

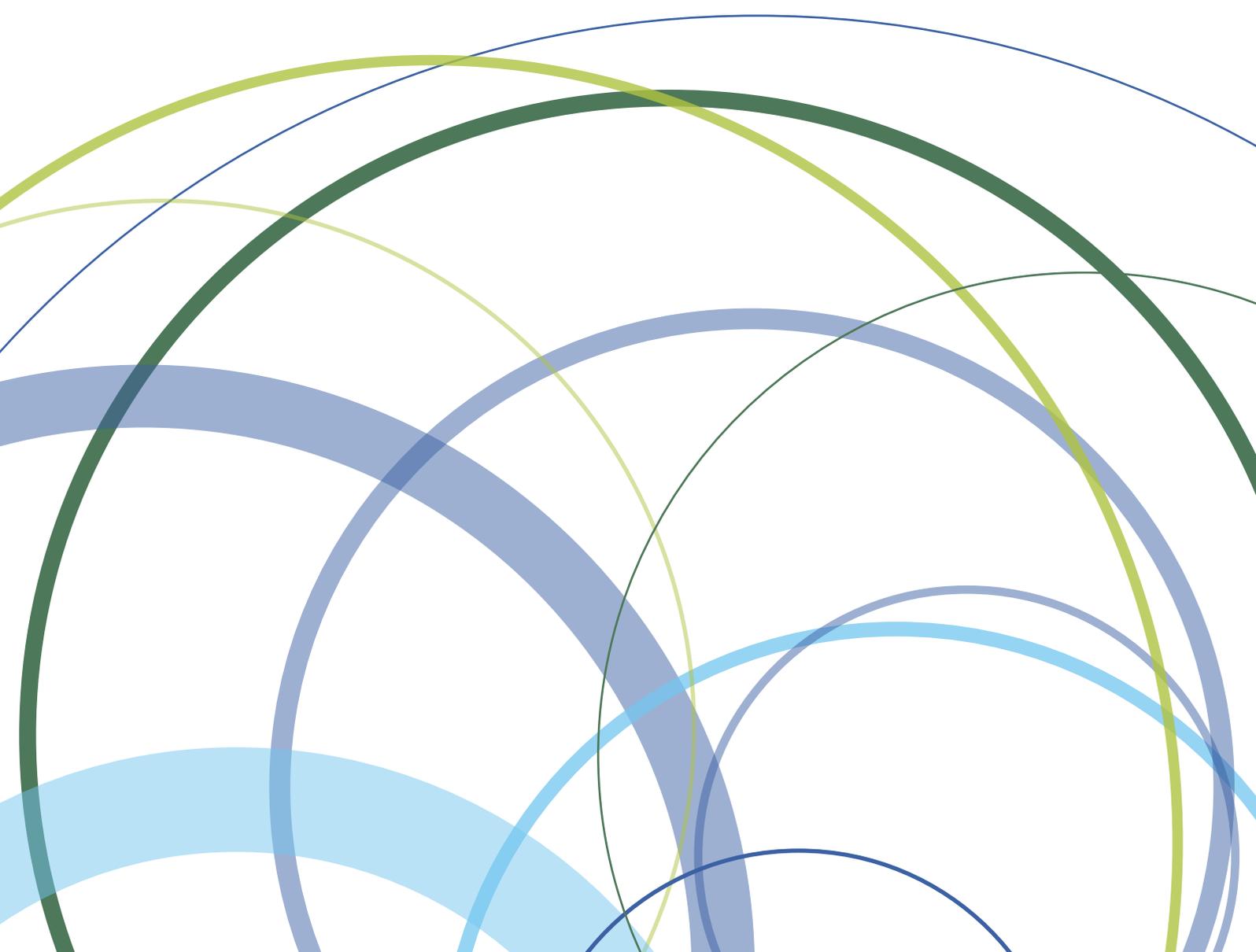


HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa



**Child and Youth
Mortality Review
Committee**

Review policy



This policy was approved by the CYMRC on 10 March 2016





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1. Purpose

The Child and Youth Mortality Review Committee (CYMRC) aims to reduce deaths of children and young people aged 28 days to their 25th birthday, and improve the quality of health, disability and other social services delivered to them.

This policy gives clear direction and guidance on the CYMRC's model of operating, theory of change and its expectations of the people and organisations that work with them.

2. Policy scope

The policy is relevant to all parties that work with the CYMRC. It is particularly relevant to the 'agents' and organisations that work with the CYMRC on local review or help to shape useful recommendations at a national level.

