NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

NLG(17)461

DATE OF MEETING	**28th November 2017**
REPORT FOR	**Trust Board of Directors – Public**
REPORT FROM	**Mortality Assurance & Clinical Improvement Committee (MACIC)**
CONTACT OFFICER	**Dr Kate Wood, Acting Medical Director** **Mrs Sue Cousland, Non-executive Director & Chair of MACIC**
SUBJECT	**MACIC minutes, October 2017**
BACKGROUND DOCUMENT (IF ANY)	**N/A**
PURPOSE OF THE PAPER:	**For Information**
EXECUTIVE SUMMARY **(PLEASE INCLUDE A BRIEF SUMMARY OF THE PAPER, KEY POINTS & ANY RISK ISSUES AND MITIGATING ACTIONS WHERE APPROPRIATE)**	**Minutes of the MACIC meeting held in October 2017**
HAVE STAFF SIDE BEEN CONSULTED ON THE PROPOSALS?	**NOT APPLICABLE**
HAVE THE RELEVANT SERVICE USERS/CARERS BEEN CONSULTED ON THE PROPOSALS?	**NOT APPLICABLE**
ARE THERE ANY FINANCIAL CONSEQUENCES ARISING FROM THE RECOMMENDATIONS?	**NOT APPLICABLE**
IF YES, HAVE THESE BEEN AGREED WITH THE RELEVANT BUDGET HOLDER AND DIRECTOR OF FINANCE, AND HAVE ANY FUNDING ISSUES BEEN RESOLVED?	**NOT APPLICABLE**
ARE THERE ANY LEGAL IMPLICATIONS ARISING FROM THIS PAPER THAT THE BOARD NEED TO BE MADE AWARE OF?	**NOT APPLICABLE**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO THE NHS CONSTITUTION IN ANY DECISIONS OR ACTIONS PROPOSED?	**NOT APPLICABLE**
WHERE RELEVANT, HAS PROPER CONSIDERATION BEEN GIVEN TO SUSTAINABILITY IMPLICATIONS (QUALITY & FINANCIAL) & CLIMATE CHANGE?	**NOT APPLICABLE**
THE PROPOSALS OR ARRANGEMNTS OUTLINED IN THIS PAPER SUPPORT THE ACHIEVEMENT OF THE TRUST OBJECTIVE(S)	**Yes**
THE PROPOSAL OR ARRANGEMENTS OUTLINED IN THIS PAPER ENSURE COMPLIANCE WITH THE REGULATORY OR GOVERNANCE REQUIREMENTS LISTED	**NOT APPLICABLE**
THE PROPOSALS OR ARRAGEMENTS OUTLINED IN THIS PAPER TAKE ACCOUNT OF REQUIREMENTS IN RESPECT OF EQUALITY & DIVERSITY	**NOT APPLICABLE**

ACTION REQUIRED BY THE BOARD	**The Board is asked to note the actions being taken by MACIC**

Minutes

Mortality Assurance & Clinical Improvement Committee (MACIC)
Tuesday 17th October 2017
at 2pm - 5pm
In the Main Boardroom, DPoW vtc to the Boardroom, SGH

Present:

Sue Cousland	Non-Executive Director **(Chair)**
Bryony Simpson	Mortality Lead
Mel Graves	Acting Assistant Director of Nursing/Head of Quality
Carrock Sewell	AMD, Pathlinks
Mr Manohar	AMD, Women & Children's Services
John Berry	Quality Assurance Lead, NEL CCG
Mike Bateson	Healthwatch Representative
Dr Mysore	Gastro Workstream Lead

In attendance:

Laura Coo	PA to Medical Director **(Minute taker)**
Robin Howes	WebV Development Manager

1.0 Apologies for absence were received from: *Lawrence Roberts, Kate Wood, Paul Twomey, Karen Fanthorpe, Wendy Booth, Lisa Revell, Stan Shreeve, Jeremy Daws, Geoffrey Barnes, Tara Filby*

Sue Cousland noted that she was aware of the large number of apologies received for today's meeting which was partly due to the Council of Governors Meeting being held at the same time, However the decision was made not to defer today's MACIC meeting as Sue Cousland and Bryony Simpson felt it would send the wrong message out given the Trusts position with mortality and the rising SHMI.

