Learning from the Deaths of Children and Young People (National Hub): Using evidence to deliver change and improve outcomes

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Background

Scotland has a higher mortality rate for under 18s than any other Western European country, with over 300 children and young people dying every year. It is estimated that around a quarter of those deaths could be prevented.

There is currently no national system to support review or to share national learning, and not all deaths are reviewed. The quality of reviews also varies across services, and Scotland.

Who we are

The Scottish Government requested a system be established for reviewing and learning from the circumstances surrounding the deaths of all children and young people in Scotland, with an aim to co-ordinate all current review activity.

Healthcare Improvement Scotland, in collaboration with the Care Inspectorate, are the co-hosts of the **National Hub** for Reviewing and Learning from the deaths of Children and Young People.

Our plans for change

Aim to ensure the death of every child in Scotland is subject to a quality review by:

- developing methodology and documentation to ensure all deaths are reviewed through a high quality, consistent process
- improving the quality and consistency of existing reviews
- improving the experiences of families and
- channelling learning from current processes to help reduce preventable deaths.

Reviews will be conducted into the deaths of all live born children up to the date of their 18th birthday, or 26th birthday for care leavers who are in receipt of aftercare or continuing care at the time of their death.

Where we started

Conducted a baseline scoping exercise to investigate the types of reviews being carried out, and understand why some deaths are not reviewed	A path-finding exercise was carried out by three NHS boards to evaluate existing child death review systems and compare local and national processes
Working with National Records of Scotland (NRS) to develop a notification system for receiving data regarding the deaths of children and young people	Established an Expert Advisory Group (with clinical and non-clinical representatives) to provide an overall advisory role

What we have achieved (so far)

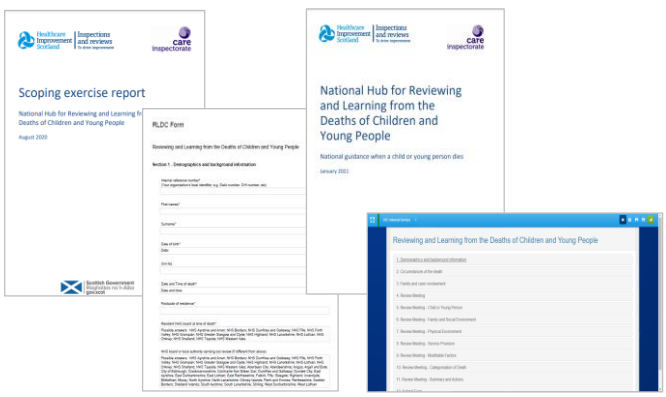
Developed a core review data set, for use by NHS boards and local authorities, and an online portal for collating data	Established a short-life working group to test the core review data set against current review systems
Developed National Guidance that sets out the process NHS boards and local authorities should follow when reviewing a death	Requested all NHS boards and local authorities nominate an implementation lead to support implementation
Established links with third sector on how to engage with families and carers, and ask what they would like in a review process	Secured agreement with the Knowledge Hub to develop a Community of Practice website to share information with colleagues

How will we make a difference?

For the first time in Scotland, national data will be collected on the deaths of **ALL** children and young people.

The health and social care system in Scotland will work collaboratively to reduce avoidable deaths of children and young people by informing the redesign of pathways and services. Where death is inevitable, we aim to improve this process for children, families and carers by learning from quality reviews.

The new National Child Death Review system will be fully implemented by 1 October 2021



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