How We Learn from Deaths / Medical Examiner & Bereavement Service Q4 and Annual Summary 2023-24 Report
SUPPLEMENTARY INFORMATION:

APPENDIX A:

MEDICAL EXAMINER & BEREAVEMENT SERVICE REPORT QUARTER 4 – 01 JANUARY 2024 – 31 MARCH 2024 AND ANNUAL REPORT 1 APRIL 2023 – 31 MARCH 2024

1.0 Introduction

The purpose of this report is to provide the Trust Board with an overview of the number of in-hospital deaths managed by the Medical Examiner (ME) & Bereavement Service during quarter 4 (Q4) 2023-24, and a summary of the annual report 2023-24 which includes the performance and outcome of Medical Examiner reviews, including those with coroner involvement.

2.0 Summary of Hospital Deaths

2.1 There were 2090 deaths reported to the Medical Examiner Service within the Trust during 2023-24, 567 of these deaths were during Q4. There has been an overall reduction of 192 deaths from the same period in 2022-2023 which reported 2282 deaths for the full year (Figure 1). The ME service has reported this data to NHS England as part of the ME quarterly data return.

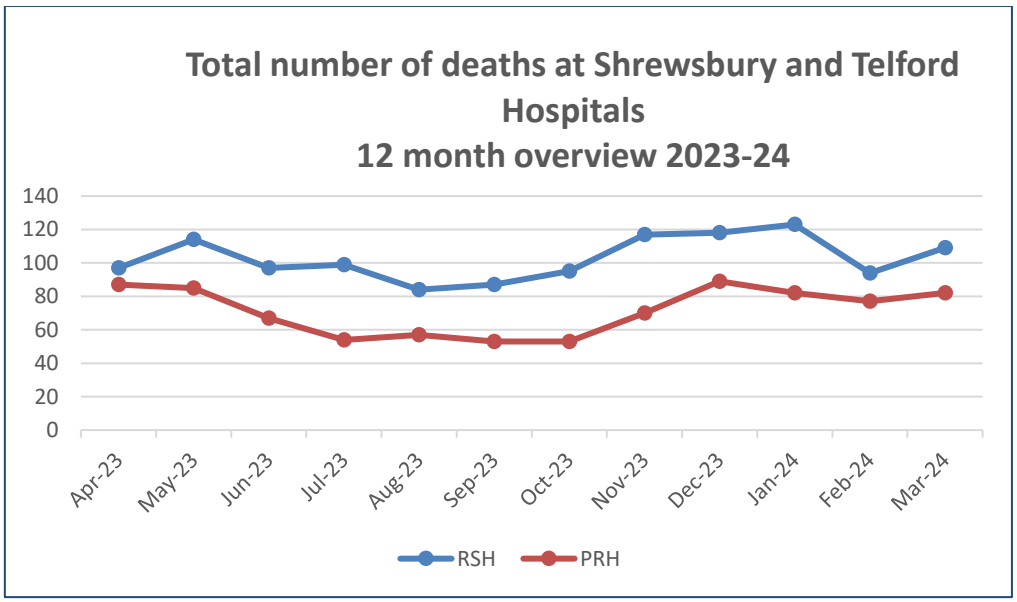

Figure 1 – Total number of deaths at SATH 12-month overview

3.0 Medical Examiner Scrutiny

3.1 Summary

Of the 2090 deaths that occurred throughout 2023-24, 2084 received Medical Examiner scrutiny (Figure 2), 99% of the overall deaths therefore receiving a review. During Q4, 100% of the deaths reported to the ME service received a review. Cases where an ME review has not taken place were due to referrals being made directly to the coroner but not by the ME service, these deaths therefore fall outside the remit for Medical Examiner review.

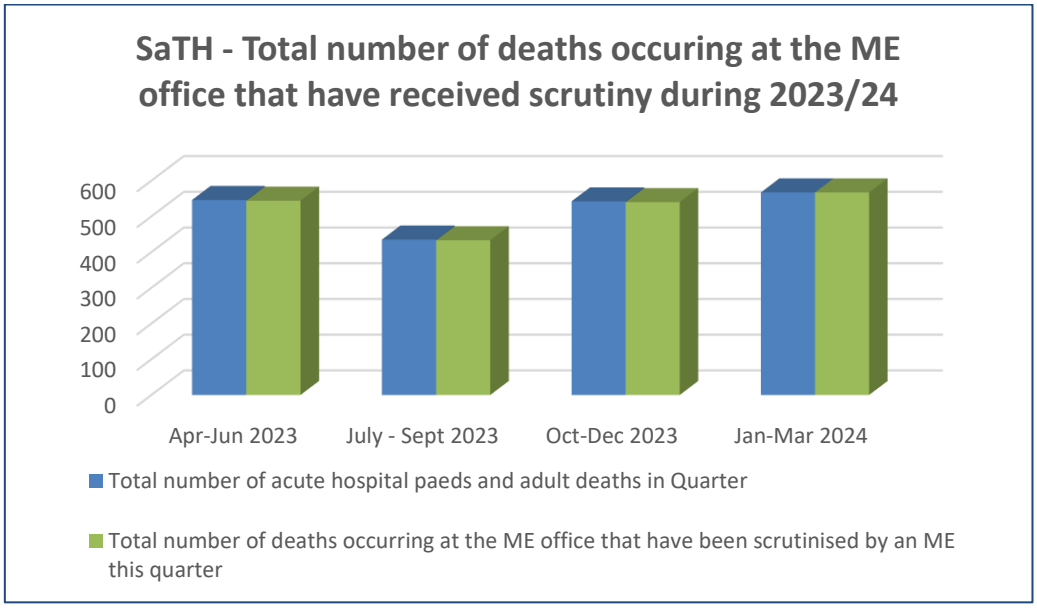

Figure 2– Total Number of Medical Examiner Reviews in 12-month overview

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 Of the 566 deaths reviewed by the ME service during Q4, 520 MCCDs were requested following Medical Examiner review and completed by the treating clinician.