2.0 Approval of minutes from previous meeting held on 19 September 2017

The minutes were agreed as a true and accurate reflection of the previous meeting.

Sue Cousland noted that the action log was not available for today's meeting therefore went through the previous minutes to look at any actions in more detail.

15 August 2017, 10.2 - Sepsis Workstream

Action: Melanie Graves and Sue Cousland to meet to agree a way forward on how the sepsis Workstream is managed.

16 May 2017, 3.12 – Repatriation of Patients

This was discussed at the September meeting and continues to be a problem, they are still delays and patients are being outliers on other Wards. It was agreed that Sue Barnett or somebody from Operations should be invited to MACIC to provide an update on patient flow for repatriation.

Action: Laura Coo to add to the November agenda and to invite Sue Barnett to provide an update to the November meeting.

19 September 2017, 4.1 – Nursing homes using advanced care plans

John Berry will provide an update at today's meeting.

19 September 2017, 7.1 - Update on Flow

Action: Laura Coo to add to future agendas as a standard item.

19 September 2017, 7.2 – Review of monthly mortality report

Bryony Simpson advised that she, Jeremy, Susannah and Phil Croft reviewed the content of the mortality report. They found there was a lot of duplication within the report and decided to remove a lot of the narratives with more focus now being given to the graphs. The revised format will be trialed next month and comments are welcome regarding the new format.

19 September 2017, 8.2 – Cardiac monitors

Mel Graves has looked into the funding for cardiac monitors. A bid for funding was put in to the Healthtree Foundation but was declined, however as the price for 2 monitors came in under £5000 2 have been ordered and once they have arrived 2 more monitors will be ordered.

19 September 2017, 8.3 – Cardiology Workstream report

It was noted at the September meeting that a formal Cardiology update had not been received for several months which is not acceptable.

Action: Sue Cousland to meet with Kate Wood as interim Medical Director to discuss.

19 September 2017, 8.4 – Clinical Process Group

It was noted that the Trust did not have a lead for misidentification and Mel Graves was going to pick this up with Tara Filby.

Mel Graves advised that Lawrence Roberts was looking into how mis-identification could be picked up through the Patient Safety Group which has not been set up yet. Sue Cousland stated that there needs to be something agreed in the interim.

Action: Mel Graves to provide a post meeting note to Laura Coo.

19 September 2017, 8.4 – Discharge letters and Dictate IT

An update to be provided for November agenda

Action: Laura Coo to add to the November agenda.

19 September 2017, 18.0 – Waiting times and RTT

Mike Bateson had asked for an update as he felt patients should know how long they will have to wait.

Action: Laura Coo to add to the November agenda.

3.0 Delivery Plan Action Log

Not discussed

4.0 Matters arising

4.1 Computer Aided Risk Score/Burden of disease

Robin Howes attended the meeting and gave a short presentation on the computer aided risk score. Robin Howes summarised the key points;
The Trust were approached by Bradford faculty of health to see if they could come up with a concise and better method of assessing how ill somebody was using regression analysis and working out whether there would be a better way to do that. From the Trusts 2014 data,

scores were put together and they came up with an equation that could calculate the score.
Work has also been done with York Hospital. The albumin level a lot of the time is due to diet and the levels at both sites are being monitored and compared. A CARS morbidity index is produced during the hospital stay. Ethical approval has only just been received for it to be used in practice. York are already live with this system, when a patient arrives a CARS score is calculated and linked within the first 24 hours, this can then be used to monitor severity/acuity/co-morbidities. A CARS score is judged to be more precise than a NEWS score.

