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

National Medical Examiner's Good Practice Series No. 12

Escalating thematic issues and maximising the impact of medical examiner scrutiny

July 2023

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

Medical examiners – senior doctors providing independent scrutiny of non-coronial deaths in England and Wales – are 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 front-line staff, with links to further reading, guidance and support.

Recommendations for medical examiners

Medical examiners and officers should:

- remain vigilant for patterns and themes that emerge through scrutiny and are not adequately addressed by referring individual deaths for further review
- escalate and share information about trends, themes and systemic issues to existing clinical and quality governance processes. This should include systems in place in healthcare providers, in Integrated Care Boards (ICBs) and regional medical examiners in England, and in Wales to NHS Wales Executive and health boards, along with partners such as Healthwatch or Llais. See also the Appendix.
- participate actively or help to develop mechanisms to link medical examiners' work with existing oversight and quality governance processes to ensure medical examiner findings are considered along with other intelligence
- consider whether there is a need to notify the coroner of certain deaths that form part of a wider concern identified by medical examiners and officers
- consider the approach of their medical examiner office to quality assurance and healthcare improvement. Medical examiner offices should implement proportionate measures to evaluate their impact. This should include evaluating how effectively they support bereaved people, along with the wider benefits delivered by the medical examiner office, demonstrated through specific examples such as opportunities identified to improve patient care.

Context and background

Implementation of the medical examiner system commenced in early 2020 and gained momentum in the subsequent months and years, despite challenges arising from the coronavirus pandemic. By early 2023, medical examiner offices in England and Wales were providing independent scrutiny of almost all non-coronial deaths in acute providers and making significant progress in extending their scrutiny to deaths in other healthcare settings and the community.

The NHS in Wales and England have developed processes to gather intelligence from medical examiner offices. Medical examiners and medical examiner officers have experience of providing effective scrutiny and recognise issues that may be detected during scrutiny. Of course, in the majority of deaths, there are no concerns about the care provided. Many of the concerns detected require only minor intervention, such as making the treating team or doctor aware of the issue through a discussion. In England, around 10% of cases are referred for clinical governance review.

However, medical examiners and medical examiner officers are ideally placed to provide early notice of issues that are more systemic and are not confined to an individual death. For example, disruption to services during the pandemic could cause delayed detection and management of conditions such as hypertension, which could lead to early deaths. It is not possible to set out all the themes and issues that may emerge, given the enormous number of patient interactions delivered by the NHS in England and Wales. This paper provides broad principles for medical examiners and medical examiner officers to consider.

The paper also considers how medical examiner offices can best realise the potential they have to support improvement through work with other parts of the healthcare system, especially healthcare providers, ICBs and health boards.

Escalating trends, themes and systemic issues

A key benefit of medical examiners and medical examiner officers is their insight into all deaths in an area. This creates earlier opportunities to identify when there may be an issue that should be investigated further.

Themes that medical examiners may identify

It is not possible to articulate the full range of themes and trends that may emerge through scrutiny. However, based on experience, examples are likely to include:

- an unusual increase in deaths with shared or similar features
- deaths in particular geographic areas, indicating there may be a potential issue at a provider or with a healthcare professional
- deaths that share characteristics, such as similar problems with care, a particular specialty or ward in a hospital, unexpected complications after similar or related procedures, or a higher number of deaths than expected in a care home
- increased or an unexpectedly high number of deaths among certain population groups
- concerns about deaths raised by bereaved people, particularly if these share similar features.

The National Medical Examiner's Good Practice Series explains that medical examiners should contact their regional medical examiner (in England) or the lead medical examiner in Wales if escalation to local partners does not appear to be leading to appropriate action.

Medical examiners should be vigilant for repeated patterns or themes in the deaths they review. Medical examiner officers should also be alert to thematic issues, as they are likely to be working full time or for the majority of the working week. The continuity provided by medical examiner officers across the working week means they have an important role to play in identifying repeated patterns or trends. Most medical examiners are present for 1 or 2 sessions each week. In Wales, reporting arrangements are continuously refined to support analysis of themes and trends as part of the all-Wales assurance and concerns management system.

Medical examiners and medical examiner officers also need to be vigilant for patterns and trends in deaths notified to coroners. While the medical examiner will not complete full

independent scrutiny for such cases, medical examiner offices may be the first agency to identify that a trend or pattern is emerging and should respond appropriately. Detecting such a pattern may lead the medical examiner office to consider further which deaths require coroner notification.

