical Director for the South-West
- James Parker, Head of the Chief Coroner's Office, and Private Secretary to the Chief Coroner
- Graham Prestwich, Lay Representative
- Helen Rose, Senior Project Manager, Medical Examiner System, NHS England
- Jonathan Slade, Medical Director, System Improvement Professional Standards North-East and Yorkshire
- Jonny Tinsley, Head of Data and Health Analysis, Office for National Statistics
- Huw Twamley, Regional Medical Examiner for North-West

- Fenella Wrigley, Chief Medical Officer, London Ambulance Service and Chair of the National Ambulance Medical Directors Group
- Stella Vig, National Medical Director, Secondary Care and Quality