Learning from Deaths Policy

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**DOCUMENT CHANGE HISTORY**

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<td>September 2019</td>
<td>Anthony Brett, Safety and Risk Lead</td>
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| Linked procedural documents | Serious Incident Policy  
Duty of Candour Policy  
Safeguarding Adults Policy  
Safeguarding Children and Young People Policy  
Learning from Deaths cohort identification and review methodology SOP |
| Dissemination requirements | To be shared on East24 as a publicly accessible document. |
| Part of Trust’s publication scheme | Yes |

The East of England Ambulance Service NHS Trust has made every effort to ensure this policy does not have the effect of unlawful discrimination on the grounds of the protected characteristics of: age, disability, gender reassignment, race, religion/belief, gender, sexual orientation, marriage/civil partnership, pregnancy/maternity. The Trust will not tolerate unfair discrimination on the basis of spent criminal convictions, Trade Union membership or non-membership. In addition, the Trust will have due regard to advancing equality of opportunity between people from different groups and foster good relations between people from different groups. This policy applies to all individuals working at all levels and grades for the Trust, including senior managers, officers, directors, non-executive directors, employees (whether permanent, fixed-term or temporary), consultants, governors, contractors, trainees, seconded staff, homeworkers, casual workers and agency staff, volunteers, interns, agents, sponsors, or any other person associated with the Trust.

All Trust policies can be provided in alternative formats.
# Contents

<table>
<thead>
<tr>
<th>Paragraph</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>4</td>
</tr>
<tr>
<td>2. Purpose</td>
<td>4</td>
</tr>
<tr>
<td>3. Duties</td>
<td>5</td>
</tr>
<tr>
<td>4. Learning from Deaths</td>
<td>6</td>
</tr>
<tr>
<td>5. The Trust’s approach to investigations</td>
<td>8</td>
</tr>
<tr>
<td>6. Bereaved families and carers</td>
<td>8</td>
</tr>
<tr>
<td>7. Supporting staff affected by the death of a patient</td>
<td>9</td>
</tr>
<tr>
<td>8. Learning from case reviews and structured judgement reviews</td>
<td>10</td>
</tr>
<tr>
<td>9. Reporting arrangements</td>
<td>10</td>
</tr>
<tr>
<td>10. Monitoring</td>
<td>11</td>
</tr>
<tr>
<td>11. References</td>
<td>11</td>
</tr>
</tbody>
</table>

## Appendices

<table>
<thead>
<tr>
<th>Appendix 1</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linking reviews with external organisations</td>
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Note: additional reading can be found in the hyperlinked documents and webpages throughout this document.
1. **Introduction**

The National Health Service (NHS) aims to deliver excellent and safe care to its service users. As part of continually developing the quality of care delivered, it is essential to embed lessons learnt from when things go well as well as from when things go wrong.

The national Learning from Deaths initiative was implemented in acute hospitals in March 2017 following a Care Quality Commission (CQC) report titled *Learning, candour and accountability: a review of the way trusts review and investigate the deaths of patients in England* (2016).

From April 2020, UK ambulance trusts will also be required to report on incidents reviewed utilising the Learning from Deaths methodology.

This policy aims to define the responsibilities for the delivery of the Learning from Deaths initiative, set out the East of England Ambulance Service NHS Trust's approach to achieving tangible outcomes from Structured Judgement Reviews, and identify the patients who will be in scope for review of their death.

> “Learning from deaths of people in their care can help providers improve the quality of the care they provide to patients and their families, and identify where they could do more”

(NHS Improvement, 2017)

2. **Purpose**

2.1 The East of England Service NHS Trust (hereafter referred to as the Trust) is committed to reviewing practice, learning from events and improving practice.

2.2 It is recognised by the Trust that learning from the deaths of people in our care has the potential to improve the quality of care we provide to patients and their families.

2.3 The purpose of this policy is to set out the governance structure and process for reporting on mortality reviews. This policy follows the *National Guidance for Ambulance Trusts on Learning from Deaths*, published by the National Quality Board in July 2019.

