

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

## Overview Report: Year 1 (Implementation year)

1 October 2021 to 30 September 2022

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## Foreword



*When I read this report, I am struck by the monumental transformation in the culture around child deaths and the review of them across Scotland, facilitated by the development of the National Hub since going live in October 2021. The groundwork had already been set by prior scoping of existing services, production of national guidance, engagement of early adopter sites, and enormous enthusiasm from all partners and stakeholders to adapt and innovate.*

*I am very proud of the National Hub team's commitment and enthusiasm to encourage collaboration between services and agencies, to open up communication channels and to support sharing learning and co-production of resources. This report details the enormous progress that has been made in all of these areas and references our support documents and other help available to encourage everyone to continue to develop and innovate.*

*Nonetheless, none of this would be possible without hearing the voices of bereaved families and listening to their desire to make improvements for future families following the death of their child. Speaking as a clinician, this is what drives us to change.*

*I look forward to continued collaborative working with our stakeholders – each of us keeping children, young people and their families at the forefront of our minds - as we pursue our priorities in the current year and beyond.*

***Alison Rennie, Consultant Paediatrician and National Hub Clinical Lead***



# Introduction

This report provides an overview and analysis of the first year's activity following the launch of the National Hub for Reviewing and Learning from the Deaths of Children and Young People (National Hub) on 1 October 2021. This first year, or implementation year, marks an important milestone in the development and delivery of the National Hub and the changes that have been implemented nationally.

This report provides an update on the National Hub's achievements and challenges during the year and offers initial reflections on the progress made by NHS board and local authorities\* as they implement new arrangements to review child deaths. It provides a foundation to inform the National Hub's first annual report, due to be published autumn 2023.

\*While we refer to local authorities throughout this report, this also takes account of Health and Social Care Partnership arrangements in local authority areas

# Background

Scotland has a higher mortality rate for under 18s than most other Western European countries, with around 300 children and young people dying every year<sup>1</sup>. It is estimated that a quarter of those deaths could be prevented<sup>2</sup>.

With no national system to support the review and learning from the deaths of children and young people, or to share national learning, Scottish Government requested that a National Hub be established, co-hosted by Healthcare Improvement Scotland and the Care Inspectorate to:

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

Reviews should be conducted on the deaths of all live born children up to the date of their 18<sup>th</sup> birthday, or 26<sup>th</sup> birthday for young people who are in receipt of continuing care or aftercare provision at the time of their death. This criteria reflects the shift in policy, practice and culture as set out in United Nations Convention on the Rights of the Child (UNCRC) and the principles of the Promise.

Phased implementation of the new child death review system was due to begin on 1 April 2020. Due to the COVID-19 pandemic, it was agreed by Scottish Government that implementation be postponed to 1 April 2021. Given the demands on local NHS boards and local authorities with respect to both the ongoing pandemic and the remobilisation efforts, Scottish Government subsequently agreed to a revised local implementation date of 1 October 2021.

The National Hub was formally launched on 1 October 2021.

A summary of outputs from the National Hub pre-implementation phase can be found in [Appendix 1](#).

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<sup>1</sup> National Records of Scotland. [Vital Events Reference Tables](#) [online]. 2021 [cited 2023 Jan 26].

<sup>2</sup> National Records of Scotland. [Avoidable Mortality](#) [online]. 2022 [cited 2023 Jan 26].

# National Hub activity for 2021-2022

This section of the report outlines the key activities and outputs from the National Hub during the implementation year (October 2021 to September 2022).

## Stakeholder engagement

Throughout the year, we met regularly with representatives from our established stakeholder groups ([Appendix 2](#)).