4.2 Of the 520 MCCDs written, 462 of these had no coroner involvement and so the target period for MCCDs with no coroner involvement to be written, is within three calendar days. 154 of the MCCDs were not completed within three calendar days during Q4. Delays were therefore experienced for bereaved relatives being able to register the death of their relative during this time.

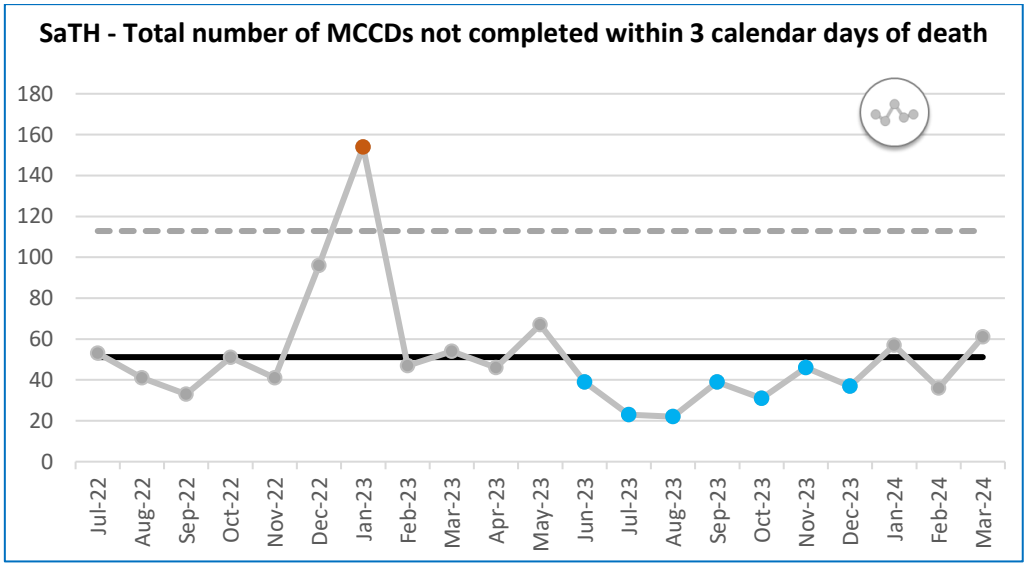

Figure 3 – Number of MCCDs not completed within 3 calendar days of death.

Performance with achieving three calendar days has been challenging during this quarter and is a worsening picture in comparison to Q3.

The above SPC chart demonstrates the variability in performance over the 12-month period and fluctuations are in line with seasonal pressures, bank holiday periods and times where the service has been impacted by industrial action.

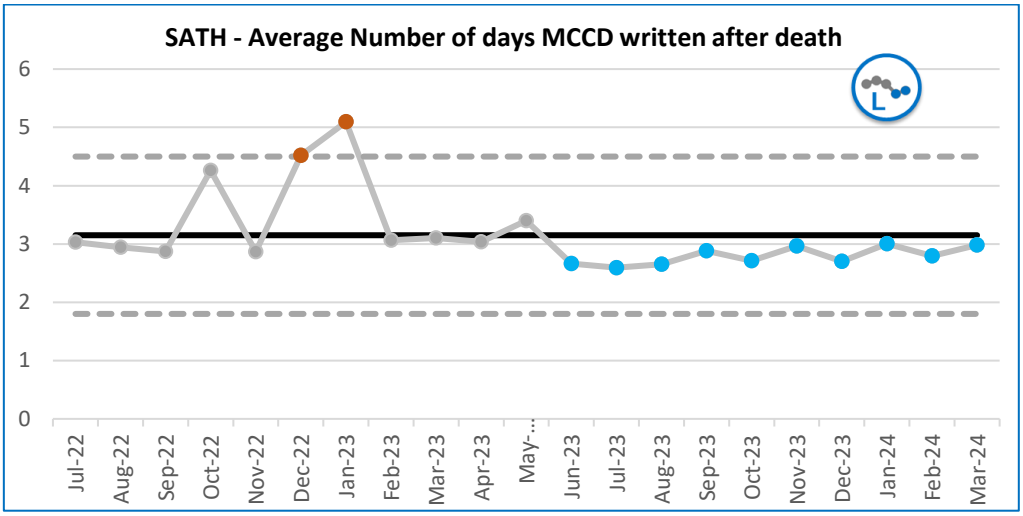

Figure 4 – SaTH Average Number of days MCCD written after death.

The above SPC chart demonstrates that typically MCCDs are being written and issued within the first 3 days following the death. However, despite the number of deaths being higher during the quarter in comparison to quarter three, the deterioration in performance during quarter 4 is not in line with the increased number of deaths and demonstrates the difficulty with ensuring timely death certification is taking place.

