The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 June 2023

Agenda item	064/23			
Report Title	How We Learn from Deaths and Medical Examiner Service Summary Board Assurance Q4 and Annual Summary Report 2022/2023			
Executive Lead	John Jones Executive Medical Director			
Report Author	Fiona McAree, Head of Learning from Deaths and Clinical Standards Roger Slater, Trust Senior Clinical Learning from Deaths Lead Lindsay Barker, Medical Examiner Service Manager			
CQC Domain:	**Link to Strategic Goal:**			**Link to BAF / risk:**
Safe	√	Our patients and community	√	
Effective	√	Our people	√	
Caring	√	Our service delivery	√	**Trust Risk Register ID:**
Responsive	√	Our governance	√	ID 435
Well Led	√	Our partners	√	
Consultation Communication	Trust Learning from Deaths Group, 4 May 2023 Quality Operational Committee, 16 May 2023 Quality and Safety Assurance Committee 31 May 2023			
Executive summary:	The Board's attention is drawn to seven sections within this report: • **Item 1.4** The Trust's latest SHMI for October 2022 was 102 which is within the expected range and is favourable to the peer group. • **Item 1.14** A targeted focus on the completion of Structured Judgement Reviews (SJRs) has been undertaken leading to an increase in completed SJRs in Q3 from 0.8% to 3.1% since the last report was presented to the Board of Directors and 2.7% of deaths have now been reviewed in Q4. Overall, SJRs have been completed for 3.4% of all deaths across the Trust during 2022-23. • **Item 1.18** 48% of SJRs mandated for patients who have a learning disability or a serious mental health illness remain outstanding for 2022-23 which are now being supported by a Specialist Lead. • **Item 1.19** SJRs which meet the criteria defined within the Trust's Learning from Deaths policy for datix reporting, are not being submitted in a timely manner for further review. • **Item 1.9** Positively, 100% of the deaths that occurred in Q4 received Medical Examiner Officer preparatory review and Medical Examiner scrutiny. Of the 514 MCCDs written, 254 of these were not completed within 3 calendar days of death, which also impacts on the bereaved registering a death. Performance in January being worse in Q4.			

	• **Item 1.12** The organisation is required to review its berevement functions to ensure it is fit for purpose. The Regional Medical Examiner has directed that any bereavement work undertaken by MEOs will need to cease by 01 April 2023 to comply with the non-acute rollout which will leave a significant gap within SaTH. • **Item 1.13** Medical Examiners referring a death to the coroner is no longer supported by the Regional Medical Examiner and is now directed to the responsibility of the lead treating clinician to facilitate the referral. • **Item 1.20** One serious incident investigation presented to the Trust Review Actions and Learning from Incidents Group (RALIG) in Q4 determined that the death was potentially avoidable due to problems in healthcare. **The risks to the organisation are:** • Insufficient SJRs completed across the Trust may result in an inability to identify themes and trends needed to assist the Trust implement quality improvement initiaitves to improve care, increase patient satisfaction and minimise the risk of avoidable deaths. • The Trust is at risk of being non-compliant with the National Learning from Deaths guidance (NQB 2017) in relation to mandated reviews for patients who have a learning disability or serious mental illness. This may cause reputational damage where SJRs are required to inform external LeDeR reviews and an inability to maximise learning opportunities to improve outcomes for these vulnerable patients. • Failure to flag SJRs which meet the criteria for datix reporting may result in potential harm incidents not being further investigated, and impact on the Trust's ability to learn from incidents and be open and transparent about level of harm with bereaved families. • Inability to meet the national target issuing MCCDs within 3 calendar days which also impacts on the bereaved registering a death and public confidence in our services. • Increasing sessions for exisiting Medical Examiners could increase operational challenges if recruitment is unsuccessful in May 23. • Change in practice for coroner referrals to be directed from lead treating clinicians will put further demand on the treating team and it is anticipated that delay in referrals will be experienced in these cases • Deaths deemed to be potentially avoidable could lead to litigation for the organisation. **The Learning from Deaths / Medical Examiner Service teams are currently progressing a number of improvement initiatives:** • To expand the team of multi-disciplinary SJR reviewers and integrate SJR completion into Consultant, Specialty and Associate Specialty (SAS) doctors appraisals.

	• To develop a report through the SJRPlus tool in collaboration with NHSE, to be available enabling easy identification of SJRs which have met the criteria for incident reporting and further review. • Support clinicians facilitate timely completion of MCCDs and ensure registration services remain appraised of the situation. • Ensure rollout of non-acute medical examiner reviews is progressed within a phased approach to manage new demand. • Review practices for coronor referrals and communicate this widely.
Recommendations for the Board:	The Trust Board is asked to review and approve this report and take assurance from this report, with particular regard to: • A review of deaths that have occured in ED is being undertaken to examine reasons for the increase in Q3 2022-23 and the findings to be reported to the Learning from Deaths Group, Quality and Safety Assurance Committee and the Board. • An assurance review is underway for patients who have died where the primary diagnosis code was acute cerebrovascular diease. • Positive findings identified following an assurance review undertaken for patients who had died where anaemia was the primary diagnosis condition, with no concerns identified. • 100% of the deaths that occurred in Q4 received Medical Examiner Officer preparatory review and Medical Examiner scrutiny despite the impact of significant operational winter pressures experienced in Q4. • The Medical Examiner service has now received notification from the National Medical Examiner that the non-acute system will become officially statutory in April 2024 with plans to introduce legislative changes from the autumn. The service's project plan to progress rollout to non-acute stakehlder continues. • Positive findings identified following an assurance review undertaken comparing mortality associated with acute respiratory and cardiac conditions between both sites, with no concerns identified. • Mandatory SJRs for patients who die with a learning disability or serious mental illness are being prioritised for completion and are now supported by the Specialist Mental Health Nurse and Mental Health and Learning Disability Matron Lead. • A targeted focus to continue to increase the rate of completed SJRs to assist implementing quality improvement initiaitves. • This summary report should be read in conjunction with Appendix A and Appendix B Full Reports which are available in the information pack.
Appendices: (Contained within the information pack)	**Appendix A:** How We Learn from Deaths Quarter 4 / Annual Summary 2022-23 Full Report **Appendix B:** Medical Examiner Service Report

1.0 Introduction

Summary of Hospital Deaths

1.1 There have been 2282 inpatient and emergency department (ED) deaths managed by the Medical Examiner Service within the Trust during 2022-23, an increase of 179 deaths compared to 2021-22. Of these deaths 626 occurred within Q4. Deaths occurring within the Emergency Department (ED) remain high compared to 2021-22.