They have asked whether NLaG would like to deploy the system within the Trust, it could be added to WebV but somebody would need to be involved to assess whether or not it would be of use in our organisation. It is also very useful for assessing patients coming through A&E and hopefully could help to identify the deteriorating patient. Version 3 is available which has been fine tuned. In our A&E they do not do electronic observations but they do pathology tests and York was the other way round. There are other models that have been tried in the past but this is generally for acute admissions. There are other parameters that would improve performance i.e lactate but it would be best to get clinicians to help validate it. Dr. Kevin Speed is involved in the CARS trial but Robin would like to involve a front line physician because of their direct patient care experience. Dr Levison-Keating suggested that the NEWS score was something that could be done straight away and would be worried that some of the patients may not get the attention they need and suggested this should be an aid to communication. Robin explained that CARS sits behind NEWS and does not replace it during the trial.

Sue Cousland suggested that patients from specific specialties such as A&E and Respiratory could trial it. Robin Howes advised that the user does not have to do anything the system updates it. The number of users can be counted and if the NEWs score is repeated it will automatically recalculate the CARs score which would also be the same if Pathology is updated. Robin Howes will arrange to give a demo to Respiratory and A&E. Mel Graves needs linking in for the critical care outreach team and the deteriorating patients. Carrock Sewell suggested for some sort of explanation to be attached to explain what the different scores mean.

Robin Howes is due to meet with Dr Menon in his new role as clinical lead role for mortality.

Action: Sue Cousland suggested for the author Professor Mohammed to be invited to MACIC with the other relevant parties.

Sue Cousland invited any further comments or questions.

Mike Bateson asked how people would be educated to use this, in response Robin Howes advised that in-house training would be provided.

Mel Graves noted that there would need to be a lot of communication around this even though it is an alert system that you present and not a monitoring system.

Mike Bateson does think there is something about communicating with the patient, Sue Cousland would be looking for feedback from those discussions of how it would be implemented and feedback from the groups would be needed. This is entirely a clinical focus.

Sue Cousland invited any further comments or questions and none were received.

Committee action:
The Committee received the update.

Robin Howe left the meeting at 14.43hrs

4.2 Update on Sepsis NED challenge

A meeting has been arranged for Monday with Sue Cousland and Mel Graves which will be key to this moving forward.

Carrock Sewell advised that the sepsis pathway is now live.

Sue Cousland invited any further comments or questions and none were received.

Committee action:
The Committee received the update.

4.3 Additional system funding to support A&E

No information available.

5.0 Patient Story

Dr Levison-Keating presented the findings from a patient story.

The patient was a 73 year old lady who was brought to A&E by her own family, she arrived at 7.20pm on a Thursday, but did not get admitted to AMU until 1.45am and she died in hospital 36 days later.

According to the pre-admission documentation the lady came into A&E coughing and vomiting a lot of blood but was not seen by the triage nurse until 2 hours later. There was nothing documented about any treatment the lady received in A&E, but it is documented that at 1.20am she was on oxygen. She was reviewed at 10.45pm but there are no comments about that in the notes. The diagnosis was a pulmonary embolism and the chest x-ray showed a suspect malignancy, the lady was on warfarin.

There was nothing documented about how the patient was feeling i.e was she short of breath, in any pain. It is not acceptable for an elderly lady to be left waiting 6 hours to be admitted. The junior doctor came at 2.45am. During her time in AMU the patient had a fall and ripped out her cannula which was unnoticed and this lady was kept up all night.

On-going care
After her initial review from the consultant the patient did not have a medical review from a consultant for the next 4 days although it was over the Easter weekend the patient continued to cough up blood and warfarin was continued. The junior doctor told the family that the patient probably had cancer but they had to wait 4 days for the consultant to discuss this with the family.

The patient was transferred to Laurel ward as an outlier where her warfarin was switched to tinzaparin due to a misunderstanding. The patient was given a CT of the abdomen 8 days after admission and was referred to Oncology and the Macmillan palliative care team.

