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Research Findings
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Death Certificate Test Site Evaluation

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The Scottish Government established two test sites in Dundee and Dumfries & Galloway between May-June 2012 to February 2013 to pilot a new approach to reviewing death certification introduced in the Certification of Death (Scotland) Act 2011. The test sites have been evaluated and the key research findings are presented here.

Main Findings

- The level of inaccurate Medical Certificates of Cause of Death (MCCDs) in both level 1 and 2 reviews has been low at 3% and given the scrutiny involved in each test site area this is a very positive result.
- In the small number of cases where an MCCD was identified as not in order the main reasons relate to: inaccurate information about the cause of death; information about the certifying doctor being omitted; and/or inaccurate or missing details about the deceased person.
- Many of the errors in MCCDs identified by the Medical Reviewers (MRs) were trivial including omissions of basic information and legibility issues which could be addressed informally with the certifying doctor.
- In Dundee the majority (72%) of the level 1 reviews were completed with less than one hour's work within 24 hours of referral; in Dumfries & Galloway this figure was just over one third (34%). The main reasons for delays were due to difficulties in contacting certifying doctors and accessing medical records.
- The test site process has highlighted a number of practical issues that could be addressed prior to national implementation. These include the ability of registrars to email rather than fax referrals; the ability to access medical records electronically; the MR and Medical Reviewer Assistant (MRA) being sited within an NHS building; and clarity about completing ISD data forms.
- The test sites have identified some of the key attributes that the Medical Reviewer and Medical Reviewer Assistant post-holders will require, namely communication and people skills, flexibility and a willingness to negotiate.
- On-going monitoring and evaluation of review duration, consistency of approach to referred review cases and MCCD accuracy levels will be required to ensure issues are addressed and the process of streamlined if and where necessary.
- Training and education about the new process will be important for the MRs and MRAs, registrars and doctors to help bed in the new process and support a high level of consistency to ensure public confidence in the new system.

The Scottish Government
Riaghaltas na h-Alba

Background

The Certification of Death (Scotland) Act 2011 made provision for a new process of independent reviews of Medical Certificates of Cause of Death (MCCDs) creating a new post of Medical Reviewer to review the quality and accuracy of MCCDs. The Medical Reviewer (MR) could undertake two levels of review: a 2basic level 1 review or a more comprehensive level 2 review.

The Scottish Government established two test sites to pilot the new approach; one in Dundee, the other in Dumfries & Galloway. Each area employed a 0.5 FTE MR and a 0.5 FTE Medical Reviewer Assistant (MRA). The MRs were overseen by a Senior Medical Reviewer and this role was taken by a Scottish Government Senior Medical Officer.

The evaluation

The aim of the evaluation was to assess the test site processes and stakeholder experiences, with a view to identifying lessons learned and informing national implementation across Scotland, which is planned to take place from April 2014.

The evaluation methods included stakeholder interviews, analysis of test data gathered by NHS ISD, and in-depth case studies of 18 MCCD reviews.

The evaluation had a number of limitations as it did not take place in 'real time' and did therefore not affect any funeral taking place and so there was no immediate impact on the public. When the process is implemented nationally reviews will need to be completed before funerals can take place and the public will also be charged a fee towards the costs of the review process. As this did not happen in the test site process the views of the public were not included in the evaluation.

The test sites

The total number of level 1 and 2 reviews undertaken (1301) in the two test sites exceeded the set target of 1190. There was a slight variation between the two areas with Dumfries & Galloway exceeding both its level 1 and 2 targets and Dundee falling slightly short of the original targets.

Overview of main findings

Accuracy and quality

The majority of MCCDs reviewed were found to be in order. Only 3% were found to be not in order across both level 1 and 2 reviews. Given the scrutiny of the test site process this is a very positive result.

The main reasons given for the MCCDs that were considered not in order were as follows (with more than one reason being given in some circumstances):

- incorrect or incomplete cause of death (88%);
- information about the certifying doctor omitted (41%);
- incorrect sequence of cause of death (32%); and
- inaccurate or missing personal details about the deceased person (27%)..

Further information about the quality of the MCCDs was recorded on quality scorecards and the information from these underpinned the above and showed that, even where the MCCD was not considered to require replacement, there might be trivial errors and legibility issues. These were often addressed by the MR talking informally to the certifying doctors concerned. Thus an educative role was part of the MR's role in the test sites.