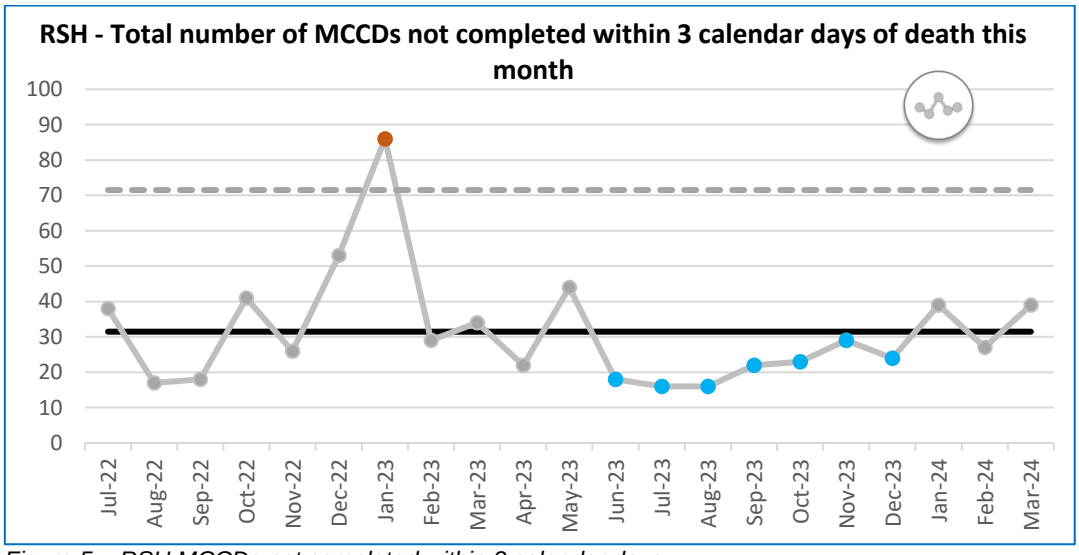

Figure 5 – RSH MCCDs not completed within 3 calendar days.

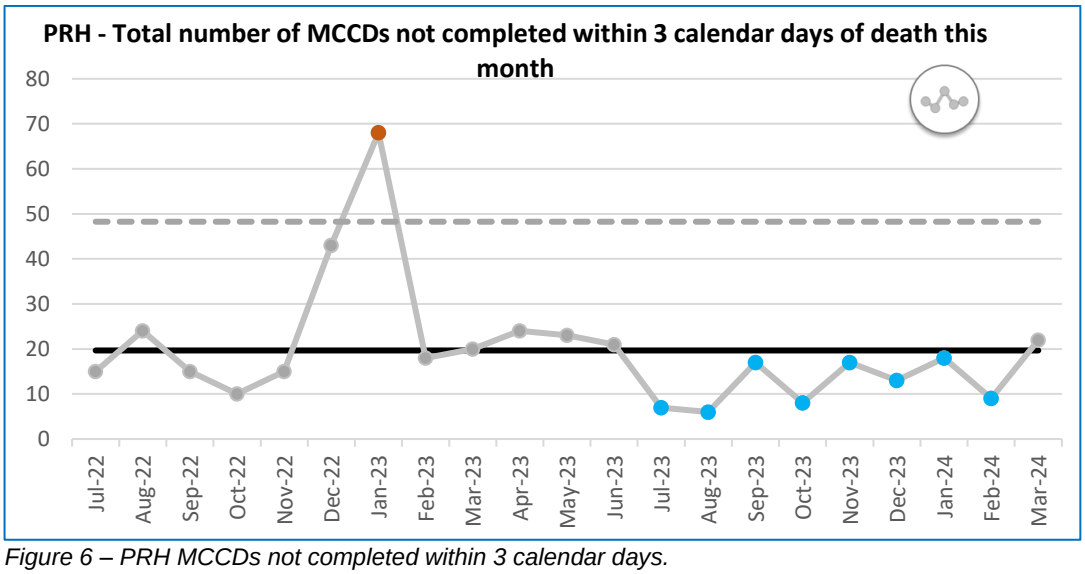

Figure 6 – PRH MCCDs not completed within 3 calendar days.

The challenges of completing MCCDs is the point of focus and work is being undertaken to raise awareness amongst the medical teams. Inclusion at the Consultant and Junior doctor induction sessions should help to promote the importance of timely death certification and the requirement of clinicians to support this process. This action is being progressed as we enter quarter 1 of the new financial year.

4.3 MCCDs rejected by Registration Services

Although all adult deaths are reviewed by the Medical Examiner, and a sign off from this review is provided to the Registrar when the MCCD is sent over to confirm this has taken place, there can still be occasions where they see it necessary to reject an MCCD that has been provided. In these cases, the Registrar will either contact the Bereavement Service to discuss the cause of death, or they will refer the death directly to the coroner.

Of the 520 MCCDs written and issued during Q4, 14 certificates were rejected by Registration Services. This quarter has seen the highest rate of MCCD rejections throughout 2023/24, which has provided learning opportunities for the Medical Examiner service. In summary for the 12-month period, the Bereavement Service issued 1889 MCCDs to the Registrar, of which they rejected 34 which were then forwarded to the coroner service, at their discretion.

Although there has been some learning identified for the ME service in respect of the MCCDs rejected, the low number over the 12-month period demonstrates the value the Medical Examiner service is having on ensuring the accuracy of death certification and therefore reducing the upset and inconvenience to bereaved relatives at the point of death registration.