2.4 This national guidance requires ambulance trusts to:

- Have a Learning from Deaths Policy that reflects national guidance which has been agreed by the Trust Board of Directors, shared with stakeholders, and published by 1 December 2019.
- Publish information, on a quarterly basis, regarding deaths, reviews, and investigations via an agenda item and paper to public Board meetings.
- Have a considered approach to the engagement of families and carers in the mortality review process.
- Publish evidence of learning and actions taken as a result of the mortality reviews in the Trust’s Quality Account.

2.5 This policy will not document the methodology of
selection of appropriate cases for reviewing or the methodology for Structured Judgement Reviews. This can be found in a supporting document titled Learning from Deaths cohort identification and review methodology SOP.

3. Duties

3.1 Chief Executive Officer
The Chief Executive Officer will have overall accountability for the implementation of this policy and the contents within.

3.2 Director of Clinical Quality and Improvement
The Director of Clinical Quality and Improvement will own the responsibility to ensure that the policy and its contents are delivered.

3.3 Serious Incident Panel
The Serious Incident Panel will be accountable for reviewing any cases identified which may meet the serious incident threshold. The Panel will be accountable for making timely decisions to ensure that external reporting requirements are achieved in line with the NHS England SI Framework.

3.4 Safety and Risk Lead
The Safety and Risk Lead will coordinate the Trust’s response to the Learning from Deaths process and ensure that relevant cases are reviewed to a high quality standard and in a timely manner. The Safety and Risk Lead will also be responsible for collating and reporting on data gathered through the process and dissemination of any lessons learnt through any reviews undertaken.

3.5 Investigation officers / Structured Judgement Reviewers
The investigation officers and those trained in reviewing appropriate cases will be responsible for delivering high quality reviews of care delivered by Trust staff. They will have received training to enable them to utilise Learning from Deaths methodology and complete structured judgement reviews. Further details on the methodology of reviews can be found in the supporting document titled Learning from Deaths cohort identification and review methodology SOP.

3.6 Patient Safety Integration Lead
The patient safety integration lead will be responsible for the embedding of any learning which is derived from structured judgement reviews and case record reviews. They will do this utilising a variety of methods used for information dissemination throughout the Trust. The patient safety integration lead will also play a vital role in the collation of lessons learnt to report to the Board and within the annual Quality Account, to demonstrate the effectiveness of the initiative.

3.7 All staff
All members of the Trust are required to engage openly and honestly with the Learning from Deaths process, to ensure that the most appropriate and beneficial learning is achieved through reviewing relevant cases.
4. Learning from Deaths

4.1 The Trust’s approach to Learning from Deaths

The Trust’s approach to Learning from Deaths will complement existing processes such as the management of incidents and the serious incident process. It will aim to enhance these processes to ensure that richer learning is achieved to develop the quality of care delivered within the Trust. If, at any stage, the review identifies that the case is best managed through either of the aforementioned policies, then it should be referred following consultation with the Trust’s Safety and Risk Lead.

The Trust is also committed to collaborative learning with other NHS care providers and will fulfil its obligation to notify any other providers of deaths occurring prior to the Trust’s arrival with the patient. The Trust will also take part in any joint reviews which it is required to do, when notified by another healthcare provider or clinical commissioning group.

4.2 Determining deaths in scope for record review

The following deaths will be in scope for the review process. This does not mean that all deaths in scope must be reviewed, only that they are eligible for consideration for review and should be reviewed as considered appropriate as described in paragraphs 5.3 and 5.4.

a) Any patient who dies whilst under the care of the ambulance service.