- **The National Hub governance group**, with representatives from Scottish Government, Healthcare Improvement Scotland and the Care Inspectorate met quarterly to oversee the strategic direction of the National Hub.
- We reviewed the terms of reference of our **expert advisory group** and revised the membership to ensure broad representation across local and national services and statutory and third sector organisations.
- Our **third sector forum** provided invaluable support as we reached out to bereaved parents and carers to improve our understanding of their experiences following the death of their child.
- The short-life working group, which includes our three pilot areas, has evolved to become the **expert advisory working group** and now includes representatives from NHS Greater Glasgow and Clyde. As early implementers of the new arrangements to review child deaths, the group has been hugely beneficial in supporting shared learning, exchange of ideas, identifying potential challenges and possible solutions, and offering a valuable sounding board for the National Hub team. Members of the group have supported the trialling of our guidance, templates and tools and helped inform aspects of further development of our work.
- We recognised the benefits of sharing learning on a UK-wide basis and initiated the first **Four Nations meeting** with our counterparts from England, Northern Ireland and Wales. This initial meeting identified significant opportunities for shared learning. A terms of reference was developed, and a programme of quarterly meetings established. Key contacts have been set up to enable collaboration on deaths across borders, and we have already received feedback from one NHS board area on the benefits of this.

Through our networks, we have continued to expand connections with key groups, services and organisations where there may be crossover in the work we do. Some examples of those we have connected with include the following:

**Water Safety Scotland (WSS)** - Drowning is among the leading causes of accidental deaths in Scotland. WSS is a voluntary association of organisations and individuals whose main purpose is to understand the risks around water in Scotland and engage with partners to develop a consistent approach to the prevention of water-related fatalities. Following discussions with WSS we have highlighted in our guidance to those carrying out reviews the importance of linking with WSS if a death is water related. The WSS Drowning and Incident Review (DIR) process aims to gather data and understand the contributory factors of a water-related incident to help gain a better understanding of how to prevent similar incidents occurring in future. **Our December 2022 national implementation leads meeting presented a case study and learning from an NHS board and WSS on the review of a water related fatality.**

**Foreign, Commonwealth and Development Office (FCDO).** Our criteria for review includes children and young people who die abroad. However, these deaths do not form part of the death registration information we receive from National Records of Scotland (NRS). In seeking other sources of information about such deaths, we:

- made arrangements with the Healthcare Improvement Scotland Death Certification Review Service to provide us with information on children and young people who die abroad and are repatriated to Scotland, and
- met with the FCDO to put in place arrangements to receive notifications for any child or young person who is a Scottish citizen who dies abroad, and recently received our first notification from them.

We have linked closely with **PELiCaN (Paediatric End of Life Care National Managed Clinical Network)** as we recognise the important crossover between their work and ours, especially our shared goals of improving families and carers' engagement and reducing data duplication.

We have met with organisations leading on **suicide reviews and drug death reviews** to explore ways in which we can share learning, both from our respective processes and also shared learning arising from the deaths of children and young people.

**Police Scotland**, in line with the definition of a child as set by the UNCRC and the criteria for review set by the National Hub, have extended their criteria for child death investigation to all children up to the age of 18 years. From January 2022, any unexpected death of a child, the cause of which is unascertained, has had a child death senior investigating officer (CD SIO) appointed to oversee the investigation – this provision previously only extended to children under 16 years. A CD SIO has undergone additional training and ensures all child deaths are investigated thoroughly while remaining proportionate and supportive to the family.

We are mindful that there is a range of services/organisations who have an interest in the learning arising from child deaths and will continue to maintain and expand our contacts during the coming year. More information about our ‘keeping connected with’ groups can be found in [Appendix 2](#).

## Supporting implementation and shared learning

### Meetings with individual NHS boards and local authorities

We met with representatives from individual NHS boards and their aligned local authorities twice during the year to discuss progress made in implementing new arrangements and to identify learning that could usefully be shared with other areas.

We structured our engagement meetings under the following headings:

- Governance and leadership
- Review processes and partnership working
- Family and carer engagement, and
- Sharing learning

### Governance and executive leadership

Executive leadership for child death reviews in NHS board areas varied, with this held by those with clinical leadership responsibilities, such as medical or nursing directors in some areas, or with public health consultants in others. Levels of involvement of executive leads

varied too, with some more actively engaged than others. We are keen to explore further the impact of these arrangements during future meetings with NHS boards and local authorities.

Establishing clear governance and reporting arrangements has been a challenge for some areas. This is not surprising given the range of existing child death review processes and various reporting arrangements which were already in place prior to establishment of the National Hub. In addition, there are differing partnership arrangements for children's services across the country.

NHS boards are reporting child death review activity to their respective NHS clinical governance groups. Some areas have established links to children's services strategic planning groups ensuring a partnership overview of all the learning arising from all child deaths in the area. Links with child protection committees have been established in all areas.