Summary
The right tests were undertaken but there were significant delays which caused a lot of distress. The patient was moved twice to MAU and Laurel in the early hours of the morning. Continued to administer anticoagulant drugs. The patient received the right care, a biopsy was performed with no problems. The Macmillan care had timely discussions about place of death and anticipatory drugs were prescribed and the lady was admitted to Amethyst where she died 36 days after admission. The cause of death was not noted in the records and the cause of death scored as a 6 (not avoidable).

A discussion took place about the transfers in the middle of the night, whilst the ideal is to avoid transfers to multiple wards and transfers in the middle of the night sometimes capacity dictates the need for such moves.

Bryony Simpson commented that this shows how thorough the structured judgement review process is and asked what feedback had been received from the family. Dr Levison–Keating noted that there were not any comments or feedback from the family recorded within the notes. The primary diagnosis was lung cancer.

Mr Manohar asked whether those people involved had been updated to be able to address what could be done differently in the future.

Sue Cousland noted that there were a lot of things highlighted that need to be picked up with the A&E dept. as there needs to be some sort of structured judgment in place. Mel Graves understands it is difficult to prevent transferring patients so late but it depends how busy the hospital is with the beds and operational pressures. Mike Bateson noted that patients being transferred late at night is something that comes up through Healthwatch time and time again but is also aware that sometimes it is unavoidable. Mike Bateson asked for clarity as to whether AMU was busy and Sue Cousland asked whether because they self-presented and came in via a car could that be what caused the delay. In response Mel Graves advised that A&E now have a streaming nurse who listens to each person and sign posts, but they were not in post at the time of this patient story.

John Berry observations were that there were issues with the documentation, delays, patients was transferred in the night and asked where do this type of patient stories go within the organisation.

Bryony Simpson advised that there are apparently no funds available to employ a data analyst to work on the findings of Mortality reviews but Jeremy Daws has identified somebody within his team who we may be help with this piece of work. Sue Cousland is still questioning within the organisation how the strands of improving together and this links into the clinical harm group and has asked for an overview of where all of the meetings fit together.

Mel Graves reported that A&E have regular huddles which are short and snappy but is unsure whether A&E has their own Governance meetings. AMU falls under the Medicine Governance meetings and possibility A&E will fall under that category too.

Mike Bateson thinks the patient stories are so power but wants to know - so what – what are you going to change, what will be done differently.

Sue Cousland suggested for a progress and update to be brought back to the December MACIC. Sue Cousland would be interested to find out what the patient had accessed out in the community any pre-hospital details to close the loops and so that lessons can be learnt.

Action: Laure Coo to add to the December agenda.

Sue Cousland invited any further comments or questions and none were received.

Committee action:
The Committee received the patient story.

6.0 Receive the Quality & Safety Challenge

No specific challenge this month.

7.0 Mortality Performance

7.1 Update on flow /repatriation of Stroke Patients

Discussed as part of the patient story

7.2 Review of Monthly Mortality Report

Bryony Simpson referred members to the monthly mortality report distributed and summarised the key points;

- Crude mortality has increased and the SHMI is now in the higher than expected range and still rising.
- DPoW is the site driving the raised SHMI , variations between the sites have already been looked into; the number of A&E waits and length of stay.
- Gastroenterology peak mortality (2 points above UCL) in Dec 16 and Feb 17 both driven by peaks at DPoW
- Cardiology peak mortality (1 point above UCL) in Jan 17
- Official SHMI published in September 2017, 'higher than expected', score of 114
- Out of hospital mortality indicators for N E Lincs and N Lincs are higher than the in hospital indicators
- DPoW access and flow measures different to those seen at SGH:
- SGH has the ambulatory care for the elderly assessment unit
- DPoW admits patients for longer on AMU and for more general non elective length of stay measures.
- DPoW has a higher level of medical outliers
- DPoW has a higher number of 4 hour A&E breaches

- DPoW has a higher proportion of multiple consultant episodes on same ward in Medicine

In summary

The Trusts mortality rates crude, non-elective crude, SHMI and HMSR are continuing to gradually increase and all demonstrate DPoW being higher than SGH.

