APPENDIX A: MEDICAL EXAMINER & BEREAVEMENT SERVICE QUARTER 2 JULY – SEPTEMBER 2023

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 & Bereavement Service during quarter 2 (Q2) 2023-24 and the outcome of Medical Examiner reviews, including those with coroner involvement.

2.0 Summary of Hospital Deaths

2.1 There were 434 deaths across both hospital sites during Q2 recorded by the Bereavement and ME service, which was a reduction of 113 deaths reported in Q1, and a reduction of 71 deaths from the same period in 2022 (Figure 1).

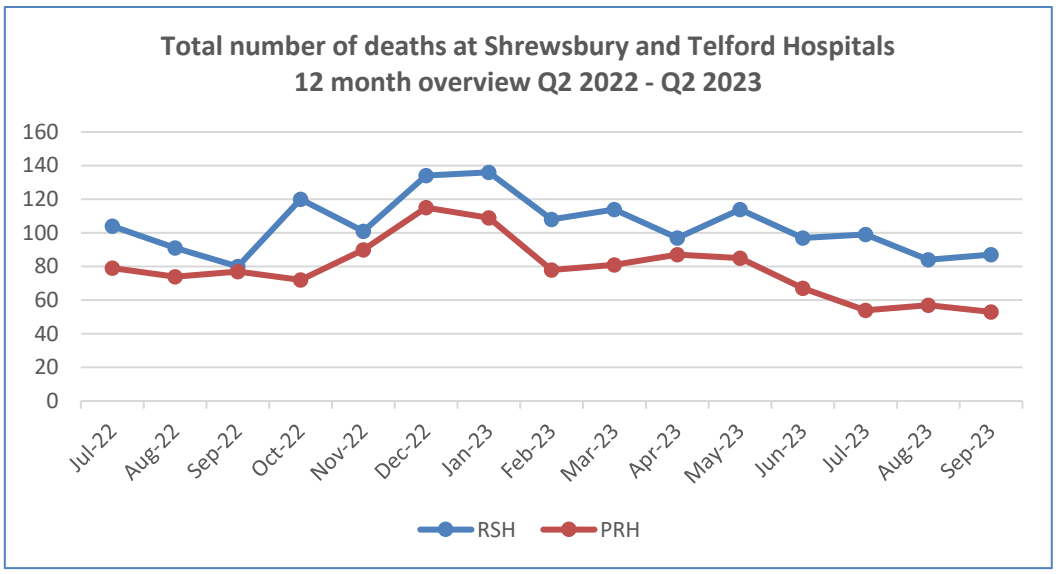

Figure 1 – Total number of deaths at SATH 12-month overview

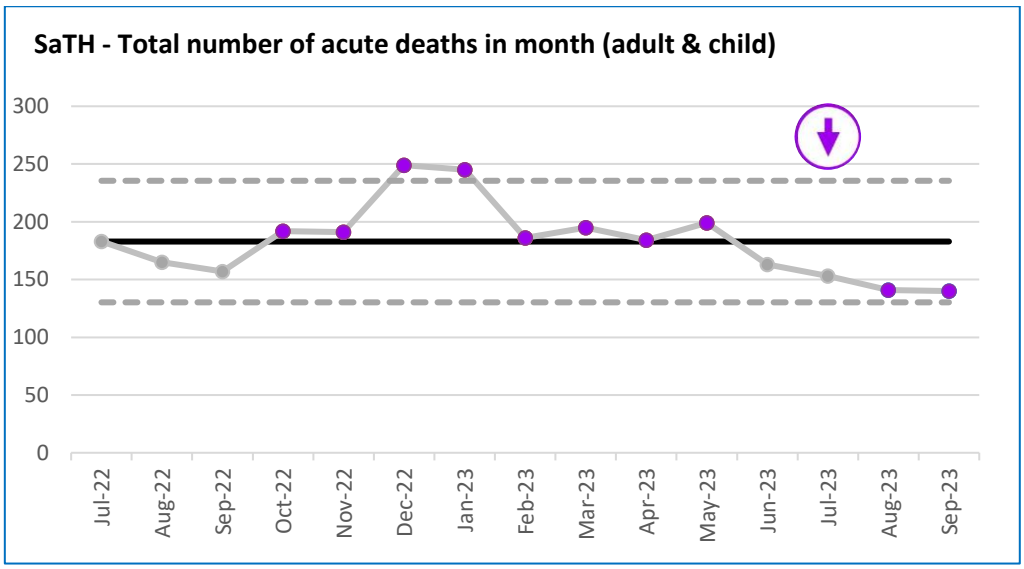

Figure 2 – SaTH – SPC of acute deaths in month (adult & child) – 12 month overview

The above SPC chart is taken from the Medical Examiner and Bereavement dashboard and shows the deaths following seasonal variance.