Periodic review of patterns and trends

The nature of arrangements in medical examiner offices will make it difficult for all office staff to meet for classic ‘away’ time. However, it is good practice to make time to reflect on learning, patterns and trends, as described in the previous section, along with feedback from bereaved people and stakeholders. Such reviews could be general, or focused on thematic areas, such as deaths following surgery or in acute medicine.

Of course, medical examiner offices should not wait for these periodic reviews to raise issues of concern. As medical examiners and medical examiner officers deliver scrutiny in real time, they should remain vigilant for issues that require immediate escalation. However, a periodic review of the overall work of the office and an opportunity to reflect on medical examiner scrutiny may enable staff to identify matters that might otherwise be less obvious.

Thresholds

As themes and trends or concern will be diverse in nature, it is not possible to specify thresholds which would trigger action. The judgment of the lead medical examiner will be important, though all medical examiners and medical examiner officers are expected to raise and escalate matters if they believe action is appropriate. Where it is unclear whether the escalation of a theme, trend or concern is appropriate, guidance can be sought from the lead medical examiner and the regional medical examiner and medical examiner officer in England.

Ensuring medical examiner offices contribute to improving care

Key benefits of a well-run medical examiner office include supporting bereaved people and giving them a voice in reviewing the quality of care, and improving care for patients by affirming good practice and highlighting examples where care could be improved, including making healthcare providers aware of the views of bereaved people.

There are a number of steps that medical examiner offices should consider to maximise their impact on supporting bereaved people and improving healthcare. While the information below is not exhaustive, nevertheless it sets out potential actions. Lead medical examiners should consider these and other opportunities to maximise the benefits the medical examiner office delivers to the healthcare system.

While it will not be appropriate or feasible to implement all the options below, medical examiner offices should have a clear strategy for learning, for evaluating their impact and maximising opportunities for learning and improving care. Medical examiner offices should consider which options can realistically be delivered within resource constraints.

Local evaluation and reflection

Each medical examiner office should consider ways it can obtain information about the impact it is having to benefit bereaved people, reflecting local arrangements. Many of these could be carried out on a periodic or one-off basis.

- Feedback
  - from members of the public. This should include compliments/positive feedback, and issues/incidents/complaints/negative feedback about the medical examiner office. Providing a website with a facility for members of the public to provide feedback will encourage open feedback.
  - from other sources, e.g. PALS, patient experience officers, ICBs, health boards, Healthwatch, healthcare staff and bereavement officers.
- Surveys
  - of medical examiner office staff, or others such as front-line health staff and local mortality leads

  - of local stakeholders
  - of colleagues in healthcare providers, ICBs or health boards who are already commissioning or carrying out surveys, such as bereavement surveys, which could include questions about medical examiners.
- Review and reflection on scrutiny with
  - analyses of medical examiner office data
  - audits of a selection of cases
  - peer reviews within offices or with other medical examiner offices
  - learning networks with local partners, such as coroners' offices and registrars, e.g. jointly reviewing complex cases.
- Engagement with bereaved people or organisations representing their interests, such as
  - SANDS, which has direct contact with and carries out surveys of bereaved people. SANDS is part of the National Stillbirth Working Group in Wales.
  - maternity and neonatal voice partnerships (each trust in England has a lay chair and clinician who may provide feedback)
  - the National Bereavement Care Pathway in England, which seeks to improve the quality and consistency of bereavement care received by parents in NHS trusts after pregnancy loss or the death of a baby. The standards will be relevant to medical examiner offices and their colleagues across health systems.
  - the National Framework for the Delivery of Bereavement Care in Wales, which supports those commissioning or providing bereavement services to respond to individuals who are facing, or have experienced, a bereavement. The framework includes core principles, minimum bereavement care standards and a range of actions to support regional and local planning. Many of these actions will be relevant to medical examiners and their offices across Wales.
  - other bereavement organisations and charities
  - representatives of faith communities.

Medical examiners should provide information about their work to responsible officers in medical appraisal and revalidation, following guidance from the Royal College of Pathologists.

Reporting to the National Medical Examiner

Medical examiner offices in England are required to provide regular submissions to the National Medical Examiner. This includes important information for quality assurance of the medical examiner office, such as

- the number of cases referred for clinical governance review due to concerns, including deaths in hospitals of people with learning disabilities or severe mental illness
- the number of cases notified to coroners
- cases where interaction with the bereaved did not take place and reasons why
- cases where completion of the Medical Cause of Death Certificate was delayed
- deaths where urgent release of a body was requested

There are also opportunities to provide narrative information about the activity of the medical examiner office. It is important that the medical examiner office clearly explains the impact it is having. In submissions to the National Medical Examiner, medical examiner offices should include:

- specific examples demonstrating how the medical examiner office has had impact on improving care for patients
- information about how the medical examiner office evaluates its own performance
- actions the medical examiner office has taken to improve support to the bereaved and the way medical examiner scrutiny is delivered.

