Contents

Foreword 4
Recommendations for 2016–2017 5
About the Death Certification Review Service 6
The review process 8
Our findings 9
Case type overview 9
Standard Level 1 and Level 2 reviews 11
Medical reviewer for cause reviews 12
Interested person reviews 12
Advance registration requests 14
Registrar referrals 15
MCCDs not in order 15
Deaths outwith Scotland 20
Breached cases 20
Training and information function 22
Complaints, concerns, comments, compliments 23
Stakeholder reflections 24
Adverse events and lessons learned 25
Foreword

The Death Certification Review Service is responsible for delivering a national system of proportionate, independent scrutiny of those deaths in Scotland not reported to the Procurator Fiscal – the first system of its kind in the UK. As the senior medical reviewer, I lead on this work for Scotland. Through collaborative working with partner organisations National Records of Scotland, NHS 24, NHS National Services Scotland and NHS Education for Scotland, and influence from wider stakeholder including public partners, we are seeing the death certification system in a way we haven’t before. This report marks the end of the first full year of the service’s work in ensuring improved accuracy and quality of completion of Medical Certificates of Cause of Death (MCCDs).

This report is a statutory requirement.

We found a high proportion (46.4%) of MCCDs reviewed to be not in order. Of those not in order, 89% (41% of all those reviewed) had minor errors requiring an email amendment and 11% (5% of all those reviewed) had major errors requiring a replacement MCCD. During the first year of operation, our focus has been on improving the quality and accuracy of MCCDs through education, both during one to one educationally-focused case review conversations with certifying doctors and educational sessions delivered to GP practices, hospices, hospitals and NHS boards. There is an early suggestion of improvement in the quality of MCCDs, however it was always anticipated the benefits of the service would not be apparent until the longer term.

As the senior medical reviewer, I am proud of the successful implementation of the service and our contribution to safer clinical practice, but acknowledge there have been challenges. I would particularly wish to thank colleagues at Healthcare Improvement Scotland, the various stakeholders involved and Scottish Government without whose support we would have been unable to achieve the launch of the service with all the interdependencies required.

Dr George Fernie
Senior Medical Reviewer
Death Certification Review Service
## Recommendations for 2016–2017

<table>
<thead>
<tr>
<th>Improving the accuracy and quality of MCCDs through education</th>
<th>1 Engaging with NHS boards: The service will develop NHS board comparative data and share this with individual NHS boards during their 6-monthly review meetings. In collaboration with individual NHS boards, the service will determine any possible reasons for outlier variation and provide additional educational support where deemed appropriate.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Engaging with undergraduate medical students: The service will engage with Undergraduate Medical Deans, with a view to providing education on death certification and the review process to final year undergraduate medical students.</td>
<td></td>
</tr>
<tr>
<td>3 Developing scenario-based educational materials: The service will work with NHS Education for Scotland to scope the potential for scenario-based educational materials to support certifying doctors.</td>
<td></td>
</tr>
<tr>
<td>Making it easier for certifying doctors to complete MCCDs through the use of electronic MCCD (eMCCD)</td>
<td>4 Promoting the uptake of eMCCD within primary care: The service will promote the use of eMCCD in primary care during case review discussions, educational session delivery and NHS board 6-monthly review meetings.</td>
</tr>
<tr>
<td></td>
<td>5 Extending eMCCD to secondary care: The service will continue to work with partner organisations to support the extension of eMCCD to secondary care.</td>
</tr>
<tr>
<td>Improving the efficiency and effectiveness of the Death Certification Review Service</td>
<td>6 Piloting Emergency Care Summary access for Level 1 case reviews: Between June–August 2016, the service will undertake a pilot of Emergency Care Summary access for Level 1 case reviews with an NHS board. The pilot will determine how many case reviews are subsequently escalated to Level 2.</td>
</tr>
<tr>
<td></td>
<td>7 LEAN review of service system/process: The service will undertake a LEAN review of the Death Certification Review Service processes to identify waste and areas for improvement.</td>
</tr>
</tbody>
</table>
About the Death Certification Review Service

Each year in Scotland there are approximately 55,000 deaths. Every death in Scotland must be certified by a doctor who completes a form called a Medical Certificate of Cause of Death (MCCD). The MCCD provides a permanent legal record of the death, records information about the death (including the cause of death), and allows the death to be registered.

