Healthcare Improvement Scotland | DCRS Death Certification Review Service

Death Certification Review Service

Annual Report 2023-2024

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Senior Medical Reviewer Overview 2023/24

The service remains committed to improving the quality of Medical Certificates of Cause of Death (MCCDs) whilst not causing any unnecessary impact on families.

This year, I am delighted to report that only 18.1% (1118) of certificates reviewed had an error requiring amendment and standard reviews were completed, on average, within one day[1].

Dr George Fernie
Senior Medical Reviewer

The success may be attributed to two significant changes we implemented this year. Our medical review team refocused our NHS board annual review meetings, initiating a self-assessment process to support boards to identify areas for internal improvement.

Our medical reviewer assistants initiated an improvement project aimed at shortening the time it takes the service to contact the certifying doctor to complete reviews. They also introduced new processes that enabled us to reduce the time required to approve repatriation to Scotland to just over one day, once the necessary documents were received.

We continue to work with NHS Lothian and other death certification stakeholders to progress development of eMCCD into secondary care.

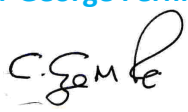
Our educational resources have been updated and we work with NHS Education for Scotland (NES) to provide new materials to support accuracy with death certification.

We have direct access to all but two NHS boards clinical portals and aim to also connect to both this year.

Looking forward, we will continue to hold 'educational discussions' with doctors with the aim of further improving the accuracy of recording of causes of death and engage with our stakeholders to ensure the impact our review work has on bereaved families and partner agencies is positive.

I would like to end by thanking my review team. They work tremendously hard to support doctors to accurately certify deaths to provide the public with assurance of death certification in Scotland.

Dr George Fernie



[1] Please refer to page 13 for details of SLA timeframes

Death Certification Review Service (DCRS) Medical Reviews

The Certification of Death (Scotland) Act 2011[2] is the legislative framework within which the Death Certification Review Service operates.

The role of the service[3] is to improve:

- quality and accuracy of Medical Certificates of Cause of Death (MCCD)s, giving the public assurance in the death registration process in Scotland.
- public health information about causes of death in Scotland, supporting consistency in recording that will help resources to be directed to areas most needed.
- clinical governance[4], helping to improve standards in Scottish healthcare.

In Scotland last year, doctors certified over **60,000** deaths.

Around **12%** were randomly selected[5] for a review by National Records of Scotland (NRS).

Our medical reviewers review the MCCD and speak with the certifying doctor about the circumstances of the death to ensure the information on the certificate is accurate.

If the certificate is **'not in order'**[6] the medical reviewer will request the certificate is amended.

The local authority will complete death registration which then allows families to finalise funeral arrangements.

Families can ask for an MCCD to be reviewed either before or after death registration if they feel the certificate does not accurately reflect the cause of death.

The service is responsible for approval of burial or cremation to Scotland for persons who have died abroad.

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[2] https://www.legislation.gov.uk/asp/2011/11/pdfs/asp_20110011_en.pdf

[3] http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/review_service_information.aspx

[4] The framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high quality of care.

[5] During death registration, National Records of Scotland randomly select MCCDs for medical review and forward to DCRS.

[6] The Certification of Death (Scotland) Act 2011, s8 (4) explains 'not in order' as "where a medical reviewer is not satisfied, on the basis of the evidence available to the medical reviewer, that the certificate represents a reasonable conclusion as to the likely cause (causes) of death, and the other information contained in the certificate is correct."

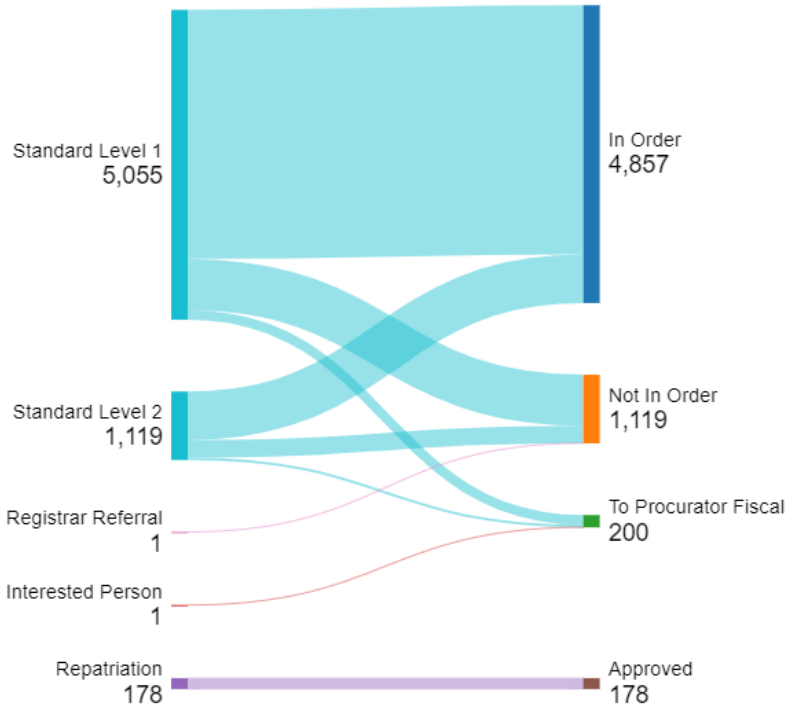
Highlights

	2022/23	2023/24
Public Assurance	5880 MCCD reviews completed 	6176 MCCD reviews completed 
Continuous Improvement	78.7% reviewed were 'in order' 	82.4% reviewed were 'in order' 
Impact on families	Level 1 reviews completed in less than 4 hours 	Level 1 reviews completed in less than 4 hours 
	Level 2 reviews completed in less than 8.5 hours 	Level 2 reviews completed in less than 7 hours 
Advance Registration requests	Decision given in less than 2 hours 	Decision given in less than 1 hour 
Repatriations to Scotland	Authorised in less than 2 days 	Authorised in less than 1.5 days 