1.2 The number of deaths that occurred in the ED across both sites for Q4 remains high in comparison to the same quarter in 2021/2022. One reason that may contribute to this is that the data shows an increase in Hospital Occupancy well above the threshold for both Q3 and Q4 2022-23 compared to the same reporting period. An assurance review into deaths that occur within the ED is being undertaken. Further details are provided at Appendix A section 2.9. and Appendix B, Figures 1 and 2.

Learning from Deaths Dashboard

1.3 SHMI data includes deaths in hospital and those which occur within 30 days of discharge. The Trust's latest SHMI for October 2022 is 102 which is within expected range and is favourable to the peer group.

1.4 A comparison of mortality associated with acute respiratory and cardiology conditions between RSH and PRH has been undertaken and no specific concerns identified.

1.5 Positive findings identified following an assurance review undertaken for patients who had died where anaemia was the primary diagnosis condition, with no concerns identified. A more detailed analysis of the review is detailed at Appendix A section 2.4.

1.6 The primary diagnosis conditions with the highest number of excess deaths across the Trust are acute cerebrovascular disease, anaemia, acute and unspecified renal disease.

1.7 Acute and unspecified renal disease remains one of the conditions associated with the highest number of excess deaths within the Trust. To improve the outcome for these patients a recommendation is made to introduce a specialist nurse-led intervention and education programme. Introduction of this service in comparable Trusts across the region has demonstrated positive outcomes for this patient group. Further details are provided in Appendix A section 2.8.

Medical Examiner Service

1.8 Positively, 100% of the deaths that occurred in Q4 received Medical Examiner Officer preparatory review and Medical Examiner scrutiny. Of these 98.4% bereaved relatives received a phone call from the Medical Examiner to discuss the care, treatment, and cause of death. The remaining 8 cases of contact not made was due to a combination of no next of kin available, relatives not returning our calls and 4 cases where the police had referred the deaths to the coroner directly. However, performance in issuing an MCCD within 3 calendar days continued to deteriorate further in this quarter due to significant pressure treating clinicians are under. The Bereavement Team continue to support the clinicians to facilitate as timely completion as possible and ensure registration services remain appraised of the situation.

1.9 In Q4 2022/23 there were 37 deaths where the Medical Examiner recommended an SJR, which is a significant reduction from the 67 that were requested in the previous quarter.

1.10 Significant progress to rollout non-acute Medical Examiner reviews has been made in Q4. The Medical Examiner service has now received notification from the National Medical Examiner that the non-acute system will become officially statutory in April 2024 with plans to introduce legislative changes from the autumn of this year. The delay to the statutory system does not alter the robust project plan that is in place to oversee the rollout of the service to our non-acute partners.

1.11 Current internal operational and administrative processes have been required to be reviewed and it has been recognised that the Medical Examiner Officers – MEOs (a specialised Medical Examiner administration function supporting the Medical Examiners) complete bereavement specific tasks which is impacting on the overall performance of the Medical Examiner service and will continue to have a detrimental effect when SATH rollout to the community providers. These tasks should be transferred and aligned to the Bereavement service to ensure the MEOs can fully function as intended. The Regional Medical Examiner has additionally directed that any bereavement work undertaken by MEOs will need to cease by 01 April 2023 to comply with the non-acute rollout which will leave a significant gap within SATH. Failure to comply with this regional directive risks the national funding being withdrawn from the Trust. A business case requesting the establishment of two Band 4 Bereavement Officers to release MEO capacity is being presented to the Trusts funding approval process in April 23.

1.12 Medical Examiners referring a death to the coroner is no longer supported by the Regional Medical Examiner and is directed as the responsibility of the lead treating clinician to facilitate the referral and the region have requested a review of current practices is undertaken. This does not impact on all deaths receiving a Medical Examiner review. Ensuring this change in our practice will provide additional capacity in the Medical Examiner team to support the expansion of the non-acute Medical Examiner service. However, it should be recognised working in this way will add further demand back onto the clinical teams and will almost certainly result in delays in referrals being made to the coroner.

<u>Completion of Structured Judgement Reviews (SJRs)</u>

1.13 The percentage of SJRs completed within Q3 2022-23 has increased from 0.8% to 3.1% with a targeted approach since the last report was presented to the Board. In Q4, 2.7% of deaths have been reviewed. Further information is detailed at Appendix A section 2.11.

1.14 The care provided to patients in nearly 57% of all SJRs completed within 2022/2023, was rated as ‘Good’ or ‘Excellent’ overall as per Figure 13. Care was rated as poor in nearly 10% of all completed SJRs in this timeframe. One case was not rated. No care for cases within the timeframe were rated overall as ‘Very Poor’. Within all the completed SJRs during 2022-23, 58 identified lessons to be learned, 54.8% of these were positive lessons and 71.2% were negative. Examples of these are provided at Appendix A section 4.9.

1.15 The completion of mandated SJR completion for patients who have a learning disability or serious mental health illness is currently subject to delay within the Trust. Some delay is currently being experienced in providing SJRs externally to support LeDeR reviews. This is due to the requirement for an increase in the number of reviewers, the historic lack of specialist mental health and learning disability support for the learning from deaths agenda and a technical problem with the online SJRPlus which prevented the online SJR being shared outside of the Trust.

1.16 Clinicians who undertake SJRs are required to complete an 'SJR datix' for all cases where ratings awarded meet certain criteria as per the Trust Learning from Deaths policy, including 'greater than 50:50 evidence if preventability. This aims to ensure that cases where potential acts or omissions in care may have resulted in serious harm and potentially avoidable death, which have not already been referred through Trust Governance processes for investigation, are flagged for appropriate muti-disciplinary review and consideration at the Trust Review Actions and Learning from Incidents Group (RALIG). During 2022-23, this process has proved challenging, and to date the Learning from Deaths team are unable to provide assurance that every SJR completed which meets the criteria for a datix is flagged timely through the datix system for further review.

Potentially Avoidable Deaths

1.17 In Q4 2022-23, there was one serious incident relating to a child who died, which was deemed to have been due to problems in healthcare and therefore potentially avoidable.

1.18 There are currently 12 serious incident investigations which have been concluded and presented to RALIG, where the outcome regarding preventability remains outstanding.

1.19 In Q4 2022-23, there have been 14 serious incidents relating to patients who have died, reported externally to the Strategic Executive Information System (StEIS). Of these, 13 of these investigations remain open.