5.0 Structured Judgement Review (SJR) & Potential Learning

5.1 There were 40 deaths in Q4 (Fig 7) where the Medical Examiner had recommended an SJR.

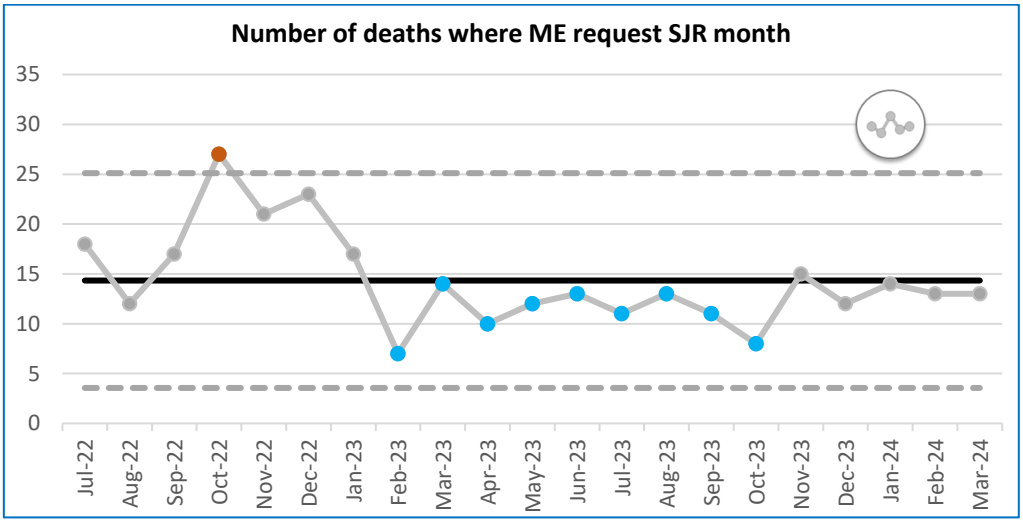

Figure 7 – Number of SJRs recommended following Medical Examiner Review

The SPC chart explains that typically the ME service can recommend on average SJRs in 15 cases a month, but you will see periods where the number recommended have got close to the upper and lower process limits with this correlating with seasonal variance.

Figure 8 below shows the categories for which the Medical Examiner has recommended an SJR review take place. The subject titles are pre-determined options that the Medical Examiner selects from the national exemplar Medical Examiner scrutiny paperwork. The cases that are identified for SJR by the Medical Examiner are then discussed at the weekly mortality triangulation meeting to facilitate SJR review to take place. This information is also submitted to NHSE as part of the quarterly return.

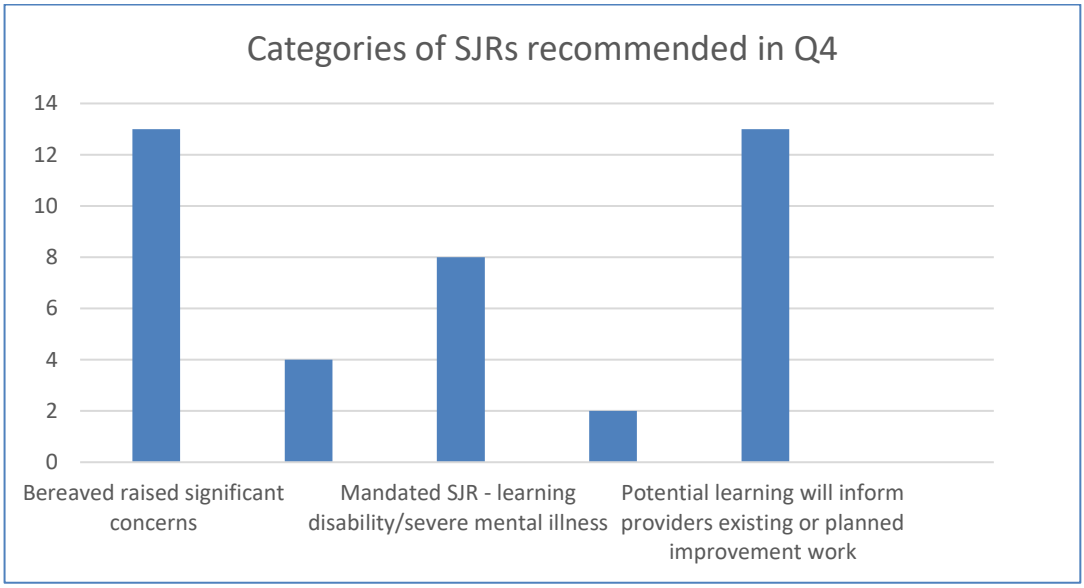

Figure 8 – Categories of SJRs recommended.