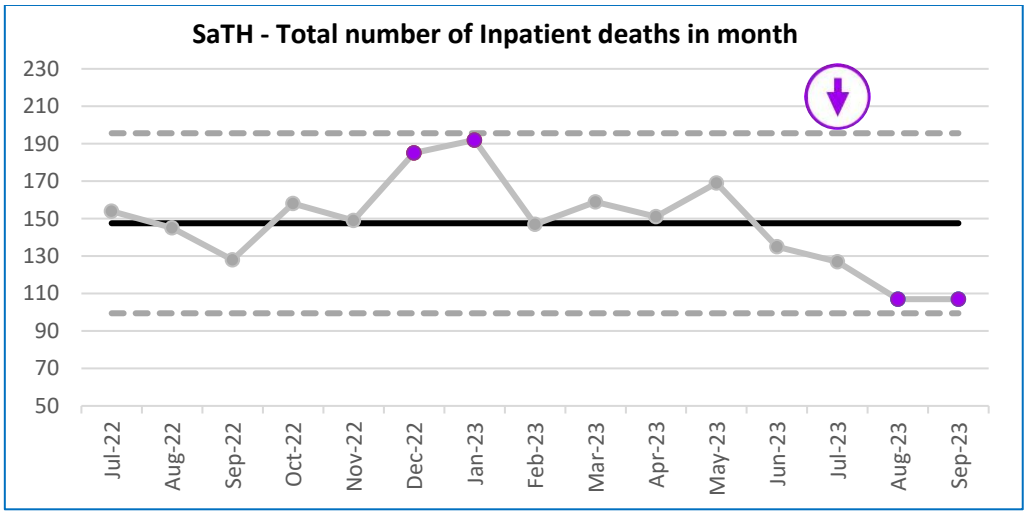

Figure 3 – SaTH total number of inpatient deaths in month

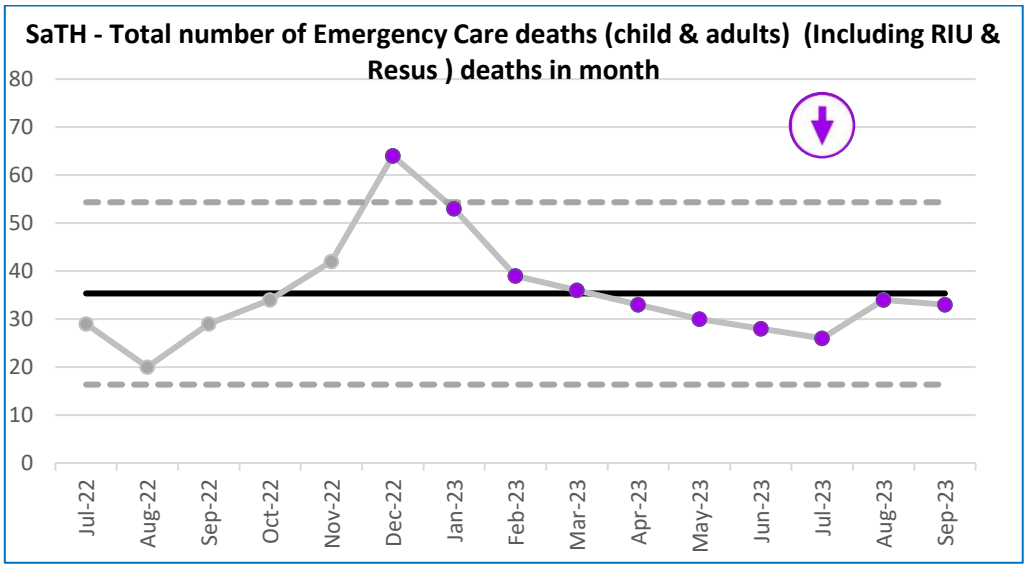

Figure 4 – SaTH total number of ED deaths in month

Figures 2, 3 and 4 identify the data by month. Work is in progress between the Medical Examiner Service, the Learning from Deaths Team and the Performance Team to split the ED data further to show the number of deaths where the patient has been under the care of an ED Consultant or where the care has been transferred to a Specialty Consultant, but the patient remains in the geographical location of the ED.

2.2 Summary of deaths by Division

Of the 434 deaths in Q2, 336 of these were patients under the care of the Medicine and Emergency Care Division (MEC), 97 were under Surgery and Cancer Care Division (SAC) and 1 under the care of the Women and Childrens Division. Figures 5,6 and 7 shows the monthly mortality data across these divisions.