The management arrangements for patient access and flow measures at DPoW are definitely different to those at SGH.

By Quarter 3 the Trust need to be publishing nationally how many deaths they have had, how many have been reviewed, what the findings are and whether any were relating to mental health or disabilities.

Improvements

Bryony Simpson advised that Dr Menon has been appointed as the Clinical Lead for mortality.

Data sharing and working more closely with the CCG, Healthwatch and N E Lincs is a positive step. The first joint meeting has taken place in October

Members agreed this update fits in with the patient story and reinforces the access and flow update which Sue Cousland requested to become a standard agenda item.

The multiple consultant episodes aspect is confusing and affects the SHMI as only the first 2 episodes can be looked at.

Action: Bryony Simpson to escalate to Claire Philips and Richard Sunley.

Sue Cousland invited any further comments or questions and none were received.

Committee action:
The Committee received the Monthly Mortality Report.

7.2.1 Monthly Mortality report redesign

The revised format will be presented at the November meeting.

7.3 Mortality Strategy & Delivery Plan

Bryony Simpson reported that this has been looked at several times and has already gone through the Trust Board, Section 8 still needs updating to link in to the various accountable people. Prior to the next meeting Bryony Simpson will approach each person for an update. Sue Cousland suggested this should follow on from the action log to use this to hold people to account for their action. Mike Bateson suggested for EMAS to be included in the stakeholder analysis.

Action: Laura Coo to add this to the November agenda

Committee action:
The Committee received the Mortality Strategy & Delivery Plan

7.3.1 M&M Guidance

Item deferred

8.0 In-depth Workstream reports (as scheduled)

8.1 Gastro Workstream report

Dr Mysore reported that Gastro is a unique specialty and they take a lot of mortality from surgery which they have no way of influencing. Last time he checked Gastro were taking between 30–40% of mortality from them. Carrock Sewell noted that there is now a general surgery sub-committee where these cases should go to as this was previously highlighted as an issue.

Action: Bryony Simpson to discuss with Kate Wood, to go through the coding as it still appears to be an issue.

Liver disease – now have a care pathway which people have started using but it is too early to evaluate it. The pathway was implemented in June and Dr Mysore hopes to have a preliminary report at the end of December.

At the moment it is Dr Mysore's opinion that they are over diagnosing for GI bleeding. All GI bleeds will be audited for accuracy of diagnosis of GI bleeding. The audit results are expected by the end of December.

Both sites agreed they cannot allow patients to go without seeing a consultant for 4 days a week therefore have agreed in principle for consultant of the week with their patients being concentrated in particular areas. When Dr Mysore is on a/l patients will be allocated another consultant. The problem previously was that the junior doctors felt they had nobody to go to and one of the main things they worried about was they did not know which consultant to go to therefore if would help to formally change the consultants name for that period of leave. The details will be finalised by Pete Bowker.

Dr Mysore left at 15.43

Sue Cousland invited any further comments or questions and none were received.

Committee action:
The Committee received the Workstream update for Gastro.

8.2 Cardiology Workstream report

No update received.

8.3 EoL Workstream report

Post Meeting note from Bryony Simpson;

Feedback from NLG EoL group

The group met on 25th September 2017. The EoL group is not a Mortality work stream but instead will be doing targeted 2nd reviews.

Agreed that Group would resume looking at in-hospital deaths, during the first part of the meeting, where the following issues were identified:

- Inappropriate admissions
- Lack of Advance Care Planning
- Issues of lack of 7 day services/equipment

Dr Adcock will also look at cases of community deaths where there was no ACP/Antic Meds/DNACPR.

