The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Mortality Review Policy

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Responsible Director:	**Medical Director**	
Approved by and date:	**Quality Committee**	**November 2017**
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Target Audience:	All trust employees.	
Document Approval, History/Changes	**See Appendix 5.** For further information contact the Governance Department on **Tel:** (0151) 556 3082	

Think of the environment…Do you have to print this out this document? **You can always view the most up to date version electronically on the Trust intranet.**

Executive Summary

Concern about patient safety and the scrutiny of mortality rates has increased following the high-profile investigations into NHS failures. There is an emergent increased drive for Trust Boards to be assured that deaths are reviewed and where appropriate changes are made. This policy is written to provide guidance for all trust employees involved in mortality peer reviews.

Contents

1. Introduction

In December 2016 the CQC published a review of the way NHS Trusts review and investigate the deaths of patients. This made a series of recommendations regarding the process of identifying, reviewing and investigating deaths and ensuring that learning is implemented. The guidance "Learning from Deaths" was issued by NHS England in March 2017.

It is essential that we learn from deaths by reviewing the care provided to patients who have died, identifying any problems in the care, and produce meaningful actions to help others. This is in keeping with the Walton Way philosophy of putting patients, families and carers at the centre of everything that we do.

At The Walton Centre NHS Foundation Trust all in-patients deaths are reviewed currently. This policy outlines how the process will be enhanced to meet the recommendations by "Learning from deaths". This policy will improve our standardised methodology for reviewing deaths in our hospital with the aim of identifying opportunities for improvement and ensuring these improvements result in measurable changes in clinical care. Instances of avoidable mortality will be identified and reported, and the learning published nationally via the Quality Account.

The Trust Board will provide leadership to ensure that the organisation addresses any significant issues identified in reviews and investigations.

Staff, patients, families and others can raise questions or concerns about this policy and how it is implemented through the Trust's Patient Experience Team.

2. Scope

This policy sets out the procedures for identifying, recording, reviewing and investigating the deaths of people in the care of the Walton Centre, NHS Foundation Trust. The Trust will seek to learn from the care provided to patients who die, as part of its work to continually improve the quality of care it provides to all its patients. Deaths occurring within 30 days following inpatient discharge or outpatient attendance are presently excluded.

It describes how the Walton Centre NHS Foundation Trust will support people who have been bereaved by a death at the Trust, and also how those people should expect to be informed about and involved in any further action taken to review and/or investigate the death. It also describes how the Trust supports staff who may be affected by the death of a patient in their care.

This policy applies to all staff whether they are employed by the Trust permanently, temporarily, through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the trust's behalf.

3. Definitions

The *National Guidance on Learning from Deaths* includes a number of terms. These are defined below.

- **Death certification** - the process of certifying, recording and registering death, the causes of death and any concerns about the care provided. This process includes identifying deaths for referral to the coroner.
- **Case record review** - a structured desktop review of a case record/note, carried out by clinicians, to determine whether there were any problems in the care provided to a patient. Case record review is undertaken routinely to learn and improve in the absence of any particular concerns about care. This is because it can help find problems where there is no initial suggestion anything has gone wrong. It can also be done where concerns exist, such as when bereaved families or staff raise concerns about care.
- **Mortality review** - a systematic exercise to review a series of individual case records using a structured or semi-structured methodology to identify any problems in care and to draw learning or conclusions to inform any further action that is needed to improve care within a setting or for a particular group of patients.
- **Serious Incident** - Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant, or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm – abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services, and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. See the Serious Incident framework for further information.1
- **Investigation** - a systematic analysis of what happened, how it happened and why, usually following an adverse event when significant concerns exist about the care provided. Investigations draw on evidence, including physical evidence, witness accounts, organisational policies, procedures, guidance, good practice and observation, to identify problems in care or service delivery that preceded an incident and to understand how and why those problems occurred. The process aims to identify what may need to change in service provision or care delivery to reduce the risk of similar events in the future. Investigation can be triggered by, and follow, case record review, or may be initiated without a case record review happening first.
- **Death due to a problem in care** - a death that has been clinically assessed using a recognised method of case record review, where the reviewers feel that the death is more likely than not to have resulted from problems in care delivery/service provision. (Note, this is not a legal term and is not the same as 'cause of death'). The term 'avoidable mortality' should not be used, as this has a specific meaning in public health that is distinct from 'death due to problems in care'.
- **Quality improvement** - a systematic approach to achieving better patient outcomes and system performance by using defined change methodologies and strategies to alter provider behaviour, systems, processes and/or structures.
- **Patient safety incident** - a patient safety incident is any unintended or unexpected incident which could have led or did lead to harm for one or more patients receiving NHS care.