**The National Hub created a guidance note with key prompts for NHS boards and local authorities to consider as they establish, review and refine their governance arrangements.**

**Governance and executive leadership will continue to be an area for discussion during future engagement meetings.**

#### [Review processes and partnership working](#)

As highlighted above, the diversity of Scotland's demographic, differing organisational structures within NHS boards and local authority areas and existing review arrangements for child deaths, meant that it was not possible to have a single universal approach to the development of new review processes.

It is clear from our discussions that NHS boards and local authorities have invested time, energy and resources into establishing their new systems. Most areas had undertaken a mapping exercise to give them a clearer understanding of existing processes for child death reviews and to consider how best to align these. While systems had been established to review child deaths occurring within a hospital environment, mechanisms to review deaths which took place within a community setting were less developed.

Larger areas had created new systems to ensure that child deaths were identified quickly and that meetings took place regularly to monitor and track progress of reviews. In areas where child deaths occurred less frequently, a more individualised approach, aligned with existing review processes, occurred. We heard about different levels of representation at these meetings, which in some areas reflected resource and capacity demands. A few areas had begun to rationalise representation and were finding a more focused 'core group' was able to progress review activity more quickly.

Some areas, particularly those with a higher number of child deaths, highlighted dedicated administrative support as being vital to the co-ordination of review activity and had invested

in this to ensure the effective management of the review process. Where dedicated lead clinician time was provided, this was found to be significantly beneficial however this was not universal across all NHS boards.

Most board areas spoke positively about improved collaboration and information flows between the NHS board and aligned local authorities. Issuing NRS data to both the NHS board and the relevant local authority was prompting early conversations and discussion about the type of review process that should be conducted. While we were beginning to see a shift in practice by a few areas towards one multi-agency review rather than separate review processes, this was not yet consistent, and we were aware anecdotally of multiple reviews still occurring. While the National Hub is not prescriptive about the type of review that should be conducted, a key principle of the review process is that wherever possible, there should only be one single review of a child's death.

**The National Hub has created a guidance note to support multi-organisation reviews and further work is in progress to develop more comprehensive guidance in relation to parallel reviews where this is required. Decision-making about the type of review process to conduct following the death of a child or young person (or young adult) will be an area for ongoing discussion with NHS boards and local authorities during 2023.**

Areas spoke about positively about the involvement of partner agencies such as Police Scotland, Scottish Ambulance Service, social work and education services within reviews and the benefits this wider contribution brings to gaining a holistic and more comprehensive view of a child's life. The involvement of general practitioners in review processes has been limited. **The National Hub has produced a 7-minute briefing for GPs and NHS boards have been encouraged to share this widely to raise awareness of the GP role in child death reviews.**

All areas spoke of the importance of staff support following a child death. We were encouraged to hear many positive examples of ways in which staff were being supported and helped to participate in reviews. This included debrief sessions, offers of chaplaincy support for staff both generally and in review meetings and how one area had developed a video and FAQ for staff to raise awareness of the review process. Several areas conveyed that while some staff had felt anxious before a review meeting, feedback following the meeting suggested that their involvement had been positive, and that they had welcomed the focus on learning. We will continue to encourage and support NHS boards and local authorities to create and promote the pre-conditions and a culture which values reflection and shared learning to support improvement.

A recurring theme from our engagement meetings was that NHS boards and local authorities believe that reviewing child deaths is worthwhile and of significant value, and that it requires resources to do it well. They were of the view that sustained investment was needed to develop and maintain a high quality review system. This is a particular challenge for NHS board areas where there are a high number of child deaths.

## Family and carer engagement

The extent to which areas had developed arrangements to involve and engage with families and carers as part of the review process varied. All areas were exploring ways to ensure a key contact for the family was allocated and that families were supported at the right time, and in the right way, to contribute any questions they had for the review team to consider and respond to.

We heard about the creation of new posts or dedicated roles to provide co-ordination and support to bereaved families, and changes being made to existing roles such as chaplaincy and bereavement co-ordinators. One area had created a single, central resource providing information on bereavement support that could be accessed by all agencies and were working on an approach to ensure this was kept up to date.