Case Overview

The service reviewed a total of **6,354** cases in 2023/24, of which **6174** (97.2%) were standard reviews[7] and 180 non-standard[8] reviews. The diagram [9] below shows a breakdown by case type and the outcome for cases reviewed.

Sankey diagram of number of cases and breakdown of case type and outcome in 2023/24[10]



Enquiry Line

The service dealt with 2,415 enquiries last year. This is a return to around 200 per month which is similar to the number recorded pre pandemic.

The majority of calls (84.8%) were from doctors seeking clinical advice on how to best represent a death on a MCCD.

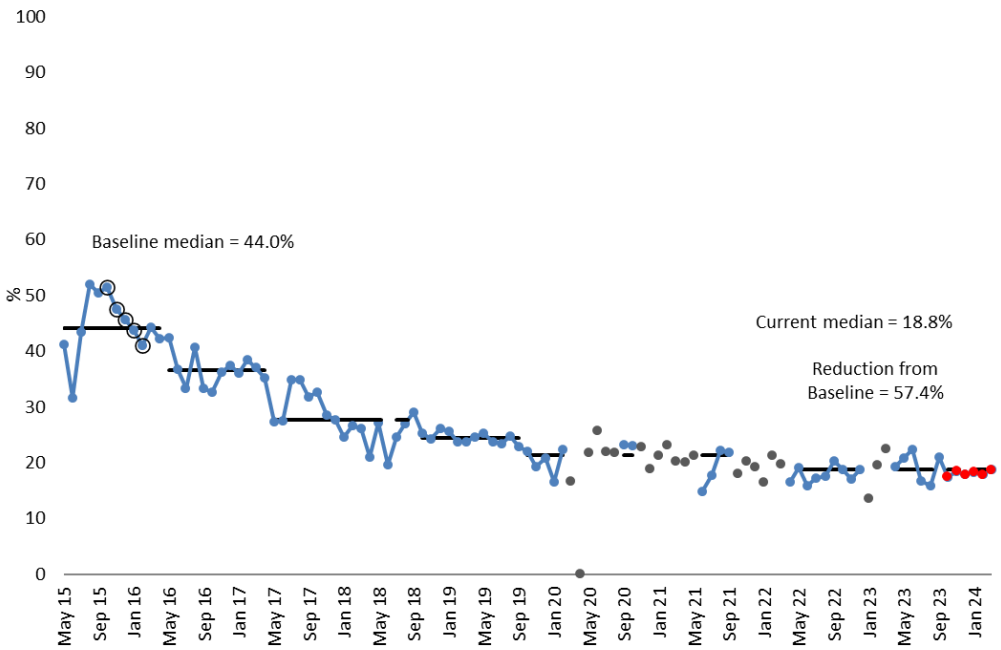
- GP clinical advice 1,637 (67.8%)
- Hospital clinical advice 349 (14.5%)
- Hospice clinical advice 63 (2.6%)
- Others (Registrars/Procurator Fiscal, families) 366 (15.2%)

[7] Standard Reviews (Level 1, Level 2). Level 1 reviews consist of a review of the MCCD and a discussion with the certifying doctors. Level 2 reviews also require a review of patient medical records.
[8] Non-standard Reviews (Interested Person reviews, Registrar referrals and Repatriations to Scotland)
[9] The Sankey diagram should be read from left to right. It shows how one category is broken down into components, then how second/subsequent categories are broken down. The diagram shows the size of the connecting paths between the categories.
[10] See Appendix 1 for full breakdown of cases and enquiries over last 3 years.

Improving the Quality and Accuracy of Medical Certificates of Cause of Death (MCCD)

Run chart analysis of monthly percentage 'not in order' from May 2015 to March 2024 indicates that the percentage ‘not in order’ has improved to a current median of 18.8% in 2022; an overall reduction of 57.4% from the baseline of 44.0%. There are signs of potential further improvement.