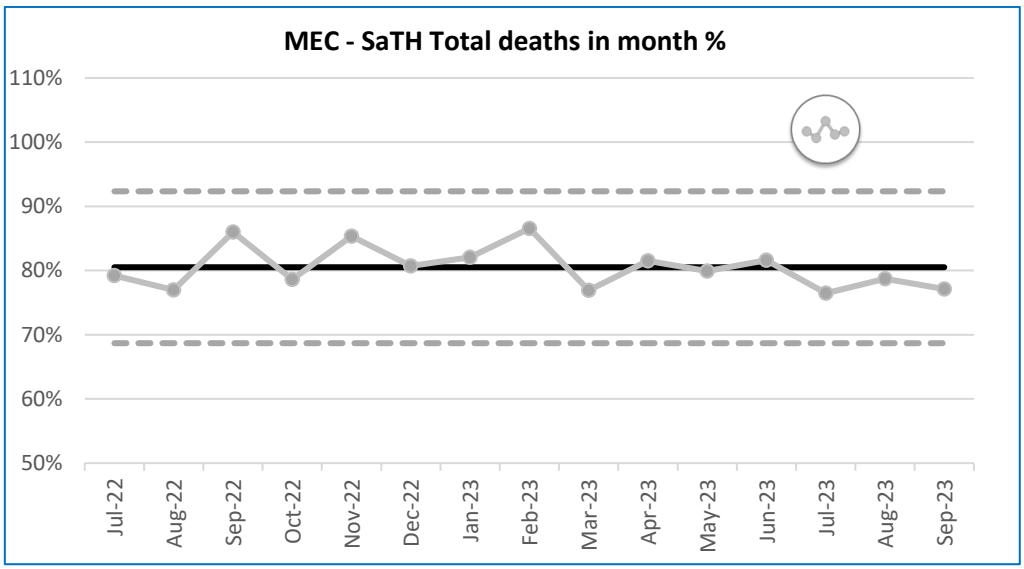

Figure 5 – SaTH MEC total deaths

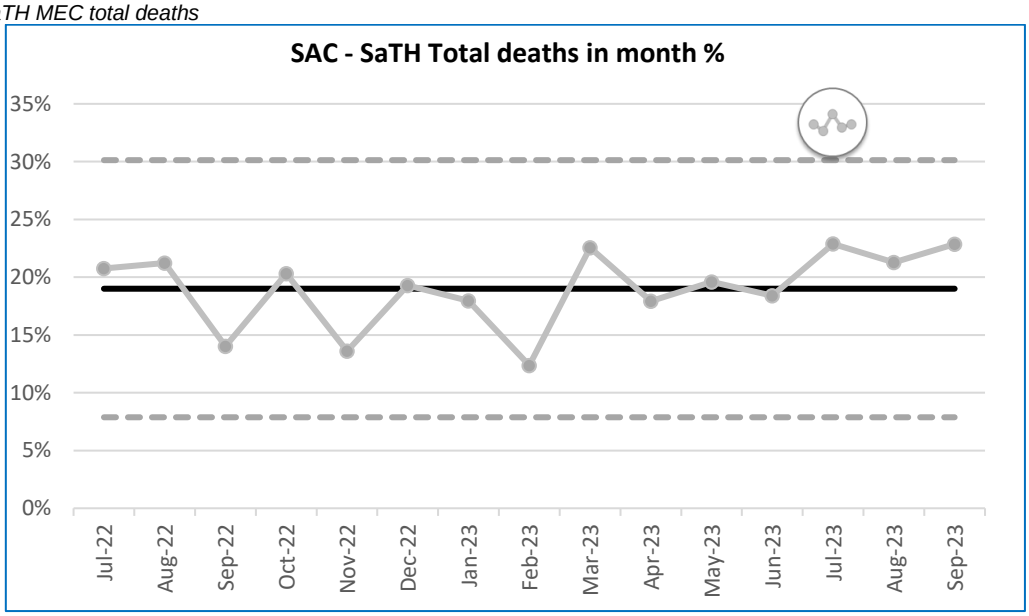

Figure 6 – SaTH SAC total deaths

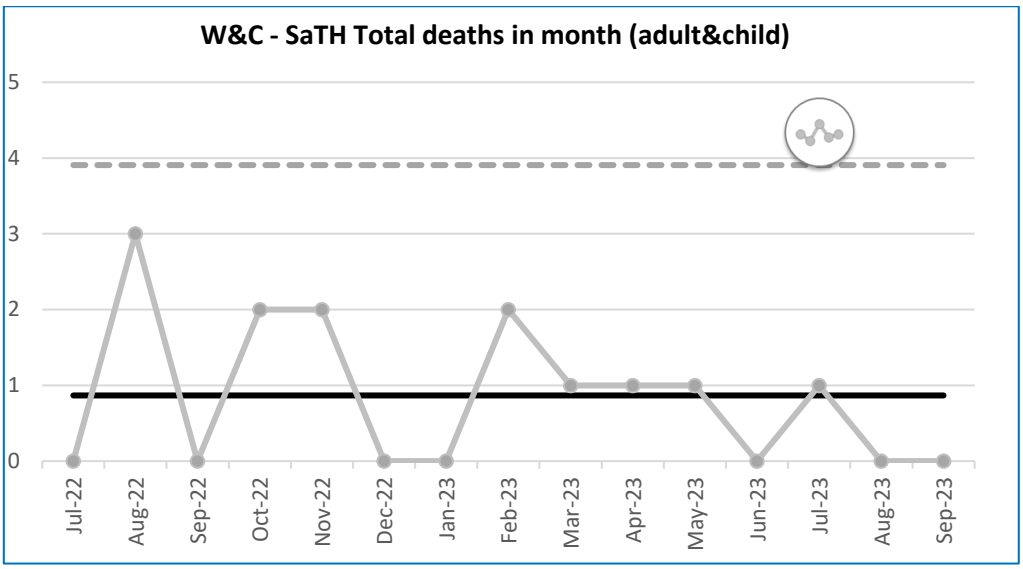

Figure 7 – SaTH W&C total deaths

2.3 Acute hospital paediatric deaths

There were 6 paediatric deaths in Q2. 2 cases that occurred in ED at RSH with the 4 remaining cases being at PRH, 3 cases in ED and 1 ward case. 5 of the 6 cases were reviewed by the ME service. 1 case was directly referred to the coroner by the police, which proceeded to a post-mortem investigation and therefore did not undergo ME scrutiny. Of the remaining 5 cases, 4 were referred to the coroner with 2 of them proceeding to post-mortem.

2.4 Acute hospital adult deaths

There were 341 inpatient deaths across both sites in Q2 and 93 deaths in the Emergency Departments (Figure 8).

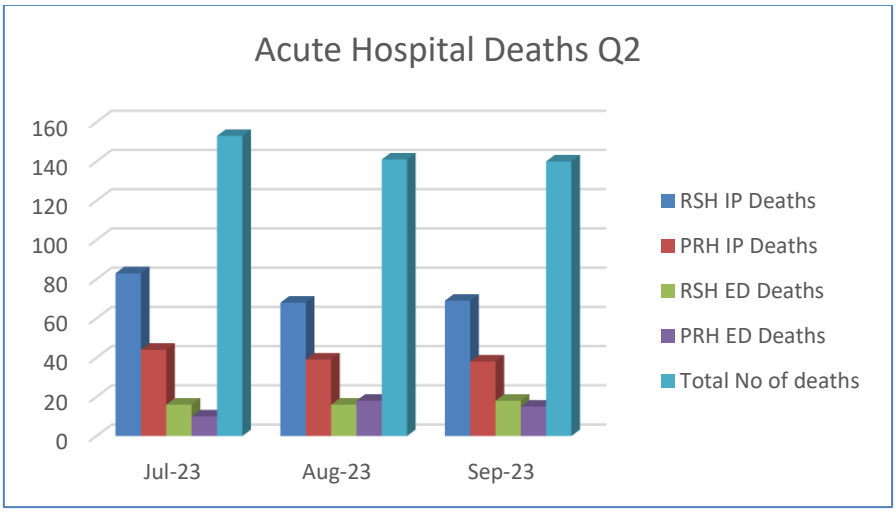

Figure 8 – Acute hospital deaths split by site, inpatient & ED in Q2

