**Practical arrangements for sharing records of deceased patients for medical examiner scrutiny:
GP and Community provider electronic patient record systems**

*This document is provided to support medical examiner offices making arrangements with GP practices to share in accessing records of deceased patients from GP practices, and summarises practical options. It will be updated periodically when new options are identified.*

**Context**

The National Medical Examiner (NME) team made a submission to the Confidentiality Advisory Group to put beyond doubt the legal basis for health organisations to share patient records for medical examiner scrutiny. However, this addresses the legal basis rather than practicalities.

The range of patient record systems in operation across the country presents a number of challenges for arranging access to patient records, and recognising this, we have avoided prescribing a top-down or a one-size-fits-all approach. This will enable each locality to identify the approach which best suits local circumstances. However, we recognise that more options will be helpful.

The NME team and the Department of Health and Social Care (DHSC) are currently working with NHS Digital and NHSX on access for medical examiners to GP electronic records and to identify options which local networks will be able to access should they choose.

In the meantime, there are a number of options and digital applications which enable GP practices to share patient records with medical examiner offices.

The vast majority[[1]](#footnote-2) of GP practices and non-acute NHS trusts use electronic patient record (EPR) systems such as EMIS and SystmOne. These can be used efficiently to share the records of deceased patients with medical examiner offices for the purpose of scrutiny.

**EMIS**

* Individual GP practices (early adopter sites) may grant medical examiners and medical examiner officers access to patient records via NHS Smartcards. Once accessed is granted, NHS numbers can be used to gain access to deceased patients records. This method may become more difficult to sustain when higher numbers of practices begin working with the medical examiner office.
* GP practices can generate a standardised patient summary document from EMIS. These can be tailored to include for example, a summary history, the last 5 consultations, active major problems, current medications and allergies. The GP practice will need to identify a member of staff to generate such summary documents to be sent electronically via secure email to medical examiners. In complex cases where more information is required for scrutiny, the medical examiner or medical examiner officer can request this.

**SystmOne**

* Individual GP practices (early adopter sites) may grant medical examiners and medical examiner officers access to patient records via NHS Smartcards. Once accessed is granted, NHS numbers can be used to gain access to patient records. This method may become more difficult to sustain when higher numbers of practices begin working with the medical examiner office.
* GP practices can generate a standardised patient summary document from SystmOne. These can be tailored to include for example, a summary history, the last 5 consultations, active major problems, current medications and allergies. The GP practice will need to identify a member of staff to generate such summary documents to be sent electronically via secure email to medical examiners. In complex cases where more information is required for scrutiny, this could be requested.
* It should be noted that once a patient record is marked “Deceased” it may not be possible to share the record. This issue can be avoided by delaying marking the record as deceased until the medical examiner has completed scrutiny and the GP completes the MCCD. Experience suggests this normally only delays marking the records “deceased” for around 24 hours.

Some offices report a workaround for this issue - by unticking the “deducted” box once in the deceased’s record, the records can be shared and accessed.

**Shared Care Record**

* Each Integrated Care System (ICS) is leading work on a Shared Care Record for their area.
* While there is a national standard for Shared Care Records, there are different approaches to meeting it in each ICS, reflecting the systems used locally. Some medical examiners report that some versions of the Shared Care Records do not provide all the information they require, while others are able to access all the information they need. This may reflect local variation. Also the levels of maturity of the Shared Care Record in each system varies, as do the number of healthcare providers which are connected to the local Shared Care Record.

**Summary Care Record**

* This is an EPR which contains basic information about a patient, outlining their interactions with health care providers, conditions, medications and allergies.
* The Summary Care Record does not contain any details of consultations, results or correspondence. It could be used as an adjunct and to contextualise a partial medical record, but on its own would be insufficient for medical examiner scrutiny.

**GP Connect**

* [GP Connect](https://digital.nhs.uk/services/gp-connect) is used to support Direct Care. NHSE and DHSC are working with NHS Digital to achieve a clear understanding that medical examiners can use GP Connect. Other work being taken forward includes ensuring GP Connect can continue to access patient details after their record is marked deceased. Medical examiners would use trust systems to access GP Connect, and not all are yet able to interface with the patient record. Regional medical examiners have been provided with NHS Digital’s assessment of trusts’ readiness to use GP Connect.

**GP IT systems – patient record summaries**

* GPs’ electronic patient record systems can provide a means to share recent entries with medical examiner offices, without granting access to the record system itself. Where access to GP IT systems is proving difficult to achieve in required timescales, these may provide adequate information for medical examiners in most cases where a death occurs in the community. It is particularly helpful that these do not entail significant work and can be completed by admin staff at the GP practice.

