Implementing the Medical Examiner System - conference 30 January 2019

On 30 January 2019, delegates gathered at the Heartlands Hospital in Birmingham to hear further updates on the progress of implementing the medical examiner system. The event was chaired by Professor Jo Martin, President of the Royal College of Pathologists, and Dr Suzy Lishman, representing the College's Medical Examiners Committee. Key speakers included Lucy Watson, Chair of the Patients' Association, HHJ Mark Lucraft QC, the Chief Coroner, and Mohamed Omer, Chair of the National Burial Council.

The introduction of medical examiners now sits within the portfolio of Minister of State for Care, Caroline Dinenage. The Minister provided this message of support:

> **"I know from the events in my own constituency of Gosport that the drivers for the introduction of medical examiners have never been greater. We must now seize this moment to introduce a medical examiner system that will deliver the benefits identified by too many reports into patient safety. My thoughts are with you at this important milestone event. The Government remains committed to the introduction of a medical examiner system which puts the bereaved at its centre, provides proportionate scrutiny for all deaths that are not investigated by a coroner and enables lessons to be learned."**

Strategic overview

Following previous events in 2018, the day was aimed at providing further information as the programme evolved and April 2019 approaches, including addressing key themes such as funding and independence. Both Aidan Fowler, the NHS Director of Patient Safety, and Jeremy Mean, the Programme Director from the Department of Health and Social Care (DHSC), presented a clear message about timescales. Whilst the introduction was to roll out from April 2019, it was clear that the system would need to grow – in some places from a standing start, and it would take time for a fully developed medical examiner system to be in place. The ambition was for there to be full coverage of all deaths in NHS acute provider hospitals by the end of the 2019/20 financial year.

Funding

DHSC reaffirmed the commitment that the cost of implementation should be net-neutral to the providers who are hosting and running the medical examiner system. Until legislation changes, whilst the system is in the non-statutory phase, the host organisations will fund the medical examiner system through a combination of the fee paid for cremation form 5, and a top-up provided by the DHSC.

The digital solution currently under development will be aimed primarily at supporting the work of the medical examiner and medical examiner officer. Providing a digital solution to allow the host organisation to track all the deaths scrutinised by each medical examiner will also provide the information that host organisation finance departments need.

A system will be put in place for host organisations to recoup the difference in cost for their medical examiner system and the income they receive from cremation form fees. The exact mechanism for this was still being worked through but the commitment to ensure the system does not create a cost pressure was emphasised.

It was noted that some standardisation of the system was necessary to deliver a proportionate and affordable scrutiny process. An example was provided of a medical examiner office with one whole time equivalent (from a rota) medical examiner and three whole time equivalent medical examiner officers per approximately 3000 deaths per year.

This number may change as more information is gathered during implementation of the system, and an appropriate range would be developed, so costs could be agreed.

In the non-statutory phase, rapid progress in the introduction of the medical examiner system was encouraged from April 2019 onwards. To support the setting up of the system the DHSC had agreed to provide funding to cover the costs of recruitment for setting up the service, via a flat fee contribution per post. Again, the digital solution will also allow recruiting providers to evidence the number of medical examiner and medical examiner officer posts they have recruited, and then claim the funding for recruitment at year end in April 2020.

When a change in legislation is passed, the funding of the system will be reviewed. It will, therefore, be important that the National Medical Examiner and regional lead medical examiners work closely with hosts during implementation to ensure that there is data on the cost per death of running the system.

Independence

Host organisations need to allow for information access in the sensitive and urgent timescales surrounding death registration but with the independence necessary for the credibility of the scrutiny process, therefore ensuring an independent line of professional accountability for the medical examiner is crucial. To support this independence, the NHS Director of Patient Safety announced the planned appointment of the National Medical Examiner to the patient safety team at NHS Improvement. The National Medical Examiner will provide professional and strategic leadership to medical examiners in England and Wales in their non-statutory role. They will advise on findings from the non-statutory scheme and will inform the requirements for the national implementation of the statutory scheme following an amendment to the Coroners and Justice Act 2009. The National Medical Examiner will also set quality standards of best practice behaviours to improve death certification processes across England and Wales. This will support better safeguards for the public, monitor and improve patient safety and inform learning from deaths initiatives.