3.0 Medical Examiner Scrutiny

3.1 Summary

428 of the deaths that occurred in Q2 received Medical Examiner scrutiny (Figure 9), 98% of the overall deaths therefore receiving a review. Those cases that did not receive review are cases directly referred to the coroner but not by the ME service. Of these, 97% of bereaved relatives received a phone call from the Medical Examiner service to discuss the care, treatment, and cause of death. The cases where contact was not made was due to a combination of no next of kin available and relatives not returning our calls.

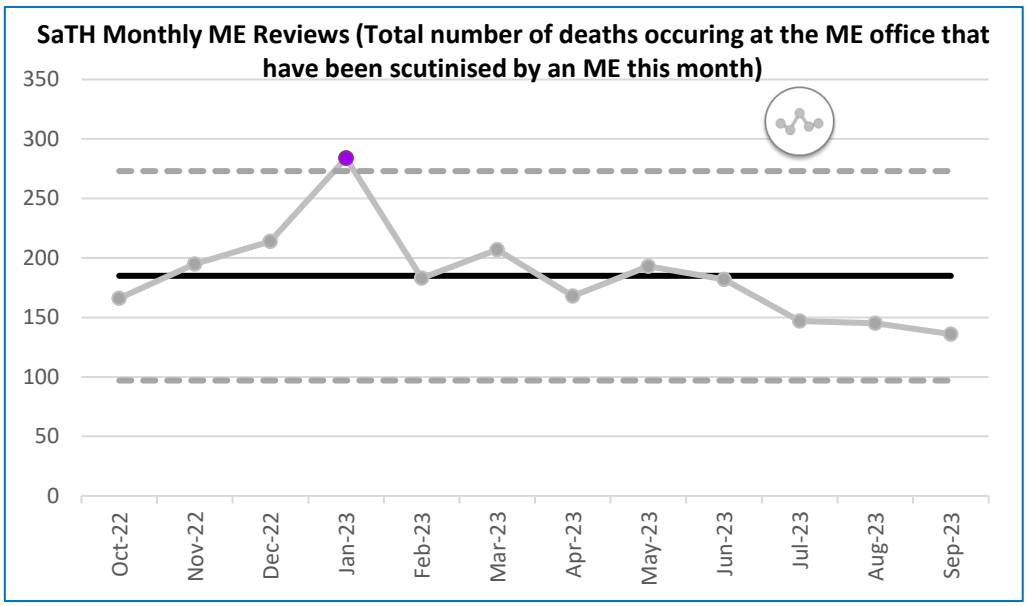

Figure 9 – Total Number of Medical Examiner Reviews in 12 month overview

You will note from the above SPC chart that the Bereavement and ME service can expect to receive an average of 150-200 deaths a month currently across both sites, with the winter period of Q4 reaching nearly 300 deaths which is nearing the upper process limit point.