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4. Duties

The Medical Director has responsibility for development, implementation and on-going review of this policy.

4.1. The Chair of the Quality Committee (a non-executive director), an assurance committee of the Board of Directors, has responsibility for oversight of the mortality review process. They have responsibility to understand the review process and ensure that this is robust and can withstand external scrutiny, champion quality improvement that leads to actions which improve patient safety and assuring that published information accurately reflects The Walton Centre's approach, achievements and challenges.

4.2. All clinical staff have a responsibility to engage with the mortality review process and contribute to organisational learning. Where incidents are disclosed by the review process, the reviewer has responsibility to report these via the Trusts risk management system, DATIX.

4.3. The Neurosurgical and Neurological Mortality Review Groups (MRG), chaired by Consultant Neurosurgeons and Consultant Neurologists, are responsible for reviewing all inpatient hospital deaths. This review will take into account standard of care received, organisational systems and identify contributory factors and learning points for organisational implementation. The reviews will have involvement from the multidisciplinary team. It will also highlight themes for improvement and ensure acceptable performance of the process. An Action Tracker, identifying leads for specific actions, will form part of the MRG minutes in order to ensure an audit trail, this will be monitored through Divisional Risk and Governance processes.

4.4. The Divisional Clinical Risk & Governance Leads must act as the gatekeeper for raising concerns about patient care with other involved organisations, and receive concerns about the care of patients discharged from The Walton Centre who subsequently die elsewhere and are identified from an external mortality review.

The Divisional Clinical Risk & Governance Leads are responsible for the initial mortality review process that includes, completion of the mortality screening form, the allocation of reviews to medical reviewers and capturing the recommended learning points from the MRG to report to Divisional Governance & Risk.

4.5. The Deputy Director of Governance is responsible for ensuring any deaths classified as unexpected are reported to the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (StEIS).

4.6. The Clinical Directors are responsible for ensuring the learning and action points are presented and discussed at Divisional clinical meetings (i.e. Consultants Meeting) such that potential changes arising from reviews are accepted. They are additionally responsible for ensuring the final set of agreed changes is communicated into the wider workforce within the Divisions.

4.7. The Divisional Directors of Operations, Lead Nurses/Matrons and the Clinical Directors working as triumvirate teams have a collective responsibility to ensure any improvements to care (clinical and non-clinical) resulting from the reviews. Any change in practice or the delivery of care should be subject to audit to ensure the change has been delivered and sustained. Additionally, they are responsible for reporting on such changes to senior fora, including Hospital Management Board, the Quality Committee and the Board of Directors.

4.8. The MRG Co-ordinator is responsible for the preparation of quarterly reports for submission to Quality Committee.

5. Inclusion & Exclusion Criteria

5.1. This policy covers the review of all in-patient deaths; deaths occurring within 30 days of patient discharge or outpatient attendance are presently excluded.

6. Engagement with bereaved families

6.1. All bereaved families (including carers and other persons close to the deceased patient) will be supplied with a copy of the trust's bereavement support information (inpatient bereavement booklet). This will include a full range of support information for families after the death of a loved one.