Examples could be as illustrated below:

"We believe the medical examiner office delivers a good service because…

- [Example 1] "…we had contact with 200 bereaved relatives, received no complaints and had very positive feedback"
- [Example 2] "…we made specific recommendations to improve [x] service"
- [Example 3] "…we identified a theme for improvement for [x] service."

Participation in health systems' oversight of care quality

Medical examiner offices already collect and report data to the National Medical Examiner. This quantitative data, along with intelligence and insight about themes and trends, should be actively shared by medical examiner offices to facilitate improvements in care. Partners and stakeholders should include (but are not limited to) ICBs, health boards, NHS Wales Executive, NHS trusts, local medical committees and GP practices, hospices, Llais in Wales and Healthwatch in England. Regional medical examiners will also use this information in work with NHS England's regional quality governance structures.

Medical examiners should contribute to work by healthcare systems and partners to review and improve the quality of care for patients. Such processes operate at various levels: within individual healthcare providers, both those hosting medical examiner offices and those that do not; with other healthcare partners and stakeholders at local levels; and at system level, such as ICBs in England and health boards in Wales. In all cases, medical examiners should liaise with the relevant clinical quality or governance lead, or patient safety specialist, or other agreed route for escalating clinical concerns. If concerns relate to multiple providers, then information should be given to all providers individually and the system where appropriate. Regional medical examiners are responsible for escalating concerns, where appropriate, within NHS England regions, both to regional medical examiners and to regions' formal quality committees. The Appendix summarises how medical examiners can link to quality/oversight processes.

The National Quality Board has published guidance on how quality concerns and risks should be managed within Integrated Care Systems in England. ICBs have a statutory duty to improve the quality of care. The National Medical Examiner expects medical examiner offices to actively contribute to and support ICBs in this function, for example through information provided to System Quality Groups. ICB medical directors and chief nurses will be able to advise on the best means of engagement. For certain more serious issues, it will be appropriate to escalate these through ICB Chief Medical Officers (and possibly the Chief Nurse).

In Wales, the statutory duty of quality requires health boards, NHS trusts and special health authorities to ensure quality-driven decisions improve the quality of health services and focus is maintained on improving outcomes for the people of Wales. Health boards in Wales are responsible for planning and delivering NHS services in their areas. These

health services include dental, optical, pharmacy, and mental health. They are also responsible for improving physical and mental health outcomes, promoting wellbeing, reducing health inequalities across their population and commissioning services from other organisations to meet the needs of their residents.

Find out more

- Coroners – Notification of Deaths Regulations 2019 guidance.
- CQC – Statutory notifications.
- Duty of Quality in Wales The Duty of Quality in healthcare in Wales.
- Health boards in Wales – information from the Welsh Government.
- ICBs in England:
  - information from NHS England
  - National Quality Board: Guidance on System Quality Groups.
- National Audit of Care at the End of Life.
- National Bereavement Alliance supports those working with bereaved people.
- National Bereavement Care Pathway in England.
- National Framework for the Delivery of Bereavement Care in Wales.
- National Medical Examiner's quarterly reporting requirements for medical examiner offices in England.

There are several charities and initiatives actively supporting those affected by the loss of a child.

- 2Wish provides support for those affected by sudden death in children and young people in Wales.
- Child Bereavement UK helps families to rebuild their lives when a child grieves or when a child dies.
- National Maternity Voices in England.
- Perinatal Mortality Review Tool.
- SANDS provides support to those affected by pregnancy loss and the death of a baby.
- National Bereavement Care Pathway seeks to improve the quality and consistency of bereavement care received by parents after pregnancy loss or the death of a baby – standards will be relevant to medical examiner offices and their colleagues across health systems.