3.2 Deaths identified by Medical Examiner for potential learning

Out of the 428 reviews completed during Q2, the Medical Examiners raised potential learning in 91 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 an increase of 12 cases from Q1.

4.0 Medical Certificates of Cause of Death (MCCD)

4.1 Of the 428 deaths reviewed by the ME service, 394 MCCDs were requested following the Medical Examiner review and completed by the treating clinician.

4.2 Of the 394 MCCDs written, 338 of these had no coroner involvement and so the target timeframe for MCCDs with no coroner involvement to be written, is within 3 calendar days. 84 of the MCCDs were not completed within 3 calendar days during Q2. Delays were therefore experienced for bereaved relatives being able to register the death of their relative during this time.

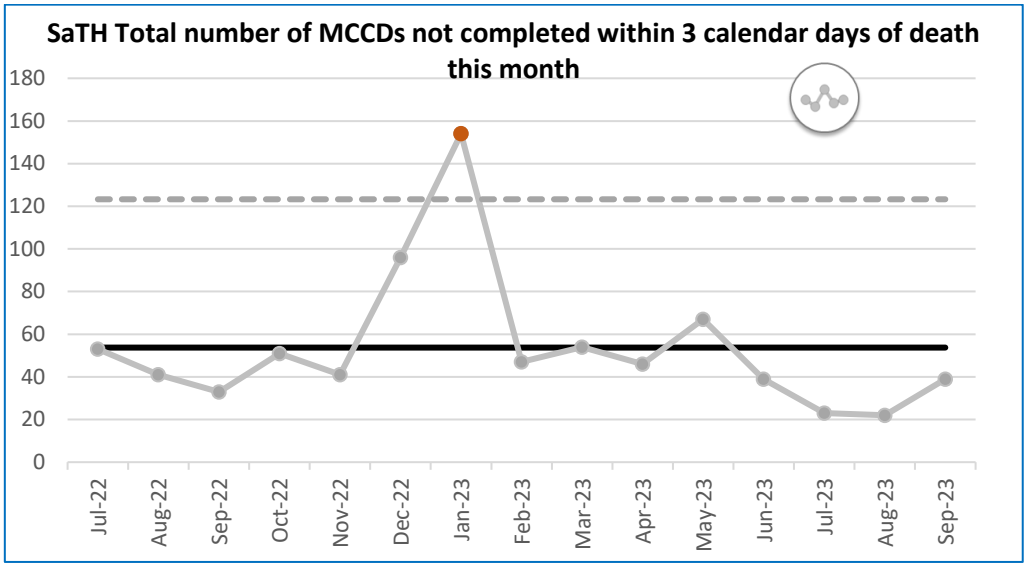

Figure 10 – Number of MCCDs not completed within 3 calendar days of death

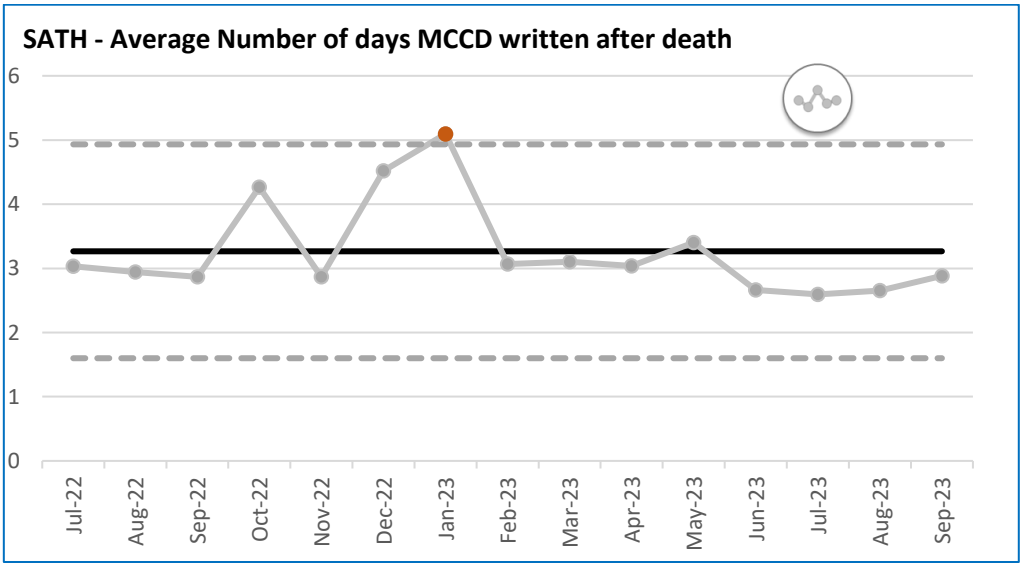

Figure 11 – SaTH Average Number of days MCCD written after death.