Run chart of monthly percentage MCCDs ‘Not in Order’ in Scotland



Note: *Run chart analysis includes periods when the service is operating as ‘business as usual’ (blue dots). Hybrid reviews implemented during the pandemic are not included in the analysis (grey dots)*

Review outcomes

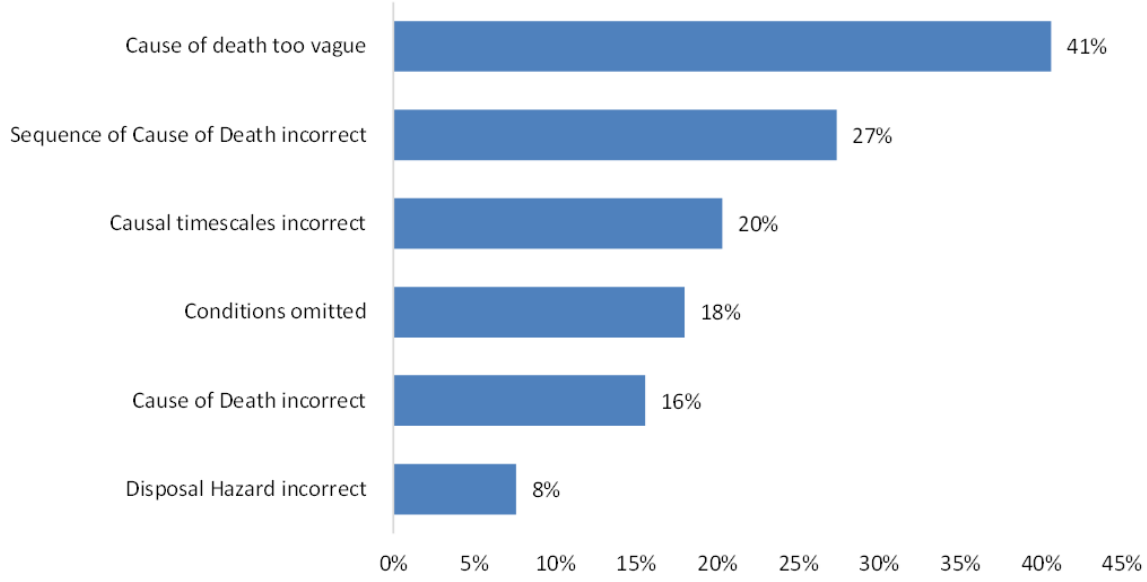
In 2023/24, 6174 medical reviews were carried out, of which

- 1,118 **(18.1%)** were found to be **‘not in order’.** Of these,
- 778 **(70%)** had at least **one clinical closure category** error recorded[11].
- **41%** of these were classified as ‘**Cause of Death too Vague’.**

[11]The cause(s) of death detailed on the MCCD must represent a reasonable conclusion as to the likely cause(s) of death, and the other information contained in the certificate is correct. Where changes are required to the cause of death, these are categorised by clinical category, for changes to the information on the certificate this is categorised as administrative errors.

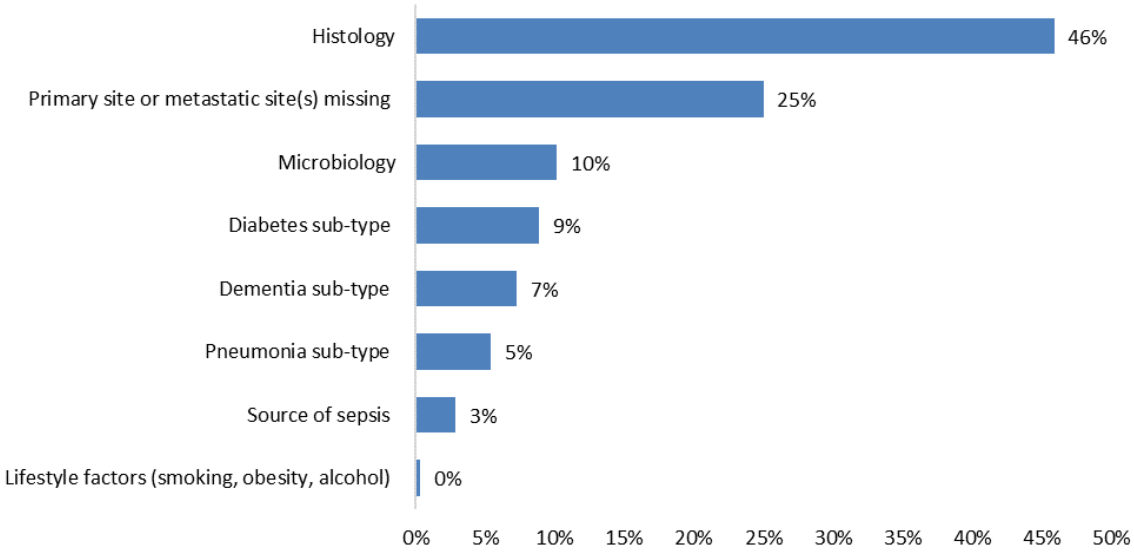
MCCDs can be closed with more than one closure category and the graph below shows the most common errors and omissions on MCCDs reviewed.

Breakdown of closure category as a percentage of clinical categories



Analysis of reviews deemed to have 'Cause of Death too Vague' shows **46%** are due to Histology and **25%** due to primary site or metastatic site(s) missing[12].

Breakdown of 'Cause of death too vague' closure as a percentage of total number



[12] See Appendix 1 for full breakdown of reasons for 'not in order'.