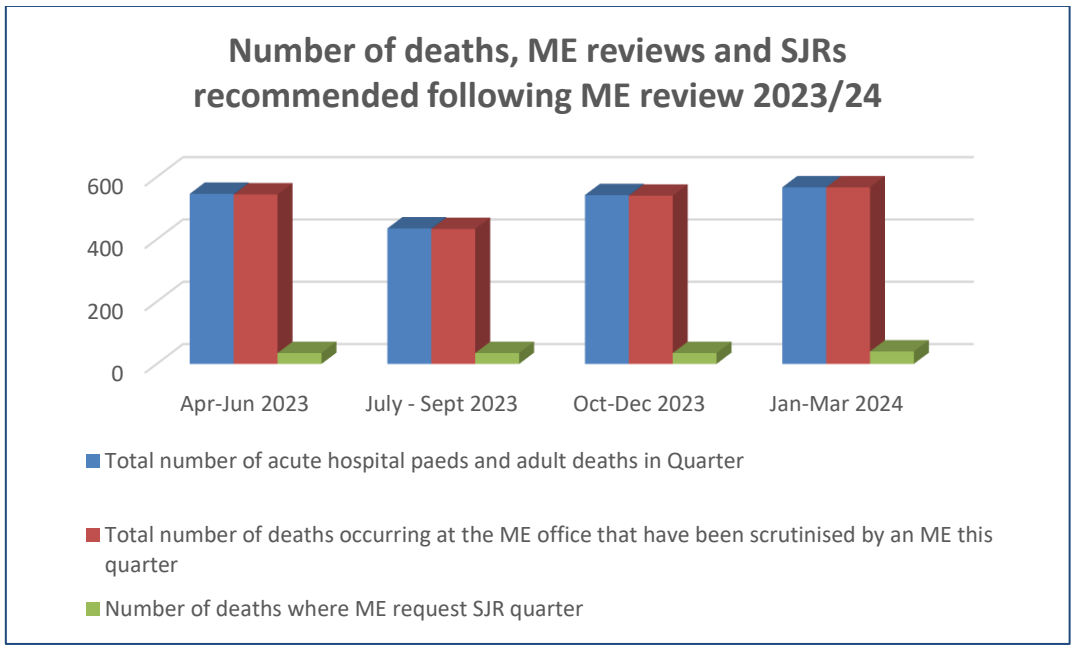

Figure 9 – Total number of SJRs recommended following ME review.

Of the 2084 deaths that received review during 2023/24, the medical examiner recommended structured judgement reviews in 145 cases, resulting in 6% of the overall deaths that received a further review by the Trust following proportionate scrutiny from the Medical Examiner Service.

5.2 Deaths identified by Medical Examiner for potential learning.

Medical Examiners raised potential learning in 97 deaths during Q4, with all these cases being referred to the relevant clinical divisions and specialties for review through their governance processes to ensure learning can be shared. The Medical Examiner service identified potential learning in 354 deaths over the 12-month period.

The Medical Examiner service advised the next of kin in 47 cases to contact PALS to raise the concerns that were discussed during the ME interaction during 2023/24.

6.0 Coroner Referrals

6.1 Across both hospital sites the Medical Examiner facilitated 95 referrals to the coroner during Q4. This is a reduction from what was referred in Q3 by 23 referrals.

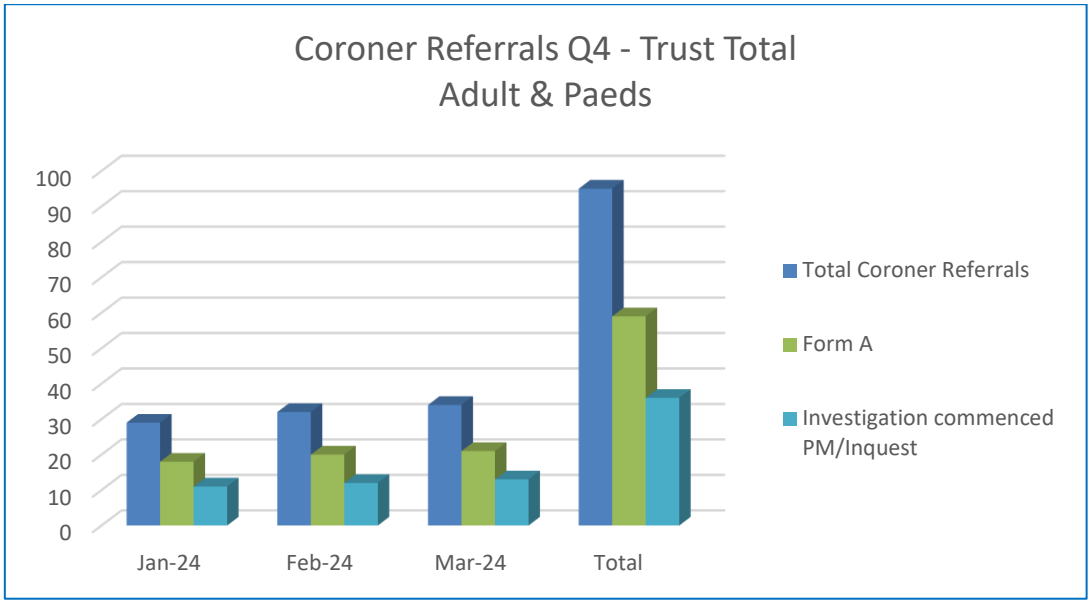

Figure 10 – Coroner referral outcomes Q4

Of the 95 referrals made for deaths on both hospital sites, the coroner took no further action in 59 of the cases by issuing a Form A and took 36 cases to investigation by authorising either a post-mortem or inquest.