The arrangements for death certification and registration have been extensively reviewed. The Certification of Death (Scotland) Act 2011\(^1\) introduced a number of changes to the system. In particular, it strengthened checks on the accuracy of MCCDs by setting up a new national system of proportionate, independent scrutiny of those deaths not reported to the Procurator Fiscal\(^2\), namely, the Death Certification Review Service. The review is free at the point of delivery.

Healthcare Improvement Scotland is named in the Act as the organisation responsible for running the service and for certain other specific duties, including managing the process of administering and authorising the burial and cremation of people who have died outside the UK and are returned (repatriated) for burial or cremation in Scotland. The Death Certification Review Service is part of Healthcare Improvement Scotland’s ‘Safer Clinical Practice’ package also responsible for medical revalidation and controlled drugs.

The aim of death certification review service is to improve:

- the quality and accuracy of MCCDs
- public health information about causes of death in Scotland, and
- clinical governance in relation to death certification.

---


\(^2\)More information about the role of the Procurator Fiscal in the investigation of deaths can be found at: www.copfs.gov.uk/publications/deaths
Figure 1 illustrates the benefits of the new system and the key factors required in its successful delivery.

**Figure 1: Death Certification Review Service driver diagram**

![Death Certification Review Service driver diagram](source)

Source: Scottish Government
The review process

MCCDs are randomly selected for review by National Records of Scotland. The randomisation model is based on a bell distribution curve and, therefore, daily workload is unpredictable.

The review of MCCDs is carried out by medical reviewers, all of whom are experienced and trained doctors from both a general practice and secondary care background. The review process enables the medical reviewer to speak to the certifying doctor about the certificate and case history. The purpose of the review is to determine if the MCCD completion is in order rather than look at the quality of care provided to the deceased prior to their death. The senior medical reviewer leads this work for Scotland.

Certificates not randomly selected for review, or previously reported to the Crown Office and Procurator Fiscal Service, are eligible to be considered for an interested person review, where individuals with a clear link to the person who has died have questions about information contained in the MCCD.

For more information about death certification in Scotland, please visit the Healthcare Improvement Scotland website: www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification.aspx
Our findings

Case type overview

The service reviewed 5,798 cases during the reporting period (13 May 2015 to 12 May 2016). A breakdown by case type is detailed below (Table 1).

Table 1: Cases by review type between 13 May 2015 and 12 May 2016

<table>
<thead>
<tr>
<th>Case type</th>
<th>Number of reviews (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Level 1 and Level 2 cases</td>
<td>5,277 (91.01%)</td>
</tr>
<tr>
<td>Advance registration</td>
<td>307 (5.29%)</td>
</tr>
<tr>
<td>Repatriation</td>
<td>170 (2.93%)</td>
</tr>
<tr>
<td>Registrar referral</td>
<td>29 (0.50%)</td>
</tr>
<tr>
<td>Interested person</td>
<td>7 (0.12%)</td>
</tr>
<tr>
<td>Medical reviewer referral</td>
<td>8 (0.14%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,798 (100%)</strong></td>
</tr>
</tbody>
</table>

Data source: Death Certification Review Service case management system (Sugar)

The service received fewer registrar referrals, advance registration and interested person applications than anticipated. The number of cases reviewed in each NHS board (Table 2) suggests the distribution of cases is random and proportional to the population death data held by National Records of Scotland.
Table 2: Number of reviews in each NHS board compared to population deaths between 13 May 2015 and 12 May 2016

<table>
<thead>
<tr>
<th>NHS board*</th>
<th>Review frequencies</th>
<th>Death frequencies 2015**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>%</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>1,158</td>
<td>23.12%</td>
</tr>
<tr>
<td>Lothian</td>
<td>681</td>
<td>13.60%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>554</td>
<td>11.06%</td>
</tr>
<tr>
<td>Grampian</td>
<td>539</td>
<td>10.76%</td>
</tr>
<tr>
<td>Tayside</td>
<td>425</td>
<td>8.48%</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>389</td>
<td>7.77%</td>
</tr>
<tr>
<td>Fife</td>
<td>332</td>
<td>6.63%</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>307</td>
<td>6.13%</td>
</tr>
<tr>
<td>Highland</td>
<td>292</td>
<td>5.83%</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>176</td>
<td>3.51%</td>
</tr>
<tr>
<td>Borders</td>
<td>92</td>
<td>1.84%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>31</td>
<td>0.62%</td>
</tr>
<tr>
<td>Shetland</td>
<td>23</td>
<td>0.46%</td>
</tr>
<tr>
<td>Orkney</td>
<td>10</td>
<td>0.20%</td>
</tr>
<tr>
<td>National</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Special Health Boards</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,020</td>
<td>100%</td>
</tr>
</tbody>
</table>

