**National Medical Examiner System roll out to Primary Care Somerset County**

As a result of several high-profile public inquiries, the role of Medical Examiner (ME) was established to provide an independent review of non-coronial deaths.

The aim of the Medical Examiner Service is to:

* Provide bereaved people with an opportunity to give feedback about the care their loved one received, ask questions and raise concerns.
* Enhance safeguards for the public and healthcare providers through improved and consistent review of non-coronial deaths.
* Improve the quality and accuracy of medical certificates of cause of death and, ensure that coronial referrals are appropriate and accurate.
* Support local learning and improvement by identifying matters for clinical governance and related processes.
* Align with initiatives such as Learning from Deaths

The role of the Medical Examiner (ME) is to review non-coronial deaths in order to:

* Agree the proposed cause of death with the attending doctor and ensure the accuracy of the medical certificate of cause of death (MCCD)
* Discuss the cause of death with bereaved people or informant in lay terms and establish if they have feedback they would like to give about the care, that could have impacted or led to the death. These conversations can be allocated to the Medical Examiner Officer (MEO) at the Lead ME’s discretion.
* A medical advice source to the local HM Coroner
* Highlight a selection of cases where concern has been raised by either family, healthcare staff or the ME, for further review under local mortality arrangements and other clinical governance procedures.

In Somerset, the Medical Examiner Service was set up in 2020 and initially reviewed deaths in the acute hospitals. The reviews are carried out by a team of senior doctors, including hospital specialists and GPs. The MEs are supported by Medical Examiner Officers (MEO) who carry out a lot of the background work, including liaising with families. In 2021 ME review was extended to include deaths occurring in mental health inpatient units and community hospitals.

Once services were established in acute settings across England, NHS England & NHS Improvement asked that the ME Services work towards extending the service out to include deaths which occur in their wider community, but not including those deaths that are dealt with directly by HM Coroner eg sudden unexplained deaths. NHS England has provided enough funding to each Trust to ensure there are enough ME’s and MEO’s to deal with the number of predicted deaths in our community, as well as the acute deaths.

In April 2024, it is expected to become a legal requirement for all non-coronial deaths to be reviewed by an ME, including those occurring in the community and the Somerset Medical Examiner Service has been gearing up to review these additional cases. Following liaison with Somerset LMC, HM Coroner, and various other stakeholders, we began the process of developing a suitable referral

pathway along with a governance structure in preparation for the first phase of the roll out. An early adopter of the process was identified as Mendip PCN and since May 2022, all 5 practices within the PCN have been using the pathways developed. Since then, significant work has gone into ensuring processes run smoothly using the feedback of those practices. So far things have worked well, and we have been slowly onboarding willing practices since then.

A simple referral form has been embedded into the EMIS templates, with the ability to pre-populate patient demographics. Anyone within the practice can complete the referral form and email it to our generic ME inbox, however, if it is not the certifying GP completing it, the person who is **must** have spoken to the GP regards the cause of death being proposed **before** it is sent. All referrals are dealt with by the team based at the Musgrove Park site. This may change going forward, depending on staffing structure and volume of referrals. Our turnaround times for cases referred are within the same day, unless the referral is made late in the day. We cannot guarantee cases referred after 3.30pm will be reviewed the same day however we will always endeavour to get them processed if we know a GP is not going to be available due to annual leave etc.

After discussion with the Senior Coroner for Somerset Mrs Samantha Marsh, it is expected that any death which has a clear cause but falls under the coroner’s jurisdiction, should be reviewed by a ME prior to the referral being made. This ensures the accuracy of the cause of death whether it is a Part A 100 or an inquest. In those cases where a cause of death is reportable to HMC, we are encouraging GPs to complete the Electronic Death Reporting Form (EDRF) and send this to SMES **instead** of the usual referral form. This cuts down the amount of paperwork that the GP must do. The ME can review the case and once the cause of death is agreed, SMES will forward the EDRF to HMC Office.

As previous communications stated, the expectation was originally to have a complete roll out nationally by August 2022, which was then extended to April 2023. However, that timeline has been extended again this year after the legislation was delayed. The expectation is that it will now become statutory for all deaths to be referred via an ME Service prior to certification by April 2024. The further extension of the statutory deadline has given us the opportunity to be able to introduce the service at a slower pace to ensure we are developing processes that work for all.

All Clinical Directors of PCNs within each Locality were contacted at the beginning of the year in the hope that the group of PCN under each Locality lead would on board at the same time, however this hasn’t happened for many reasons. As we are nearing the beginning of the statutory phase in April 2024, we would like to encourage everyone to come onboard as soon as possible to enable everyone to get used to the processes before it becomes mandatory. We have learned that practices who have started to use SMES already are not only providing the valuable feedback we need to smooth out the referral process, but it also helps us as a new service look at our internal processes to ensure we provide the most effective, efficient service to the bereaved people of Somerset.

If your practice would like further information about SMES, please email Helen Waldon (formerly Gilliland, Implementation Lead for Somerset Medical Examiner Service - Helen.Waldon@somersetft.nhs.uk