6.2. Communication with bereaved families will always be honest and open; in line with the Trust's values. The booklet will also include information on how to raise concerns relating to the pathway of care their relative experienced during their hospital stay. This is essential where the family and carers consider their loved ones care may have been delivered differently and whose death might have been prevented

6.3. There will be information on the mortality review process and how a mortality review would be conducted. We would also seek guidance from families whether and how they would like involvement (given families can change their mind about this).

6.4. Where there is a formal duty of candour identified in relation to a patient safety incident the appropriate steps will be taken to keep the bereaved family informed. This means that, when things go wrong, following a full investigation the Trust will explain to families and carers what went wrong or make sure accountability is clear when failure is found.

7. Mortality Review Process

7.1. All patient deaths will be reported via Datix and escalated to the relevant Clinical Lead for Neurology, Neurosurgery and Critical Care. The Clinical Risk and Governance Lead will then assess whether the death was unexpected and allocate a reviewer to undertake a Structured Judgement Review where appropriate (see section 8 for criteria). If required an RCA will be undertaken. All deaths will be reviewed through the Mortality Review Group Meeting, those cases fulfilling the criteria in section 8 will undergo a full structured judgement review, and will also be discussed by the MRG.

7.2. If the death of a patient is reported to the Coroner and the patient subsequently undergoes a post-mortem examination, the results of the examination should be included in the review. If, at the time of death, it is felt that more information about the patient's illness or cause of death would help clinical understanding and therefore the mortality review process, or could help the patient's family, consideration should be given to discussing the benefits of a hospital post-mortem with the next-of-kin and obtaining consent from that person.

7.3. The Informatics Team reviews the Patient Administration System and identifies inpatient deaths occurring on a monthly basis, providing a report to the Neurosurgery and Neurology Chairs of the MRG and the Meeting Co-ordinators. The Co-ordinators screen the reports and allocates cases to the reviewers as appropriate. The reviewers provide a case summary providing detail for those cases where clinical care/organisation issues contributed to the death, and could be changed, all cases are discussed at the MRG meeting.

7.4. All cases will be reviewed using the MRG Review Notes (See Appendix 1 for neurosurgery and neurology templates) as follows:

- A Case Summary – Date of admission and death, age, comorbidities, operations, complications, progress.
- Admission Type – Elective/Emergency
- Category – Vascular / Tumour / Cranial Trauma / Spinal Trauma / Hydrocephalus / Spinal / Functional / Neurology
- Treatment - whether the management fell within standard clinical practice?
- Hospital Care - Did clinical care contribute to death?
- Organisational Systems - did organisational factors contribute to death?
- Palliative Care/End of Life Care (EoLC)
- Lessons learned – what clinical / organisational changes are needed?
- Recommendations / Actions – How can the changes be implemented?

7.5. The MRG will challenge the review findings and recommendations to the point where it adds value to our knowledge about why deaths occur and how care in the widest sense can be improved. Where potential improvements in care in organisations who have been involved in the management of patients who subsequently died at The Walton Centre are identified as part of the review process, these opportunities must be brought to their attention. Equally, if as part of a mortality review undertaken in another organisation, care at The Walton Centre has been considered suboptimal, the management of such patients must be subjected to full mortality review. The Walton Centre will also collaborate with other Trusts where required to carry out mortality reviews when a person has received care from several heath care providers. This can be discussed at the Divisional MRG Meetings and the Clinical Risk & Governance Lead will feedback to any external organisations involved.

7.6. The review will be presented by the original reviewer at the monthly MRG meeting. Learning points will be discussed and accepted for implementation. These actions may require changes to clinical practice or organisational processes.

7.7. At an appropriate time following delivery of the improvement, changes will be audited via the Clinical Audit Team, to ensure that they have been sustained. These assurances will also be reported into:

- The Trusts Quality Committee for assurance, overseen by the Non-Executive Director with responsibility for Mortality Reviews and
- The Hospital Management Board for cross Divisional organisational learning.

7.8. Any unexpected death will be reported to StEIS following the mortality screening review and an RCA undertaken subsequently. A full report will be submitted to both NRLS and StEIS in accordance with national reporting requirements following completion of the RCA. On these occasions, the duty of candour will be invoked.