## Shared learning

From our engagement meetings and work presented through our national meetings, there was wide recognition of the value of child death reviews and a real willingness to share the learning from the process of establishing systems and conducting reviews. Some areas told us that they had benefited significantly from offers to shadow review meetings being held in larger board areas, and that access to shared documents and templates available on our community of practice site had been helpful and reduced duplication of effort. It was too soon to see the learning from individual reviews and how this is cascaded, however we will explore this further with NHS boards at future meetings.

Overall, NHS boards and local authorities have valued these engagement meetings with the National Hub team, and we plan to continue these opportunities for discussion and reflection in 2023. **We will undertake a survey with implementation leads prior to the next cycle of meetings to inform and focus our discussions on aspects of local implementation.**

## National implementation leads meetings

We hosted two national meetings with implementation leads and staff involved in establishing child death review arrangements in their local area, with the aim of supporting shared learning and making connections with peers. Sessions were well attended, with 40 and 56 attendees joining the December 2021 and June 2022 meetings respectively.

Sessions to date have focused on sharing practical examples of learning from our early implementation sites, promoting the work of national organisations such as Police Scotland, the Scottish Ambulance Service, and drawing lessons from other learning systems, for example adverse events. The National Hub team also delivered a training session on the core review dataset alongside the launch of refreshed guidance.

We gathered feedback on the usefulness of these sessions and requested topics of interest to shape future meetings. Overall, feedback has been very positive, with attendees valuing the opportunity to learn from others and to engage directly with the National Hub team.

### Community of practice

We created an online community of practice as a safe space for those involved in child death reviews to share resources, post questions and to signpost to relevant events and news. Our community continues to grow, with 97 registrants (October 2022). At a recent national meeting, we asked for feedback on the usefulness of our community of practice. Key responses were that the site was easy to use, and that the sharing of information, tools and templates was highly valued and provided useful insight into work other areas were progressing.

Based on the feedback received, we developed a 'frequently asked questions' (FAQ) document built from discussion threads and email queries received into the National Hub mailbox. **We will update the FAQs six-monthly to reflect any emerging themes.**

### Ongoing development of resources and guidance

Informed by discussions at our stakeholder groups and implementation leads meetings, we refreshed our report [\*When a child dies: Learning from the experiences of bereaved families and carers\*](#). Guidance to support completion of the core review data set was expanded, and we posted a recorded learning session with implementation leads on our community of practice.

Supplementary guidance notes were also produced in relation to information sharing, cross board reviews and a 7-minute briefing for general practitioners.

Additional supplementary guidance due for completion during 2022-2023:

- Multiple process reviews (in conjunction with the Crown Office and Procurator Fiscal Service (COPFS)).
- An optional national information sharing agreement template for use by NHS boards and local authorities.

We encouraged NHS boards and local authorities to contact the National Hub out with planned meetings through our dedicated mailbox, and queries were responded to either directly by email or through MS teams calls. Examples include:

- advice on a death occurring overseas or elsewhere in the UK,
- orientation for new implementation leads,
- provide a 'sounding board' for areas as they develop new processes,
- information sharing queries,
- information about safer sleeping, and
- requests for information from Scottish Government.

While we have not recorded the volume of this activity, we are conscious that the number of direct contacts from organisations is increasing. **From October 2022, we will capture data on all queries to the National Hub to better identify recurring themes and inform future developments.**

### Support for funding for NHS boards

Through our links with Scottish government, they have supported funding for NHS boards for 2022-2023, with an extension to include the Island NHS boards. We plan to discuss with NHS boards how this funding has been used during our engagement meetings in 2023.

### Family engagement

A key objective of the National Hub is to improve the experiences of, and engagement with bereaved families and carers. With the support of our third sector forum partners, we developed a survey to help improve our understanding of families' and carers' experiences following the death of their child. Feedback from bereaved families informed our [report](#), published in June 2022, which highlights that:

- Families and carers' experiences of care and support following the loss of their child varied considerably. While some families spoke very positively about the compassionate care and practical and emotional support they received, others faced difficulties in accessing the help they needed.
- Families and carers did not always understand the review process or how they could contribute to it, and not all felt they were kept informed about the progress of the review.
- Families felt that their capacity to process or retain new information was significantly impacted following their child's death, and that this was not always recognised by staff.

