Death Certification Reforms: New Duty on Local Authorities

This document provides an overview of the death certification reforms and an update on work to prepare for implementation of these reforms from April 2013. It has been prepared for distribution to Local Authorities and Directors of Public Health. Additional information is provided in supporting notes at the end of the document.

The Department of Health is working with a wide range of organisations and groups to reform the process of death certification. These reforms, enabled by the Coroners and Justice Act 2009, will introduce a unified system of scrutiny by independent medical examiners of all deaths in England and Wales that do not require investigation by a coroner (i.e. similar for burials and cremations).[1] The reforms, which are part of the Government's response to the Shipman Inquiry, will strengthen safeguards for the public, make the process of death certification simpler and more open for the bereaved and improve the quality of mortality data.[2]

The Government is proposing to fund scrutiny by medical examiners on a cost-recovery basis through a statutory fee chargeable for all deaths that are not investigated by a coroner.[3] This statutory fee, collected locally, would replace and make more effective use of the existing fee charged by doctors for the completion of cremation forms which will be removed by the new process.[4] (These fees, which are around £160 for each cremation where applicable, amount to £46m per year across England and Wales).

The Coroners and Justice Act 2009 put a duty on Primary Care Trusts to appoint medical examiners for their area, establish a local medical examiners service, make arrangements to collect the proposed statutory fee and ensure achievement of required service standards and levels of performance. The new architecture of the NHS announced in October 2010 led to a ministerial decision to transfer these responsibilities to upper-tier local authorities through a provision in the Health and Social Care Bill.[5] This decision was based on the need to maintain local control and independence and the belief that these essential criteria could not be met in any other way.

Local authorities will be able to use service models that are appropriate for their area; these models may include direct provision of a standalone function, commissioning the service from a healthcare provider that can assure independence, integration with existing related services and collaboration with neighbouring authorities to provide a combined service.

All medical examiners will be required to have at least 5 years post-qualification experience, a current licence to practice and relevant expertise based on the completion of prescribed e-Learning and face-to-face training.[6] In most areas, medical examiners will need to be supported by officers or people providing an officer function.[7]

The workload is considerable. Current estimates suggest that up to 300 full-time equivalent medical examiners will be needed across England and Wales to scrutinise and confirm around 390,000 deaths per year and provide advice to doctors on a further 40,000 deaths that are subsequently investigated by a coroner. It is anticipated that most medical examiners will be appointed on a part-time basis (for at least 8 hours a week) so that they can maintain their licence to practice through their other clinical duties and keep up to date more generally with clinical developments. On this basis, there may be a headcount of about 1,000 medical examiners across England and Wales.[8]

The new process has been tested and refined in death certification pilots in Sheffield, Gloucestershire, Powys, Mid-Essex, Brighton and Hove, Leicester and Inner North London.[9] The pilots have demonstrated that the new process can be introduced successfully and is able to achieve the aims of the reforms. Feedback from the pilots has been used to draft regulations and will be used in guidance to recommend ways that local authorities can address transitional issues in implementing the new process.

The pilot work suggests that an area with 5,000 deaths per year would probably require a team of 7 part-time medical examiners (providing 2-3 full-time equivalent posts) supported by ~3 full-time equivalent medical examiner's officers (or people providing this function). The cost of providing (or commissioning) the services needed in each area will be recovered from the proposed statutory fee and work is currently being carried out - with input from local authority representatives - to ensure that the level of fee set takes account of the costs of alternative service models and other local considerations.[10]

The death certification regulations are now expected to be published for consultation in October 2011 and, subject to the Bill's Parliamentary passage, will be laid in Parliament in May / June 2012 with a commencement date of April 2013. The extended period between introduction and commencement is intended to provide time for local authorities to establish a local medical examiner's service for their area. The Department of Health will assist local authorities by providing a suggested outline of preparatory activities[11], and access to national and regional support.

The death certification programme is working with a wide range of stakeholders and is co-ordinated by a DH-led Steering Group that includes clinicians, coroners, NHS managers, public health as well as representatives from the funeral industry, bereavement services, local government and the relevant other government departments.

The Office for National Statistics is monitoring the impact of the new arrangements on official mortality statistics. Data from the pilot projects are being examined to estimate the likely size and nature of any systematic changes in frequency of specific causes of death due to the introduction of medical examiners. This work will continue during implementation to ensure that any artefactual changes in cause of death statistics are recognised as such.

Overall the process is expected to improve the quality and reliability of death statistics and their value for public health and other purposes.

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Supporting Notes

The following notes are referenced in the summary provided above. For further details, please see general information at ***www.dh.gov.uk/deathcertification*** and, in particular, the Death Certification Programme's responses to feedback from local registration services and to FAQs from coroner's officers and staff. These responses will be published respectively at ***www.lrsa.org.uk*** and ***www.coronersofficer.org.uk*** and, if necessary, can be requested by email from deathcertification@dh.gsi.gov.uk.

