

Registering a death (to-be overview)

A high-level view of the stages, potential channels, outcomes and capabilities we're considering as part of the high-level to-be journey of registering a death.



Stages

The main stages of 'registering a death' as a service.

Blue A stage common to all journeys
White A stage in some journeys

Outcomes

Policy and user outcomes, that align to more detailed user needs.

Blue User need or outcome
Dark Blue Policy outcome

Capabilities

What the service needs to do to support an outcome or need

Yellow Considered in design
White Not considered in design to date

Death

Someone dies in the hospital or in the community, and the relevant people are made aware.

Check

The proposed cause of death is often checked with the medical examiners office and the bereaved

Record

When confident, the attending practitioner writes a paper MCCD form

Scrutiny

The medical examiner office will scrutinise the proposed cause of death

Issue

The MCCD is then sent to the local registrars and the bereave know that they can register a death

Investigate

A death may be referred to a coroner for further investigation at any time

Register

The bereaved or informant can now arrange a funeral and settle the deceased estate

Arrange & settle

The bereaved or informant can now arrange a funeral and settle the deceased estate

Audits

Policy need outcome

Provide a better service for the bereaved (TBD)

Policy need outcome

Improve the quality and accuracy of medical certificates of cause of death (MCCDs)

Policy outcome

Improve the quality of cause of death information for public health surveillance

Policy need outcome

Quicker certification of death and reduces costs (outcome TBD)

Policy outcome

Allow for the cause of death to be proposed and scrutinised within 24-48 hours after the death (TBD)

Policy need outcome

Ensure that the right deaths are referred to a coroner

Policy outcome

Rejections of MCCDs by the registrar are reduced (TBD)

Policy outcome

Minimise disruption to registering a death as a service (death management journey) (TBD)

Policy outcome

There is a clear, auditable record of the changes made to the proposed cause of death and any advice given

Policy outcome

Easier identification of trends and unusual patterns to enable local learning, and changes to practice and procedures

Policy need outcome

Strengthen safeguards for the public
Risk Policy Outcome
Malpractice will be easier to detect

Outcome

An attending practitioner can easily check their proposed cause of death

Outcome

An attending practitioner can easily get advice and guidance on a proposed cause of death and how to record it

Outcome

An attending practitioner can get the right patient information they need easily

Outcome

At anytime and anywhere, the right attending practitioners (or when appropriate, the medical examiner) can easily record the proposed cause of death

Outcome

Attending practitioners feel confident in proposing and recording the right cause of death

Outcome

The right medical examiner can access the right cause of death to be reviewed

Outcome

Medical examiners and medical examiner officers get the data they need to review a cause of death

Outcome

A medical examiner can propose changes to the cause of death and the attending practitioner can access and make those changes easily.

Outcome

A medical examiner is confident that the proposed cause of death is accurate and that there has been no malpractice

Outcome

The representative know that the death has been certified and that they can register a death

Outcome

Attending practitioners and medical examiners refer the correct cases to the coroner

Outcome

Coroners get the information they need to make a decision about whether or not an investigation is needed.

Outcome

Registrars get the information they need to register the death in the within 5 days of the following medical examiner sign off

Outcome

A funeral director gets all the information they need to make the necessary funeral arrangements

Capability

A way for a changes to the proposed cause of death is recorded, stored and tracked for audit purposes

Capability

A way for the relevant medical professionals to access the cause of death information to inform local learning, practice and procedures.

Capability

A way for all information related to one patient to be easily retrievable for audit purposes

Capability

A way for the funeral directors to get the information they need to make the necessary funeral arrangements

Capability

A way for the funeral directors to get any missing information they need from attending practitioners or medical examiners

Capability

A way for bereaved families to learn about the death certification process, what to expect and who's involved

Capability

A way for attending practitioners to check their proposed cause of death with other the relevant professionals

Capability

Ways for anyone recording the proposed cause of death to clearly understand how when to complete a form

Capability

Ways to quickly get the right information about the patient & their medical history to record the proposed cause of death

Capability

Ways for the right practitioner to easily & accurately record the relevant information needed about any type of death (Under/over 28 days, AHME)

Capability

Ways for attending practitioners to have confidence that they've documented an acceptable cause of death accurately for (MEx/ Registrar/ Funeral Directors)

Capability

Ways for MExs and MExOs to be made aware that a proposed cause of death needs to be completed or reviewed

Capability

Ways for MExs and MExOs to securely access or get the information needed to review the proposed cause of death information

Capability

Ways for medical examiners to propose any changes to the recorded cause of death

Capability

Ways for the medical examiner to have confidence that the right attending practitioner has made the correct changes to the proposed cause of death.

Capability

A way to make the representative aware, in way that suits them, that they can now register the death and what to expect next.

Capability

A way for the attending practitioners and medical examiners to have confidence that the correct cases are referred to the coroner

Capability

A way for the registrar to get the data they need to register a death in a timely manner

Capability

A way for a medical examiner or an attending practitioner to be made aware that the proposed cause of death needs to be amended or if it has been rejected

Capability

A way for the funeral directors to get the information they need to make the necessary funeral arrangements

Capability

A way for the funeral directors to get any missing information they need from attending practitioners or medical examiners

Capability

Ways to get advice or information from the relevant professionals about the patient or on the proposed cause of death

Capability

Ways for someone else to record the proposed cause of death if the attending practitioner is unavailable/ e.g. Not working for the next 4 days

Capability

A way for others professionals involved in the patients care to be informed that their patient has died.

Capability

Ways for MExs or MExOs to be aware of all outstanding cases to be scrutinised and which cases to review first.

Capability

Ways for MExs or MExOs to be aware of all outstanding cases to be scrutinised and which cases to review first.

Capability

Ways for to capture data that informs the national health statistics