Cause of Death Too Vague Educational Learning
How to complete an MCCD **Part 1 (a) Cause of Death - disease or condition directly leading to death*** **Part 1 (b) Antecedent causes – any morbid conditions giving rise to above cause** **Part 2 Other Significant conditions contributing to the death**
74 year-old man with Chronic Obstructive Pulmonary Disease (COPD) and Prostate Cancer with multiple bone metastases (malignant growths) presented to hospital with malignant spinal cord compression. Steroids and radiotherapy were given, however remained paraplegic and developed left basal pneumonia (sputum cultured Streptococcus Pneumoniae). Despite treatment, he died from pneumonia.
MCCD completed by the certifying doctor **Part 1** (a) Chest infection (b) Metastatic prostate cancer **Part 2** (a) Chronic Obstructive Pulmonary Disease
Amended MCCD following medical review **Part 1** (a) Streptococcus Pneumoniae Hospital Acquired Pneumonia (b) Malignant spinal cord compression (c) Adenocarcinoma of Prostate with metastases **Part 2** (a) Chronic Obstructive Pulmonary Disease

This does not mean mode of dying, such as heart or respiratory failure.

Educational conversations

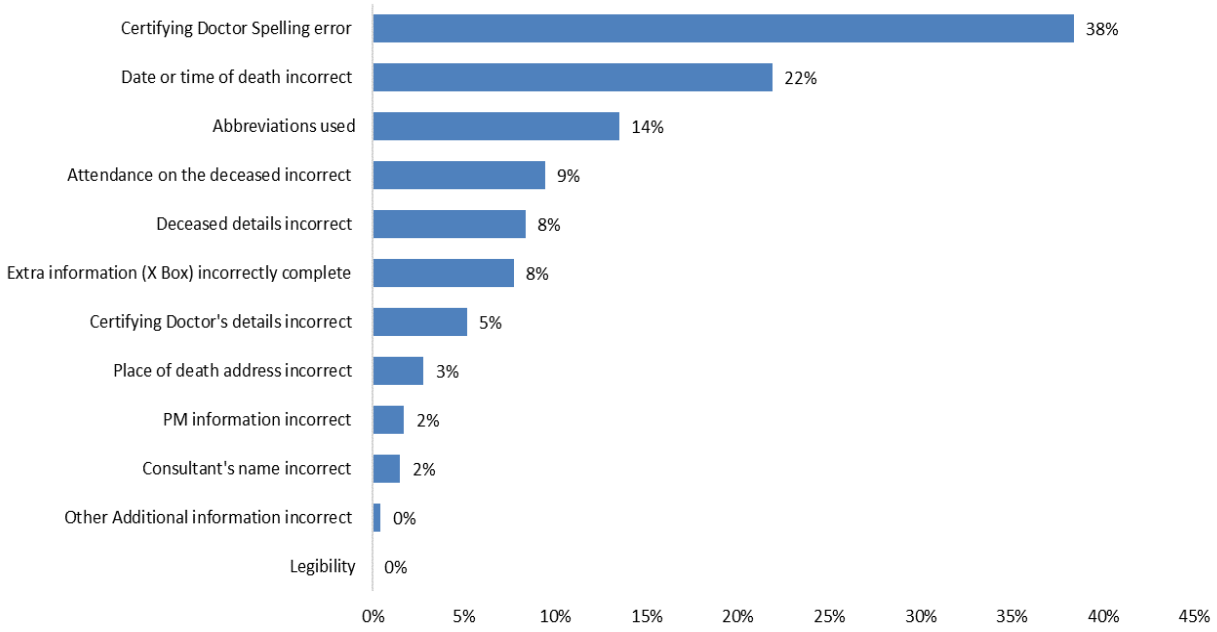
Medical reviews are 'educational conversations' and whilst some MCCDs require an amendment, many are deemed 'in order' (54.1%) or 'in order with educational support' (46.9%). The 3 most common areas for education are;

Cause of death sub-type should be more specific	Cause of death is Dementia, however MCCD should include sub-type, such as Alzheimer, Vascular.
Intervals inaccurate	Cause of death is frailty. Duration of illness should be recorded.
Time of death incorrect or ward details missing	Time of death should be time of 'last breath'. Ward information/number must be included.

Administrative Improvements

Administrative errors include spelling mistakes, use of abbreviations and failing to sign the certificate. Last year, 42% of MCCDs 'not in order' had an administrative closure category recorded. Certifying doctor spelling error was recorded against 179 (38%) of MCCDs reviewed.

Breakdown of 'Administrative errors' category as a percentage of total number[13]



Reports to the Procurator Fiscal

Sudden, suspicious, accidental, and unexplained deaths including deaths which may give rise to public anxiety, are required to be reported to the Procurator Fiscal[14].

Our medical review team found 200 (3.2%) of all certificates reviewed last year should have been reported to the Procurator Fiscal. The most common oversight in reporting was where a fracture or trauma (52%) or known industrial disease (34%) had caused or contributed to the death.[15]

Crown Office and Procurator Fiscal Service Education Learning When completing an E5 (report to COPFS form)

GPs to provide direct dial numbers or direct email addresses to avoid long delays waiting in automated telephone and email systems.

Hospital doctors to provide direct telephone numbers or mobile/page numbers to avoid long waits on hospital main telephone lines.

If you require guidance on whether to report a death to the Procurator Fiscal consider calling the DCRS enquiry line for guidance first.

[13] Table 3 and 4 within Appendix 1 provides full details of clinical and administrative errors recorded over the last 3 years.
[14] reporting-deaths-information-for-medical-practitioners.docx (live.com)
[15] See Appendix 1 for full breakdown of main reasons for reporting to the Procurator Fiscal

Enquiry Call Educational Learning
A hospital doctor called the enquiry line for advice on how to represent the death of a 78-year-old man who was admitted to hospital with shortness of breath and confusion following a series of falls. The man had community acquired pneumonia and a subdural haemorrhage (bleed on the brain). He had also suffered a previous subdural haematoma two years earlier. No evidence of a skull fracture. The pneumonia was treated but the man continued to have delirium and deteriorated ten days after admission.
Even though there was no clear single traumatic event, the falls did contribute to his death and so the death was due, at least in part to an accident. The medical reviewer recommended the doctor report the death to the Procurator Fiscal.

