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CORPORATE AND COMMUNITIES OVERVIEW AND SCRUTINY PANEL 25 JULY 2023

UPDATE REPORT: REGISTRATION OF DEATHS WITHIN FIVE DAYS (AND OUT OF HOURS REGISTRATION)

Summary

1. The Cabinet Member with Responsibility for Communities, the Assistant Director of Communities and the Head of Service for Registration, Coroners and Resettlement have been invited to the meeting to update the Panel on the position with the registration of deaths within the statutory deadline and the process for registering deaths out of hours

Background

2. It is a statutory requirement that all deaths, excluding those referred to the coroner, are registered within five days of the date of death. Performance in this area has been in decline for several years but significantly so in the last year or so, and processes have changed because of the COVID-19 pandemic. In November 2021 the Panel requested further information (additional to the regular reports received on performance and in-year budget monitoring) to understand the reason for declining performance and what mitigating action was being taken. In addition, the Panel also asked for information in relation to the process of registering deaths outside of normal working hours.

Registration of Deaths – Process and Performance Overview

3. The statutory requirement to register deaths within five days is contained in the Births and Deaths Registration Act 1953.

4. For the Registration Service (Registrar) to register a death they must receive the necessary documentation (medical certificate cause of death) before the appointment with the informant. Prior to 2020, the medical certificate cause of death (MCCD) was completed by the doctor who saw the deceased during their last illness and within the previous 14 days. Provided those two elements were met and the cause of death was acceptable for registration purposes, the GP would then advise the family to collect the MCCD from the surgery (or bereavement office at the hospital). The informant (usually the family) would have made an appointment to register the death and arrive with the MCCD and any other required documentation to complete the registration process.

5. In late 2019, a pilot scheme began introducing Medical Examiners on the back of the inquiry into Dr Harold Shipman. Medical Examiners are senior medical doctors who are contracted for several sessions per week, outside of their usual clinical duties, to provide independent scrutiny of causes of death. They are also trained in the legal and clinical elements of death certification processes. The purpose of their role is to:
    - Provide greater safeguards for the public by ensuring independent scrutiny of all non-coronial deaths
    - ensure the appropriate referral of deaths to the Coroner
    - provide a better service for the bereaved and an opportunity for them to raise concerns to a doctor not involved with the care of the deceased
    - improve the quality of death certification
    - improve the quality of mortality data

6. During the COVID-19 pandemic the care of patients in the hospitals was prioritised. During this time, new laws were introduced as part of the Coronavirus Act and this enabled registration of deaths to be completed by telephone. Additional relaxation of rules included the ability for doctors to email the MCCD to Registration Services, therefore not requiring families to attend hospitals or GP surgeries during times of restricted movement. Registration Services were able to demonstrate an improved performance during this time, whilst still dependent on the timely submission of the form from the doctor.

7. Following the COVID-19 pandemic, services began to return to business as usual although some of the elements in the Coronavirus Act remained, such as the electronic transmission of the MCCD to the Registration Service. Medical Examiners returned to scrutinising hospital deaths and during 2022 began rolling out the pilot to include deaths in the community as well. Post pandemic there has also been increased pressure on health services and availability of doctors, and this has provided a significant challenge to the death registration process.

8. In summary, the following factors have all contributed to the delays the Registration Service is now experiencing in completing death registrations within the statutory timeframe:
    - the rolling out of the Medical Examiner Service across the county
    - less availability of doctors
    - the settling in of a new process.

Action Taken to Manage Impact on Performance

9. The Registration Service continues to take action to try to improve performance and minimise the impact to the public. These actions include:
    - Extra appointment availability, especially during periods of high demand (e.g. winter)
    - Chasing paperwork to meet the appointments booked
    - Issuing communications to the surgeries reminding them of processes and the expectation on doctors
    - Meeting with the Coroner Service and medical examiners to share information, data and improve process

- Feeding back through the General Register Office and the National Panel for Registration that the impact of the medical examiner service means that the statutory requirement to register deaths in five days is unachievable.

10. As outlined in paragraph 8, the main factors contributing to the delays are beyond the control of the Registration Service. Whilst the Service takes action to influence change, the impact on performance will be limited and it is expected that the Service will continue to struggle to meet the statutory timescale expectations.

Registration of Deaths – Out of Hours

11. This Service receives a small number of requests to register a death out of normal working hours for those communities that require the service to enable them to meet their faith needs. On average, 8 are received per year which are requested out of hours which equates to 0.12% of the total number of deaths the service registered for year 2022/23.

12. On Monday to Friday, the Service is available using the normal number between 9am and 5pm. Outside these hours, an answerphone message will provide the emergency number that can be called which is monitored between 8am and 9am and 5pm until 10pm each weekday. Overnight, a message can be left which is responded to from 8am the following day.

13. During weekends and bank holidays, the Service is available to be contacted between 8am and 10pm on the emergency number. Outside of these hours, the call will transfer to the answerphone which is responded to when phone is switched back on the following day.

14. When a call is received, the Registrar on duty will check that all the paperwork has been submitted from the doctor ready to be used for the registration. The Registrar will then contact the family and arrange a time and location for the registration and the meet the family to complete the death registration process and issue the paperwork to enable the burial to take place. This information has been provided to the hospitals, GPs and faith groups.

Purpose of the Meeting

15. The Panel is asked to consider and comment on the detail in report, and:
    - Agree any comments to highlight to the Cabinet Member
    - determine whether any further information or scrutiny on this performance indicator is required
    - Consider whether to continue to monitor this area through the Panels quarterly performance and in-year budget monitoring reports.

Contact Points

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Background Papers

In the opinion of the proper officer (in this case the Assistant Director for Legal and Governance) the following are background papers relating to the subject matter of this report:

- Agenda and Minutes of the Corporate and Communities Overview and Scrutiny Panel on 28 March 2023, 1 November, 21 September, 13 July and 17 March 2022, and 8 November 2021

All agendas and minutes are available on the Council's website here.