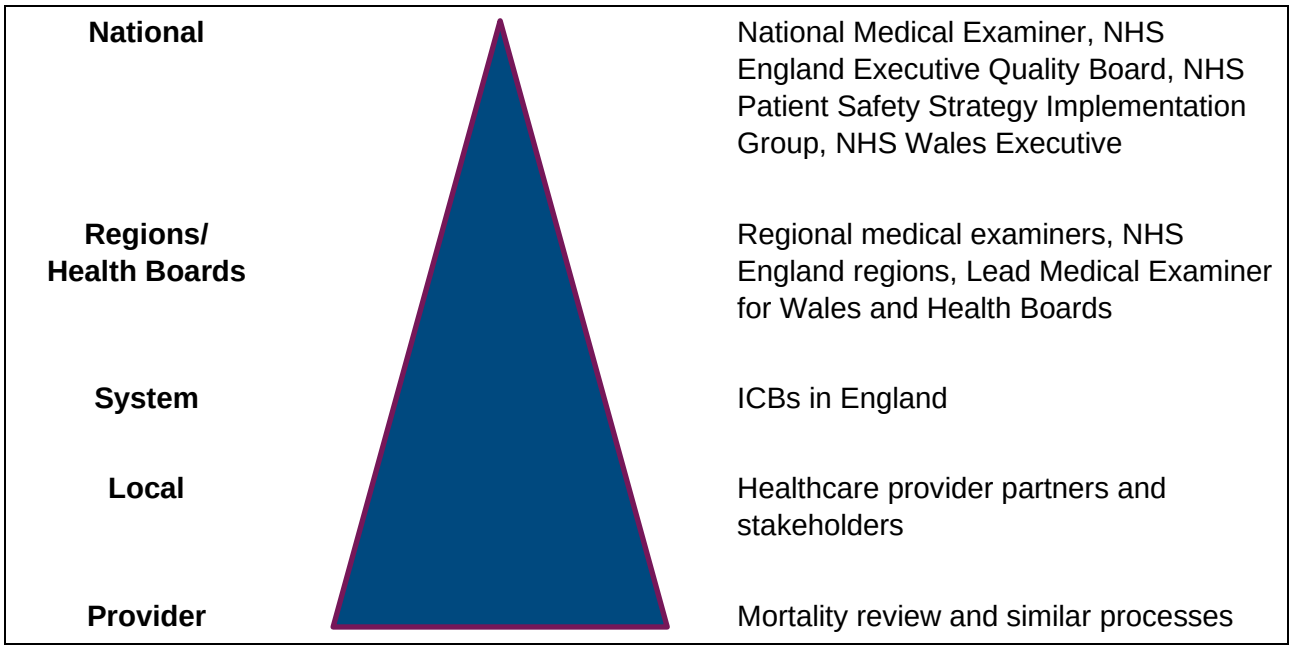
Acknowledgments

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
- Maxine Anderson, Senior Project Manager, NHS England
- Jane Crossley, Team Leader Death Certification Reform, Department of Health and Social Care
- Nick Day, Policy & Programme Lead, Medical Examiner System, NHS England & NHS Improvement
- Douglas Findlay, Lay representative
- Dr Chris Goddard, Lead Medical Examiner, Southport and Ormskirk Hospital NHS Trust.
- Matt Fogarty, Deputy Director of Patient Safety (Policy and Strategy), NHS England
- Michael Gregory, Regional Medical Director, North West region, NHS England
- Natalie Harris, Healthcare Standards and Governance Lead, Welsh Government
- Zoe Hemsley, Regional Medical Examiner (South East) NHS England
- Dr Suzy Lishman, Royal College of Pathologists
- Berenice Lopez, Consultant Chemical Pathologist, Norfolk and Norwich University Hospital
- Kathryn Lupton, Quality Strategy Lead, NHS England
- Michael Marsh, Regional Medical Director, South West region, NHS England
- Amanda Martin, Regional Medical Examiner Officer (South East) NHS England
- Graham Prestwich, Lay representative
- Dr Jason Shannon, Lead Medical Examiner for Wales, NHS Wales Shared Services Partnership.

Appendix – Medical examiners and quality/oversight processes

Medical examiner offices should link fully and effectively to existing clinical and quality governance and oversight processes at the provider, local, system, regional and national levels.



Example

(Note: this illustration is not intended to reflect the full range of appropriate immediate actions when an urgent matter is detected, e.g. criminal activity or action to prevent avoidable deaths. It does not address the full range of actions that individuals and organisations may be required to take).

- A medical examiner office detects a notable number of deaths with a related characteristic at one healthcare provider.
- Medical examiner office
  - provides information to existing clinical governance processes at the provider and to the provider's medical director if appropriate
  - provides information in agreed format to ICB/health board clinical governance processes

- report the issue detected in quarterly submission to National Medical Examiner's office (which is then collated for each regional medical examiner/medical examiner officer)
- ensure other local and national patient safety reports are completed (though others may lead on this) such as their organisation's local risk management systems, which in England are routinely uploaded to NHS England patient safety systems to support national learning.

- Regional medical examiner and medical examiner officer
  - report the issue detected in the quarterly summary provided to National Medical Examiner
  - provide information to NHS England's Regional Medical Director.
- Lead Medical Examiner/Office for Wales
  - report the issue detected in quarterly summary provided to National Medical Examiner
  - provide information using agreed clinical governance processes to NHS Wales Executive.