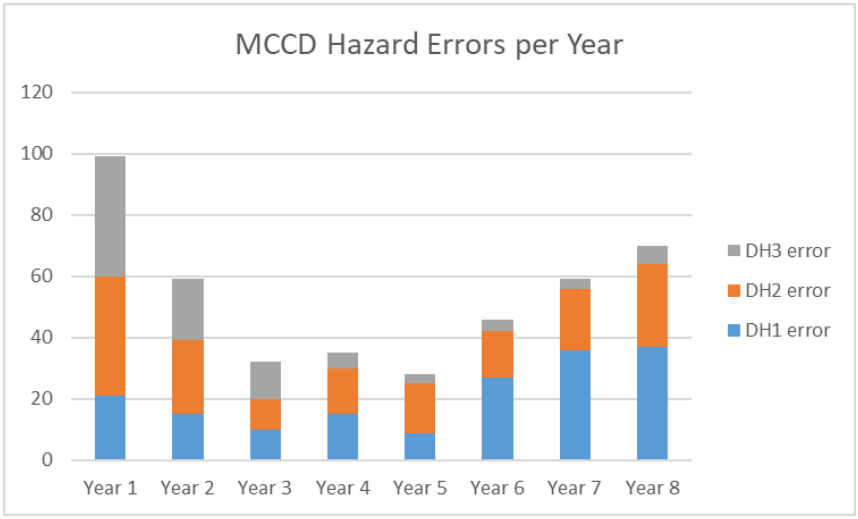
Hazards Audit

It is the duty of the certifying doctor to confirm the deceased body is safe to handle and cremate. If there are hazards, these should be recorded accurately on the MCCD.

Failure to correctly record hazards requires a new certificate to be written. This results in delays for families progressing with funeral arrangements and poses a health risk to funeral directors who may have already handled the body.

Our medical review team carried out the first national observational study of hazard error rates, auditing all MCCDs reviewed between May 2015 and May 2023 for DH1, DH2 and DH3[16] hazard errors. The table below shows improvement between 2015 and 2019, however errors in hazards rose again during the pandemic.

Breakdown of 'MCCD Hazard Errors by year'



[16] DHI – Does the body post a public health risk (notifiable infectious disease/contraction of contamination before death
DH2 – Is there a cardiac pacemaker or other potentially explosive device present
DH3 – Is there radioactive material or hazardous implants present

The audit highlighted the issue was most prevalent within primary care and on average reviews took over a day to complete, as new certificates were required. This is of concern, as some faiths hold funerals within 24 hours of the death.

Admin and report to Procurator Fiscal **Educational Learning** 
Primary care - doctors should submit MCCDs electronically
Secondary care – doctors should print clearly using block capitals and black ink and ward information must be included
No abbreviations, no **Cerebrovascular Accident (**use Ischaemic Stroke or Cerebral Infarction) – use of abbreviations will require the MCCD to be amended
Cancer staging should not be recorded on the MCCD
Check whether there are any hazards present
Signatures must be legible
Know which deaths require to be reported to Procurator Fiscal
Influenza derogation is in place which means there is no need to report Influenza unless there are other concerns
Submit EF5 forms to the PF electronically. It reduces legibility errors
If necessary, contact DCRS for advice, weekdays 8.30am – 5.30pm (0300 123 1898)

Advance Registration

Families who have suffered a bereavement may need the funeral to go ahead promptly. The service aims to support this through our advance registration process, which allows funerals to proceed before the MCCD review is complete.

The number of advance registration applications remains low. In 2023/24, there were,

- **65** (1%) requests, of which
- **49** (75.4%) were approved
- **16** (24.6%) were declined. Of these
- **13** (81.3%) were due to the review being complete or nearing completion.

Of the 65 advance registrations, **all** received a decision within one hour, **8** (12.3%) were subsequently found to be ‘not in order’ and **3** (4.6%) were reported to Procurator Fiscal.

Non-randomised reviews

Interested person, registrar referrals, 'for cause' reviews

The service reviews MCCDs requested by members of the public (Interested Person review)[17] and local authority registrars (Registrar Referral)[18] if they feel the certificate is not accurate.

The volume of these types of requests remains low. Last year, the service reviewed

- 1 Interested Person request. The death was subsequently reported to the Procurator Fiscal.
- 1 Registrar referral. The MCCD was found to be 'not in order'.

Deaths outwith Scotland (repatriations)

The service is responsible for approving burial or cremation in Scotland, of people who have died abroad and are to be repatriated to Scotland.

In 2023/24, the service received **178** repatriation requests, of which,

- **121** (70%) were male, **57** (30%) were female
- **113** (63.5%) were individuals aged 60 years or older
- **59** people (33.1%) died in Spain

Two postmortem applications were approved.

The table below provides some additional demographics including age, top 5 countries people have been repatriated from and funeral type.