The report highlighted the need for families to have a key contact person to prevent them having to repeat their story to different professionals, clarify expectations and help guide them through the review process.

We made eight recommendations, including four directly for NHS boards, local authorities/health and social care partnerships and public protection committees. Two recommendations relate to the National Hub. One is to conduct a further survey with parents once child death review arrangements have been more fully embedded to establish where change and improvement has been made and the difference this makes to bereaved family's experiences. The second recommendation relates to feedback from families who

said that an information leaflet would be helpful, particularly as they experienced difficulties retaining new information. We are currently working with third sector partners and consulting with bereaved parents on the development of this.

## Data sharing and analysis

While various information sharing protocols and impact assessments were in place prior to the implementation year, achieving Public Benefit and Privacy Panel approval in October 2021 marked an important landmark. We subsequently launched a notification system to enable the sharing of data between the NRS, the National Hub and NHS boards and local authorities. We worked with implementation leads to identify designated contacts in each area who would receive a weekly information data list relating to child deaths in their area.

From NRS data provided to the National Hub, we can conclude that there were 286 deaths during the first year of National Hub implementation. Almost 60% (170) of all deaths occurred in infants under the age of 12 months, with the majority of those occurring during the neonatal period (Figure 1). The number of deaths was consistent across age groups for the remaining children under 18 years, with the exception of those in the 5-9 years age group, and young adults who met our criteria for review aged 18-25 years. Fifty seven percent of all deaths were male; 43% female (Figure 2).

We are unable at this stage to provide further comprehensive analysis of the data on child deaths occurring during 2021-2022 for several reasons. The timeframe from notification of a death to conclusion of a review can vary depending on factors such as ongoing investigation of a death, or capacity issues within NHS boards and local authorities. A core review data set containing the information required for analysis can only be submitted to the National Hub on completion of the review. Therefore, only a proportion of reviews of deaths occurring during the implementation year had been concluded by the end of September 2022. In addition, ongoing delays in the establishment of a secure online portal meant that the National Hub was unable to receive core review data set information. It is anticipated that this issue will be resolved at the start of 2023.

A more detailed analysis of data will be included in the National Hub's first annual report (anticipated publication autumn 2023).

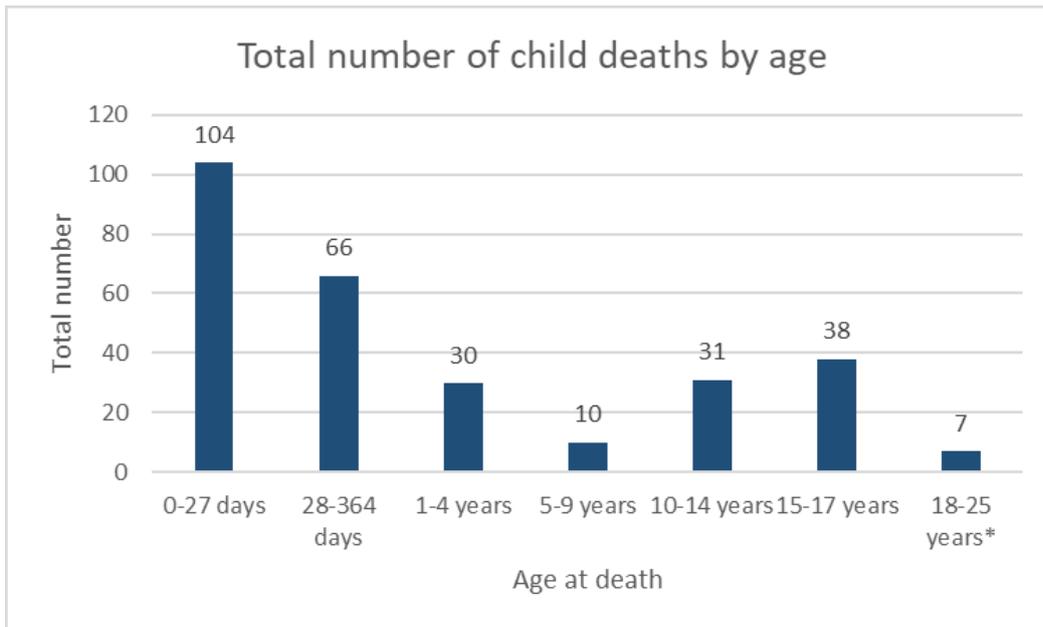


Figure 1: Total number of deaths by age (1 October 2021 to 30 September 2022).