Risk register

1.18 There is one risk on the Trust Risk Register relating to recruitment within the Learning from Deaths however, the Trust has agreed to recruit at risk to clinical and non-clinical roles within the corporate Learning from Deaths team and additional PA sessions to support the Learning from Deaths Clinical Lead and completion of SJRs across all specialities. Recruitment is in progress and once the additional resource is in post and fully established, it is anticipated that the risk will close.

1.19 Should the next recruitment round not be successful to increase Medical Examiners this will be a risk to further rollout of the non-acute service and an alternative approach to securing Medical Examiner sessions will need to be reviewed. It is a possibility to offer additional sessions to current Medical Examiners who may have the flexibility in their job plan to take on additional sessions. This model does come with operational challenges in that the more sessions one individual undertakes, the greater the impact to the rota in times of leave and sickness.

1.20 The organisation is required to review its bereavement function to ensure it is fit for purpose or there is risk funding will be removed from the Regional Medical Examiner. A business case to secure additional bereavement personnel is being progressed through the appropriate organisation approval framework.

1.21 Whilst the Regional Medical Examiner request to change to our current practice whereby the Medical Examiner does not oversee the referral of a death to the coroner will create additional capacity for the Medical Examiner for the non-acute rollout, it will put further demand on the treating team. It is anticipated that delays will be experienced in these cases being referred to coroner, similar to the delays that are seen in the completion of the MCCD.

2.0 Recommendations

2.1 The Board of Directors is asked to review and approve this report and note the findings and progress made to improve the learning from deaths and medical examiner agenda.

Appendix A

The Shrewsbury and Telford Hospital NHS Trust

MEDICAL EXAMINER & BEREAVEMENT SERVICE REPORT
QUARTER 4 – JANUARY – MARCH 2023 / SUMMARY OF ANNUAL REPORT

1.0 Introduction

1.1 The purpose of this report is to provide the Trust Board with an overview of the number of hospital deaths managed by the Medical Examiner & Bereavement Service during Q4 (Jan-March 2022/23) and a summary of annual performance with the outcome of Medical Examiner reviews, including those with coroner involvement.

2.0 Number of Hospital Deaths

2.1 There were 2282 deaths managed by the Medical Examiner Service within the Trust during 2022-23, 626 of these deaths were during Q4 which was a reduction of 3 deaths reported in Q3. However, this is an increase of 130 deaths from the same period in 2022 (Figure 1).

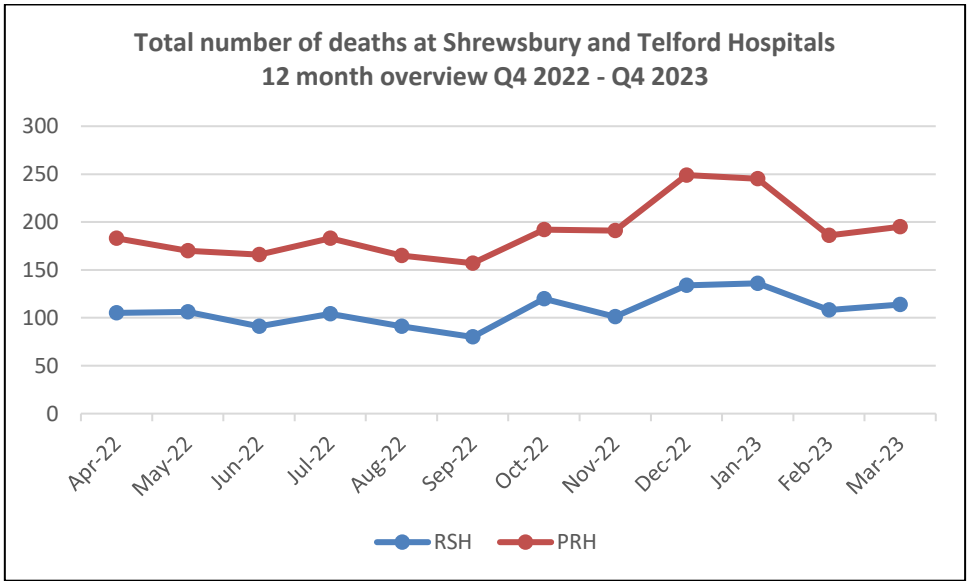

Figure 1 – Total number of deaths at SATH 12-month overview

2.2 Acute hospital paediatric deaths

There were 3 paediatric deaths in Q4 that occurred in ED at PRH. All 3 deaths were direct referrals to the coroner by the Police due to being unexpected deaths. The coroner ordered post mortems for all the deaths and they were all reviewed by a Medical Examiner with potential learning recommended for one of the cases. This was due to no formal death verification being undertaken and recorded in the notes. This has been raised with the department to ensure learning can be shared and embedded into current practices.

2.3 Acute hospital adult deaths

There were 498 inpatient deaths across both sites in Q4 and 128 deaths in the Urgent Emergency Care Departments (including the 3 paediatric cases) during this quarter (Figure 2).

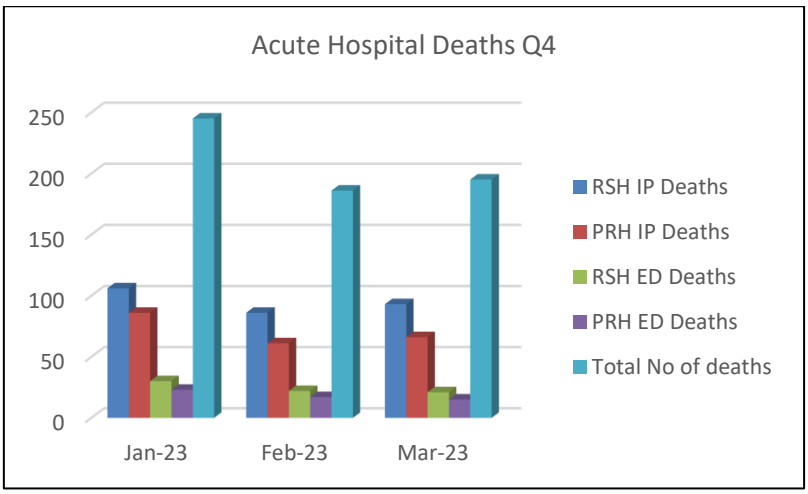

Figure 2 – Acute hospital deaths split by site, inpatient & UEC

There were 8 more inpatient deaths in Q4 than reported in Q3, and 11 fewer deaths in the Urgent Emergency Care Department in Q4 than what was seen in Q3.