Age	No of deaths	Repatriated from	No of deaths	Funeral type	No of deaths
0 - 19	3	**Spain**	59	**Burial**	61
20 - 39	13	**Cyprus**	17	**Cremation**	117
40 - 59	49	**USA/Canada**	11		
60 - 79	95	**Greece**	7		
80+	18	**Italy**	7		
		Portugal	7		

[17] http://www.healthcareimprovementscotland.org/our_work/governance_and_assurance/death_certification/review_service_information/interested_person_review.aspx

[18] Death certification in Scotland: The Death Certfication Review Service (healthcareimprovementscotland.org)

Service Performance

Service Level Agreements

The service operates under agreed service level agreements set by the Scottish Government. The table below explains the timescales and how, on average, we performed.

Level 1 review **Target – 1 working day** Target met < 4 hours	**Level 2 review** **Target – 3 working days** Target met < one day
Advance registration request **Target – 2 hours** Target met < 1 hour	**Senior medical reviewer review** **Target – 1 working day** No cases
Interested person request **Target – 14 days** Target met < 4 days	**Repatriation request** **Target – 5 days** Target met < 1.5 days

Around 168 (2.6%) of case reviews breached[19] SLA timescales, of which

- 141 (83.9%) were due to the certifying doctor being unavailable
- 124 (74%) were in secondary care

Primary care doctors use electronic MCCD which results in instantaneous selecting for medical review. However, secondary care doctors continue to use paper MCCD and certificate selection does not happen until the local authority registrar begins death registration. This can be anything up to 8 days after the death. This reduces the likelihood of the doctor being available within the hospital and the availability of patient notes which are required to support reviews.

[19] See Appendix for full breakdown of breached cases.

Clinical Governance

As part of the MCCD review process, medical reviewers will discuss clinical governance issues or concerns raised by families with the certifying doctor. In 2023/24, no significant clinical governance concerns were identified.

Service Improvements

Stakeholder engagement

In October 2023, the service gathered views on the death registration process from 127 death informants[20]. The table below shows the key findings.

We asked …	You told us…	
Who advised you the Medical Certificate of Cause of Death could be selected for review?	The local authority registrar provided this information when trying to progress death registration.	74%
Did the review cause a delay in your funeral arrangements?	The majority reported no impact.	86%
Did you make an Advance Registration request. If so, how satisfied were you with the outcome of the request?	All 3 respondents were very satisfied.	100%
How satisfied were you with the speed of the Advance Registration response?	All 3 respondents were very satisfied.	100%
What 3 words would you use to describe the Death Certification Review process?	Long and not enough communication. More contact with families.	1.5%

Whilst the feedback was generally positive, the death registration process changed significantly during the pandemic and the service was keen to understand the impact for other key stakeholders.

The service works closely with National Records of Scotland (NRS), Association of Registrars of Scotland (ARoS), Crown Office and Procurator Fiscal Service (COPFS),

[20] The person who registers the death is formally known as 'the informant'.

NHS boards and funeral directors with the aim of ensuring the death registration process does not negatively impact on families.

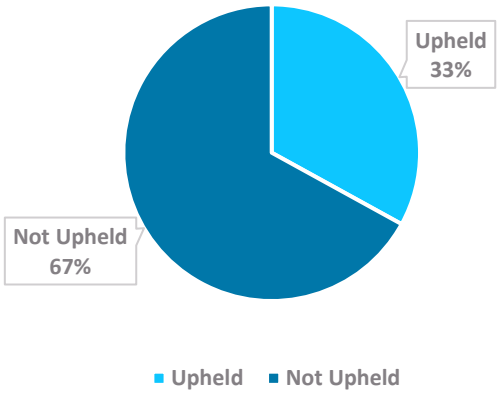
In collaboration with NRS and ARoS, the service held a workshop to identify what was working well and areas for improvement. A number of areas for improvement were identified including: quality of MCCDs (spelling errors, abbreviations), delays by doctors submitting the MCCD to the registrar, availability of doctors, specifically locums and/or notes and delays to death registration caused by late reporting of deaths to the Procurator Fiscal.

The Death Certification Review Service management board has representation from all key stakeholder agencies. All work closely together to effect positive change.

Complaints and Freedom of information (FOI) requests

The service received 6 complaints this year, of which 2 were upheld and instigated changes to service call management procedures and 4 were not upheld.

Breakdown of complaints in 2023/2024



The service responded to 3 Freedom of Information (FOI) requests.

In 2024/25 we will…

- Support implementation of eMCCD into secondary care with key stakeholders.
- Continue to work with NHS boards to reduce the number of clinical and administrative errors on MCCDs and educate on appropriate reporting of deaths to the Procurator Fiscal.
- Regularly engage with stakeholders to ensure our medical reviews do not negatively impact on families.
- Finalise direct access to NHS board clinical portals to reduce administrative resource requirements within boards.

Acknowledgements

Thank you to colleagues at Healthcare Improvement Scotland, National Records of Scotland and our own team. Your excellent collaborations have helped us to assure accurate death certification over the last year. Special thanks to our data analysts Keir Robertson, Alexandra Dunn, and data and measurement advisors Lucy Aitken and Tim Norwood, your support in developing our data reports has been invaluable.

Death Certification Review Service Management Board

The service is funded by the Scottish Government and supported by the DCRS Management Board. We hope you have enjoyed reading about our work. If you have any comments, please get in touch.