Our performance with this metric has improved during Q2, however compliance dipped in September despite there being less deaths during that month compared to July and August.

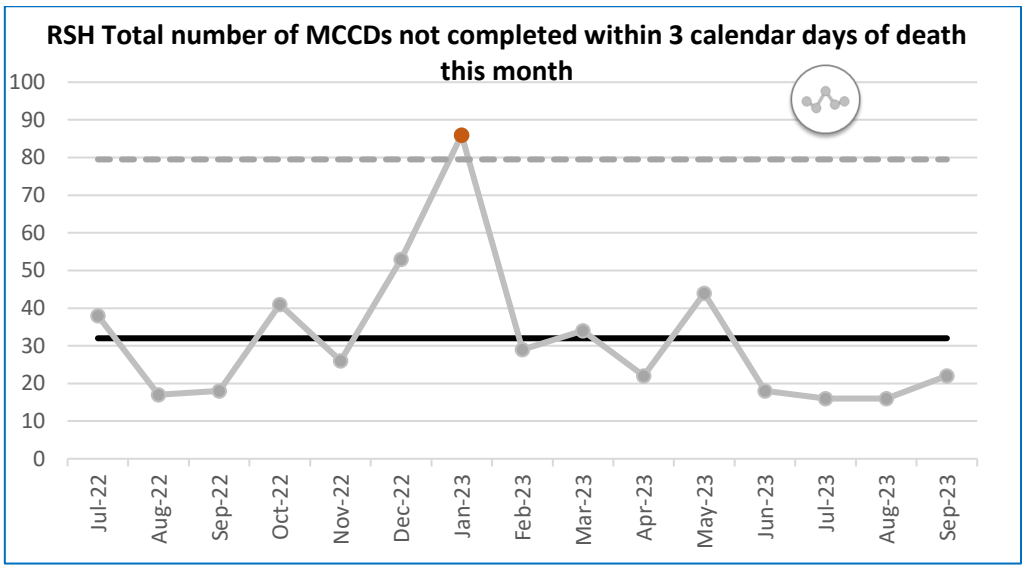

Figure 12 – RSH MCCDs not completed within 3 calendar days

Despite there being less deaths at PRH during September, typically performance for completing MCCDs at this site took longer and so a renewed focus on ensuring doctors attend promptly is required.

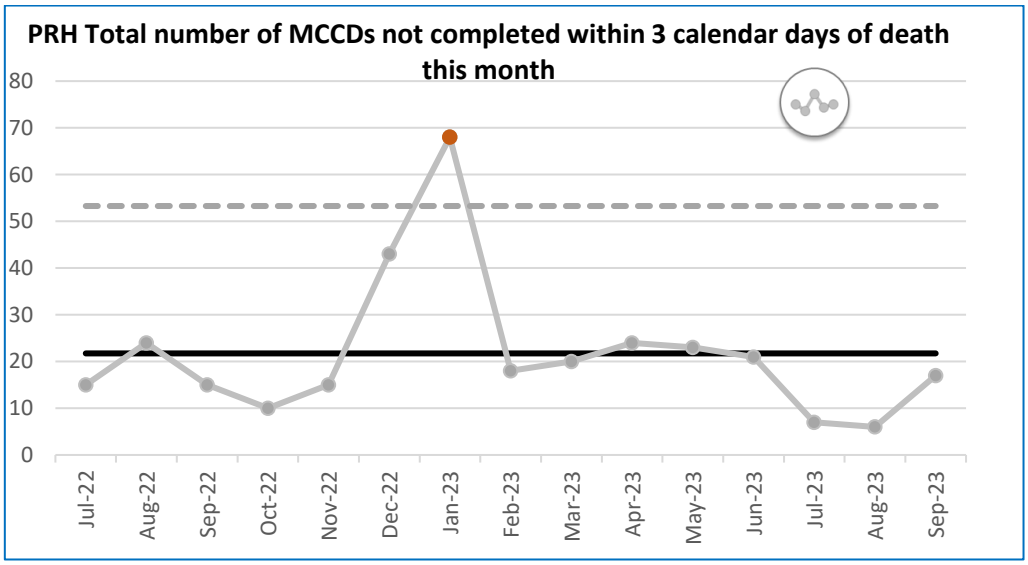

Figure 13 – PRH MCCDs not completed within 3 calendar days

Our performance in respect of meeting 3 calendar days is being monitored by the Regional Medical Examiner and has been a point of discussion following quarterly submissions to the National ME. This is seen as a risk to our performance and has been highlighted in previous reports with support requested from senior clinicians to release their clinical teams to complete death certification seen as a priority. This has been further supported by the Medical Directorate. We continue to keep the Registration services appraised of any cases where there will be a delay in facilitating registration.

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 394 MCCDs written and issued, 10 certificates were rejected by Registration Services in Q2.