This is defined as the patient dying between the 999 call being made and their care being transferred to another part of the healthcare system, or to the point of the patient being discharged from ambulance care after a decision is made not to convey them to hospital. This includes cases where patients are transported using subcontracted alternative ambulance resource. This means that a patient should be considered under the care of the ambulance service:

- While the 999 call is being handled (this will include NHS111 calls transferred to the ambulance service);
- Prior to the arrival of the ambulance resource;
- At scene;
- While the patient is being transported;
- Prior to handover being concluded.

b) Any patient who dies after handover. It is acknowledged that identification of these patients may be an issue and that the Trust is only under this obligation when notified of these deaths. In such cases, it is good practice to undertake a joint review with the healthcare provider where the patient died.

c) Any patient who dies within 24 hours of contact with the Trust where a decision was taken not to convey them to hospital. This contact includes “hear and treat” patients as well as patients who were visited by ambulance personnel. This criterion excludes patients at the end of life and recognised to be in the dying phase of their illness, where their documented wish was to remain at home.
4.3 Determining which deaths should be subject to case record review

The Trust will review all deaths where ambulance service personnel, other health and care staff, and/or families or carers have raised a concern about the care provided, including concerns about end of life care. This includes any concern raised that cannot be answered fully at the time or anything not answered to the satisfaction of the person raising the concern.

In addition, the Trust should review a sample of each of the four categories listed below:

- Deaths of patients assessed as requiring Category 1 and Category 2 responses where there has been a delayed ambulance response*.
- Deaths of patients assessed as requiring Category 3 and Category 4 responses.
- Deaths that occur following handover to an NHS acute trust, community or mental health trusts or to a primary care provider, when this information is known.
- Deaths of patients who were initially not conveyed to hospital and who then subsequently had re-contact with the ambulance service within 24 hours. The death should have occurred as part of that episode of care and not during a subsequent episode of care.

The Trust will determine the number of cases reviewed across the four identified categories listed above within each financial quarter. It should be noted that it is recommended that UK ambulance trusts review 40-50 per quarter. This is in line with the findings that this number produces a rich source of information on care quality and on problems in care, as described in Royal College of Physicians’ Using the Structured Judgement Review Method: A Guide for Reviewers (England) (2016).

* A delayed response is defined as one that is double the 90th centile response time, as set out in the NHS England Ambulance Response Programme (2017): >30 minutes for Category 1 calls and >80 minutes for Category 2 calls. This will be reviewed if national targets change.

4.4 Additional review requirements

Deaths of patients with learning disabilities
The Trust must report all deaths of those aged over four with a known learning disability to the Learning Disabilities Mortality Review (LeDeR) Programme. The Trust will contribute to their review processes when approached and share its review findings with LeDeR when relevant (Appendix 1).

Deaths of patients with severe mental illness
The Trust should report these deaths to the relevant mental health trust and/or management team where the person was known to be under their care. The Trust should also contribute to their review processes where approached (Appendix 1).

Maternal and neonatal deaths
These should be reported to the HSIB (Healthcare Safety Investigations Branch) and MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) (Appendix 1).
Paediatric deaths
The Child Death Review Statutory and Operational Guidance outlines the Trust’s statutory duties with regards to notification and information gathering. The Trust should participate in child death review meetings, i.e. Child Death Overview Panel (CDOP) meetings, when approached (Appendix 1).

Safeguarding concerns
Any deaths where there are safeguarding concerns should be referred to the Trust’s Safeguarding Lead in line with their statutory duties (Appendix 1).

Deaths in custody
These deaths fall under the relevant police forces’ remit (Appendix 1).

In some cases, in addition to reporting arrangements listed above, there may be occasions when the Trust will make the decision to conduct its own review of the death, for example, to identify early learning improvement actions in advance of the national review process. However, this is discretionary and is in addition to the Trust’s requirements to notify the national review programmes of the death.

The Trust will consider each case individually in order to determine whether it should also undertake a review in each circumstance, and will consider its decision to undertake an independent review of these deaths in discussion with the relevant review programme, to minimise duplication where possible.

5. The Trust’s approach to investigations
5.1 When an in-scope case is identified, a case record review will be undertaken within one month of the identification. This will be undertaken using approved methodology by a member of staff trained in its use. The member of staff will not have been involved in the care of the patient.

5.2 When the overall care of the patient is rated as an overall ‘poor’ or ‘very poor’, a second review will be undertaken by a different member of staff (not involved in the patient’s care).