7.9. A Quarterly Report focusing on avoidable deaths is submitted to Quality Committee which reports to the Trust Board.

7.10. A summary of the evidence of learning and action as a result of mortality reviews and an assessment of the impact of actions that the Trust has taken will be published as part of the Trusts annual Quality report.

8. Disclosure and Reporting on Incidents

Where reviewers identify true incidents (omissions and / or commissions of care that did or could have led to harm), it is their responsibility to report them. Incidents recorded on the mortality review form will be triangulated with DATIX reports to ensure reporting is taking place.

9. Selecting Deaths for Investigation

9.1. Where a review carried out by the Trust under the process above identifies patient safety incident(s) that require further investigation, this will be managed in line with the Trust's Serious Incident Policy. The Governance Team will review all serious incidents and discuss with the relevant Divisional Governance Leads and Deputy Director of Governance the level of investigation required.

9.2. If required the incident will be subject to a serious incident review (refer to RCA template) including a full Root Cause Analysis (RCA) undertaken by the Division responsible for the care at the time of death. The Divisional Governance Lead together with the appropriate Clinical Director will allocate a reviewer to lead the RCA and report back to the Serious Incident Panel.

9.3. The mortality review process should be seen as a parallel and potentially complimentary exercise. Where a full review has been completed, and the death was considered unexpected, the RCA conducted under the Serious Incident Policy will be used to comply with the requirements of this policy

9.4. Patients who die in the care of The Walton Centre who have learning disabilities (a reduced intellectual ability and difficulty with everyday activities), mental health needs (pre-existing, severe), or are a child (< 18 years old) will all receive full mortality review. All deaths of patients with learning disability will be reported to the Care Quality Commission. When the Learning Disabilities Mortality Review (LeDeR) Programme becomes established in the North West, the Trust will participate in the multiagency review of these deaths.

9.5. Other categories of deaths for review (consistent with the National Guidance on Learning from Deaths) include:

- All deaths where bereaved families and carers or staff have raised a significant concern about the quality of care provision
- All deaths in a service speciality, particular diagnosis or treatment group where an 'alarm' has been raised with the provider (i.e. via Summary Hospital –level Mortality indicator, audit, CQC).
- All deaths in areas where people are not expected to die – for example, in certain elective procedures
- Deaths where learning will inform the provider's existing or planned improvement work.
- A further control sample of deaths that do not fit the identified categories, so that providers can take an overview of where learning and improvement is needed most overall.

10. Wider Organisational Learning

Within and across Divisions, learning from the mortality reviews will be triangulated with other quality data such as complaints, incidents, clinical audit findings to inform the Trust's wider strategic plans and safety priorities. Themes emerging will complement the presentation of learning to the Trust's Hospital Management Board in accord with the Organisational Learning Policy.

11. Policy Implementation Plan

A presentation on the new national requirement to enhance the mortality review process in every Trust and report avoidable mortality will be made by the Medical Director at the Trust's Clinical Senate. The Policy will be shared with the Divisions via their Governance meetings. The policy will be made available to all staff via the Trusts policy intranet site. Communications regarding the policy being adopted by the Trust will be shared via corporate communications.

12. Monitoring

The effectiveness of this policy will be measured by the following set of Key Performance Indicators:

1. Percentage of deaths allocated within 3 working days (standard = 98%)
2. Percentage of deaths screened within 7 working days (standard 95%)
3. Percentage of reviews completed within 30 working days of screening allocation (standard = 80%)
4. Percentage of deaths reviewed (standard = 100%)
5. Percentage of unexpected deaths reported to NRLS, StEIS and Board (standard = 100%)
6. Percentage of improvements reported to Hospital Management Board, Quality Committee and Board of Directors (standard = 100%)
7. Percentage of auditable improvements where change has been assured (standard = 95% within one year of change, although not every change will yield full assurance, requiring further cycles of improvement).

This information will be presented on a quarterly basis to Trust Board.