5.0 Structured Judgement Review

5.1 There were 35 deaths in Q2 (Figure 14) where the Medical Examiner had recommended an SJR.

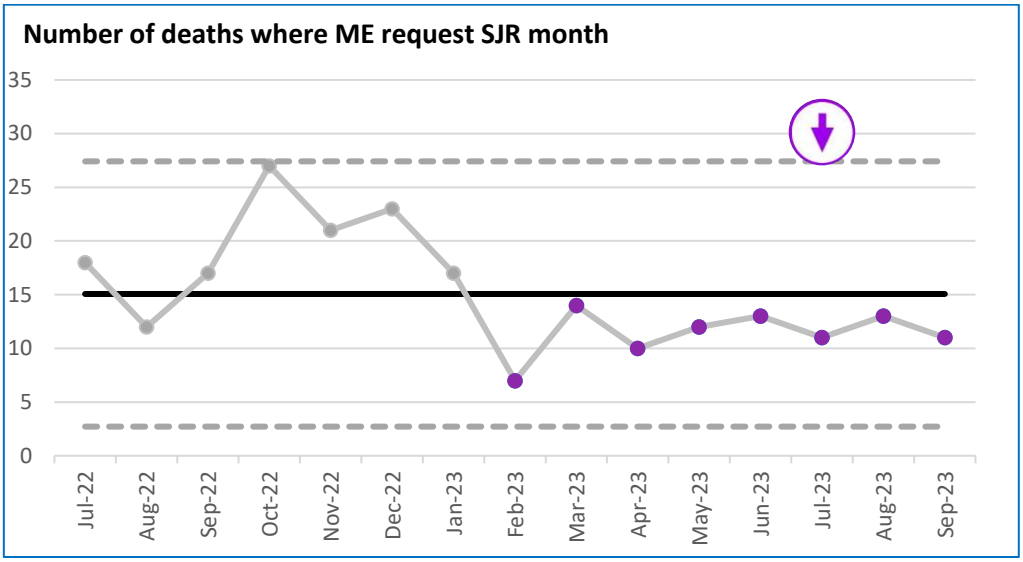

Figure 14 – Number of SJRs recommended following Medical Examiner Review

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 15 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.

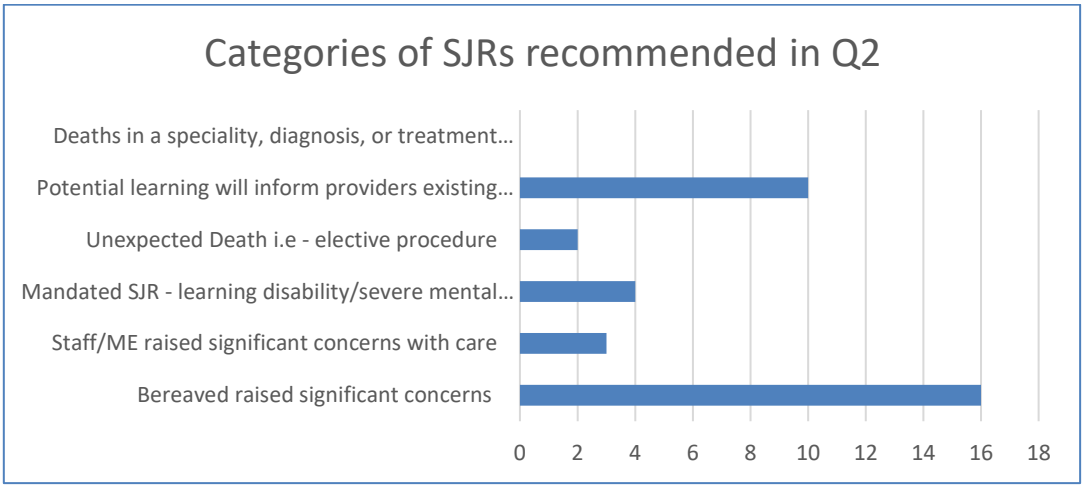

Figure 15 – Categories of SJRs recommended

6.0 Coroner Referrals

6.1 Across both hospital sites the Medical Examiner facilitated 93 referrals to the coroner during Q2. This is a reduction from what was referred in Q1 by 13 referrals.