***EMIS****EMIS allows GP practice staff to download and save a PDF summary of recent entries in the patient record, with just one click. One medical examiner office has agreed with GP practices in their area that this can be used as part of the referral process. When the GP practice staff notify the medical examiner office of a death, they send the summary to the medical examiner office by secure email.*

***SystmOne****SystmOne can also provide a summary of recent entries. This function defaults to the last 6 consultations, though the date range can be amended to include more. The output is a PDF document which can be attached to secure emails by GP practice admin staff as part of the process of referring a death to the medical examiner office.*

* In most cases, we understand the summaries generated by EMIS or SystmOne are likely to be sufficient for the medical examiner, especially in the case of palliated or expected deaths in the community. In the minority of cases where the medical examiner decides they need further information, they can search their own organisation’s patient records as these may contain further relevant details if the patient was treated there, and/or ask the GP practice to provide more detail.

**Informal notification of death (NEMs)**

* This is a death notification system which works from the NHS Spine and could feed directly to medical examiner offices alerting them of deaths that have occurred in their area.
* NHS Digital are in the process of making this application available to all medical examiner offices.

**National Electronic Referral System (e-RS)**

* This is a national e-referral system which many GPs already use to make clinical referrals and is supported by NHS Digital. GP practices can use this system to alert their medical examiner office of a death.
* This system is being used successfully by a number of GP practices and medical examiner offices across England. Please contact your [regional medical examiner](https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/#national-and-regional-contacts) for further information.

**Death Documentation templates**

* Some primary care networks use software provided by CCGs to support the completion of death documentation and cremation forms. Templates are created within SystmOne and EMIS to enable auto-population of documents (not the MCCD).
* Minor adaptations of such Death Documentation templates could be used to create a GP referral to the medical examiner office.

Please contact your [regional medical examiner](https://www.england.nhs.uk/establishing-medical-examiner-system-nhs/#national-and-regional-contacts) for further information about use of Death Documentation templates within your local area.

**Community NHS trusts**

* Smartcards often provide an option for access to records in community trusts. Medical examiner officers will often have a small number of community trusts in their area (e.g. 4 or 5) so it is manageable to arrange access on medical examiner and medical examiner officer smartcards.

**Hospices and Care homes**

* Many of these providers use EMIS and SYSTMOne so solutions that are applied for GP practices may be of assistance in work with hospices and care homes.

**Case Studies**

**East Kent Hospitals University Foundation Trust**

All GP Surgeries and Hospices use EMIS. The medical examiner office purchased licences to enable medical examiners and officers to have read-only access to EMIS records of deceased patients using a standard web browser. As many GP practices were hesitant about the process, the medical examiner office set up one data sharing agreement with the CCG.[[2]](#footnote-3)

When a GP practice signs up with the medical examiner office, they sign the data sharing agreement and release their EMIS code giving medical examiners and officers permission to review their data using a web browser.

**Following a death:**

An administrator at the GP surgery alerts the medical examiner office of a death with basic details, and the name of the GP who will provide the circumstances, medical history and preliminary view of the cause of death.

When the GP provides this, medical examiners use web browsers to view the record. The advantage of electronic access is the ability to view attachments to the patient record which may not be visible in a PDF document emailed by the GP practice. Not uncommonly, patients have had minimal contact with a GP, but may have been seen by out-of-hours or community teams, whose reports are visible to medical examiners when accessed using a web browser.

Other advantages of having access using EMIS are:

* **Identifying a Qualified Attending Practitioner to complete the MCCD**: where the patient has been cared for by a hospice as well as primary care, medical examiners and officers can view both sets of records. Often the GP will have not seen them in the 28 days before death, but hospice doctors have and it is possible to identify a doctors who meets the attending/seen requirements to complete the MCCD.
* **Reducing unnecessary coroner notifications, especially of deaths in the Emergency Department in ED**. In the past, because minimal patient information was available to clinical teams, many deaths were notified to the coroner. The medical examiner office is able to access their GP records and locate information to supports possible diagnoses and the completion of an MCCD.

**Ashford and St Peters Hospitals Foundation Trust**

Ashford and St Peters Hospitals Foundation Trust has made innovative use of existing NHS platforms to meet local expectations and challenges

**Reporting a death – Primary care**

Experienced clinicians were regularly using the [eRS system](https://digital.nhs.uk/services/e-referral-service) to communicate patient referrals between GPs and the acute trust. Ashford & St Peter’s explored adapting this for the medical examiner service.