3. Commitment to the Treaty of Waitangi

The CYMRC acknowledges the special relationship between iwi and the Crown under the Treaty of Waitangi. It supports and practises the principles of partnership, participation and protection in its policy and action.

4. Context

The CYMRC has a specified purpose and requirements, mandated by law.¹

Its terms of reference² are set by the Health Quality & Safety Commission. Under these terms, the CYMRC:

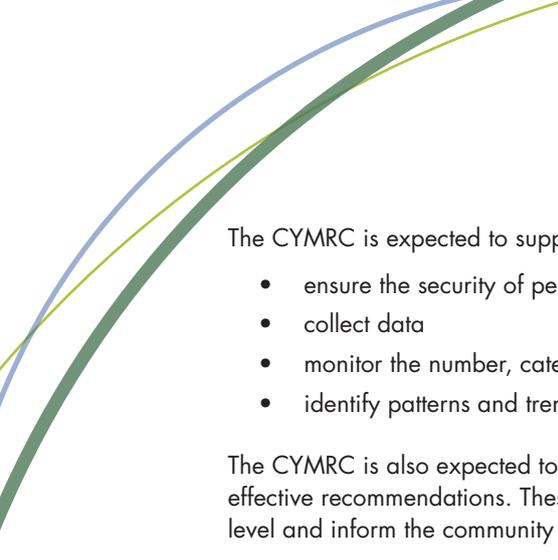
- reviews and reports on deaths of children and young people, with a view to reducing deaths and a focus on continuous quality improvement
- advises on any other matters related to mortality the Health Quality & Safety Commission specifies in writing
- develops strategic plans and methodologies relevant to its functions to reduce morbidity and mortality
- oversees mortality review so relevant, evidence-based advice is provided as quickly as practicable.

The CYMRC supports local review nationwide:

- as a quality improvement initiative
- for developing system and practice improvements to reduce morbidity and mortality within local communities
- as a data collection system for national review.

¹ Under the New Zealand Public Health and Disability Act 2000, see <http://www.hqsc.govt.nz/our-programmes/mrc/about-us/legislation/> for more information. The functions of mortality review committees are set out in section 59E (1) (a) and (b) of the Act.

² Available at: <http://www.hqsc.govt.nz/our-programmes/mrc/cymrc/about-us/terms-of-reference/>



The CYMRC is expected to support the development and enhancement of systems to:

- ensure the security of personal information (as referred to in clause 3 of Schedule 5 of the Act)
- collect data
- monitor the number, categories and demographics of deaths relevant to its functions
- identify patterns and trends over time.

The CYMRC is also expected to analyse and use data collected locally and nationally to develop and share effective recommendations. These recommendations should be useful for policy development at a national level and inform the community of ways to reduce mortality and morbidity.

Building and maintaining effective national relationships across government is important for the CYMRC. It wishes to be a trusted and valued advisor across government, in the area of child and youth health and wellbeing. Through positive relationships at a national level, the work of the CYMRC will be valued and result in positive outcomes.

5. Model of operating

The CYMRC's model of operating (shown in Table 1) clearly specifies its processes across local and national levels.

Table 1: The CYMRC's model of operating

| NATIONAL | LOCAL |
|--|--|
| <ol style="list-style-type: none"> 1. Following a death, the national Mortality Review Data Group (MRDG) is notified and data is collected nationally. 2. This is fed into the MRDG database so local coordinators can see what has been collected and be prompted to start their collection processes. | <ol style="list-style-type: none"> 3. The local coordinator/district health board (DHB) makes a decision about whether a case will be reviewed or not, based on prioritisation requirements of the CYMRC. 4. If a case is to be reviewed: <ol style="list-style-type: none"> a. local coordinators request information locally from organisations that hold information about the child or young person who died b. the local coordinator enters the information into the MRDG database c. the information is provided to an intersectoral review process, whereby a group of CYMRC 'agents' from the key organisations involved locally analyse the life and death of the child or young person d. opportunities for system improvement are identified e. the local coordinator completes a post-review form soon after the review, to feed detail about findings and recommendations back to the national CYMRC. |
| <ol style="list-style-type: none"> 5. Information is analysed and developed, quantitatively, into national and DHB data reports and, both quantitatively and qualitatively, into Special Topic reports. 6. The CYMRC releases national data reports each year providing quantitative reporting. DHB-level reports are also provided. | |

6. Theory of change

The CYMRC's theory of change is based on a parallel national and local information collection and review processes, both aimed at influencing change.