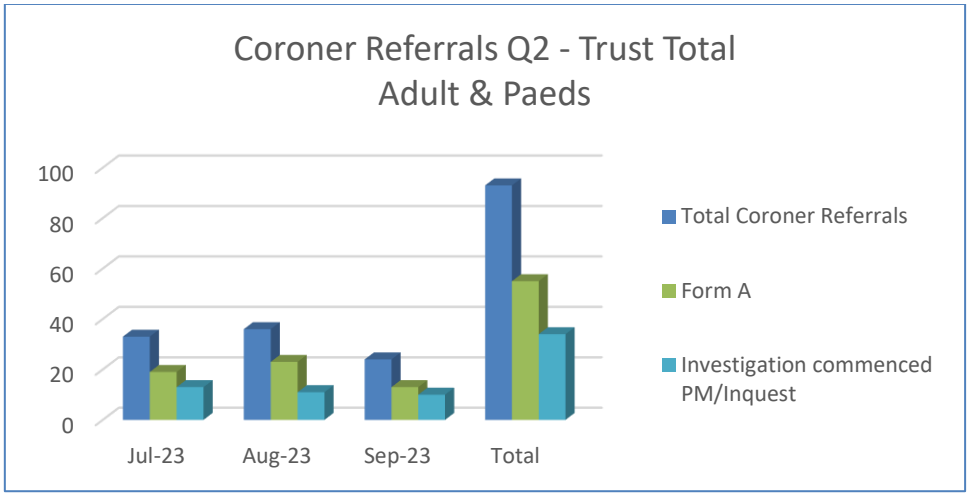

Figure 16 – Coroner referral outcomes Q1

Of the 93 referrals for deaths on both hospital sites, the coroner took no further action in 55 of the cases by issuing a Form A, and took 34 cases to investigation by either post-mortem or inquest. The remaining 4 cases were followed by the GP who issued MCCDs.

7.0 Urgent body release/faith requests

7.1 There were 4 requests for urgent body release for faith purposes in Q2, and these requests were facilitated in the timeframe required during core working hours.

8.0 Service Highlights / Non-Acute Rollout

8.1 The National Medical Examiner continues to provide a monthly update on the DHSC plans for the ME system becoming statutory in April 2024 and is positive that the draft regulations will be shared imminently.

8.2 Despite not receiving confirmation of the legislative changes to allow the statutory system to come into place, our project for extending the ME service to the community continues at pace and remains part of the organisations 'Getting to Good' programme. The lead for the service provides regular updates to that group to discuss progress against the plan on a page, provide reassurance against milestones, provide evidence of delivered actions and seek support and direction on the areas deemed to be risks to the delivery of the project.

8.3 To ensure the service can cope with the additional demand from receiving referrals from across the ICS, recruitment of additional Medical Examiners has taken place with new members of the team starting during Q2. This now completes our allocated establishment of Medical Examiners from the financial envelope that is in place for our service by NHSE. We have a team of 17 MEs doing 18 sessions.

8.4 Approval from the Trust's senior leadership team and the Innovation and Investment Committee was granted in support of creating a dedicated bereavement service for the Trust by appointing two Band 4 Bereavement Officers and a Band 5 Bereavement Supervisor. This supports the plan to release MEO capacity to ensure the ME service is compliant with how the MEOs work in their role, and do not carry out Trust bereavement work. With the IIC giving approval, recruitment of these posts took place throughout Q2, and the successful candidates will join the team during Q3. This is a significant step forward for the Trust in ensuring it

provides a robust and supportive bereavement service, but also supports the bigger agenda of developing the ME service to ensure it is ready for the statutory footing.

8.5 Collaborative working with both Stirchley Medical Practice and RJAH continued throughout Q2 with engagement with other community partners, such as the Severn Hospice and Dawley Medical Practice taking place, with plans for them to come on board during Q3.

8.6 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 has taken place between SATH and the ICS and agreement has been reached for the ICB to fund the recurring cost of this electronic system so that rollout to ST&W GPs can take place. This has gone through the procurement process with training on the system to be arranged during Q3 of 2023/24. All GP practices have received instruction from EMIS to switch on permissions for SaTH's ME service to gain access so as and when GP practices come on board, the service is ready to access their EPR.

8.7 During Q2 the remuneration for doctors completing cremation forms was re-introduced following agreement by the Remuneration Committee and Local Negotiation Committee for approval of the option for 60% of the fee being paid to the doctor completing the form with 40% being retained by the Trust for the administration attached to processing the forms.

8.8 The National Medical Examiner is seeking each ME service to submit plans for providing an out of hours service to support cases of urgent body release for faith purposes during weekends and bank holidays. Across ST&W during 2022/23 the Registration of Deaths services have advised that they have had 2 requests for registration of deaths over the weekend to facilitate urgent burial. The ME service is therefore considering an on-call system for the Medical Examiners as a "fee for service" agreement whereby should we get a request for out of hours body release a Medica Examiner will attend to undertake review and oversee death certification and receive remuneration for that review. The ICS does not appear to have enough demand to justify a formal on-call system being put in place, although this will be reviewed as the service works with more community stakeholders.

9.0 Risks

9.1 The office accommodation at RSH for the Bereavement & ME service is challenged and not fit for purpose. The trust's process for requesting review of accommodation has been followed and commenced in Summer 2022. Despite this, there has been no progress against this action, and it remains a risk to the expansion of the ME service as we recruit additional staff members and have clearer definition between the service function of Bereavement and ME services. This is currently a milestone on the project plan overseen by the "Getting to Good" programme that is off track, however, significant efforts by key stakeholders is currently under way to find a resolution.

10.0 Summary

10.1 In summary, although an improving picture throughout Q2 in the performance of issuing MCCDs within 3 calendar days can be demonstrated, the sustained delivery of this KPI is challenged due to the availability of the treating doctor attending to complete death certification. The challenges in our performance for issuing MCCDs does require senior leadership support to ensure there is a clear expectation of clinicians to provide timely support to this process. The departments involvement in junior and senior doctor inductions would help support the delivery of this important message.