Duration of reviews

The majority (72%) of level 1 reviews in Dundee took less than one hour and were completed within 24 hours, but in Dumfries & Galloway this figure was just over one third (34%). The main reasons for delays that occurred were due to difficulties in contacting the certifying doctors and/or in accessing the medical records. There are some practical improvements which can be made to avoid unnecessary delays (outlined in the next paragraph) but it is also likely that when the process is being used in 'real time' that the difficulties in contacting the certifying doctors will be reduced (as less time will have elapsed between the death and the review so the doctors will not have moved jobs, be on holiday etc).

Practical issues to be addressed

There are a number of practical improvements that could usefully be addressed prior to national implementation. These include the following:

- The ability of registrars to email rather than fax referrals will save some time as there were problems during the test site process with faxes not being received and the registrar needing to confirm with the MR that a fax had arrived. This will require ensuring that registrars have access both to emails and scanners to scan in documents.
- The ability to access medical records electronically. During the test sites the MRs sometimes had to travel to see medical records thus taking more time. In Dumfries & Galloway the MR overcame some of the access problems by asking GPs to fax a four-page summary (known as the intermediate/ emergency care summary) of the records to her and by making use of the internal NHS mail to access records from community hospitals.
- The MR and MRA being located within an NHS building. In the Dundee test site the MR was situated in a university building and this raised some difficulties in terms of access to NHS IT systems and the internal mail system.
- Clarity about completing ISD data forms. The test site process showed how important it is to provide training and follow up with MRs to ensure that data fields required are understood and are being correctly completed.

Impact on registrars

The test sites have shown that the new process creates some further work for registrars. This includes time to prepare documents for referral, to communicate with the MR, to file documents away after the review and to send a replacement MCCD (where this occurs) to National Records Scotland, and change the cause of death in the register if this is required. (In the national implementation registrars will also require time to communicate with the public about the review process and to gather and administer the fees being charged.)

Communication

The evaluation has highlighted the importance of good communication. This includes communication between the MRs and registrars, doctors and NHS ISD. It has also been pointed out that good communication between doctors, funeral directors, as well as registrars, with the relatives of the deceased person, will be essential when the new process is implemented nationally.

Person specification for MRs/MRAs

The key components of the person specification for the MR/MRAs have been identified during the test site process as including:

- ability to communicate well and to have good 'people skills' so that they can establish good relationships quickly and maintain them;
- for the MRs, at least five years' experience in a variety of areas and with a specialism in one area;
- ability to negotiate and compromise;
- willingness to be flexible: for example about when they speak to doctors due to doctors' shift patterns;
- ability to act decisively when required; and
- ability to take on an educative role with doctors to help them complete MCCDs more accurately.

Consistency

The evaluation has highlighted the importance of ensuring consistency across areas. This includes consistency in the approach to identifying MCCDs as out of order and working with doctors, but also consistency of approach, once the national implementation is in place, to when the process can be expedited more quickly and when not. There are some concerns that in some areas of the country it might be easier to gain an expedited process (for example where issues of faith mean a burial is required quickly) than others and if such inconsistency arises it could potentially cause tensions. It will be the responsibility of the Senior Medical Reviewer to ensure such consistency.

Training and education

There is a need for a range of training and education to take place:

- for the MRs and MRAs so that they have clear guidance as to how to undertake the process including exceptions to the rule. This will include careful discussion about when to rule an MCCD as out of order and when to simply have an informal discussion with the certifying doctor;
- registrars will also require input about how they are to handle the new process including the collection of the £30 fee; and
- for doctors about the new system and the levels of quality and accuracy in the MCCDs that will be sought. This should include inputs about support for the bereaved through this process.

Ongoing review

Once the national implementation is in place it will be important to undertake regular monitoring and evaluation:

- to check that there is consistency across all areas;
- to check whether there are unnecessary delays happening that could be resolved; and
- to check whether the overall sample size (at this stage it is intended this will be at 25%) is proportionate to the numbers of inaccurate MCCDs being found.

This document, along with full research report of the project, and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Internet at: http://www.scotland.gov.uk/socialresearch. If you have any further queries about social research, please contact us at socialresearch@scotland.gsi.gov.uk or on 0131 244-2111.

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