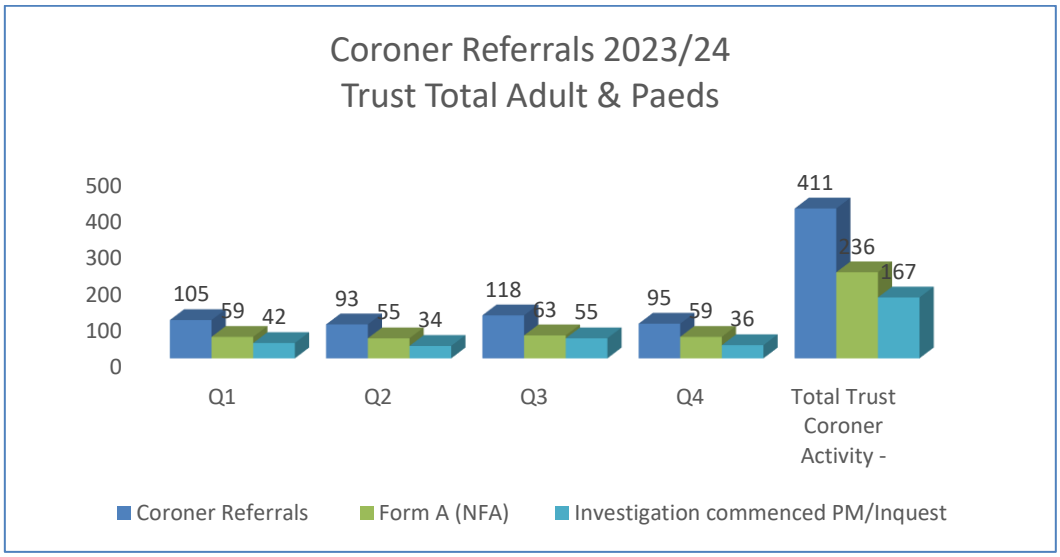

Figure 11 – Coroner referral outcomes 2023/24

Figure 11 shows the coroner referral activity for the full year and confirms 411 referrals were made during this time, of which the coroner took no further action in 236 of the deaths and took 167 cases through for further investigation. This is a reduction of 48 referrals from what was made during 2022/23.

7.0 Urgent body release/faith requests

7.1 There have been 14 requests for urgent body release for faith purposes throughout 2023/24, 5 of these being in Q4. These requests were facilitated in the timeframe required during core working hours with family members being supported by both services to ensure prompt review and death certification was achieved.

8.0 Service Highlights / Non-Acute Rollout

8.1 The Department of Health and Social Care has now confirmed the date for statutory commencement is the 9th September 2024.

8.2 The project for extending the ME service to the community continued at pace throughout 2023/24 as the statutory footing was expected by April 2024. This has ensured the ME service is in a good position for the statutory commencement in the Autumn.

Information sharing events were held with GP practices across the ICS throughout Q4, to inform them of the referral process and changes to the death certification regulations. Positive engagement was achieved and saw 32 GP practices attending the three sessions that were held. These GP practices are now fully aware of the process and equipped to start referring their deaths to the ME service and are being encouraged to do so ahead of the statutory commencement.

A full update has been provided to the ICB with progress in engaging GP practices across the system.

8.3 By the end of Q4, 13 community providers are on board and routinely referring their deaths to the ME service including Shropshire Community NHS Trust.

8.4 Training for the Medical Examiner Officers on EMIS was undertaken during Q4 with full access being granted.

8.5 The ME & Bereavement office accommodation constraints have been resolved and the ME service moved into a new office at RSH in January providing the necessary space to facilitate independent review of deaths. The improvements to the PRH office will take place in April 2024 which will increase the number of workstations available.

8.6 Further work on the out of hours ME service has been undertaken with discussions held with all Medical Examiners on their willingness to take part in an out of hours on call system. This will be in place to prevent delays in releasing bodies for faith purposes and ensure a proposed cause of death in organ donation cases is approved by an independent medical examiner, before obtaining coroner approval for organ retrieval.

8.7 The standard operating procedure for review of paediatric cases has been taken through the Paediatric Governance processes and subject to some minor amendments on ensuring clarity on the process, was approved. The minor amendments were taken back to the Paediatric Governance Lead Paediatrician for final approval in April 2024 and are to be published on the intranet. Proportionate ME review of paediatric deaths will be in place before the statutory commencement.

9.0 Risks

9.1 Delay in the statutory system could see disengagement from community providers and create difficulties with managing the impending demand in a coordinated manner. Work will continue to ensure communication with the ICB and GP practices continues, and any updates received from the National ME and DHSC are shared to encourage practices to come on board before the statutory commencement. At the time of writing there has been one Medical Examiner resignation, equating to one session a week. A review on staffing establishment is being held on how best to use the funds this post has released to ensure the service is staffed appropriately. 1 WTE Medical Examiner Officer vacancy has been appointed to and expected to start in post during Q1 of 2024/25. It is anticipated that the ME service will be fully staffed as we take on more demand from the community and before the statutory commencement.

10.0 Summary

10.1 In summary, the Bereavement & Medical Examiner service has continued to provide an efficient, effective, and supportive service to the bereaved during 2023/24.
Performance of issuing MCCDs within three calendar days has deteriorated during Q4 and the sustained delivery of this KPI is challenged in part because of the availability of the treating doctor attending to complete death certification. The internal process of the Bereavement Service is also being reviewed to ensure the service is working in the right way to support timely completion and unnecessary delays are avoided. The production of the monthly performance dashboard provides the required analysis to support the ongoing work of reviewing the department's processes and therefore the delivery of this key target.

In the statutory ME system, the changes to death certification regulations will see the 5-day target for death registration starting from the day the registrar receives an approved MCCD from the ME service, and not from the date of death. However, it was considered prudent to keep the KPI of three calendar days for MCCD completion as this supports the bereaved with prompt death registration and supports mortuary capacity constraints. Support by Senior Trust Leadership has been received with the Bereavement & ME Service being included in doctor induction to deliver the message on the importance of timely death certification. This will be progressed during quarter one of 2024/25.

