National Hub for reviewing and learning from the deaths of children and young people

7-minute briefing for GPs – CDR process

Healthcare Improvement Scotland

care inspectorate

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Scotland has a higher mortality rate for under-18s than most other Western European countries. Around 300 children and young people die each year. Around a quarter of those deaths could be prevented. Healthcare Improvement Scotland, in collaboration with the Care Inspectorate, hosts the National Hub for reviewing and learning from the deaths of children and young people.

We use a multidisciplinary and multi-agency approach, focused on using evidence to deliver change.

2

The National Hub aims to:

- ensure that the death of every child in Scotland is subject to a quality review
- improve the experiences and engagement with families and carers, and
- share learning from reviews across Scotland that could direct action to help reduce preventable deaths.

3

Since 1 October 2021, reviews are 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 continuing care or aftercare at the time of their death.

Reviews do not seek to apportion blame but to identify learning that can lead to improvements in quality of care.

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Once the relevant NHS board of residence has become aware that a child or young person registered with your practice has died, the board and local authority will decide what type of review should be carried out and who should be involved in the review.

Where appropriate, the organisation leading the review will invite you and the bereaved family and carers to contribute.

The review should identify any contributory and modifiable factors, details of the care provided and any lessons that could inform service improvement or reduce the risk of future deaths.

5

National Hub guidance recommends that all bereaved families and carers should be given a single named key contact, whose role includes supporting them through the review process.

Families and carers should be informed of the review, and asked to input any questions they would like answered at the review. They must also be provided with feedback from the review, including responses to their questions.

Ideally, the key contact's details should also be made available to you.

6

Following the review, the NHS board will securely submit a core review data set to the National Hub. The data set captures key information from the child or young person's life and the circumstances surrounding their death.

Since October 2021 in Scotland, collecting these data sets allows national analysis and identification of themes and trends for the first time. Read our first Data overview report, March 2024.

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See and share the National Hub's bereavement support leaflet, Supporting families in Scotland with the child death review process. It contains clear information about the review process when a child dies, including what to expect and where to find bereavement support.

Find out more about the National Hub on the Healthcare Improvement Scotland website or email the team at his.cdrnationalhub@nhs.scot