5.3 Following the second review of care, the case will be presented to the Serious Incident Panel to decide whether the case meets serious incident criteria. Relevant further reporting to STEIS/NRLS will follow if deemed appropriate and the case will be managed under the Serious Incident Policy and process.

5.4 If the case does not meet serious incident criteria, a structured judgement review will be undertaken using approved methodology by a member of staff trained in its use.

5.5 If the case is initially reviewed and the overall score is rated as ‘adequate’, ‘good’, or ‘excellent’, feedback shall be sent to the members of staff whom attended the patient within one month of the case record review being undertaken.

5.6 Further and more detailed information on the review process in the supporting document, Learning from Deaths cohort identification and review methodology SOP.
6. **Bereaved families and carers**

6.1 The Trust is committed to engaging with bereaved families or carers of patients in a meaningful and compassionate manner. The Trust aims to ensure that all questions or concerns raised by a family are addressed within any case review or investigation which it undertakes.

6.2 The Trust will ensure that it complies with Regulation 20 of the Health and Social Care Act (2014), the Duty of Candour. Further details of the Trust’s approach to the management of Regulation 20 can be found in the Duty of Candour Policy. The Trust will continue to discharge its Duty as per this policy and in line with its serious incident process.

6.3 Specifically in relation to Learning from Deaths methodology, where it is found that the patient experienced very poor care as part of the structured judgement review, the Trust is committed to notifying the patient’s family under the Duty of Candour regardless of if the event meets serious incident criteria or not.

6.4 The patient’s family will be notified upon identification of sub-standard care and upon completion of the review of care which follows. Any report or learning which is produced as a result of such a review shall be shared with the patient’s family upon its conclusion.

6.5 Upon initial contact with the patient’s family, they shall be asked if they have any questions or concerns which they would like included as part of the review. These will be addressed within the review.

6.6 The patient’s family will also be asked whether they would like to be involved in the review in any other way, such as meeting with the reviewer during the process and upon its conclusion. Points of contact throughout the review should also be established during the initial contact with the patient’s family.

6.7 Signposting to services specialising in bereavement management will be available should it be required.

6.8 Accessible information will be made available as far as is reasonably practical upon request from the patient’s family or representative.

7. **Supporting staff affected by the death of a patient**

7.1 The death of a patient, whatever the circumstances, can have a considerable impact on the staff involved. The Trust is committed to supporting staff members when this occurs.

7.2 The Trust encourages and supports staff members to raise and discuss concerns which they may have at any time.

7.3 The Trust has a range of support options available to staff in these circumstances, including (but not limited to):

- Chaplaincy services
- Wellbeing Hub
• Employee Assistance Programme
• Staff welfare process (when involved in an incident)
• Freedom to Speak Up Guardians

7.4 It shall be the responsibility of the member of staff’s locality leadership team to arrange the necessary referral and offer pastoral support at such times. However, if at any stage throughout the process it becomes apparent that the member of staff may benefit from enhanced support, the individual identifying this need can make recommendations.

8. Learning from case reviews and structured judgement reviews

8.1 The Trust is committed to learning from when the care delivered is both deemed adequate or inadequate.

8.2 Each case record review, structured judgement review, or serious incident investigation, should identify lessons learnt.

8.3 It may be that the care delivered to the patient was adequate, good, or excellent, and this should be fed back to the members of staff involved in the patient’s care, to reinforce good practice.

8.4 There may be occasions when the care delivered is assessed as poor or very poor. On these occasions, there may be some rich learning which can be shared both internally and externally to promote improvement in the care delivered to patients.

8.5 Internal learning will be shared amongst staff utilising the communication and engagement mechanisms which the Trust has in place. These include the intranet, internal publications, and professional update programmes.

8.6 Learning can also be shared externally by reporting into the National Ambulance Risk and Safety Forum, where all UK ambulance trusts can benefit from the learning achieved from such reviews.

8.7 The patient safety integration lead shall take the responsibility for ensuring that any lessons learnt from such reviews are embedded into practice.

