

IMPROVEMENT GOALS

1. Capture, analyse and disseminate appropriate data and learning from child death reviews.
2. Drive the quality of child death review at every stage through bench-marking and quality improvement (QI) methodology.
3. Study and analyse the patterns, causes and associated risk factors of child mortality in England, providing information to target preventative health and social care and to assist in policy decisions.

NATIONAL

How the project provides evidence of quality and outcomes of care nationally

Publication of Thematic Report 'Learning from deaths: Children with a learning disability and autistic children aged 4 – 17 years'. It has been our best performing report to date with 3970 page views in the first 10 days after publication. November 2024- the report had 9,823 Views and 3,493 Downloads since publication (approx 4 months).

Child drowning deaths in England 1 April 2022 to 31 March 2023' -summary report published on 22nd of July 2024. The report had 1,450 downloads since publication.

Published Child Death Review Data Release: Year ending 31 March 2024, which had 366 downloads to date.

Contributed evidence and expertise to ROSPA National Accident Prevention Strategy.

Presented at the annual ACDRP Conference covering topics: Ethnicity, Deprivation, Social Patterns and Child Mortality in England - 'Associations, Patterns, and Causes', as well as 'Asthma and Anaphylaxis and 'Modifiable factors in CDOP Reviews'.

Submitted evidence to NICE for updated asthma guidance, which has been published and included NCMD suggestions.

SYSTEM

How the project supports policy development & system management

In February, the government updated the Homelessness Code of Guidance to include cots for children under two in temporary accommodation, supported by NCMD data on child deaths in such settings

NCMD joined a group that will gather evidence on the impact of suicide for The suicide prevention strategy for England: 2023 to 2028.

NCMD presented at the Parliamentary Launch of first national Sudden Unexplained Death in Childhood (SUDC) Awareness Day. It was attended by 130 professionals, MPs, and bereaved SUDC ambassador families, representing affected families from across the country.

Following our recommendations from the Trauma Report, a meeting took place in July between ROSPA and the British Retail Consortium (BRC) to discuss adding voluntary additional labelling to baby bath seats to make clear they are not a safety device, and children should not be left unattended.

NCMD and Sands submitted evidence to the Government's Preterm Birth Committee.

Presented at the Institute of Health Visiting Conference on health inequalities and the role of health visitors.

LOCAL

How the project stimulates quality improvement

NCMD supported dissemination of a new Child Death Review toolkit for CDR professionals, a project led by The University of Birmingham. The toolkit is freely available to use on the NCMD website.

Establishment of the NCMD Safety Engagement & Training Programme. This initiative is designed to ensure that safety messages arising from our reports and other outputs reach all professionals on the ground so they can help support families to make informed choices about how to care for their children safely.

Hosted 'Preventing Future Child Deaths Through Shared Learnings' webinar showcasing the impact CDOPs have had locally on driving a change to prevent child deaths.

Presented at #AskAboutAsthma 2024 Conference and the London wide event 'Learning from the Deaths of Children due to Asthma and Anaphylaxis'.

Hosted 'Consanguinity in child death review: Update' webinar providing guidance to CDOPs when dealing with consanguineous relationships in child death review.

PUBLIC

How the project is used by the public and the demand for it

NCMD attended a photography exhibition commissioned by the All Party Parliamentary Group for the Households in Temporary Accommodation. Our data was presented alongside the work of artist Anthony Luvera.

Our mailing list subscribers have increased by 15% compared to last year.

NCMD blog: Published two articles. One in collaboration with RLSS UK on Water Smart Schools. The other on Sudden Unexpected Deaths in Infancy for families with infants at increased risk.

54,000 users viewed the website a total of 127,000 times in the period, with almost half of that traffic arriving via organic search – proving that the NCMD is answering questions from the public and professionals on child mortality.

Regular Newsletters distributed in March, June and October.

Co-wrote a blog with RLSS for health visitors that was published by IHV. The blog highlights the role of health visitors in drowning prevention at home.