Data source: 2015 Provisional Scotland Deaths from National Records of Scotland

*778 cases did not have a NHS board code, these are not included in this table

**2015 Provisional Scotland Deaths from National Records of Scotland
Standard Level 1 and Level 2 reviews

Standard Level 1 and Level 2 reviews are designed to check the quality and accuracy of MCCDs and to improve the way that information about deaths is recorded. Medical reviewers examine a random sample of about 10% of all deaths through a Level 1 review which is normally completed within one working day. An additional small number of MCCDs are examined through a Level 2 review usually completed within 3 working days.

The bereaved can still make initial funeral arrangements while the review is under way. However, the funeral itself cannot take place until the review is completed and a Certificate of Registration of Death (Form 14) is produced. The service reviewed 5,277 standard Level 1 and Level 2 cases during the reporting period (Figure 2).

Figure 2: Breakdown of Level 1 and Level 2 standard reviews between 13 May 2015 and 12 May 2016

This is in line with pre-implementation forecasts of 4,000 Level 1 and approximately 1,000 Level 2 reviews, and is an indication that the case selection method is working as expected. The service escalated 251 (5%) of standard Level 1 cases to a Level 2 review. A total of 145 (3%) of standard Level 1 and Level 2 cases selected for review were subsequently reported to the Procurator Fiscal by the certifying doctor for reasons of non-criminality in keeping with the Scottish Fatalities Investigation Unit’s guidance.
Medical reviewer for cause reviews

Standard Level 1 and Level 2 reviews are designed to check the quality and accuracy of MCCDs and to improve the accuracy of death certification. Under Section 3 of the Certification of Death (Scotland) Act 2011, ‘for cause reviews’ may be identified by the medical reviewer, senior medical reviewer or through other intelligence (for example data trends, feedback from registrars, Scottish Government). Eligible MCCDs are selected for a Level 2 for cause review.

The service requested three for cause reviews in relation to three doctors during the reporting period, where there was sufficient concern about the quality of MCCD completion. These were investigated locally with additional review of further MCCDs to ensure improvement. To date, 8 MCCDs have been reviewed. There is an ongoing quality improvement review process at a local level following such reviews.

Interested person reviews

MCCDs not randomly selected for review, or previously reported to the Crown Office and Procurator Fiscal Service, are eligible to be considered for an interested person review. To apply for an interested person review, the applicant must have a clear link with the person who has died. Those who can apply include family members of the deceased, healthcare professionals who were involved in the care provided, and the funeral director who arranged the funeral. An interested person review does not assess the quality of care provided to the person who has died. As it was anticipated this might be a misconception, specific education was directed to this point at the funeral industry roadshows pre-implementation. Any application for an interested person review must be made within 3 years of the death of the person who died. Applications can only be made in relation to people who have died after 13 May 2015.

The service received 7 interested person applications in the reporting period (Table 3); 2 applications were declined. One application was made in error by a registrar instead of a registrar referral (incorrect box ticked on form), and the other declined application was previously reviewed by the Procurator Fiscal and therefore outwith the service’s remit. All applications were received after the death was registered.
Table 3: Number of interested person applications between 13 May 2015 and 12 May 2016

<table>
<thead>
<tr>
<th>Applicant category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person having charge of the place of disposal of the body of the deceased</td>
<td>3</td>
</tr>
<tr>
<td>A healthcare professional (or other carer) who was involved in the deceased's care prior to the deceased's death</td>
<td>2</td>
</tr>
<tr>
<td>A person who under the Registration or Births, Deaths and Marriages (Scotland) Act 1965 is required or stated to be qualified to give information concerning the deceased's death</td>
<td>2</td>
</tr>
</tbody>
</table>

Data source: Death Certification Review Service case management system (Sugar)

The service received fewer interested person applications than expected in the first year of operation. The service will work with public partners to review the Death Certification Review Service webpage, with a view to improving awareness of, and access to, the interested person review application process.
Advance registration requests

If an MCCD is selected for review and the bereaved need the funeral to go ahead promptly, in special circumstances they may request advance registration. Special circumstances identified during the Scottish Government consultation include:

- if there are religious or cultural reasons to bury a person’s body quickly
- if holding up the funeral would cause a lot of distress, and
- for other reasons, such as family have travelled from abroad for the funeral.