Change occurs through:

- local recommendations being taken forward and implemented by the agents who have taken back learnings from local review
- national recommendations being taken forward by the national organisation that helped shape useful recommendations with the CYMRC at the national level.

The role of the CYMRC in both national and local change is facilitative.

- Local reviews are facilitated with an expectation that those around the table will be motivated and able to create change identified as important within a review.
- National work focuses on influencing stakeholders through the engagement process and the development and review of recommendations.

7. Policy

a. Data requirements

The CYMRC requires a minimum data set completed on 70–100 percent of all deaths within scope, with an overall aim of 100 percent.

Having data on all cases allows the CYMRC to ascertain, monitor and track mortality and helps quantitative data to be as accurate as possible.

The CYMRC will work with other mortality review committees to prevent data collection on cases from being duplicated.

b. Case review requirements

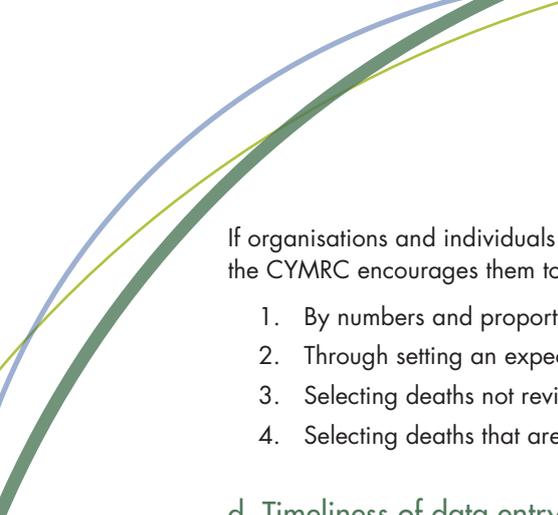
The CYMRC requires 70–100 percent of deaths to be reviewed.

It recognises the importance of intersectoral case review in providing robust analysis of causation and prevention. At an intersectoral case review meeting, the lives and deaths of children and young people are analysed to look for system improvements that will save lives and improve services and wellbeing.

c. Prioritisation directions for funded data collection and review

The CYMRC uses the following prioritisation criteria to identify cases that require data entry and intersectoral case review meetings:

1. Deaths of members of groups with higher rates, where rates clearly demonstrate inequity across groups (ie, international comparisons or across population groups) and therefore suggest improvements are possible.
2. Deaths where vulnerability of an individual or group has been identified.
3. Deaths according to a plan, based on future Special Topic report topics.



If organisations and individuals are able to review more cases than those prioritised by the CYMRC, the CYMRC encourages them to use the following prioritisation criteria:

1. By numbers and proportion.
2. Through setting an expectation of numbers of cases to be considered across common causes.
3. Selecting deaths not reviewed elsewhere.
4. Selecting deaths that are not related to medical conditions.

d. Timeliness of data entry and review

The CYMRC will work at a national level to develop and establish systems and processes to support timely data entry and review, namely within 12 months of a death.

This work will involve clarifying national roles and agreements with agencies and organisations (including coroners) that can influence timely information provision.

e. Review methods

The CYMRC expects high-quality, standardised review processes to occur locally. This means putting in place the best support available for local analysis and identification of prevention opportunities. Support will include providing clear guidelines and support material and training for coordinators and chairs.

f. Role clarity

The CYMRC recognises that role clarity and understanding are essential for the success of its model of operating and theory of change. Table 2 clarifies the CYMRC's expectations of those involved in its review and other work.