Name	Designation	Organisation
Lucy Aitken	Data & Measurement Advisor	Healthcare Improvement Scotland
Lynsey Cleland	Director of Quality Assurance	Healthcare Improvement Scotland
Cathy Dunlop	Registration Services Manager, East Ayrshire	Association of Registrars of Scotland
Dr George Fernie	Senior Medical Reviewer	Healthcare Improvement Scotland (DCRS)
Angela Hay	Operations Team Manager	Healthcare Improvement Scotland (DCRS)
Alexandra Jones	Public Partner	Healthcare Improvement Scotland
Katrina McNeill	Senior Policy Manager	Scottish Government Burial, Cremation, Anatomy and Death Certification team
Janice Nicolson	Principal Educator, Medical Education	NHS Education for Scotland
Carolyn Nickels	Head of Registration	National Records of Scotland
Rosemary Pengelly	Public Partner	Healthcare Improvement Scotland
Elainne Sibbald	Principal Procurator Fiscal Depute	Scottish Fatalities Investigation Unit
Dr Ruth Stephenson	Deputy Senior Medical Reviewer	Healthcare Improvement Scotland (DCRS)
Maria Stirling	Specialty Trainee	Scottish Academy of Trainee Doctors
Andrea Telford	Service Manager	Healthcare Improvement Scotland (DCRS)
Maggie Buettner Young	IT Programme Manager & Engagement Lead	National Services Scotland (Digital and Security)

Appendix 1: Service data

The tables below provide a more detailed breakdown of the service data over the last 3 years[21]. Percentages have been rounded to 1 decimal place. This means they do not always add up to 100%.

Table 1: Cases reviewed by type

Case type	Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023- 31 Mar 2024	
Standard Level 1 and Level 2	5444	(98.2%)	5875	(96.8%)	6174	(97.2%)
Repatriation	87	(1.6%)	191	(3.1%)	178	(2.8%)
Interested Person	11	(0.2%)	4	(0.1%)	1	(0%)
Registrar Referral	2	(0%)	0	(0%)	1	(0%)
MR For Cause Referral	0	(0%)	0	(0%)	0	(0%)
Total	*5544*		*6070*		*6354*	

Table 2: Number and percentage of 'not in order' standard cases by outcome

Outcome	Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024	
Email amendments	892	(88.4%)	869	(84.8%)	985	(88.1%)
Replacement MCCD	117	(11.6%)	156	(15.2%)	134	(11.9%)
Total	*1009*		*1025*		*1118*	

Table 3: Number and percentage of clinical closure categories for MCCDs with errors

Closure Category	Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024	
Cause of Death too vague	351	(48.2%)	279	(37.3%)	316	(40.6%)
Cause of Death incorrect	92	(12.6%)	114	(15.2%)	121	(15.6%)
Sequence of Cause of Death incorrect	167	(22.9%)	174	(23.3%)	213	(27.4%)
Causal timescales incorrect	167	(22.9%)	168	(22.5%)	158	(20.3%)
Conditions omitted	129	(17.7%)	135	(18%)	140	(18%)
Disposal Hazard incorrect	45	(6.2%)	74	(9.9%)	59	(7.6%)
Total	*951*		*944*		*1007*	

Note: there can be more than one closure category error in each case

[21] Data source: Death Certification Review Service eCMS and National Records of Scotland.

Table 4: Number and percentage of cases with closure category 'administrative error'

Administrative Error	Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024	
Attendance on the deceased incorrect	49	(11.8%)	38	(9%)	44	(9.4%)
Abbreviations used	65	(15.7%)	53	(12.6%)	63	(13.5%)
Certifying Doctor's details incorrect	44	(10.6%)	18	(4.3%)	24	(5.2%)
Certifying Doctor Spelling error	133	(32.1%)	172	(41%)	179	(38.4%)
Consultant's name incorrect	6	(1.4%)	13	(3.1%)	7	(1.5%)
Date or time of death incorrect	67	(16.2%)	80	(19%)	102	(21.9%)
Deceased details incorrect	34	(8.2%)	29	(6.9%)	39	(8.4%)
Extra information (X Box) incorrectly complete	46	(11.1%)	37	(8.8%)	36	(7.7%)
Legibility	4	(1%)	3	(0.7%)	0	(0%)
PM information incorrect	7	(1.7%)	9	(2.1%)	8	(1.7%)
Place of death address incorrect	11	(2.7%)	6	(1.4%)	13	(2.8%)
Other Additional information incorrect	4	(1%)	3	(0.7%)	2	(0.4%)
Total	*470*		*461*		*517*	

Note: there can be more than one administrative error in each case

Table 5: Cases reported to procurator fiscal by type

Case type	Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024	
Standard Level 1 and Level 2	255	(98.8%)	228	(100%)	199	(99.5%)
Interested Person	3	(1.2%)	0	(0%)	1	(0.5%)
MR For Cause Referral	0	(0%)	0	(0%)	0	(0%)
Registrar Referral	0	(0%)	0	(0%)	0	(0%)
Total	*258*		*228*		*200*	
% cases reported to PF	4.7%		3.9%		3.2%	