The service will usually approve or decline an advance registration application within 2 hours. If the application for advance registration is approved, the funeral can go ahead. If the application for advance registration is not approved, the funeral will have to wait until the Level 1 or Level 2 review is finished.

The service received 307 advance registration applications for the reporting period, of which 85% were approved. The number of requests for advance registration has steadily declined over the first year of operation. The service received fewer ‘vexatious’ advance registration applications than expected. The number of applications made on faith/religious grounds has remained low, and steadily decreased over the year. A breakdown of reasons for advance registration is detailed below (Figure 3).

Figure 3: Breakdown of reasons for advance registration between 13 May 2015 and 12 May 2016

Data source: Death Certification Review Service case management system (Sugar)
The Death Certification Review Service operates 24 hours a day, 7 days a week. Core business hours are Monday–Friday 8.30am to 5.30pm. The service provides an out-of-hours on-call medical reviewer service, primarily to deal with advance registration requests. The service has received fewer out-of-hours contacts than expected, approximately one every month.

**Registrar referrals**

Section 2 of the Certification of Death (Scotland) Act 2011 states that “A district registrar for a registration district may refer for review under Section 8(1) of that Act a certificate of cause of death where the district registrar considers it appropriate to do so.” MCCDs referred by the registrar are reviewed at Level 2. The service received 29 registrar referrals during the reporting period; of which 69% were found to be ‘not in order’. The service received fewer registrar referral cases than anticipated.

**MCCDs not in order**

We found a high proportion (46.4%) of MCCDs reviewed to be not in order. Of those not in order, 89% (41% of all those reviewed) had minor errors requiring an email amendment and 11% (5% of all those reviewed) had major errors requiring a replacement MCCD (Figure 4).

*Figure 4: Percentage of MCCDs with major or minor errors between 13 May 2015 and 12 May 2016*

Data source: Death Certification Review Service case management system (Sugar)
The not in order percentage changed significantly throughout the first year, particularly in the first 3 months where a hybrid manual/electronic review system was introduced, and medical reviewers became familiar with the review process. The weekly not in order run chart analysis (Figure 5) detects a reduction in the not in order percentage from December 2015. Since December 2015, the percentage of MCCDs deemed not in order has varied around a median of 46.4%. There is an early suggestion of improvement in the quality of MCCDs, however it was always anticipated the benefits of the service would not be apparent until the longer term.

**Figure 5: Run chart showing weekly percentage of MCCDs not in order between 13 May 2015 and 12 May 2016**

Data source: Death Certification Review Service case management system (Sugar)

MCCDs reviewed by the service and found to be not in order can be further classified by the seriousness of errors detected using various error categories (referred to as closure categories).
MCCDs deemed not in order can have multiple error categories. Figure 6 illustrates the prevalence of major errors observed in cases requiring a replacement MCCD. Incorrect cause of death was the most common recorded error and was observed in 55% of cases requiring a replacement MCCD. Inaccuracy in the sequence of cause of death and timescales were also common observed errors in cases requiring a replacement MCCD.

Figure 6: Percentage of closure categories for major errors between 13 May 2015 and 12 May 2016

Data source: Death Certification Review Service case management system (Sugar)
Figure 7 illustrates the prevalence of minor errors where the clinical decision was made that the error could be corrected with an email amendment by the certifying doctor, without the need to re-issue an MCCD. The most common errors observed related to accuracies in the cause or time of death, but the most prevalent error is the cause of death being too vague, with nearly 50% of minor error cases reviewed with this error.

**Figure 7: Percentage of closure categories for minor errors between 13 May 2015 and 12 May 2016**

- Cause of Death too vague
- Causal timescales omitted
- Other
- Cause of Death incorrect
- Registrar error
- Sequence of Cause of Death incorrect
- Conditions omitted
- Abbreviations used
- Deceased details incorrect
- Extra information box un-ticked
- Certifying Doctor Spelling error
- Additional information not completed
- Certifying Doctor’s details incorrect
- Deceased details omitted
- Legibility
- Disposal Hazard not completed
- Awaiting Clinical Information
- Certifying Doctor’s details omitted

Data source: Death Certification Review Service case management system (Sugar)
The service undertook a study of all Level 1 and Level 2 reviews between 13 May 2015 and 30 April 2016 to find out if there was any difference in the quality of MCCDs completed by hand, and those completed electronically (eMCCD). The service observed an 8% in order quality gap between MCCDs completed electronically and handwritten (Table 4).