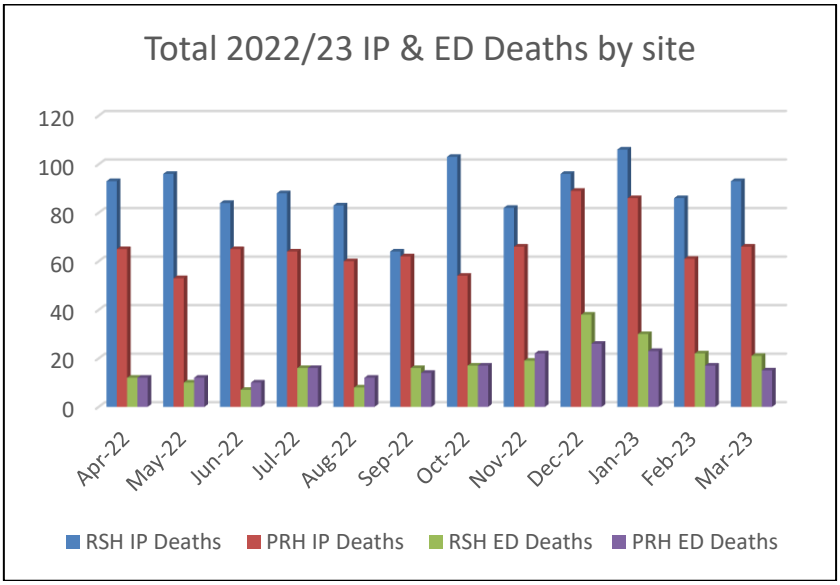

Figure 3 - 12-month overview of number of IP & ED deaths by site.

2.4 Deaths in patients with Covid-19

There were 82 deaths reported for patients who had a positive covid-19 PCR result in the preceding 28 deaths prior to their death in Q4 (Figure 4). All deaths in patients with a positive result are reported to CPNS data collections by the Bereavement Team.

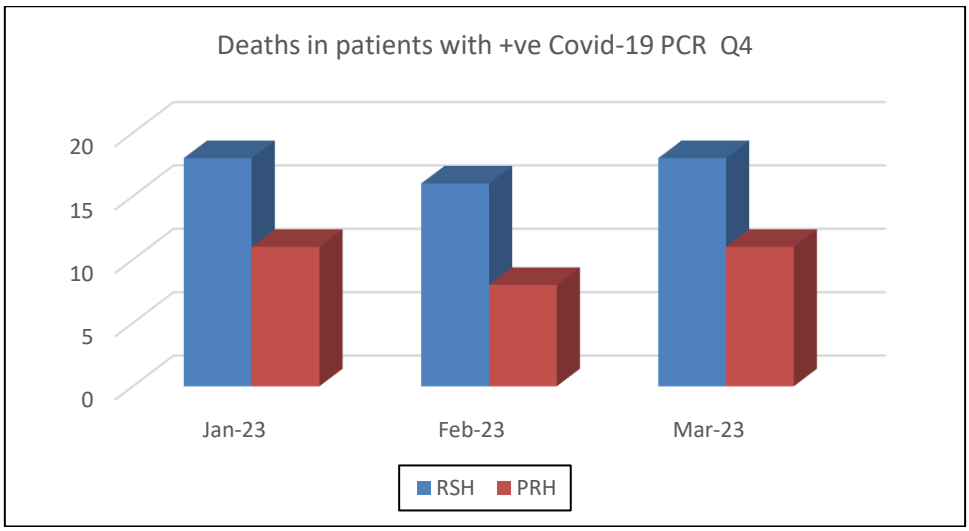

Figure 4 – Number of patient deaths with positive covid-19 PCR

A 12-month summary overview of the covid-19 deaths is seen in Figure 5 for further information;

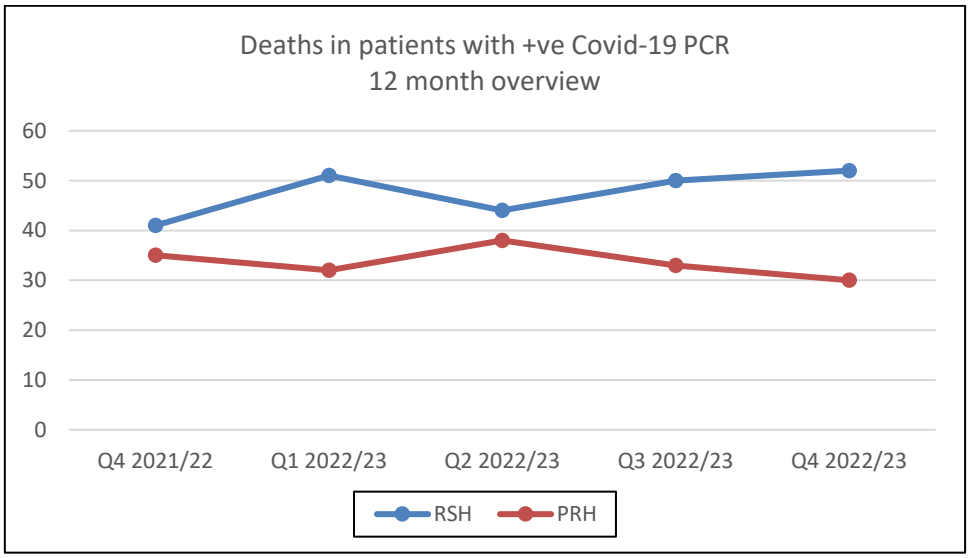

Figure 5 – 12-month summary overview of covid-19 deaths for patient with a positive PCR

3.0 Medical Examiner Review Scrutiny

3.1 Summary

Positively, 100% of the deaths that occurred in Q4 received Medical Examiner Officer preparatory review and Medical Examiner scrutiny (Figure 6). Of these 98.4% bereaved relatives received a phone call from the Medical Examiner to discuss the care, treatment and cause of death. The remaining 8 cases of contact not made was due to a combination of no next of kin available, relatives not returning our calls and 4 cases where the police had referred the deaths to the coroner directly.