13. References

13.1. Supporting policies/documents

- https://improvement.nhs.uk/resources/serious-incident-framework/

Appendix 1 - Neurosurgical MRG Template

Report – Month Year Mortality

The information in this report is derived from the M&M committee meetings and the monthly M&M seminar **(as detailed in section 1 below)**.

M&M review notes	
Case summary	date of admission & death, age, co-morbidities, operations, complications, progress
Admission type	elective / emergency
Category	vascular / tumour / cranial trauma / spinal trauma / hydrocephalus / spines / functional
Treatment	did the management falls within standard clinical practice?
Hospital care	did clinical care contribute to death?
Organisational systems	did organisational factors contribute to death?
End of life care	were end of life care issues adequately addressed?
Lesson learned	what clinical / organisational changes are needed?
Recommendations /actions	how can the changes be implemented?

There were X inpatients neurosurgical deaths: X vascular
X tumour
X cranial trauma, etc.

ID	Clinical case summary	Category	Admission type	Comments
S1	Diagnosis Date of admission: Date of death: Summary			Treatment • Clinical Care • Organisational systems • End of life care • Lessons learned • Recommendations /actions •

Co-chairs of the neurosurgery M&M committee

Appendix 2 - Neurology MRG Template

Neurology Mortality & Morbidity Meeting Report – Quarter X, 20XX/XX

The information in this report is derived from the MRG Meeting, covering Quarter X

Attendance at M&M meeting – XX

Neurology deaths

There were X inpatients neurological deaths: X vascular, X neoplastic, etc.

MRG review notes	
Case summary	date of admission & death, age, co-morbidities, operations, complications, progress
Admission type	elective/emergency
Category	vascular/neurodegenerative/neoplastic/epileptic/infective/inflammatory
Treatment	did the management falls within standard clinical practice?
Hospital care	did clinical care contribute to death?
Organisational systems	did organisational factors contribute to death?
End of life care	were end of life care issues adequately addressed?
Lessons learned	what clinical/organisational changes are needed?
Recommendations /actions	how can the changes be implemented?

Clinical case	Comments
W number **Presenting** **cons initials** Diagnosis: Date of admission: Date of death: Admission type: Category: <u>Summary</u> Details. Expected death.	<u>Treatment</u> Did the management falls within standard clinical practice? <u>Hospital care</u> Did clinical care contribute to death? <u>Organisational systems</u> Did organisational factors contribute to death? <u>End of life care</u> Was the AMBER care bundle utilised? **N** • Was there documentation that the following were addressed: Psychological/spiritual matters? **Y** • Nutritional concerns? **N/A** • Control of symptoms? **Y** • Patient preferences? **N/A as patient on critical care** • Other comments: **organ donation** <u>Lessons learned</u> What clinical/organisational changes are needed? <u>Recommendations/actions</u> How can the changes be implemented? **Comments from meeting** Complete on day.

Appendix 3 - Equality Impact Assessment (EIA) Form

This section must be completed at the development stage i.e. before ratification or approval. For further support please refer to the EIA Guidance on the Equality and Diversity section of the Intranet.

Part 1

1. Person(s) Responsible for Assessment: Author see frontsheet

2. Contact Number:

3. Department(s):

4. Date of Assessment:

5. Name of the policy/procedure being assessed:

6. Is the policy new or existing?

(New) Existing

7. Who will be affected by the policy (*please tick all that apply*)?

Staff (Patients) Visitors Public

8. How will these groups/key stakeholders be consulted with?
Staff feedback based on policy implementation and operational performance will be incorporated.