\* Deaths of young people aged 18-25 years in receipt of continuing care or aftercare provision at the time of death

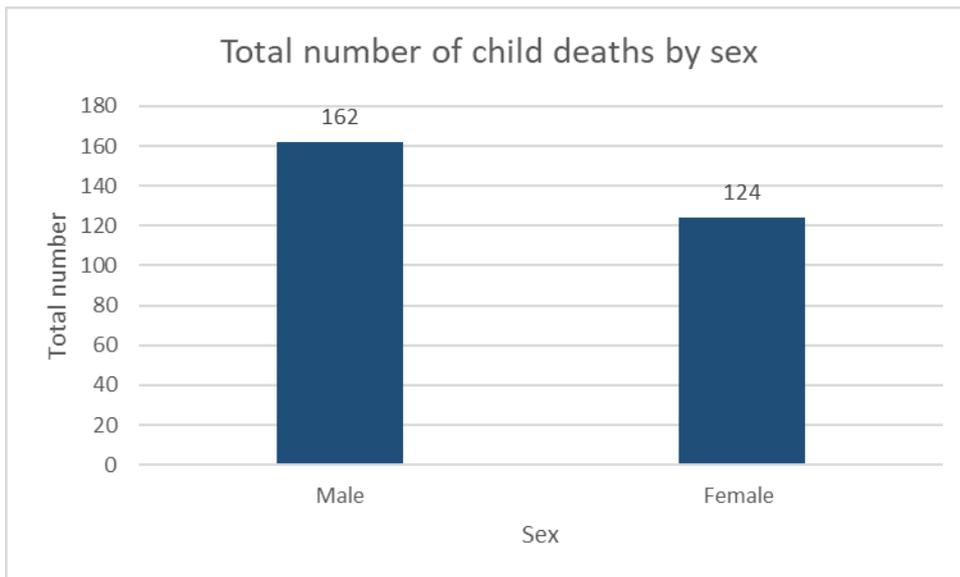


Figure 2: Total number of deaths by sex (1 October 2021 to 30 September 2022)

**From other sources of data we received on deaths outside Scotland, we note:**

- 1 notification from the Foreign, Development and Commonwealth Office
- 12 notifications from the Death Certification Review Service
- 1 notification from NHS England

## Care Inspectorate and National Hub interface

While the National Hub has an overview and analysis of the learning from the deaths of all children and young people, the Care Inspectorate retains responsibility on behalf of Scottish Government to review the quality of reports provided where the death has concerned a looked after child or care leaver, and to provide feedback to the relevant local authority/partnership. It is accepted that existing statutory requirements require updating to reflect a more multi-agency approach<sup>3 4</sup>. We will continue discussions with Scottish Government policy colleagues regarding the regulations covering deaths of looked after children, and opportunities to review and revise guidance. In the meantime, local authorities will continue to notify the Care Inspectorate of these deaths, along with a requirement to provide a report on the death of any looked after child.

We have worked together to ensure that wherever possible, National Hub and Care Inspectorate processes align, and that NHS boards and local authorities are clear about the respective areas of responsibility. Guidance on the notification and reporting of the deaths of looked after children and young people in receipt of continuing care or aftercare by local authorities has been refreshed to incorporate both the Care Inspectorate and National Hub processes.

We plan to further develop the core review dataset to more fully capture information on the deaths of older young people and care leavers. We will work together with key stakeholders to do this.

## Promoting the work of the National Hub

While the value of the National Hub and of reviewing child deaths has been widely acknowledged, we are mindful of the need to continue to extend the awareness of our work, particularly during times of competing service/organisational demands, the impact of the ongoing pandemic and workforce challenges. We endeavour to communicate updates on the work of the programme in various ways:

- Quarterly flash reports, accessible on the [National Hub webpage](#)
- Social media – twitter, blogs
- Media releases
- Updates to service or organisational meetings
- Poster presentation for conferences.