10.2 The expansion of the service to ICS stakeholders has made considerable progress over the course of 2023/24 and has engaged with a substantial number of community partners during this time, with them now referring their deaths into the service for ME review. Further work continues with the ICB in agreeing a process for how the ME service will escalate concerns and provide feedback from the reviews of community cases.

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Lindsay Barker, Head of Medical Examiner and Bereavement Services
June 2024

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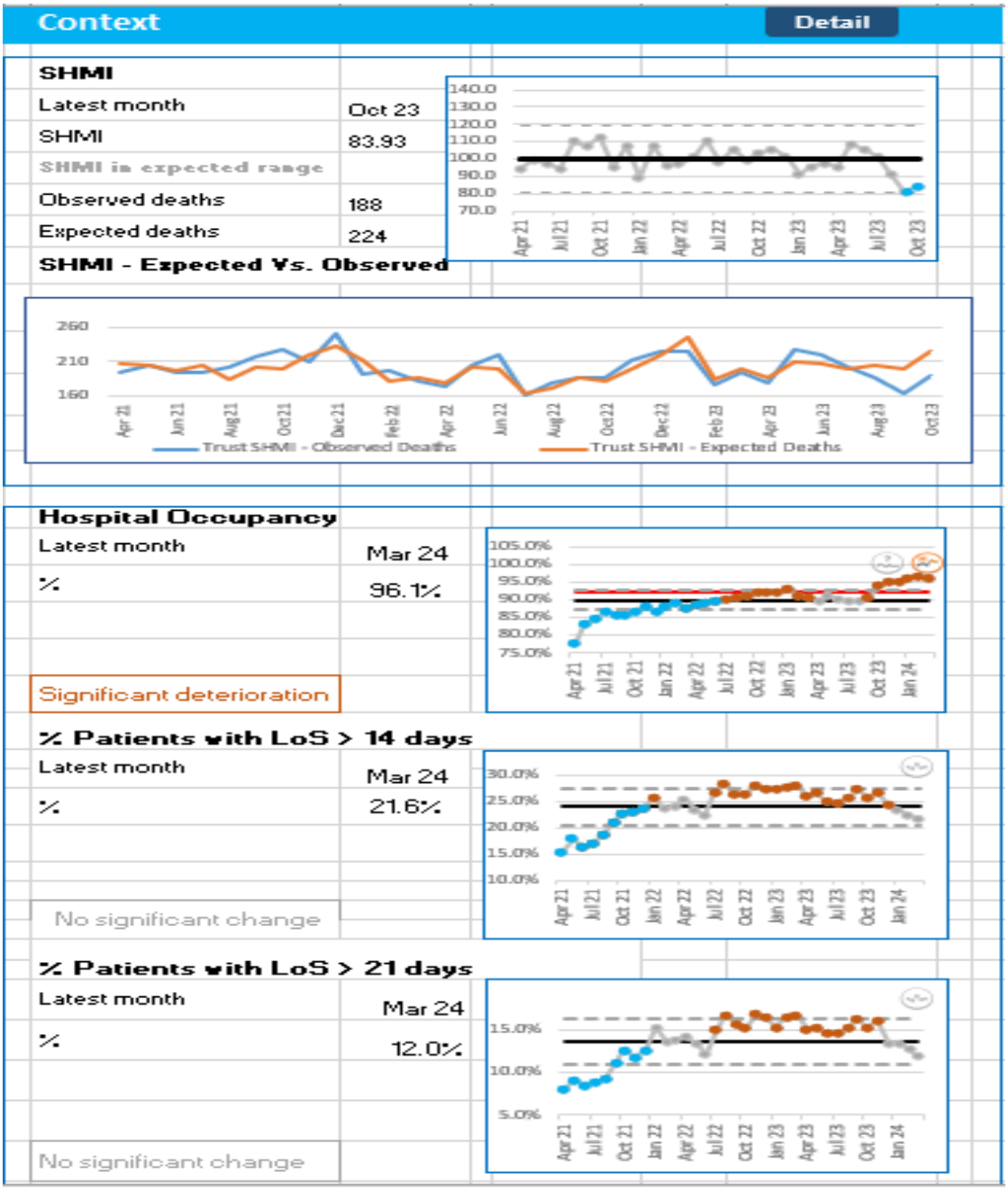
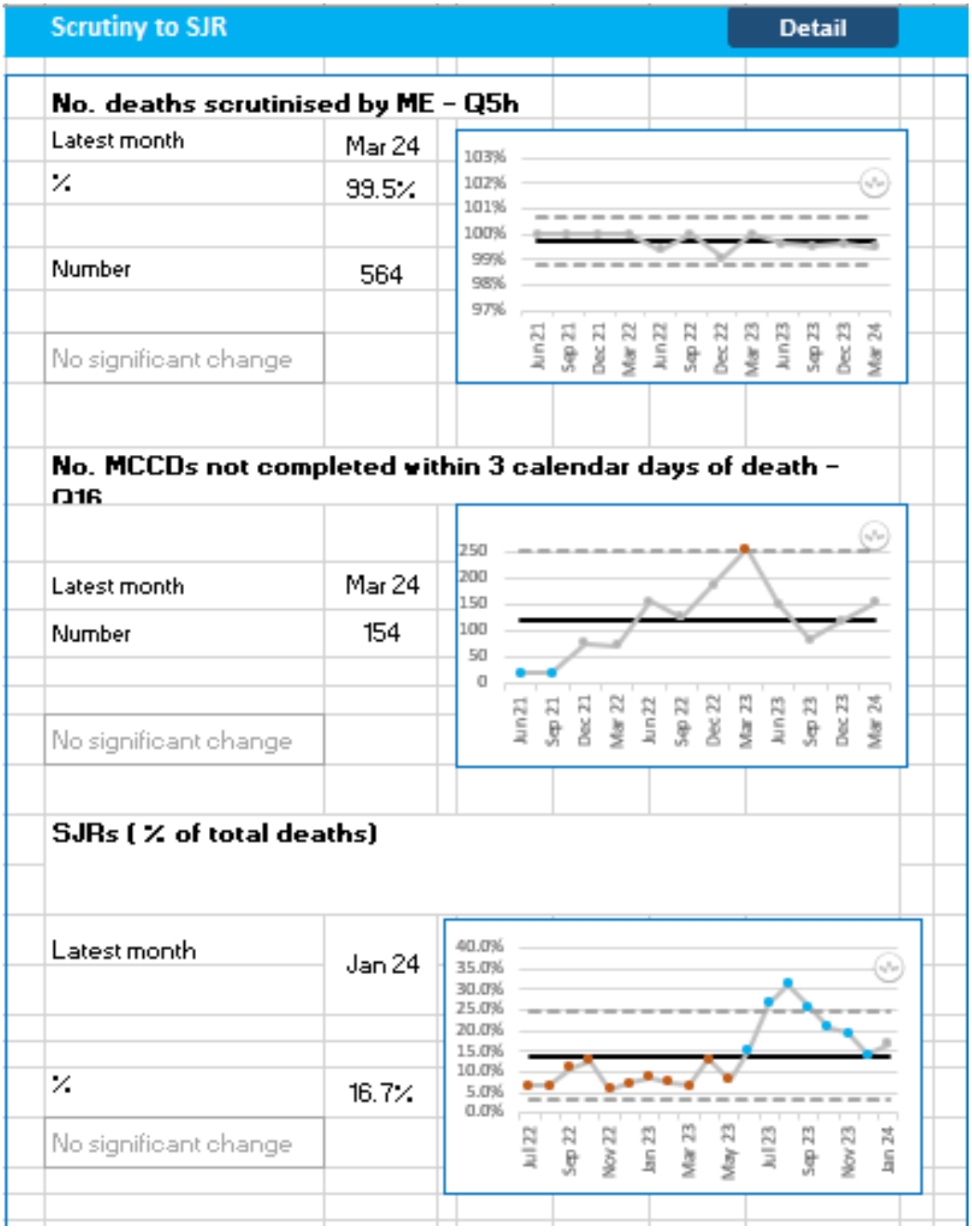
SUPPLEMENTARY INFORMATION