### Table 4: In order quality gap between eMCCD and MCCD

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Electronic</th>
<th>Handwritten</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>In order</td>
<td>63%</td>
<td>55%</td>
<td>8%</td>
</tr>
<tr>
<td>Email amendment</td>
<td>35%</td>
<td>39%</td>
<td>4%</td>
</tr>
<tr>
<td>Replacement MCCD</td>
<td>3%</td>
<td>6%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Data source: Death Certification Review Service case management system (Sugar)

eMCCD is available within primary care and uptake as at 31 March 2016 is approximately 34.5% via SCI-Gateway. Feedback from certifying doctors during advice calls, case reviews and SurveyMonkey questionnaire comments suggests difficulty around SCI-Gateway access, user permissions and use. Users are directed to NHS National Services Scotland SCI-Gateway Release Notes and the local NHS board IT facilitators for advice and support. Relevant enquiries recorded on the service enquiry register are fed back to NHS boards at their 6-monthly review meetings with the service.

During this first year of operation, our focus has been on improving the accuracy and quality of MCCDs through education, both during one to one educationally-focused case review discussions with certifying doctors, and educational sessions delivered to GP practices, hospices, hospitals and NHS boards by medical reviewers and the senior medical reviewer.
Deaths outwith Scotland

The service is responsible for checking relevant paperwork and authorising burial or cremation of people who have died outside the UK and have been returned to Scotland, often in tragic and upsetting circumstances.

For some deaths that occur outside the UK, the paperwork provided by the country where the person died may not contain information on the cause of death. If, following reasonable enquiries, the cause of death is still not clear, the family may be able to apply to the service for assistance (including financial assistance) to arrange a post-mortem examination. This may help to establish the cause of death. This is not an investigation of a “suspicious” death and is not designed to provide a second opinion as there are other local and national processes available for these aspects.

The service received 170 repatriation applications during the reporting period; 31% of which were approved for burial, 69% of which were approved for cremation.

The service received 6 post-mortem examination requests in the reporting period: 2 requests were approved and 4 requests were declined as a post-mortem examination had already been carried out in the country of origin, and a cause of death was or was likely to be available.

Breached cases

The service aims to complete reviews within the timescales below (Table 5).

Table 5: Service level agreement timescales

<table>
<thead>
<tr>
<th>Type</th>
<th>Service level agreement timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>Within 1 working day</td>
</tr>
<tr>
<td>Level 2</td>
<td>Within 3 working days</td>
</tr>
<tr>
<td>Advance registration decision</td>
<td>Within 2 hours</td>
</tr>
<tr>
<td>Senior medical reviewer escalation</td>
<td>Within 1 working day</td>
</tr>
<tr>
<td>Interested person</td>
<td>3 to 14 days</td>
</tr>
<tr>
<td>Repatriation</td>
<td>Within 5 working days</td>
</tr>
</tbody>
</table>
During the reporting period, 128 (3%) cases breached the service level agreement timescales; of which 60 were due to the certifying doctor subsequently referring the case to the Procurator Fiscal, and therefore outwith the Death Certification Review Service remit.

Death registration proceeded as normal for breached cases and believed unlikely to have impacted on the bereaved. No complaints were received in relation to breached cases. A breakdown of breach reasons are detailed below (Table 6).