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<sup>3</sup> The Children (Scotland) Act 2014 introduced a new duty on local authorities to provide continuing care and extended eligibility for the receipt of aftercare to all categories of young people who cease to be looked after on or after their 16th birthday up until their 26th birthday.

<sup>4</sup> Regulation 6 of the Looked After Children (Scotland) Regulations 2009 instructs that local authorities have a duty to notify Scottish Ministers and the Care Inspectorate of the death of a looked after child and make arrangements to carry out a review.

Our stakeholder chart ([Appendix 2](#)) illustrates the wide range of stakeholders that we meet with regularly as well as those we keep informed about our work. Our communications plan, refreshed twice yearly, details our approach.

# Conclusion and priorities for 2022-2023

At a time of unprecedented demand on public services, there have clearly been challenges for NHS boards and local authorities as they establish new arrangements to review all child deaths. These relate mainly to resources and the administration of reviews, governance arrangements, and engaging families in the review process in the right way and at the right time.

Despite these challenges, NHS boards and local authorities have made significant progress in the development of new systems and processes. They too have recognised the value that learning from reviews brings and are working to create a culture of open and reflective learning, engaging staff across services/organisations, and bereaved families in the review process.

Through the strong networks and firm foundation established prior to, and throughout the implementation year, the National Hub team will continue to support local areas as they embed fully their review arrangements.

The National Hub team has identified the following priority activities for 2022-2023:

## **1. Provide ongoing support to NHS boards and local authorities to ensure every child death is subject to a quality review.**

- Continue engagement meetings with NHS boards and aligned local authorities twice a year. In advance of the first meeting, we will survey implementation leads on their experiences of year 1 to enable a more focused discussion.
- Implement a process to receive quarterly progress updates on reviews from NHS boards.
- Further explore decision making by NHS boards, local authorities, and partners in determining the type of review to be conducted to mitigate the risk of multiple reviews. We will launch multiple review process guidance.
- Build on existing guidance, resources and opportunities for learning informed by our stakeholders.

## **2. Continue to develop systems to support information sharing and learning.**

- Launch the cloud-based portal to enable the secure sharing of data from NHS boards and local authorities to the National Hub.
- Publish a national information sharing agreement for use as required by NHS boards and local authorities.
- Publish a national information leaflet for bereaved parents and carers.

- Promote shared learning through our community of practice, national learning events, thematic 'shine a light' webinars.

**3. Publish first annual report.**

- Undertake an analysis of year 1 data, identifying themes from initial data submissions.
- Publish and share our findings through a range of webinars and briefings.

**4. Refine/further develop data sub-sets.**

- Older young people/young adults, and
- SUDI

**5. Develop quality markers to support local audit/self-evaluation.**

# Appendix 1: Summary of outputs from the National Hub - pre-implementation phase

- Published a report on a [scoping exercise](#) conducted during 2020.
- Established and engaged a range of stakeholder groups (see [Appendix 2](#)).
- Established three pilot site NHS boards to trial and share learning from new systems and processes and inform the development of guidance and resources.
- Worked together with our Third Sector Forum to develop a survey to help us better understand the experiences of bereaved families and carers.
- Published [National Guidance](#) (January 2021) which sets out the process NHS boards and local authorities should follow when responding to, and reviewing, the death of a child or young person.
- Developed a core review data set to allow the consistent gathering and analysis of data on all child deaths across Scotland.
- Completed impact assessments, including a Children's Rights and Wellbeing Impact Assessment (CRWIA), taking account of the UN Convention on the Rights of the Child (UNCRC) and The Promise, and integrating these principles and values into our work.
- Established a network of implementation leads for each NHS board and local authority. This followed a request from Scottish Government to all NHS board and local authority chief executives outlining actions to be implemented. An initial meeting with the implementation leads in November 2020 provided a platform for future engagement meetings and activity.
- Worked with National Records of Scotland (NRS) to commence development of a notification system for receiving data regarding the deaths of children and young people.
- Explored with our counterparts in England, the learning gained from the National Child Mortality Database (NCMD).
- Created poster presentations promoting the work of the National Hub through NHS Scotland Event, International Forum (International Health Improvement) and Royal College of Paediatrics and Child Health (RCPCH) Conference.