To further provide for that independent line of professional accountability, NHS Improvement will be recruiting seven regional lead medical examiners and regional lead medical examiner officers in England. There will be an additional lead medical examiner and medical examiner officer for Wales recruited by NHS Wales Shared Services Partnership. The regional lead medical examiners and the lead medical examiner for Wales will provide professional leadership to medical examiners. They will adopt a collaborative working relationship with the other regional lead medical examiners by sharing experiences and expertise to support peer learning. The regional lead medical examiners will ensure medical examiner offices comply with the legal and procedural requirements associated with the current and proposed reformed processes of certification, investigation by coroners and registration of deaths.

The set-up of the system locally will be determined by the average number of deaths. It is not expected that every acute provider organisation will have a medical examiner office as some organisations may have a very low number of deaths. In these instances, an agreement is expected to be formed with an established medical examiner office locally. The size and shape of the area that a particular medical examiner office covers can be captured on the digital system. A seven days a week service is expected, but there will be no service at night. This would involve the medical examiners engaging in a rota system to cover weekends to support rapid release of the deceased when required. The NHS Director of Patient Safety stated that he would work with the National Medical Examiner to further develop the detail and that NHS Improvement are committed to delivering the introduction of

medical examiners and providing better safeguards for the public, improving the quality of the medical certificate of the cause of death and supporting patient safety.

Training medical examiners

Dr Suzy Lishman outlined the two components of the training; 26 core e-learning modules and face-to-face events. Details of the training, which is relevant to both medical examiner and medical examiner officers, is available as a link on the Royal College of Pathologists website.

Dr Alan Fletcher, Senior Medical Examiner, Sheffield and Dr Helen Mansfield, Senior Medical Examiner at Gloucester, joined the panel discussion to provide their insight from a pilot perspective. They spoke about the how the out-of-hours service should be set up to respond to the local demographic. It was highlighted that the training made reference to the sensitivities of pre-emptive scrutiny. Suggestions were made to support those organisations with a small number of deaths per year to set up a service level agreement with a neighbouring medical examiner office. It was also outlined that levels of demand can fluctuate and reviews should be proportionate.

Working with key stakeholders

Lucy Watson, Chair of the Patients' Association addressed the conference and highlighted that patients will welcome the role of the medical examiner and urged host organisations to include patient groups in the recruitment process and the establishment of the system.

The relationship between the coroner and the medical examiner is crucial and HHJ Mark Lucraft QC, Chief Coroner, also emphasised the importance of involving senior coroners in the recruitment process. He also reflected on the learning his office disseminates and welcomed the National Medical Examiner to provide similar advice to the medical examiner system. His key message was one of working together at both a national and local level.

With aspects of the medical examiner system still in development, Mohamed Omer outlined the perception of the impact of the system is that it may cause delay. He too emphasised the need for regular communication to address this perception and outline how the system is proposed to work allowing for rapid release of the deceased and an out-of-hours service.

Daisy Shale and Dr Dawn Chaplin manage the medical examiner officer's role in Sheffield and Birmingham respectively. Daisy and Dawn outlined the crucial role of the medical examiner officer to support the efficient functioning of a medical examiner office and their role in overseeing cases from end to end. As well as the primary role of scrutinising the cause of death, they also described the medical examiner system as a process of detecting and passing on to other reviews.

Cathie Mason, Senior Coroner at Leicester, echoed the words of the Chief Coroner, and suggested in all instances that the prospective host organisation meets with the local coroner and registrars to discuss the medical examiner system and how it will work locally. The number of inappropriate referrals to the coroner had reduced in Leicester since the introduction of the medical examiner system.

Stuart Cella of the General Register Office (GRO) made reference to the cause of death list for registrars and how the National Panel for Registration had sought to develop the document, working with medical experts.

Representatives from both the NHS in England and Wales were present at the event and Jason Shannon, National Clinical Lead for Mortality Review in Wales, joined the panel

discussion. He stated that both administrations were proposing to deliver a similar system to the same timescales with local differences only occurring due to the structure of the two health systems. A memorandum of understanding will be agreed to ensure that the medical examiner system introduced, works for both England and Wales.

Whilst there was much discussion on scrutiny of non-coronial deaths which occur inside hospitals, it was acknowledged that more work was needed to support scrutiny of deaths outside of hospitals. DHSC committed to setting out further thinking at the next national event on 25 April 2019.

Dr Suzy Lishman

Meeting Organiser

February 2019