**Table 6: Breakdown of breach category between 13 May 2015 and 12 May 2016**

<table>
<thead>
<tr>
<th>Category number</th>
<th>Reason (previous report categories)</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Difficulty contacting certifying doctor or other member of the team</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>Delay in receiving amendment from certifying doctor</td>
<td>11</td>
</tr>
<tr>
<td>3</td>
<td>Certifying doctor report to Procurator Fiscal</td>
<td>60</td>
</tr>
<tr>
<td>4</td>
<td>Foreign &amp; Commonwealth Office</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Post-mortem examination to be arranged</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>Delay in receiving associated paperwork</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Delay in medical reviewer dealing with case (hybrid manual system)</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>Delay in contacting registrar (hybrid manual system)</td>
<td>2</td>
</tr>
<tr>
<td>9</td>
<td>Certifying doctor on annual leave</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>Certifying doctor unavailable</td>
<td>40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>128</strong></td>
</tr>
</tbody>
</table>

*Data source: Death Certification Review Service case management system (Sugar)*

The service provides NHS boards with any breach data during their 6-monthly review meetings.
Training and information function

The Death Certification Review Service supports doctors, healthcare professionals, funeral directors, registrars and members of the public through the case selection and review process to minimise impact on the bereaved, and support continuous system and service improvement.

During 2015–2016, the service received 610 telephone/advice enquiries and delivered 24 educational sessions to NHS boards. The service met with NHS boards every 6 months to provide feedback on performance statistics and discuss their educational support requirements. Engagement from NHS boards in terms of educational support has been variable across Scotland and uptake was lower than expected.

The service participated in the National Association of Funeral Directors, Association of Registrars of Scotland and Strathcarron Hospice Palliative Medicine Conferences. The service also delivered an educational session to the Scottish Fatalities Investigation Unit West. The service has hosted 93 district registrars for shadowing experience.

An educational discussion takes place between the medical reviewer and certifying doctor for all MCCD reviews. The service conducted a SurveyMonkey questionnaire to evaluate participant experience. The results demonstrate a high degree of respondent satisfaction and medical reviewer compliance (figures 8 and 9).

Figure 8: SurveyMonkey results for questions 1–4 and Question 6

![SurveyMonkey results for questions 1–4 and Question 6](image)

Data source: Death Certification Review Service Survey Monkey December 2015 to May 2016
In response to feedback in 2015–2016 from partnership organisations, service staff and stakeholders, the service will:

- increase the number of educational sessions by using webinars
- introduce scenario-based education
- publish and distribute ‘DCRS Tips for Certifying Doctors’ on the Death Certification Review Service webpage
- develop relationships with Undergraduate Medical Deans and explore how education on death certification and the review process can best be delivered, and
- create a link on the service’s webpage where certifying doctors and NHS boards can request educational support from the Death Certification Review Service.

**Complaints, concerns, comments, compliments**

The service received 8 complaints in its first year of operation: 6 related to service provision and 2 related to policy/communication. All complaints received were processed within the NHS complaints timescale.

The service also received 9 compliments.
Stakeholder reflections

“I am happy that, one year on, the implementation of the new Death Certification Review Service has been a success. I hope that the benefits of the new system, with improved accuracy and clarity and the accumulation of data, for example on the cause of deaths, will be realised and used in the future. The hard work of everyone involved in the preparation has led to this success. We have seen that there have not been many issues, such as delays to funerals, and, by working with the community, the service should be able to address any potential problems.”

Salah Beltagui
Convener of the Muslim Council of Scotland

“Although the Jewish Community shared the concerns of others about the potential of the new Death Registration system to impose delays, we welcome the steps that have been taken to ensure that the new procedures are culturally and religiously sensitive, and have been pleasantly surprised that there have been few difficulties with the new system that cannot be addressed by ensuring that all NHS staff are fully briefed on its implementation.”

Ephraim Borowski,
Director, Scottish Council of Jewish Communities

“Initially, our staff were worried about how the public would react to being told that an MCCD had been selected for review but we are now over a year into the new system and I am pleased to say it has bedded in well. In the beginning there were a few problems with the electronic system but these issues seem to have been resolved and the system is working well across Scotland.”

Jacqueline Doyle
President, The Association of Registrars of Scotland
Adverse events and lessons learned

The service has reflected on interesting case reviews and adverse events which have lead to changes in existing standard operating procedures and the creation of new standard operating procedures. The service shared lessons learned with NHS boards and partner organisations where appropriate. A small number of prescribing governance issues were identified in Level 1 case reviews. The service is currently piloting Emergency Care Summary (ECS) access for Level 1 case reviews with an NHS board. ECS may provide a summary of electronic healthcare-related information to support the case review. The pilot will determine how many case reviews need to be escalated to Level 2.
For more information about Healthcare Improvement Scotland’s Death Certification Review Service, visit www.healthcareimprovementscotland.org/deathcertification or telephone 0300 123 1898