# Appendix 2 - National Hub key stakeholders

## Keep connected with...

- ADP & Homeless Programme
- Association of Child Death Review Professionals (ACDRP)
- Chief social work officers
- Children’s Health in Care in Scotland (CHICS)
- Children’s Health Scotland
- Children with Exceptional Healthcare Needs (CEN)
- COSLA, Suicide Action Plan
- Foreign, Development and Commonwealth Office
- Learning Review Implementation Group
- Maternity and Children Quality Improvement Collaborative (MCQIC)
- MBRRACE-UK
- Mental Welfare Commission

## Key stakeholder groups



## Keep connected with...

- National Bereavement Care Pathway (NBCP)
- National Child Bereavement Project
- National Committee on Burial and Cremation
- National Records of Scotland (NRS)
- Public Health Scotland Drug Deaths Action Plan
- Royal Society for the Prevention of Accidents (RoSPA)
- Scottish Fire and Rescue Service
- Scottish Learning Disabilities Observatory (SLDO)
- Scottish Paediatric Society
- Scottish Perinatal Network (SPN)
- Scottish Prison Service (SPS)
- Sudden Unexpected Death in Infancy (SUDI)
- The Promise Scotland
- Water Safety Scotland

## Stakeholder groups

Here is a breakdown of the key stakeholder groups illustrated on the previous page.

<p><b>Governance group</b></p> <ul style="list-style-type: none"> <li>• Care Inspectorate</li> <li>• Healthcare Improvement Scotland</li> <li>• National Hub team</li> <li>• Scottish Government</li> </ul> <p><b>Third sector partners</b></p> <ul style="list-style-type: none"> <li>• CELCIS</li> <li>• Child Bereavement UK</li> <li>• Children’s Hospices Across Scotland (CHAS)</li> <li>• Stillborn and Neonatal Death Charity (Sands)</li> </ul> <p><b>Expert advisory working group</b></p> <ul style="list-style-type: none"> <li>• Child Protection Committees Scotland</li> <li>• Pilot Sites and Early Implementers (Greater Glasgow and Clyde, Lanarkshire, Lothian &amp; Tayside)</li> <li>• Police Scotland</li> <li>• Royal College of Psychiatrists</li> <li>• Social Work Scotland</li> </ul> <p><b>NHS board and local authority implementation leads group</b></p> <ul style="list-style-type: none"> <li>• All local authorities</li> <li>• All NHS boards (territorial)</li> <li>• Crown Office and Procurator Fiscal Service</li> <li>• NHS 24</li> <li>• Police Scotland</li> <li>• Scottish Ambulance Service</li> </ul> <p><b>Four nations group</b></p> <ul style="list-style-type: none"> <li>• Child Death Review Programme (Wales)</li> <li>• NCMD (England)</li> <li>• National Hub (Scotland)</li> <li>• Northern Ireland Maternal and Child Health (NI)</li> </ul>	<p><b>Expert advisory group</b></p> <ul style="list-style-type: none"> <li>• Child Bereavement UK</li> <li>• Child Health Commissioners Group</li> <li>• Child Protection Committees Scotland</li> <li>• Children’s Hospices Across Scotland (CHAS)</li> <li>• Convention of Scottish Local Authorities (COSLA)</li> <li>• Crown Office and Procurator Fiscal Service (COPFS)</li> <li>• Death Certification Review Service</li> <li>• Education Scotland</li> <li>• Faculty of Public Health</li> <li>• General Practitioner Representative</li> <li>• NHS Chief Officer Group</li> <li>• NHS Education for Scotland</li> <li>• Paediatric End of Life Care Network (PELiCaN)</li> <li>• Police Scotland</li> <li>• Public Health Scotland</li> <li>• Royal College of Paediatrics and Child Health</li> <li>• Royal College of Pathologists</li> <li>• Royal College of Psychiatrists</li> <li>• Sands, the stillborn and neonatal death charity</li> <li>• Scottish Ambulance Service</li> <li>• Scottish Neonatal Consultants' Group</li> <li>• Scottish Government</li> <li>• Social Work Scotland</li> </ul>
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