9. Reporting arrangements

9.1 The Trust will present quarterly reports on the outcomes of the Learning from Deaths reviews to the Quality Governance Committee. The report should also be made available to the Board of Directors and be published in public Board papers.

9.2 The reports will include the following information:

   • The number of completed reviews, including the overall rating of care.
   • The number of deaths for which an
investigation was indicated and, of these, the number of completed investigations.

- A summary of the learning themes from reviews and investigations undertaken in the previous quarter and resulting recommendations and actions taken. This includes recognising examples of good quality care.
- A consolidated total of the number of live and completed reviews and investigations relating to that financial year (from quarter two 2020/21 onwards).

9.3 The Trust will produce an annual summary of learning from deaths within its Quality Account (from June 2021). This will provide a consolidation of the quarterly reporting information together with a narrative analysis of learning and resulting key themes, actions taken and the outcomes of these.

10. Monitoring

10.1 The implementation of this policy will be monitored via the reporting arrangements set out within section 9 of this policy.

11. References

11.1 The following documents informed the development of this policy:

- National Guidance for Ambulance trusts on Learning from Deaths, National Quality Board, June 2019;

- Learning From Deaths: Guidance for NHS Trusts on Working with Bereaved Families and Carers, National Quality Board, 2018;

- Just Culture Guide, NHS Improvement, 2018;


- Serious Incident Framework, NHS England, 2015;

Appendix 1 - Linking reviews with external organisations

Where the death in question meets multiple nationally-agreed criteria for review, ambulance trusts are encouraged to engage with all relevant organisations, as set out below. Legal duties such as the coronial process take precedence over non-statutory processes.

All deaths where the patient was known to have a learning disability

All deaths of people aged four and above with a learning disability should be reported to the Learning Disabilities Mortality Review programme (LeDeR).

When requested, trusts should provide LeDeR reviews with information on the circumstances leading to the person’s death, for example, by sharing information or participating in a multiagency review. Ambulance trusts should also share the findings from their own review into the death with the LeDeR programme as soon as they can.

Ambulance trusts may find LeDeR’s e-learning tools help them to understand the LeDeR review process.

Ambulance trusts can submit their findings as an attachment to the LeDeR notification web-based platform at: http://www.bristol.ac.uk/sps/leder/notify-a-death/

All deaths where the patient had a known severe mental illness

In addition to conducting their own reviews, ambulance trusts are requested to notify the relevant trust and/or relevant management services of the patient’s death when this organisation or service is known. This could be the mental health trust, crisis resolution and home treatment team or equivalent.

Maximum learning is likely to come from these trusts and/or services leading these reviews. Therefore, ambulance trusts are requested to contribute information to these processes when approached.

Ambulance trusts may find the Royal College of Psychiatrists’ Mortality Review Tool helps them to understand how mental health trusts may review the deaths of patients with a severe mental illness under their care.

All maternal and neonatal deaths

There are multiple reporting channels for these deaths and the appropriateness of each depends on whether deaths meet certain clinical criteria. The trust’s responsibilities are to:

- Determine whether the death falls within scope of Healthcare Safety Investigation Branch’s (HSIB) maternal investigations or neonatal investigations – that is, using the Each Baby Counts (EBC) criteria. See HSIB’s maternity webpage for more detail on its investigation criteria, investigation process and how it works with trusts, as well as trusts’ HSIB-specific responsibilities;
- Report the maternal or neonatal death to MBRRACE-UK when deaths meet its criteria;
• Report the neonatal death to Each Baby Counts and NHS Resolution’s Early Notification Scheme where deaths meet their EBC criteria; and
• Ensure neonatal deaths are reviewed and investigated as set out in the Child Death Review Statutory and Operational Guidance; see below for more detail on this.

Use of MBRRACE-UK’s Perinatal Mortality Review Tool (PMRT) is mandated to support standardised perinatal mortality reviews.