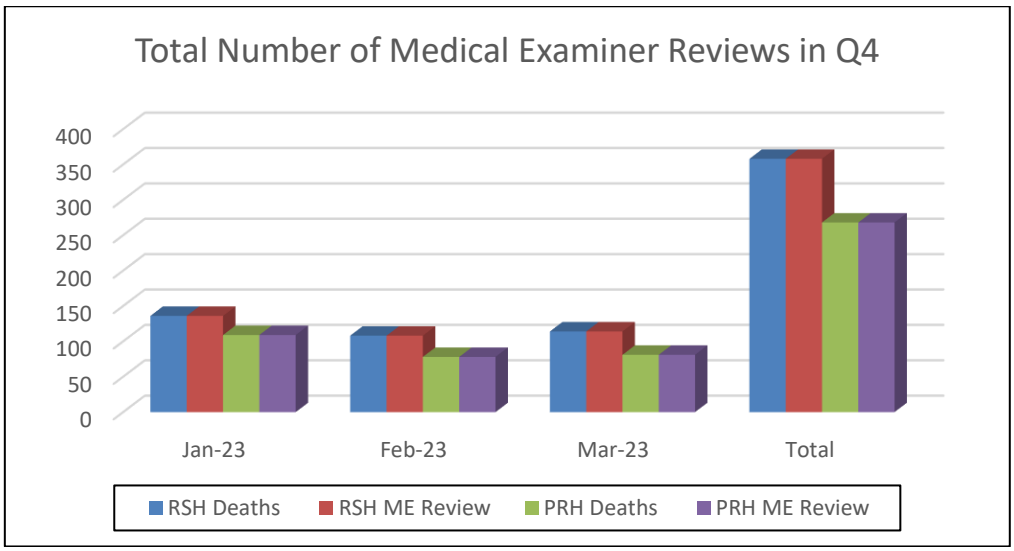

Figure 6 – Total Number of Medical Examiner Reviews in Q4

The Medical Examiner Service reviews 100% of the adult deaths that happen in our hospitals (Figure 7). The paediatric deaths that occurred were direct referrals to the Coroner Service, however despite this, the ME service carried out proportionate review in these cases.

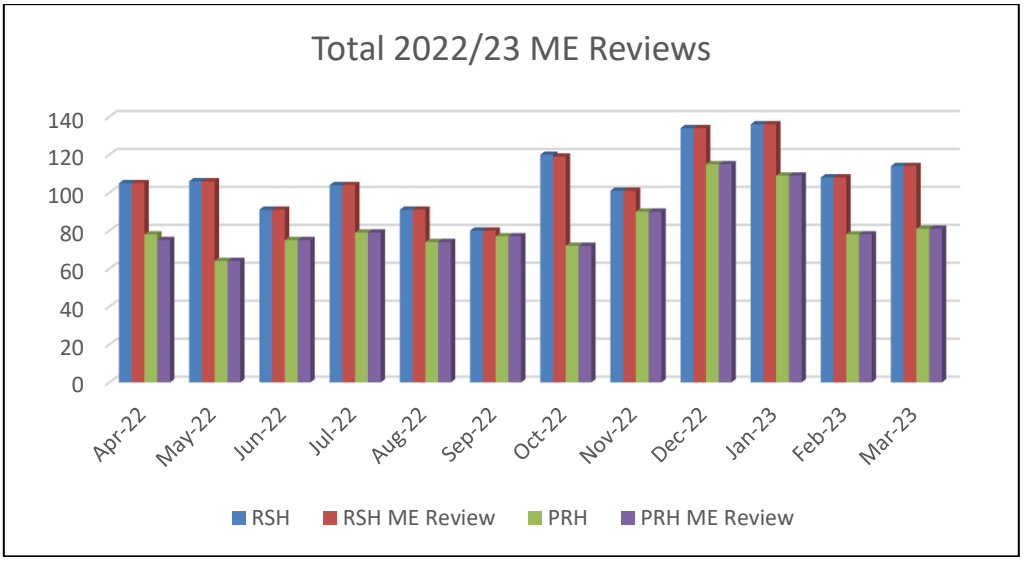

Figure 7 – Total 2022/23 Medical Examiner Reviews

3.2 Deaths identified by Medical Examiner for potential learning

Out of the 626 reviews completed during Q4, the Medical Examiners raised potential learning in 81 deaths, 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. This is a reduction of 20 cases from Q3.

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 Of the 626 deaths, 514 MCCDs were requested following the Medical Examiner review and completed by the treating clinician.

4.2 Of the 514 MCCDs written, 255 of these were not completed within 3 calendar days of death, with performance in January being significantly worse than the remainder the of quarter

(Figure 8). This was due to the significant operational clinical pressures being experienced in January 2023 and the time constraints for releasing the treating clinician to write the MCCD. Delays were therefore experienced for bereaved relatives being able to register the death of their relative during this time.

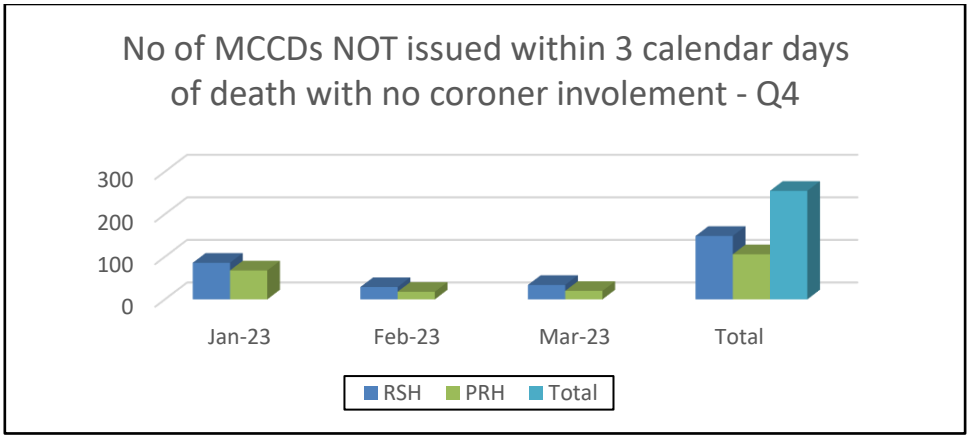

Figure 8 – Number of MCCDs not issued within 3 calendar days of death

This area of performance is a significant operational challenge for the Medical Examiner service as we are reliant on the availability of the treating clinicians being able to write the certificate in a timely manner. We endeavour to support the doctors in completing this task and escalate as necessary to the consultant if required. We also keep the Registration services appraised of any cases where there will be a delay in facilitating registration.