The adapted eRS service provides a one click system when a GP attends a death in the community. It provides the option of either constructing an MCCD immediately or discussing with the Medical Examiner office first. The one button press creates a referral which is pre-populated by EMIS and then programmed to attach the last 6 months of GP records to the data packet. The GP Practice staff scan the MCCD, and the system attaches this to the records and sends all to the ME office – via the eRS, immediately closing the record on the spine.

The system requires smartcard access for all users and provides an option to select the relevant GP practice (not always the one that is closest to where the patient lives). Once the referral is complete it is then logged into Ashford & St Peter’s database and allocated to an ME for scrutiny. Once this is complete and the next of kin details are input then its all forwarded to the Registry office.

**Summary**

There is more detailed [guidance](https://future.nhs.uk/MedicalExaminerResources/view?objectId=141472773) available for replication of this service if it is considered a suitable fit. The system has been a great success for Ashford and St Peters and has avoided the need for any individual data sharing agreements or direct EMIS access for ME’s. The eRS process permits rapid responses and there have been no delays in a patients deduction from the Spine either.

**Liverpool University Hospitals NHS Foundation Trust – accessing GP electronic patient records using EMIS referral system**

**Context**

All GP Surgeries and Hospices in the area covered by the Liverpool medical examiner office use EMIS.

**Process**

The GP Practice is informed of a death of a patient in the community. The GP admin team collect and record the Next of Kin contact details in the patient record. At the same time the GP admin team inform the family of the deceased that the Medical Examiner Office will contact them, reiterating that the process is new but routine. Once this is complete, the GP completes the death notification summary in EMIS web (called national exemplar). The contents of the form are similar to that of the coroners referral. This digital form is designed to automatically populate patients demographics and last few months (in our example 3-6 months) of consultation in to the form. After this, the GP completes the MCCD, saves the death notification summary, and informs the admin team.

The admin team download the EMIS form to a secure drive identifiable by EMIS patient number. EMIS web auto-populates the last 3 months documents to the saved file, and the GP admin team add the scanned MCCD to the folder. At this stage the MCCD is not signed.

The GP admin team compress the folder as a zip file, and then send this to the medical examiner office by secure email. Changes are only made if there are amendments required to the MCCD.

This completes the ‘referral’ to the medical examiner office and they are then able to contact the families and complete the scrutiny.

1. *According to the article at the link, EMIS was at 56% and SystmOne at 34% in 2016.* [*https://bmjopen.bmj.com/content/bmjopen/8/2/e020738.full.pdf*](https://bmjopen.bmj.com/content/bmjopen/8/2/e020738.full.pdf) [↑](#footnote-ref-2)
2. NHS England’s Information Governance team created processes and templates for medical examiners with the intention of avoiding the need for individual data sharing agreements between providers, or for the medical examiner office to complete a local Data Protection Impact Assessment (DPIA).

NHS England and NHS Improvement, on behalf of NHS Trusts and NHS foundation trusts, submitted an application under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2002 (‘section 251 support’) to process confidential information without consent. The Secretary of State for Health and Social Care, having considered the advice from the Confidentiality Advisory Group, supported the application which means that confidential patient information can be shared with medical examiners by health and care organisations for the purpose of the medical examiner programme. Details of the approved application (ref: 21/CAG/0032) can be found on the [Health Research Authority's website](https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/confidentiality-advisory-group-registers/).

Trusts which comply with the standards in the Data Security and Protection Toolkit can use the [organisation assurance checklist](https://future.nhs.uk/MedicalExaminerResources/view?objectId=26079024) and the [data sharing statement](https://future.nhs.uk/MedicalExaminerResources/view?objectId=26078960) to confirm to other healthcare providers the basis for sharing the records of deceased patients for the purpose of medical examiners’ independent scrutiny.  However, it is for the trust hosting the medical examiner office, as Controller of the data being processed by the medical examiner office, to decide if they need to complete a DPIA to cover sharing the records of living individuals, namely the next of kin’s contact details.  [ICO guidance](https://ico.org.uk/for-organisations/guide-to-data-protection/guide-to-the-general-data-protection-regulation-gdpr/data-protection-impact-assessments-dpias/when-do-we-need-to-do-a-dpia/) explains that Controllers must complete a DPIA where a type of processing is likely to result in a high risk to the rights and freedoms of individuals. [↑](#footnote-ref-3)