Table 2: CYMRC system expectations of roles

| | |
|----------------|---|
| National CYMRC | <ul style="list-style-type: none"> • Provide policy and guidance to support national systems and processes. • Provide policy and guidance to support best practice local review. • Put in place appropriate training and support at all levels. • Clarify policy expectations and roles with national organisations. • Facilitate helpful national relationships and memorandums of understanding as required to best support local work. • Foster and maintain relationships with local review groups. • Ensure data is valid by putting data dictionaries, entry guidelines and training and support in place for coordinators. • Fully use the information and data collected via the MRDG and local coordinators. • Work with national agencies and organisations to shape the best possible recommendations that will lead to national change. • Monitor mortality outcomes. • Monitor the implementation of national recommendations. |
| Secretariat | <ul style="list-style-type: none"> • Support the governance of the CYMRC system through preparation and administration of agendas and papers for national CYMRC meetings. • Advise the CYMRC on: <ul style="list-style-type: none"> – system issues affecting child and youth mortality that can be appropriately addressed at a national level – national responses to mortality review findings – the performance of the CYMRC mortality review system. • Provide the day-to-day management of the CYMRC system on behalf of the national CYMRC. This includes: <ul style="list-style-type: none"> – providing publication and communication support – supporting the facilitation of national responses to mortality review findings – engaging with key agencies to influence improvements – managing contracts – providing training and technical assistance to local child and youth mortality review groups – maintaining the CYMRC handbook – managing CYMRC agents' status. |
| MRDG | <ul style="list-style-type: none"> • Provide notification and national collection and provision of information via the database. • Provide support for coordinators experiencing any problems with the database. • Forward national recommendations to the CYMRC, as well as extracts of information required for contract management and performance improvement. |
| Local agents | <ul style="list-style-type: none"> • Recognise and meet the requirements of the New Zealand Public Health and Disability Act 2000. • Ensure their organisation provides information in a timely manner, in response to requests from local coordinators. • Actively participate in review processes. • Work constructively with other agents and the coordinator and chair. • Take a supportive, 'no-blame' approach within review. • Be thoughtful about their own organisational practices within review. • Feed back appropriately within their organisation to effect improvements in practice where it would improve quality or safety of services. • Take back recommendations and change that would improve quality and safety, and champion these as an organisation. |

| | |
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| Local branches of national (and local) organisations that support agents | <ul style="list-style-type: none"> • Support their nominated agent(s) to fulfill their role(s) by: <ul style="list-style-type: none"> – putting in place systems to provide information quickly and efficiently on request – putting in place systems to appropriately receive feedback and guidance from local review, through the agent representing them – supporting agents to champion change identified as important through local review. |
| Coordinator | <ul style="list-style-type: none"> • Provide induction and support of agents so they can fulfill their roles. • Ensure agents are registered through the Mortality Review Agent Management System (MRAMS) before they participate in local review. • Notify agents and request information on cases. • Enter data into the MRDG database. • Coordinate review of cases prioritised for local review. • Undertake the secretariat function for the local review group, as directed by the chair. • Complete post-review forms following review. • Complete quarterly reporting (as required). • Participate in ongoing training and development as required. |
| Chair | <ul style="list-style-type: none"> • Provide expert leadership for quality review, according to the guidelines and specifications of the CYMRC. • Champion CYMRC local review within the DHB and the local community (including the organisations represented within the review group). • Support the coordinator in agreeing the application of review prioritisation guidance by the CYMRC. • Lead intersectoral review processes. |
| DHB | <ul style="list-style-type: none"> • Provide appropriate support to the coordinator and chair. • Develop systems to feed back findings from local review into larger DHB systems for quality improvement. • Consider funding additional child and youth death reviews that are not prioritised by the CYMRC (eg, medical). |

g. Contract reporting

The CYMRC would like the work of coordinators to focus on data entry and review. It would also like to develop current database systems to extract information required for contract management and performance improvement directly, and remove any separate requirement for contract reporting over time.

h. Addressing issues raised for small DHBs

The CYMRC will work with smaller DHBs to manage resources to best effect in areas where the number of deaths are low. It will take a flexible approach and negotiate and work with smaller DHBs to ensure a satisfactory conclusion. Solutions may involve developing regional partnerships with shared approaches to coordination, or to models of national coordination. The detail of plans for each DHB will be developed during implementation planning.

8. Review of policy

This policy, supporting operational guidance and forms will be reviewed in November 2016 and thereafter every three years, or as required by the CYMRC.

9. Definitions and acronyms

| | |
|------------------|--|
| The Act | New Zealand Public Health and Disability Act 2000. Section 59E and Schedule 5 govern the CYMRC |
| Agent | Under Schedule 5 of the Act, the CYMRC can appoint agents to collect and analyse data on its behalf (see also MRAMS) |
| CYMRC | Child and Youth Mortality Review Committee |
| DHB | District health board |
| Intersectoral | Intersectoral means 'between sectors'. The World Health Organization argues we must 'involve many other sectors of society in addition to health in the struggle for a healthier society' ³ |
| Mortality review | Mortality review is when an established review method is used to learn from a specific death in order to learn how best to prevent such deaths in the future |
| MRAMS | The CYMRC's Mortality Review Agent Management System (see also Agent) |

³ World Health Organization. 2011. *Intersectoral Action on Health: A path for policy-makers to implement effective and sustainable action on health*. Kobe, Japan: The WHO Centre for Health Development.



Child and Youth Mortality Review Committee

“...Unuhia i te rito o te harakeke...”
“...taken away too early...”

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