An overview of performance in 2022-23 can be seen below (Figure 9) where it can be seen that performance in issuing MCCDs in 3 working days became challenged following the Emergency Covid Legislation being withdrawn and Medical Examiners were no longer permitted to undertake the completion of death certification.

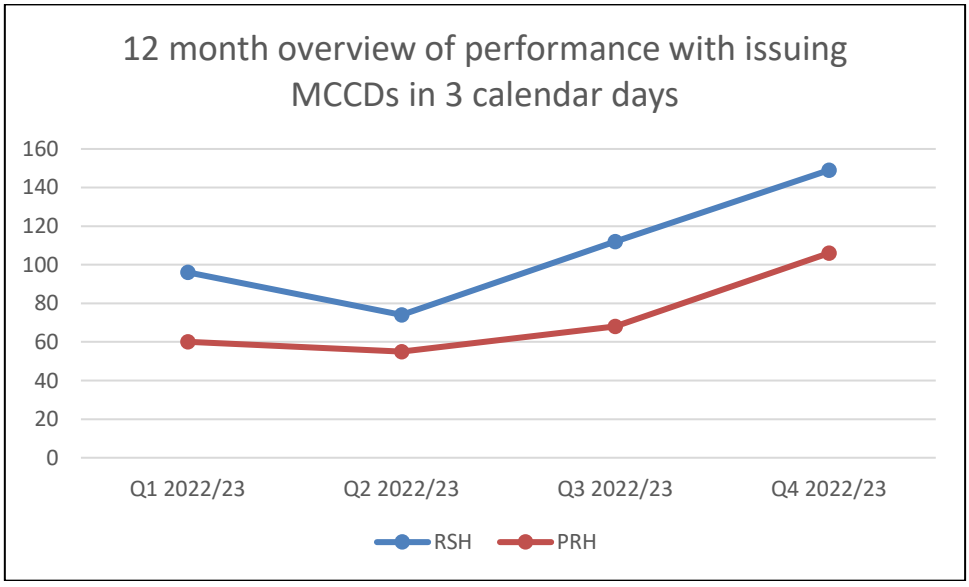

Figure 9 – 12 month overview of performance with issuing MCCDs in 3 calendar days of death.

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 we have 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 514 MCCDs written and issued, 7 certificates were rejected by the Registration Services in Q4.

5.0 Structured Judgement Review

5.1 There were 37 deaths in Q4 (Figure 10) where the Medical Examiner had recommended an SJR, which is a significant reduction from the 67 that were requested in the previous quarter.

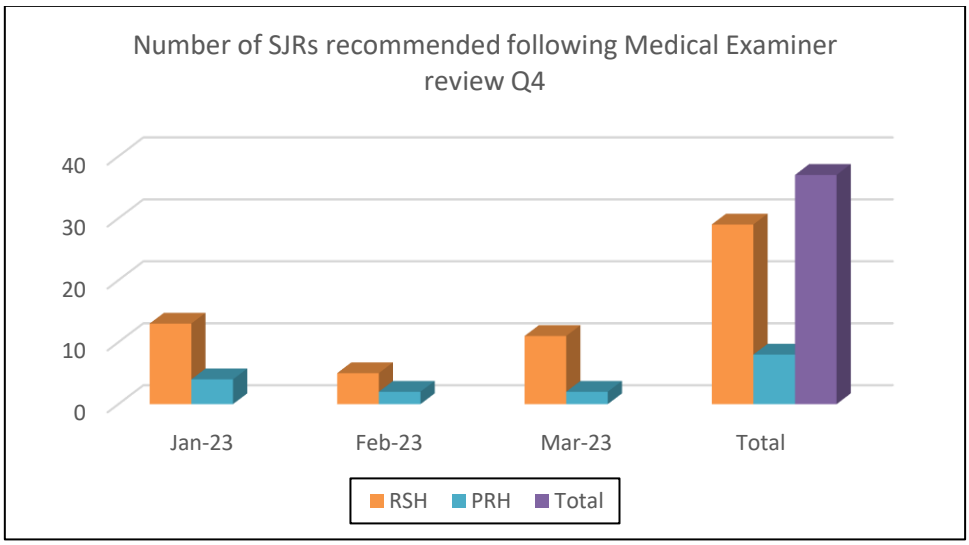

Figure 10 – Number of SJRs recommended following Medical Examiner Review

Figure 11 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.

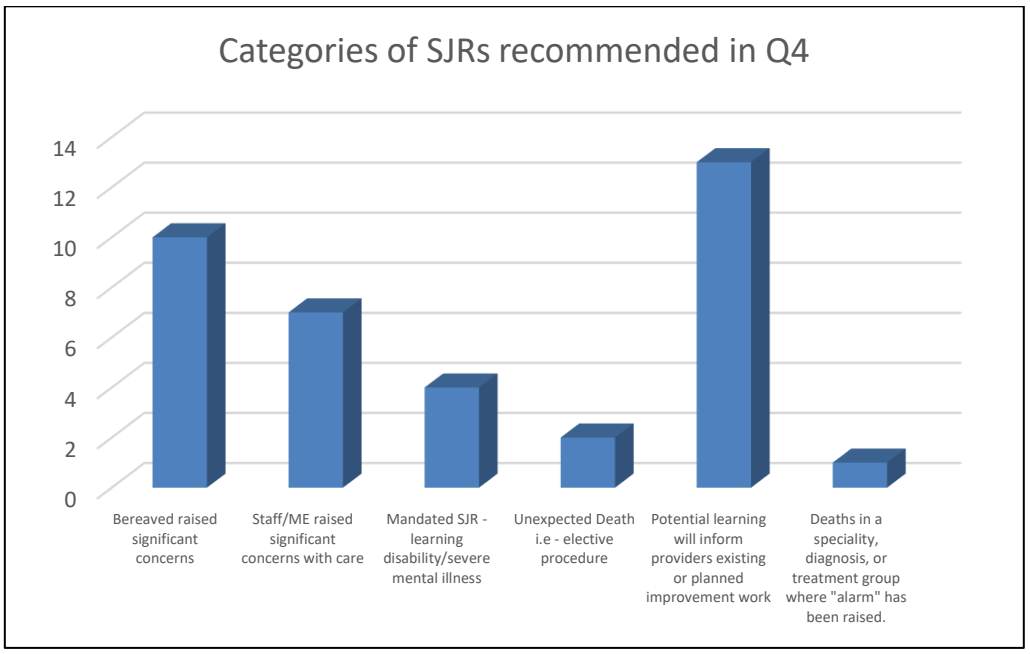

Figure 11 – Categories of SJRs recommended

A 12-month summary of SJRs is detailed in the Learning from Deaths annual report.

