

National Hub for Reviewing and Learning from Deaths of Children and Young People

7 minute briefing for GPs



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Scotland has a higher mortality rate for under-18s than any other Western European country, with over 300 children and young people dying each year. Around a quarter of those deaths could be prevented.

Healthcare Improvement Scotland, in collaboration with the Care Inspectorate, co-host 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, and will ultimately aim to reduce preventable deaths and harm to children and young people.

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The National Hub aims to:

- ensure 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 review processes across Scotland that could direct action to help reduce preventable deaths.

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From 1 October 2021, quality reviews using a consistent process 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.

The aim of reviews is not to apportion blame – they should identify learning that can lead to improvements in quality of care.

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Once the responsible NHS board has become aware that a child or young person registered with your practice has died, the NHS 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 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.

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Following the review, a [core review data set](#) will be completed and sent to the National Hub.

The data set captures key information from the child or young person's life and the circumstances surrounding their death.

This will mean that for first time in Scotland, we will have national data, which will allow national analysis and identification of themes and trends.

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The National Hub [guidance](#) says that all bereaved families and carers should be given a single named point of 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. The details of this named contact should also be made available to GPs.

Please contact the [National Hub](#) team if you're having trouble contacting your NHS board or local authority.

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See further information including the national guidance, core review data set and information for families and carers [here](#).

We are also developing a national leaflet with our third sector partners. It will explain the different types of reviews that may be carried out, as well as the role of the National Hub and other national organisations.