9. What is the main purpose of the policy?

10. What are the benefits of the policy and how will these be measured?

11. Is the policy associated with any other policies, procedures, guidelines, projects or services? *If yes, please give brief details*

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? *Please specify specifically who would be affected (e.g. patients with a hearing impairment or staff aged over 50). Please tick either positive, negative or no impact then explain in reasons and include any mitigation e.g. requiring applicants to apply for jobs online would be negative as there is potential disadvantage to individuals with learning difficulties or older people (detail this in the reason column with evidence) however applicants can ask for an offline application as an alternative (detail this in the mitigation column)*

None

Protected Characteristic	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact	Reasons to support your decision and evidence sought	Mitigation/adjustments already put in place
Age			X		
Sex			X		
Race			X		
Religion or Belief			X		
Disability			X		
Sexual Orientation			X		
Pregnancy/maternity			X		
Gender Reassignment			X		
Marriage & Civil Partnership			X		
Other			X		

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.)

13. Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? *See Guidance for more details (NB if an absolute right is removed or affected the policy will need to be changed. If a limited or qualified right is removed or affected the decision needs to be proportional and legal).*
No

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete Part 2, please see the full EIA document on the Equality and Diversity section of the Intranet and speak to Hannah Sumner, HR Manager or Clare Duckworth, Matron for further support.

Action	Lead	Timescales	Review Date

Declaration

I am satisfied this document/activity has been satisfactorily equality impact assessed and the outcome is:

No major change needed – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken ☒

Adjust the policy – EIA has identified a need amend the policy in order to remove barriers or to better promote equality ☐
You must ensure the policy has been amended before it can be ratified.

Adverse impact but continue with policy – EIA has identified an adverse impact but it is felt the policy cannot be amended. ☐
You must complete Part 2 of the EIA before this policy can be ratified.

Stop and remove the policy – EIA has shown actual or potential unlawful discrimination and the policy has been removed ☐

Name: C. Pope Date: November 2017

Signed: or/Sent from work email account

Appendix 4 - Policy approval checklist

The Mortality Review is presented to Quality Committee for Approval.

In order for this policy to be approved, the reviewing group must confirm in table 1 below that the following criteria is included within the policy. Any policy which does not meet these criterion should not be submitted to an approving group/committee, the policy author must be asked to make the necessary changes prior to resubmission.

Policy review stage

Table 1

The reviewing group should ensure the following has been undertaken:	**Approved?**
The author has consulted relevant people as necessary including relevant service users and stakeholders.	Yes
The objectives and reasons for developing the documents are clearly stated in the minutes and have been considered by the reviewing group.	Yes
Duties and responsibilities are clearly defined and can be fulfilled within the relevant divisions and teams.	Yes
The policy fits within the wider organisational context and does not duplicate other documents.	Yes
An Equality Impact Assessment has been completed and approved by the HR Team.	Yes
A Training Needs Analysis has been undertaken (as applicable) and T&D have been consulted and support the implementation	Yes
The document clearly details how compliance will be monitored, by who and how often.	Yes
The timescale for reviewing the policy has been set and are realistic.	Yes
The reviewing group has signed off that the policy has met the requirements above.	Yes

Reviewing group chairs name: A. McCracken	**Date: 24.11.2017**

Policy approval stage

☒ **The approving committee/group approves this policy.** ☐ **The approving committee/group does not approve the policy.** **Actions to be taken by the policy author:**

Approving committee/group chairs name: A. McCracken	**Date: 19.10.2017**

Appendix 5 - Version Control

Version	**Section/Para/ Appendix**	**Version/description of amendments**	**Date**	**Author/Amended by**
1.0	New Policy	Drafting and consultation with relevant groups, committees and Board	Oct 17	C. Pope
1.1	6.	Engagement with bereaved families and post mortems	Nov 17	C. Pope

Translation Service

This information can be translated on request or if preferred an interpreter can be arranged. For additional information regarding these services please contact The Walton centre on 0151 525 3611

Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar 0151 525 3611.

هذه المعلومات يمكن أن تُتَرْجَم عند الطّلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على 0151 5253611

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داواکرێت یان ئەگەر بەباش زانرا دەکرێت وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ١٥١٥٢٥٣٦١١ .

一经要求，可对此信息进行翻译，或者如果愿意的话，可以安排口译员。如需这些服务的额外信息，请联络Walton中心，电话是：0151 525 3611。