6.0 Coroner Referrals

6.1 Summary

Across both hospital sites the Medical Examiner facilitated 115 referrals to the coroner during Q4. The split by hospital site is seen in Figure 9 and 10 below. This is a reduction from what was referred in Q3 by 24 referrals.

Of the 67 referrals for deaths at RSH the coroner took no further action in 35 of the cases by issuing a Form A, with the remaining 32 cases being investigated by post mortem or inquest.

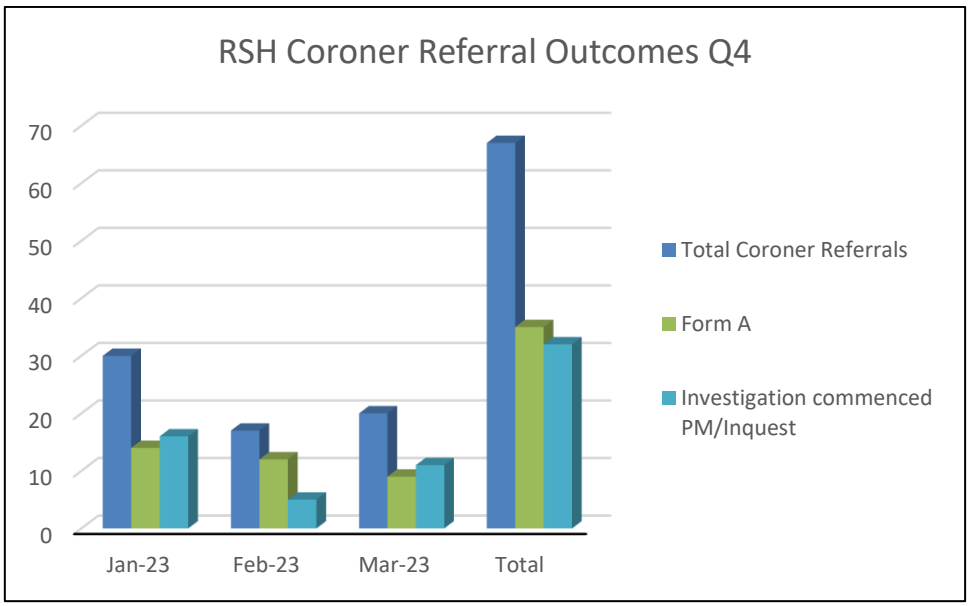

Figure 12 – RSH coroner referral outcomes Q4

Of the 48 referrals for deaths at PRH the coroner issued Form A's for 21 cases, with 27 cases being taken for investigation by PM or inquest.

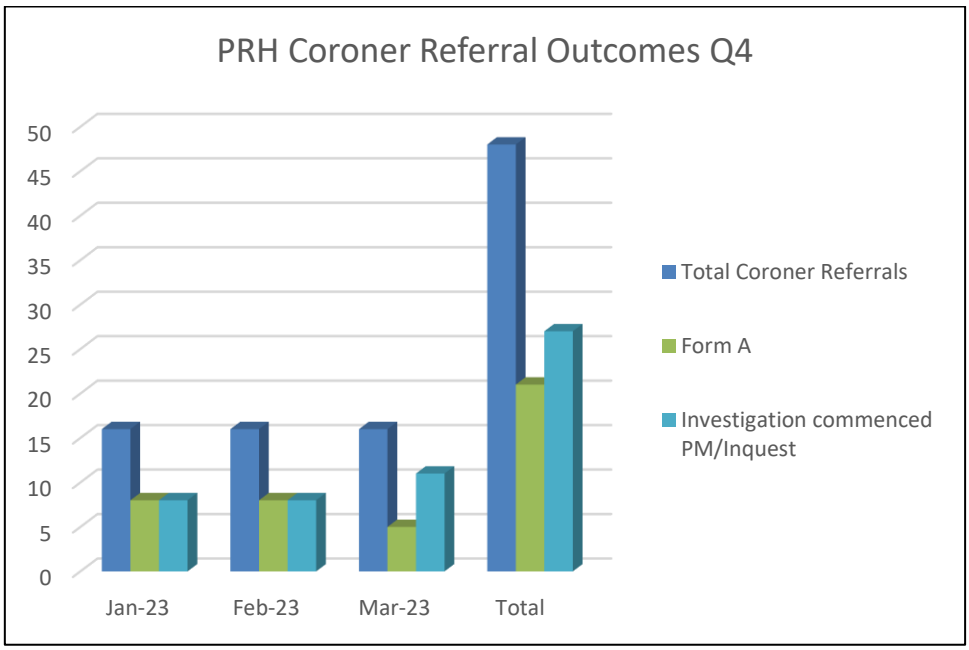

Figure 13 – PRH coroner referral outcomes Q4

Of the 2282 deaths in 2022-23, there have been 459 referrals made to the coroner (Figure 14).

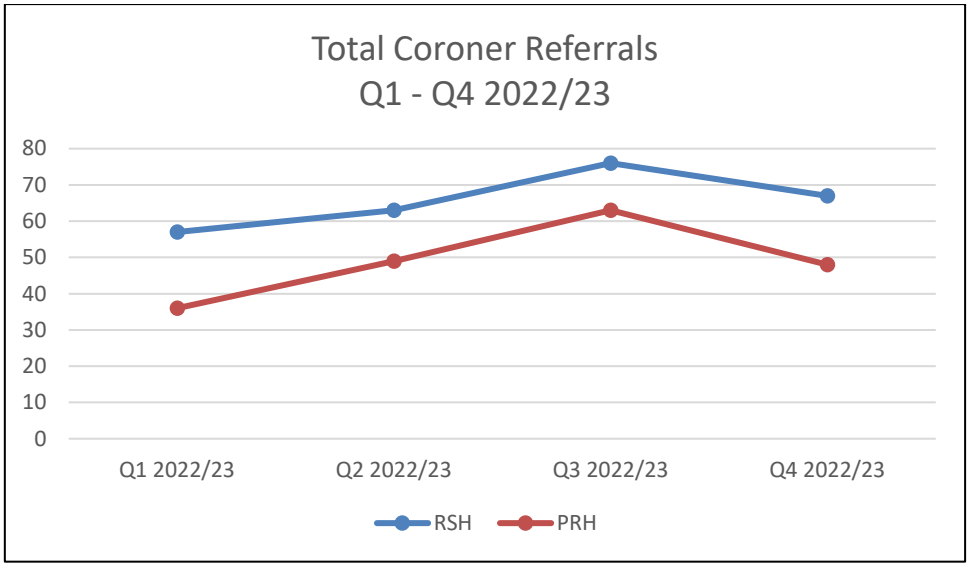

Figure 14 – Total coroner referrals 2022-23

The Regional Medical Examiner has advised us that he does not support the Medical Examiner referring a death to the coroner as this is the responsibility of the lead treating clinician to facilitate the referral to the coroner and has asked us to review our current practices. This does not impact on all deaths receiving a Medical Examiner review. Ensuring this change in our practice will provide additional capacity in the Medical Examiner team to support the expansion of the non-acute Medical Examiner service. However, it should be recognised working in this way will add further demand back onto the clinical teams and will almost certainly result in delays in referrals being made to the coroner. Further discussions will take pace with the Medical Director with regards to progressing this change in practice.

