Certifying a death 'future state' user journey (April 2024)

Death

Someone has died in hospital or in the community and initial conversation around the cause of death takes place.

Someone dies, the attending practitioner is identified and has initial conversations with medical staff and the representative (forewarn) about the cause of death.

The attending practitioner will contact the medical examiners office to discuss the proposed cause of death and complete an available medical examiner to review the information on the proposed cause of death.

The medical examiner will log in & open a case in the medical examiners system (Medital) and advise B.guidance given to the attending practitioner around the proposed cause of death.

The medical examiner will access patient notes and offer to have conversation around proposed cause of the death is agreed, and there is no need for a coroner's referral. Medical examiner officers can begin to record the proposed cause of death.

Potential risk

Relying on both the medical examiner and attending practitioner to both be available at the same time to discuss the cause of death is a time consuming process with MEO being contacted multiple times without initial discussion.

Potential risk

If Medical Examiners may not have the specialist knowledge to check provide advice & guidance on non-specific CDS. There may be a need for specialist advice/changes given by medical examiner to specialist consultants.

Question

What happens if the medical examiner is not available?

Question

How with they be made aware of any prioritised cases?

Potential risk

Factors details still likely yet to be typed & shared by the attending practitioner and typed again when a new case is created by the medical examiner. Leading to unnecessary delays and errors.

Potential risk

No access to patient details at this point. Medical examiner can't access the patient notes to be opened or for notes to be recorded around a cause of death. Notes are likely to be recorded of system or not at all.

Potential risk

Notes are currently not tracked or linked to the MCCD. Notes around the cause of death may be difficult to track and cause delays in retracing.

Record

The attending practitioner will record the proposed cause of death.

Attending practitioner can access the online form to record the cause of death and complete the form.

Online MCCD

Paper MCCD

The attending practitioner completes the form. Once completed the form is sent to medical examiners office to scrutinise the form.

Attending practitioner accesses Medical Examiner Paper form (English & welsh)

Attending practitioner will scan and upload form to Medical examiners office

Potential risk

Manual workload management & assignment increased the risk of delays, errors and missed referrals.

Potential risk

No case management in MCCD. There is current no way for Medical Examiner to access and manage caseload.

Question

What information is needed for scrutiny?

Question

How will falls necessarily log into the MCCD system? Without this the system regrouped their own MCCD.

Question

How will falls be able to access the all they MCCDs they need to review?

Potential risk

Manual workload management & assignment increased the risk of delays, errors and missed referrals.

Potential risk

Increased volumes of MCCDs to be scrutinised may place significant pressures on the Medical Examiner workforce, leading to increased errors and delays in the scrutiny process.

Potential risk

Currently no way to control Medical Examiner access to sign off on MCCD. **Currently a Medical Examiner can sign off there own MCCD.**

Question

Will all Medical examiner services need to use the Medical examiner system? Or can they use their own? Will there be a need for governance around this?

Question

How will falls or MEOs gather all the relevant patient information?

Question

Is there a need for an offline journey for MEO?

Scrutiny

A medical examiner will review the cause of death & suggest any changes needed.

A Medical examiner or medical examiner officer will review the cause of death, log in and review the completed MCCD.

Medical examiner officers will gather all relevant patient information from medical examiners, calling the informant for any information and recording this in the medical examiner system.

Medical examiner officer will also log in to a the access the mord form separately.

Medical examiner (in some cases the MEO) will escalate the case if more information is required to the regional medical examiner

Medical examiner system

If changes are needed to the MCCD, the medical examiner will contact the informant to make the changes. The MCCD will need to be edited or rewritten and reviewed again.

Where are no issues, the medical examiner signs off the MCCD and the MCCD is sent to the observer version of the MCCD will automatically be issued to the relevant registrar office.

Later on, the Medical Examiner will log in to the MEI system, complete the form and sign off on Scrutiny. The MCCD cannot be accessed at this time.

Reasons Scrutiny Stopped - examplar

Medical Examiner: 48 Medical examiner Officer: 0 Medical Examiner: 0 Other: 10

Potential risk

Increased volumes of MCCDs to be scrutinised may place significant pressures on the Medical Examiner workforce, leading to increased errors and delays in the scrutiny process.

Potential risk

Significant delays due to **separate systems/lack of integration** with the MCCD MEI system leading to increased errors and delays in the scrutiny process.

Question

How will the attending practitioner be made aware of an escalation?

Potential risk

Difficult tracking changes to MCCD. There is no way to see amendments and missed opportunity to inform local learning.

Potential risk

Increased risk of delays and errors. Relying on accessing overreaching a phone conversation before finding time to complete the form can lead to increased mistakes.

Potential risk

Significant delays due to **separate systems/lack of integration** leading to a backlog of MCCDs the medical examiners if there are any errors.

Potential risk

There is currently no process to track or monitor changes to the MCCD.

Question

Will the medical examiner need to be informed of changes the attending practitioner makes amendments?

Potential risk

Unnecessary steps and lack of integration with MCCD/MEI with likely some delays in the scrutiny process.

Potential risk

Currently no way to identify if an MCCD has not been received by the registrar.

Issue

The Medical Certificate Cause of Death is issued to the registrar office.

MCCD sent/notification

The representative will receive a notification (email/phone) that the MCCD is available to review and they may even have been an appointment to register a death.

(Paper) The attending practitioner will scan and send a paper MCCD to the registrar the email

The attending practitioner records the cause of death on the medical certificate and sends to others involved in the patients care.

Potential risk

Manual workload management to provide the representative with a copy of the MCCD. Currently, no functionality for digital MCCD to create paper slip.

Question

Why is the MCCD paper slip still needed for the representative?

Question

Will this cause the Bereavement Office forms about the MCCD being created? What level of involvement do we expect them to have with the GP?

Potential risk

Manual process and **lack of integration and automation** with regular systems when sending on the MCCD.

Potential risk

Significant delays due to **lack of integration and automation** with internal systems such as EMI when updating the patient details.

Notify

Other medical professionals are notified of the death.

Review (All child deaths under 18)

All deaths of children (under 18 years) are reviewed by an independent team.

The attending practitioner will complete the notification to inform the Child Death Review team information sent/within MCCD.

Potential risk

Duplication of effort with CDOC & Medical Examiners, service for deaths under 18.

Question

Is there a clear distinction between CDOC & MEO for all deaths under 18 years.

The CDOC panel will review all events leading up to the death and the cause of death itself.

Question

Will the Medical Examiner Officers have the same level of access to MEI?

Investigate

The coroner may decide to investigate a death.

The attending practitioner refers the case to the coroner, including the MCCD, to determine whether or not an investigation is needed

Local registry receives the completed MCCD from the coroner, and completes a waiting stem if certification is needed. Re-entering data into their systems (PDSS).

Local registry or the representative can call back either to arrange an appointment.

Potential risk

Manual processing increased error rates and delays in the process will likely impact **the resource required to scrutinise the MCCD on time.**

Register

The bereaved or the representative can register the death.

Representative attends the appointment with the local registrar. Discussion around bereavement support and other government services such as 'tell us once'.

Representative can now move on with the funeral proceedings and other bereavement support. Using other government services such as 'tell us once'.

Potential risk

Time spent manually processing the information needed from the MCCD to process the death.

Potential risk

If MCCDs are sent to a single registrar, **there may be a bottleneck per day that will need to be manually rerouted to local registry offices.** This will likely introduce unnecessary delays and errors.

Arrange & settle

The bereaved or the representative can arrange a funeral and settle the deceased estate.