All paediatric deaths

In reviewing these deaths ambulance trusts should be guided by the Child Death Review Statutory and Operational Guidance. This guidance sets out the responsibilities of ambulance trusts in relation to notification and information gathering. Where indicated, ambulance staff are required to provide information (on a standardised reporting form) and, on occasion, contribute to other specific investigations (eg coroner, patient safety incident investigations, Healthcare Safety Investigation Branch) and should anticipate being asked to participate in child death review meetings or Child Death Overview Panel (CDOP) meetings.

In most circumstances, it is not appropriate or helpful for ambulance trusts to conduct their own mortality review when a child’s death is already being investigated through wider child death review processes. Such duplication may add little to the overall understanding of how and why the child died and can confuse and add unnecessary burden on bereaved families.

Deaths in custody – that is, police and prison suites, youth offender institutions, immigration removal centres and under Section 135 and 136 of the Mental Health Act

Police forces have a statutory obligation to refer relevant deaths to the Independent Office for Police Conduct (IOPC). Ambulance trusts should contribute to its investigation process when approached.

Deaths where safeguarding concerns have been raised

Ambulance trusts have statutory obligations with regards to these deaths. Staff should refer relevant deaths to their named professional/safeguarding lead manager and director of nursing, who will undertake a review and refer to relevant multi-agency processes to ensure compliance to statute and a wider review of potential learning. Relevant deaths should also be referred for review by the Clinical Commissioning Group Accountable Officer.
## Equality Analysis

### What is the aim of the policy/procedure/practice/event?

To highlight the Trust’s commitment to learning from the deaths of our service users, whether that be from when things go well or when things don’t go to plan.

### Who does the policy/procedure/practice/event impact on?

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### Who is responsible for monitoring the policy/procedure/practice/event?

Anthony Brett, Safety and Risk Lead

### What information is currently available on the impact of this policy/procedure/practice/event?

It will have some impact on the capacity of the safety and risk team to complete the reviews when appropriate patients are identified.
It will impact on service users or their families as the Trust may need to discharge the statutory Duty of Candour if things did not go to plan.
The impact on staff will be limited to their involvement in any reviews and remaining open and honest when being asked some potentially challenging questions (as per the Management of Incidents Policy and Serious Incident Policy).

### Do you need more guidance before you can make an assessment about this policy/procedure/practice/event? No

### Do you have any examples that show that this policy/procedure/practice/event is having a positive impact on any of the following protected characteristics? Yes/No, If yes please provide evidence/examples:

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Please provide evidence:

There are no examples as yet as this is a new policy and process which has not yet started. However, the process will have a positive impact on all service users, including those with protected characteristics.
Are there any concerns that this policy/procedure/practice/event could have a negative impact on any of the following characteristics? No

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Please provide evidence:

**Action Plan/Plans - SMART**

Specific

Measurable

Achievable

Relevant

Time Limited

**Evaluation Monitoring Plan/how will this be monitored?**

Who – Anthony Brett, Safety and Risk Lead

How – through monitoring of the use of the policy and upon the policy review date

By – as above

Reported to – the director of clinical quality and improvement and CQSG/QGC/Board
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<th>Reporting arrangements</th>
<th>Acting on recommendations</th>
<th>Change in practice and lessons to be shared</th>
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<td>Ensure the style and format of the document is in line with the Trust’s requirements</td>
<td>Safety and Risk Lead</td>
<td>The safety and risk lead will review this aspect of the document prior to it being proposed for recommendation for approval, and if necessary it will be returned to the author for amendment</td>
<td>At each review of the document.</td>
<td>The document register / library will act as an audit trail</td>
<td>Reported to the Clinical Quality and Safety Group, the Quality Governance Committee, and the Board.</td>
<td>The document author will address any actions or changes required.</td>
<td>Required changes to practice will be identified and actioned. The safety and risk lead to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
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<td>All ambiguous language and non-generic terms are explained and elaborated to ensure the understanding of the audience is fully gained</td>
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<td>Required changes to practice will be identified and actioned. The safety and risk lead to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.</td>
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<td>The document has been circulated to all relevant stakeholders for information and feedback</td>
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<td>For the document to be reviewed in advance of its formal review date to ensure changes can be consulted on and approved in good time for it to be re-published before 'expiry'</td>
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