1 Deaths that are "investigated" are those where a coroner's post-mortem examination is carried out and / or inquest is held because a coroner has reason to suspect that the deceased died a violent or unnatural death, the cause of death is unknown, or the deceased died while in custody or otherwise in state detention. Approximately 25% of deaths in England and Wales currently require investigation. A further 25% of deaths are currently notified to a coroner and require initial assessment including appropriate enquiries and consideration but do not require post-mortem examination or inquest.

2 It is generally accepted that the causes of death certified by a significant proportion of doctors are not sufficiently precise for epidemiological purposes and that many medical certificates of cause of death (MCCDs) are not completed fully and legibly. This view is based on published audits of medical certificates of causes of death (MCCDs) or of their counterfoils and feedback from local registration services and it is supported by analyses carried out on data collected by the areas piloting the death certification reforms. Whilst improved training for doctors in certification of death has some impact on the quality of causes of deaths and certificates, it is not sufficient and is too far removed from the specifics of each case to achieve the aims of the reforms.

3 The Death Certification Programme acknowledges that concerns have been raised about the requirement for the proposed statutory fee. These concerns, outlined below, will be kept under review. However, at the current time, ministers have decided that the fee needs to remain as the preferred option for funding the new service; the key reasons for this decision are that it replaces (and extends) an existing fee that is largely ineffective and that in the current economic climate there is unlikely to be any viable alternative.

Concern	**Response / Action**
Risk that a single standard fee will not enable cost-recovery in areas with different requirements and cost-structures.	Consideration of alternative options for structuring the fee to allow some local flexibility and / or recovery over a multiple year period.
Reputational risk to local authorities – particularly if the fee needs to include a variable local element.	Further discussion of concern and clear communication of purpose and benefits of reforms.
Local collection of the fee will create procedural difficulties and incur costs.	Alternative options identified and assessed for use by local authorities in making arrangements and estimating costs appropriate for their service model.
It is unclear what action needs to be taken if the fee is not paid.	Further discussion of concern – particularly in relation to timing / arrangements for payment of fee where it is expected to be covered by a Funeral Grant from the Social Fund.

Supporting notes continued

4 The reforms to the process of death certification will include removal of cremation forms 4, 5 and 10. Procedures to ensure that crematoria are advised about the removal of any implants are currently being clarified and are currently expected to be included in guidance on the release of the deceased.

5 The amendment to the Coroners and Justice Act 2009 is stated in clause 50 of the Health and Social Care Bill (as at 19th August 2011).

6 The Royal College of Pathologists has been nominated by the Academy of Medical Royal Colleges to act as 'lead college' for eLearning and face-to-face training of medical examiners; however, medical examiners do not need to be pathologists and are likely to come from a wide range of speciality areas. The eLearning has been developed in collaboration with eLearning for Healthcare and current materials are available at www.e-lfh.org.uk/medical_examiner for use by doctors and others that are interested in the role of medical examiner or role / function of the medical examiner's officer; introductory materials may also be of interest to others who want to learn more about the new process. Access to the materials requires enrolment.

7 The Death Certification Programme has worked with the Bereavement Services Association (BSA), Coroner's Officers Association (COA) and Association of Anatomical Pathology Technicians (AAPT) to prepare an Outline Specification for the Provision of the Medical Examiner's Officer Function. This outline specification will be provided to local authorities as guidance for the selection / recruitment of medical examiner's officers or people in a related service that provide this function.

8 It is anticipated that each area / service would have a lead medical examiner and that one lead examiner in each region would represent colleagues in discussions at a national level. Local and regional leads would probably also need to have time arrange peer audits and other quality assurance activities and to ensure appropriate links with teams responsible for public health surveillance and local clinical governance.

9 The pilots in Sheffield, Gloucestershire, Powys, Mid-Essex and Brighton and Hove started at various dates between 2008 and 2010 and have been and continue to be developed incrementally to cover as much of the new process as is possible alongside existing legislation. The pilots at the Royal London and Royal Free hospitals in Inner North London and at the Royal Leicester Infirmary ran for a short period to test the provision of an out-of-hours service to meet requirements for urgent certification.

10 The Death Certification Programme is working on service models and associated costs and issues with a senior manager from Hampshire County Council nominated by the Local Government Group and with senior managers from local registration services in Cambridgeshire, Gloucestershire, Hampshire, Kent, Lancashire, Southwark, Lincolnshire, Oxfordshire and Solihull that represent their regions on the Local Registration Services National Panel.

11 The first preparatory activity is for each local authority to nominate a director or senior manager who will lead planning and preparation for the service and who may be the Accountable Officer for the service once it has been established. It would be helpful if local authority chief executive officers could identify a lead contact for their area by December 2011 so that the Death Certification Programme can brief them following the public consultation and ensure they are able to make a rapid start to planning and preparation once the regulations have been introduced. It would be helpful if the lead person has working knowledge of and / or close links with the local authority's registration and coroner services or public health function.