7.0 Urgent body release/faith requests

7.1 There were 2 requests for urgent body release for faith purposes in Q4, both at RSH and both requests were facilitated in the timeframe required.

8.0 Service Highlights / Non-Acute Rollout

8.1 On 11 July 2020, the National Medical Examiner for NHS England communicated to acute organisations and set out what local health systems need to do to prepare for the statutory Medical Examiner system. SaTH as the local acute organisation must extend its services to provide independent scrutiny of all deaths not taken for investigation by a coroner.

The Medical Examiner service has now received notification from the National Medical Examiner (Appendix A) that the non-acute system will become officially statutory in April 2024 with plans to introduce legislative changes from the autumn of this year. The delay to the statutory system does not alter the robust project plan that is in place to oversee the rollout of the service to our non-acute partners.

8.2 With support from the organisations 'Getting to Good' programme the extension of the ME service has been a defined improvement project since August 2022 and reports to the Learning from Deaths Committee monthly and the Operational Delivery Group quarterly. A plan on a page detailing the scope, impact, high level milestones, risks and metrics to measure improvement is available, along with a detailed project plan to support the monitoring of workstreams.

8.3 Workstreams include ensuring there is an adequate Medical Examiner workforce to cope with increased demand, compliance with Information Governance protocols, developing arrangements to access provider health records and agreement of operational processes to ensure referrals are timely for bereaved families. The project team has been extensively engaging with all non-acute providers within STW ICS to agree plans which will be critical to project success and has seen significant improvements to the services development already.

8.4 Currently the service undertakes approximately 2000 medical examiner reviews per year and a forecast for the increased demand has been provided by the regional ME is expected to reach circa 5164 reviews per year. To manage this new demand from local community providers the regional team recommended and funded SATH's ME establishment to increase from 14 PAs to 18 PAs by the end of March 2023. These are specialised roles requiring at least five years' experience as a registered medical practitioner and unfortunately in Q4 two separate recruitment drives have taken place with limited success. Further interviews are planned for mid-April providing refreshed optimism to recruit into the additional 4 PAs, although the ME Clinical Lead and Service Manager remains in close liaison with the Medical Director to agree further plans in order to provide business continuity for rollout.

8.5 The project team have also been required to review current internal operational and administrative processes through the project initiation stage and it has been recognised that the Medical Examiner Officers – MEOs (a specialised Medical Examiner administration function supporting the Medical Examiners) complete bereavement specific tasks which is impacting on the overall performance of the Medical Examiner service and will continue to have a detrimental effect when SATH rollout to the community providers. These tasks should be transferred and aligned to the Bereavement service to ensure the MEOs can fully function as intended. The Regional Medical Examiner has additionally directed that any bereavement work undertaken by MEOs will need to cease by 01 April 2023 to comply with Appendix C which will leave a significant gap within SATH. Failure to comply with this regional directive risks the national funding being withdrawn from the Trust. A business case requesting the establishment of two Band 4 Bereavement Officers to release MEO capacity is being presented to the Trusts funding approval process in April 23.

8.6 In order to ensure the mandated target date is reached and with agreement from the Regional Medical Examiner, a pilot is planned to go live in April with one local GP practice, Shropshire Community Health NHS Trust and the Robert Jones Agnes Hunt Orthopaedic Hospital. Switching on rollout for these providers is acceptable as will only increase demand marginally which can be managed within the current establishment for both Medical Examiners and MEOs. A phased approach to rollout will take place thereafter once the service is fully recruited and confident in new operational processes.

8.7 Access to patient health records has been granted from the majority of community providers in STW however, through close engagement with the STW Local Medical Committee representing the 51 GP practices in the system, Information Governance colleagues and other Medical Examiner services in England who have already rolled out, it has been agreed the most appropriate means in which to access GP records is through 'EMIS viewer'. This is a cloud based extension to EMIS providing reading access only and will provide the most efficient ways of working for both the SATH Medical Examiner service and local GPs. A wider discussion is required between SATH and the ICS to agree how this electronic system can be funded as the rollout to more GPs take place. This will be explored further in Q1 23/24.

9.0 Risks

9.1 Should the next recruitment round not be successful to increase Medical Examiners this will be a risk to further rollout of the non-acute service and an alternative approach to securing Medical Examiner sessions will need to be reviewed. It is a possibility to offer additional sessions to current Medical Examiners who may have the flexibility in their job plan to take on additional sessions. This model does come with operational challenges in that the more sessions one individual undertakes, the greater the impact to the rota in times of leave and sickness.

9.2 The organisation is required to review its bereavement function to ensure it is fit for purpose or there is risk funding will be removed from the Regional Medical Examiner. A business case to secure additional bereavement personnel is being progressed through the appropriate organisation approval framework.

9.3 Whilst the Regional Medical Examiner request to change to our current practice whereby the Medical Examiner does not oversee the referral of a death to the coroner will create additional capacity for the Medical Examiner for the non-acute rollout, it will put further demand on the treating team. It is anticipated that delays will be experienced in these cases being referred to coroner, similar to the delays that are seen in the completion of the MCCD.

10.0 Summary

10.1 In summary the performance of the Medical Examiner service during Q4 was challenged due to the winter pressures seen during January 2023. Despite this, 100% of deaths were still reviewed and MCCDs and coroner referrals facilitated. The challenges in our performance for issuing MCCDs in 3 working days does require reviewing to ensure there is support from senior colleagues in releasing doctors to write these in a timely manner is required.

Appendix A – National ME Statement regarding statutory position.

National ME Statement 27th April 2