MCCD Performance Framework

575,000 deaths per year - 540,000 deaths in England, 35,000 deaths in Wales
500,000 non-coronial deaths requiring an MCCD
250,000 GMC registered Drs

2000 trained MEs

KPI: 5 calendar days from death to registration - changing in April 2024

Outcomes needed for a successful death management journey

Death	Check	Record	Scrutiny	Issue	Investigate	Register	Arrange & settle	Audits
Someone dies in the hospital or in the community, and the relevant people are made aware.	The proposed cause of death is often checked with the medical examiners office and the bereaved	When confident, the attending practitioner writes a paper MCCD form	The medical examiner office will scrutinise the proposed cause of death	The MCCD is then sent to the local registrars and the bereavee knows that they can register a death	A death may be referred to a coroner for further investigation at any time	The bereaved or informant can now register the death at a local registry office	The bereaved or informant can now arrange a funeral and settle the deceased estate	

Policy Outcomes

Provide a better service for the bereaved (TBD)	Improve the quality and accuracy of medical certificates of cause of death (MCCDs)	Improve the quality of cause of death information for public health surveillance	Quicker certification of death and reduces costs (outcome TBD)	Allow for the cause of death to be prepared and scrutinised within 24-48 hours after the death (TBD)	Airytime, anywhere medical examiners can scrutinise a proposed cause of death, provide suggestions and sign off the proposed cause of death	Ensure that the right deaths are referred to a coroner	Rejections of MCCDs by the registrar are reduced (TBD)	Registrars no longer need to understand medical terminology (TBD)	Minimise disruption to registering a death as a service (death management journey) (TBD)	There is a clear, auditable record of the changes made to the proposed cause of death and any advice given	Easier identification of trends and unusual patterns to enable local learning, and changes to practice and procedures	Strengthen safeguards for the public	Malpractice will be easier to detect

User Outcomes

An attending practitioner can easily check their proposed cause of death with the ME's office	An attending practitioner can easily get advice and guidance on a proposed cause of death and how to record it	An attending practitioner can get the right patient information they need easily	At anytime and anywhere, the right attending practitioners (or when appropriate, the medical examiner) can easily record the proposed cause of death	Attending practitioners feel confident in preparing and recording the right cause of death	The right medical examiner can access the right cause of death to be reviewed	Medical examiners and medical examiner officers get the data they need to review a cause of death	A medical examiner can propose changes to the cause of death and the attending practitioner can access and make those changes easily	A medical examiner is confident that the proposed cause of death is accurate and that there has been no malpractice	The representative know that the death has been certified and that they can register a death	Attending practitioners and medical examiners refer the correct cases to the coroner	Coroners get the information they need to make a decision about whether or not an investigation is needed.	Registrars get the information they need to register the death within 5 days following medical examiner sign off	A funeral director gets all the information they need to make the necessary funeral arrangements

Primary User Needs

Information sharing and access	Communication with others / Speed	Information sharing and access / Speed / Accuracy	Trust / Speed / Access / Access to an MCCD in Welsh / Respective my beliefs	Accuracy / Respect for my beliefs / Access to an MCCD in Welsh	Knowing when to act / Trust	Information sharing and access / Knowing when to act	Communication with others / Accuracy	Knowing when to act / Accuracy	Information sharing and access / Request for my beliefs	Communication with others / Receiving help	Accuracy / Speed / Receiving help / Access / Trust		Information sharing and access / Speed	Communication with others / Information sharing and access / Access

Success Indicators

Medical examiner sign off within 2 days

Registration in 5 days

Failure Indicators

Offline update vs digital
Number of MCCDs that are ported but not submitted

Duplicate MCCDs
Repeated Medical Examiner rejections

Registrar challenges / queries
Cause of death sent in too long for the NHS system