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3 April 2019

By email:
Trust Medical Directors
Trust Directors of Nursing

Dear Colleague,

Re: Medical Examiners

Reforms to how death is certified is long overdue and was originally proposed over a decade ago following various independent reviews and reports stemming from the Harold Shipman murders. Implementation in hospitals first makes sense, because, in London, 52% of deaths occur in hospitals, with around 15% in care homes and 25% in the community.

With the appointment of a National Medical Examiner, the new medical examiner system across England and Wales is now starting to take shape. Attached with this letter is correspondence from Alan Fletcher, the newly appointed National Medical Examiner. In his letter, Alan provides some more information on what additional information will be coming soon and next steps for individual organisations.

The non-statutory system will introduce a new level of scrutiny whereby all deaths will be subject to a medical examiner's scrutiny. This will move to a statutory system in the coming years.

In London, we hosted Dr Fletcher at the London Learning from Deaths Network on 28th March 2019. A number of colleagues have suggested that it would be useful to brief your Board of Directors about this matter.

Some of the key points to note are:

1. Medical Examiner systems to review all hospital deaths must be in place by April 2020, but the timing of implementation over the next 12 months will be dictated by local preparedness.

2. There will be funding available, the extent and nature of this will be clarified by the Department of Health and Social Care within the next few weeks.

3. Although Medical Examiners will be based within (and employed by) Trusts, they need to be independent of that Trust when undertaking medical examiner work. In practical terms this means that they will have an external reporting line via the regional medical examiner, and they cannot be the Trust mortality lead/Learning from Deaths lead/chair of the Trust mortality surveillance group or equivalent. Medical Examiners will be expected to share full information with Trusts to inform mortality reviews and your clinical governance systems, which will help support the Learning from Deaths process. They

can act as Structured Judgement Review (or similar) reviewers, but not for cases for which they have been medical examiners.

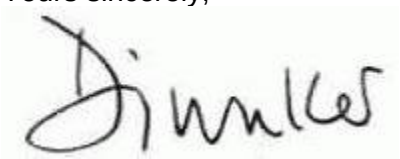
One of the strengths of the new medical examiner system is increased engagement with bereaved families, an area highlighted for improvement in the CQCs recent report *Learning from deaths: a review of the first year of NHS Trusts implementing the national guidance*.
We know that a number of you have already got this system in place but need to adapt it to meet the new requirements.

If you have not done so already, we recommend that you commence planning for how a local medical examiner system will work within your Trust, where possible in discussion with neighbouring Trusts, for example, at a Health and Care Partnership (STP) level, as some resource sharing (e.g. at weekends) may be required.

A National Medical Examiners web page and regular bulletins are both under development, which will provide you with updated information as and when it becomes available. Please also note the contact email nme@nhs.net for any specific queries. We attache the first bulletin from Alan Fletcher.

Thank you for your support with this important initiative. Although there have been frustrations along the way, I know you all agree that this is an important change which will have a significant impact on the way we support families and learn from deaths.

Yours sincerely,



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Chair of the London Learning from Deaths network

cc. CCG Chairs
Directors of Quality, CCGs
Directors of Nursing, CCGs

Dear Medical and Nursing Directors

Having been in post as National Medical Examiner for a few weeks now, I wanted to write to introduce myself and to share some updates with you about plans for roll out of the medical examiner system.

Since being in post I have heard that communications about plans for the roll out of the medical examiner system have not been as effective as they could have been. This is something that I want to address through communications like this. I don't yet have all the answers to all the questions being posed but I am determined to be clear about what is needed to deliver an effective system that is at the heart of patient safety going forwards.

I have started work to recruit a team of lead medical examiners, supported by lead medical examiner officers, in each of the English regions and in Wales. Adverts for these posts will be out in April and I'm keen to have people in post – to support me and you - by the Summer.

Timescales for implementation

I know from sharing my own experience of the medical examiner role in Sheffield, that up and down the country and in Wales, there are the number of established early adopter sites. The enthusiasm shown by these and many others to start at the earliest opportunity is testament to real appetite to deliver a national system. In my role as the National Medical Examiner, I want to bring together practice across the country to deliver a truly national system.

This won't be achieved overnight and I know many providers have questions about setting up in the best way. And for those just starting on this journey, a phased roll out from the end of April 2019 makes sense to demonstrate respect for the various religious festivals occurring throughout much of April. More information will be provided at the national event on 25 April about timing and finance. To book see the Royal College of Pathologists website: https://www.rcpath.org/event/implementing-the-medical-examiner-system-2.html

My vision is that we use the flexibility the non-statutory process offers to deliver a system that will provide proportionate scrutiny to all non-coronial deaths. I want to enable this to be delivered for all deaths in secondary care by the end March 2020 and for all deaths by the end of March 2021. This will enable the statutory system to come into force and deliver the system that too many reports into patient safety have rightly demanded.

In my national role, I will be working closely with the Chief Coroner on how the system for scrutiny works together. I encourage you to work with local senior coroners and registrars, including to appoint those best placed for the role of medical examiner - and medical examiner officers, to support the system and make best use of medical examiners' time.

Medical examiner training

The Royal College of Pathologists provides medical examiner training. Before taking up post, medical examiners are expected to complete 26 core e-learning modules available here: https://www.e-lfh.org.uk/programmes/medical-examiners

In addition, all medical examiners are expected to attend a one day face to face training session within six months of taking up post. To book a place: https://www.rcpath.org/event/medical-examiner-face-to-face-training-session-1.html

Dates and locations throughout 2019 are as follows:-

11th April	Sciences Hub Cardiff
16th May	Royal College of Pathologists London
20th June	Leeds Beckett University
10th July	Royal College of Pathologists London
11th Sept.	Birmingham (location to be decided)
Mid Oct.	Date/location tbc
14th Nov.	Royal College of Pathologists London

Digital case management system

A digital system is in development to support the end to end management of cases handled within each medical examiner office. Following the government's service standard for digital projects, the project team are using agile delivery techniques to build the new system with a focus on user needs and experience. The system is now in the alpha phase, and in the coming months a growing number of medical examiner offices will be able to help to pilot the system and to submit real data to help test and improve it. I will give you more information about how the system is being rolled out in future notes like this one and on the medical examiner web page that is in development.

Funding for local medical examiner offices

The Department of Health and Social Care (DHSC) is committed to the introduction of the medical examiner system in a way that is cost neutral to the NHS.

During the non-statutory phase of implementation, DHSC, NHS Improvement and NHS England will collectively support acute trusts to manage the financial impact of establishing and running local medical examiner offices. We will be providing further information on reimbursement of costs in the coming weeks. This will include more detail on how costs not covered by the fee generated from Part 5 of the Cremation form will be reimbursed. Additional funds will cover the cost of providing proportional scrutiny for burials and for deaths of children (under 18 years old), where no fees are payable. Additional funding will also be provided to cover cases where the medical examiner undertook scrutiny, but the outcome resulted in coroner investigation.

Please share this note with relevant colleagues in the NHS and for further information or specific enquiries please email nme@nhs.net

With best wishes

Dr Alan Fletcher
National Medical Examiner