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Sprint 1 playback

What we learned about the current user experience

The research

Objective

To validate the information we already have about each user group's journey and collect additional insights.

Participants

21 participants across 9 focus groups

- 3 GPs
- 4 MEOs
- 5 MEs and Lead MEs
- 4 hospital doctors doing the under 28 day
- 5 hospital doctors doing the over 28 day

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Main themes

1. Efficiency and time management
2. The "cause of death" is a collaborative decision
3. Faith affects the MCCD process
4. Some MCCD fields are used less often than others
5. Disputes at the registrar's office happen less often

Efficiency and time management is a primary user need

MEs find that a cause of delay is trying to ***get back*** in contact with APs who are not aways available.

"There are delays in referrals from primary care (GPs) to certify the cause of death"

- P15, ME

"GPs are often part time, so we try to get GPs to put someone else down if they won't be available. Or to call us and discuss it before completing the MCCD"

– P9, MEO

"Having a digital version will speed things up if the doctor does not need to come to the office and sign something."

- P14, ME

"When we get given MCCD's by wards they do not have contact details for Dr's and if completed at night we have difficulty in contacting them when amendments are needed."

-P11, MEO

The MCCD is not a priority when AP's are short on time.

"The amount of time in a working day is incredibly limited."

-P20 GP

"The system needs to avoid adding any additional burden to professionals."

- P16 GP

"In times of doctor strikes we [MEOs] have had conversations with Dr's to say it [the MCCD] is not a priority as they are treating the living."

- P11, MEO

It is common for APs to be duplicating notes across multiple channels meaning a lot of time is spent on admin.

We have a very extensive check list of people to notify that includes the GP, other teams, HV, midwives etc
etc
mostly by phone, but some are emails, and some like the CDOP are on line forms (duplication is very annoying!!)

Time

Digital system | Notifying multiple systems | P2 | Pain point

The AP's experience of how long the scrutiny takes varies wildly.

2 hours

P5, an AP in a hospice

2 days

P12, Welsh AP in a hospital

What does this mean for the future service?

Is there a risk that our new design will take longer for the APs to complete than the current service?

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The "cause of death" is discussed before writing the MCCD

For some APs, in hospitals doing over 28 day MCCDs, having a discussion with their ME before they write the MCCD saves time because it prevents needing to re-do it.

4 Discuss & draft	5 Record	6 Scrutiny
Variable	Variable	Variable
The proposed cause of death is identified	The proposed cause of death is recorded	The proposed cause of death is checked for accuracy and malpractice

For under 28 day MCCDs, APs talk to their team as MEs lack neonatal experience.

"Its never 1 person deciding COD, it is always the team."

-P17, under 28

What does this mean for the future service?

Should we capture in the MES the casual conversation between MEs and APs before the MCCD is formally written?

Will there be consequences for APs (e.g. looking like a bad doctor) if an MCCD is sent back to them for changes?

The AP's and the informant's faith affects the MCCD process

To abide by their faith, an AP may abstain from doing a cremation form.

The MCCD for people of certain faiths are prioritised to allow for a quick burial.

Even if we [MEs] have everything certified in time if the registry office isn't open (as it is only open 2 hours each day on the weekend) then there are still delays in registering the death. So need to prioritise the faith deaths.

-P15, ME

Covid-19 easements allowing ME's to complete MCCD's was much appreciated in [city name] too. Our faith community would like the ME to be able to issue MCCD's in future because it made things quicker and easier for them.

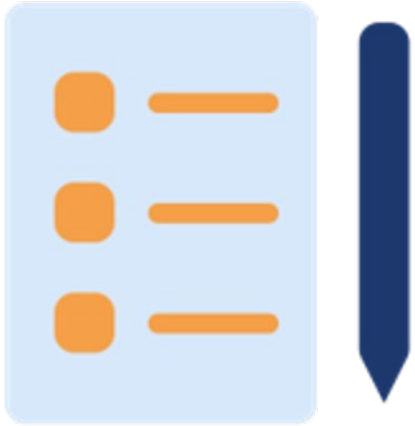
-P15, ME

What does this mean for the future service?

If the cremation form is integrated into the MCCD, does that mean that some APs will abstain from completing MCCDs as a whole?

How would we show prioritisation of certain MCCDs?