Table 6: Reasons Cases reported to procurator fiscal

Reason for reporting to PF	Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2022 - 31 Mar 2023	
Choking	6	(2.3%)	5	(2.2%)	3	(1.5%)
Concerns Over Care	15	(5.8%)	5	(2.2%)	9	(4.5%)
Drug Related	3	(1.2%)	2	(0.9%)	6	(3%)
Flagged in Error	0	(0%)	0	(0%)	0	(0%)
Fracture or Trauma	86	(33.3%)	96	(42.1%)	103	(51.5%)
Industrial Disease	54	(20.9%)	77	(33.8%)	68	(34%)
Infectious Disease	85	(32.9%)	42	(18.4%)	2	(1%)
Legal Order	4	(1.6%)	3	(1.3%)	4	(2%)
Neglect or Exposure	3	(1.2%)	3	(1.3%)	7	(3.5%)
Stroke	0	(0%)	0	(0%)	0	(0%)
Other Report to PF	4	(1.6%)	1	(0.4%)	1	(1%)
Total Cases	*258*		*228*		*200*	

Note: there can be more than one reason in each case

Table 7: Number of calls received by the enquiry line

	Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024	
eMCCD issue	0	(0%)	0	(0%)	0	(0%)
Funeral Director	11	(0.5%)	16	(0.6%)	23	(1%)
GP Clinical Advice	1511	(66.3%)	1716	(67.4%)	1637	(67.8%)
GP Process Advice	154	(6.8%)	157	(6.2%)	130	(5.4%)
Hospice Clinical Advice	40	(1.8%)	36	(1.4%)	63	(2.6%)
Hospice Process Advice	6	(0.3%)	10	(0.4%)	5	(0.2%)
Hospital Clinical Advice	346	(15.2%)	384	(15.1%)	349	(14.5%)
Hospital Process Advice	44	(1.9%)	48	(1.9%)	39	(1.6%)
Informant/family	52	(2.3%)	34	(1.3%)	40	(1.7%)
Interested Person	6	(0.3%)	3	(0.1%)	2	(0.1%)
Other	27	(1.2%)	42	(1.6%)	26	(1.1%)
Procurator Fiscal	6	(0.3%)	8	(0.3%)	11	(0.5%)
Registrar	23	(1%)	45	(1.8%)	38	(1.6%)
Repatriation	1	(0%)	3	(0.1%)	5	(0.2%)
Signposted	40	(1.8%)	44	(1.7%)	47	(1.9%)
No advice type recorded	12	(0.5%)	0	(0%)	0	(0%)
Total	*2279*		*2546*		*2415*	

Table 8: Advance registration requests with outcomes

Request outcome	Year 7 01 Apr 2021 - 31 Mar 2022		Year 7 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024	
Approved	45	(73.8%)	63	(86.3%)	49	(75.4%)
Not approved	16	(26.2%)	10	(13.7%)	16	(24.6%)
Review outcome						
In order	52	(85.2%)	56	(76.71%)	54	(83.1%)
not in order	8	(13.1%)	13	(17.81%)	8	(12.3%)
PF	1	(1.6%)	4	(5.48%)	3	(4.6%)
Total	*61*		*73*		*65*	

Table 9: Number (and percentage) of Breached Cases

Reason for breach	Year 7 01 Apr 2021 - 31 Mar 2022		Year 8 01 Apr 2022 - 31 Mar 2023		Year 9 01 Apr 2023 - 31 Mar 2024	
Certifying doctor unavailable	193	(88.1%)	196	(84.1%)	141	(83.9%)
DCRS delay	0	(0%)	10	(4.3%)	6	(3.6%)
Delay in obtaining/receiving required information*	0	(0%)	25	(10.7%)	20	(11.9%)
Other	26	(11.9%)	2	(0.9%)	1	(0.6%)
Total	*219*		*233*		*168*	

**Includes delay in obtaining additional information, receiving medical notes, or receiving email amendment/replacement*

Note: In 2022, the service reviewed and updated the closure categories for breached reasons to support better reporting. Historical data around reasons for breached SLA times can be found in previous DCRS Annual Reports

Table 10: Number and percentage of interested person reviews

	Year 7		Year 8		Year 9	
Request outcome	01 Apr 2021 - 31 Mar 2022		01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024	
Not Approved	1	(9.1%)	2	(50%)	0	(0%)
Approved	10	(90.9%)	2	(50%)	1	(100%)
Total Requests	*11*		*4*		*1*	
Review outcome approved						
In order	3	(30%)	1	(50%)	0	(0%)
Not in order	4	(40%)	1	(50%)	0	(0%)
Reported to PF	3	(30%)	0	(0%)	1	(100%)

Table 11: Number and percentage of registrar referral reviews

	Year 7		Year 8		Year 9	
Review outcome	01 Apr 2021 - 31 Mar 2022		01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024	
In order	0	(0%)	0	(0%)	0	(0%)
Not in order	2	(100%)	0	(0%)	1	(100%)
Escalated to PF	0	(0%)	0	(0%)	0	(0%)
Total	*2*		*0*		*1*	

Table 12: Number and percentage of repatriation reviews

	Year 7		Year 8		Year 9	
Request outcome	01 Apr 2021 - 31 Mar 2022		01 Apr 2022 - 31 Mar 2023		01 Apr 2023 - 31 Mar 2024	
Approved	87	(100%)	191	(100%)	178	(100%)
Not approved	0	(0%)	0	(0%)	0	(0%)
Total	*87*		*191*		*178*	

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