APPENDIX B: OVERVIEW OF THE LEARNING FROM DEATHS DASHBOARD - CONTEXT, SCRUTINY TO SJR, CARE



APPENDIX B: Overview of the Learning from Deaths Dashboard - Context, Scrutiny to SJR, Care (ctd)



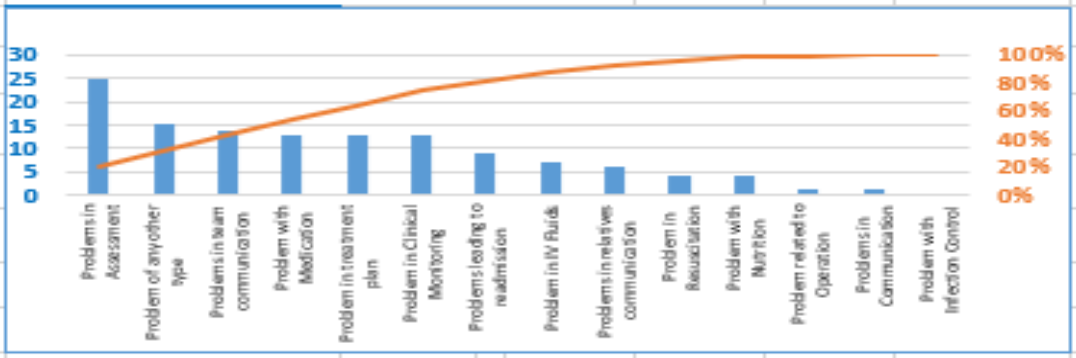
APPENDIX B: Overview of the Learning from Deaths Dashboard - Context, Scrutiny to SJR, Care (ctd)

Care | Detail

Good care identified

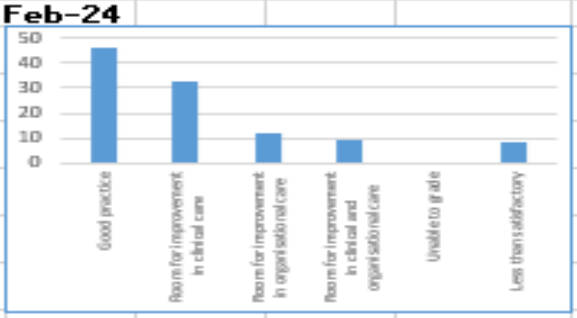
In 46 out of 108 cases (43%) good care was identified

Problems with care Mar-23 to Feb-24



NCEPOD definitions Mar-23 to Feb-24

Good practice	46
Room for improvement in clinical care	33
Room for improvement in organisational care	12
Room for improvement in clinical and organisational	9
Unable to grade	0
Less than satisfactory	8



Deaths where a significant concern about the quality of care provided is raised by bereaved families and carers – Q20a

Latest month	Mar 24
Number	15
No significant change