Some MCCD fields are used less often than others



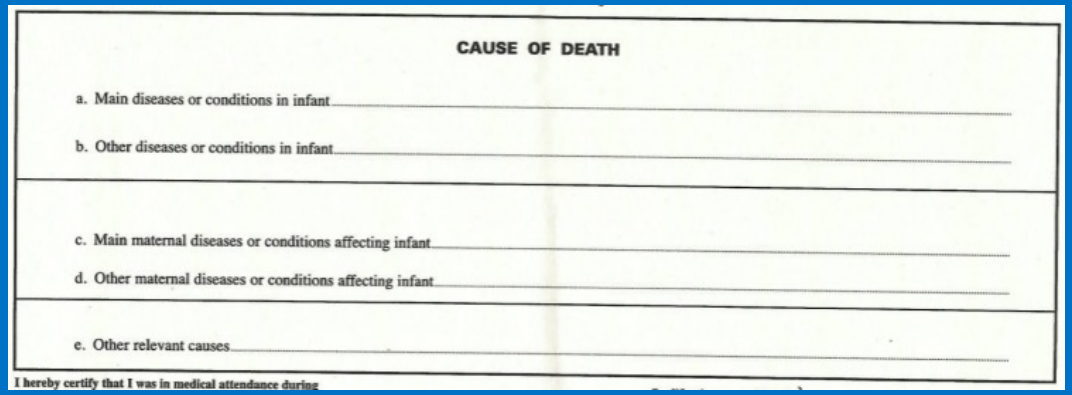
Fields that are rarely used: Box E

"It is not clear what is supposed to be in that other box : "E" anything else"

-P3

"on a P65 Where there are complexities, I don't often complete 'section E' - anything else section"

-P1



CAUSE OF DEATH

a. Main diseases or conditions in infant

b. Other diseases or conditions in infant

c. Main maternal diseases or conditions affecting infant

d. Other maternal diseases or conditions affecting infant

e. Other relevant causes

I hereby certify that I was in medical attendance during

Fields that are rarely used: onset of illness

The interval section is a pain to complete and difficult to figure out.

-P18, ME

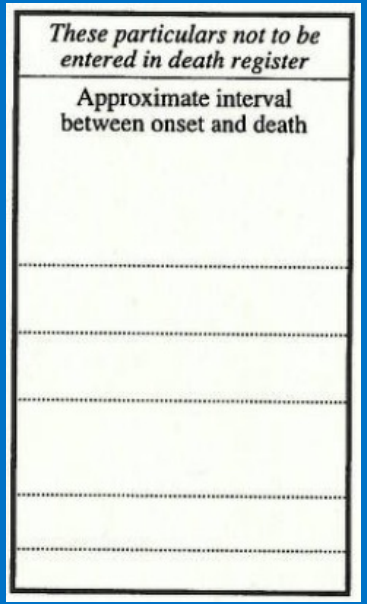
Not many people fill in length of illness as it isn't going to be used on the DC.

-P21, GP

but...

"This is sometimes useful to show timescales for example, a historic road traffic collision with traumatic injuries/ paraplegia, which then led to perhaps a related issue e.g. aspiration pn eumonia due to the historic physical injuries."

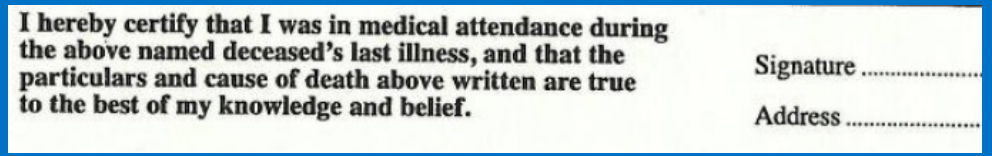
-P9, MEO



If the coroner is asking a doctor to complete an MCCD for a patient they did not attend, then they edit the declaration.

Advice from GRO - to cross out the 'i was in attendance...' part, then just complete the GMC section and date

9



I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature .....

Address .....

What does this mean for the future service?

How do we include all relevant fields without having loads that are optional?

Is the full declaration still relevant? How would we allow those who were not the AP to sign the declaration?

Family members are informed early on of cause of death and our findings suggest disputes at the registrar's office are less frequent since the implemented ME process.

If the family do dispute the cause of death, then it is passed to the coroner before the MCCD is written.

We have had relatives trying to negotiate a cause of death and remove things they do not want on an MCCD. Where a relative refuses to accept the Cause of death offered, we end up with a Coroners Referral.

-P15, ME

If the family don't agree with you would pass it to the coroner as there is little to be gained with arguing with the family.

-P17, under28 AP

All of the user groups we have spoken to have experience speaking to the bereaved about the cause of death.

Speaking to families is done by MEs.
-P12, over28 AP

Sometimes the ME will ask the MEO to ring the family if it's a straight forward death.
-P10, MEO

The bereavement office will have spoken to the family, so they know if we need the cremation form.
-P12, over28 AP

What does this mean for the future service?

How can we do what is best for the bereaved?

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The questions

- Is there a risk that our new design will take longer for the APs to complete than the current service?

- Should we capture in the MES the casual conversation between MEs and APs before the MCCD is formally written?
- Will there be consequences for APs (e.g. looking like a bad doctor) if an MCCD is sent back to them for changes?

- If the cremation form is integrated into the MCCD, does that mean that some APs will abstain from completing MCCDs as a whole?
- How would we show prioritisation of certain MCCDs?

- How do we include all relevant fields without having loads that are optional?
- Is the full declaration still relevant? How would we allow those who were not the AP to sign the declaration?

Any questions?

Carry on the conversation:
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