RESPeCT – NLaG and York not adopting at present due to scale of resource need to train staff and implement but Hull and Doncaster are so will need to be monitored. There are only 8 areas in the country that are currently planning to adopt it.

Complaints –July/Aug nearly all from DPOW – issues to be raised with multi agency group at NEL. Dawn Ojadi leaving and no plans to replace

Inequity of provision re Specialist Palliative Care both in and out of hospital. Dr Adcock covers NL and Dr Boland is at DPOW – address through multiagency group. EoL training has been offered for Clinicians at NLaG but no uptake.

Need for EoL champions - approach Drs Ali and Menon regarding a surgical Champion

8.4 Still Birth Workstream report

Mr Manohar reported that the NLaG still birth rate was 4.2, the national average is 4.1 so NLaG are only slightly outside of that. The Trusts had 18 still births over a 12 month period; 6 were premature, 1 still birth it is still not known when it happened but was anti-partum. A midwife allocated to still births has been appointed, Nicola Kerry who will start with the trust on 6th December.

Mr Manohar explained that the Trust cannot achieve the national requirement of how to manage and monitor small babies as the extra scanning equipment needed would cost approx. £50,000 and the ultrasound department do not have the capacity. This is a similar problem in other hospitals in the region due to funding. This is included on the governance dashboard as a risk but is a low priority

Sue Cousland asked whether the figure of 18 still births was reasonably consistent, Mr Manohar said it was reasonable.

Sue Cousland invited any further comments or questions and none were received.

Committee action:
The Committee received the Workstream update for Still Birth.

9.0 Community-wide review

9.1 North East Lincs

Dr Ali mentioned the Lincolnshire East CCG and patient flow at the previous meeting and John Berry has had a discussion about it with his colleagues who have said that Louth hospital has been downgraded but if the Trust were picking up any scenarios where they were having trouble getting patients back to Louth they should get in touch with John on an individual basis.

A piece of work is ongoing at present linking to advanced care planning and looking at whether it is in relation to the care homes and out in the community. A meeting will be held next week to discuss further.

John Berry has spent some time with N Lincs where it is a different model of care all together. A few themes were highlighted in relation to GPs; they are linked in to residential homes in N Lincs which is not the same in N E Lincs however the Roxton practice does this. John is having conversations to ask if GPs can be aligned to care homes.

EMAS –If patients are coming to their end of life, there is something about patients come to NLaG when they wanted to die in the residential home, need to consider what are the diversions that can be used rather than EMAS.

Young carers and how they handle things needs to be looked into which leads on to a whole piece of work to do with care homes and domiciliary care homes in N E Lincs.

Work is ongoing with care providers to ensure our service users die with dignity and respect.

Sue Cousland advised that Sally Dunmore who works for EMAS looks at alternative pathways.

Action: John Berry to contact Sally Dunmore.

Sue Cousland invited any further comments or questions and none were received.

Committee action:
The Committee received the update

9.2 North Lincs

A representative was not present to provide an update.

10.0 Mortality Lead Exception Report.

10.1 Board Assurance Framework (BAF)

To be looked at in detail at the November meeting.

Action: Laura Coo to add to the November agenda

11.0 Performance

11.1 KPI's in development

Bryony Simpson reported that data is still being collected and is work in progress, the number of cases reviewed each month overall still needs to be improved. All deaths should be looked at with a screening tool to say which need to be progressed further, a number of random case note reviews will still be carried out but it has been agreed that the KPIs should be a minimum of 5 structured judgement reviews per month. Bryony Simpson attended the consultant meeting at DPoW and the consultants had said they need an extra hour per month in their SPA time to cover this. Carrock Sewell noted that the view of the AMDs at that time was that the reviews of mortality cases already fit in as part of their job.

Action: Bryony Simpson to discuss with Kate Wood.

Action: KPIs to be reviewed in detail at the November meeting.

Sue Cousland invited any further comments or questions and none were received.

Committee action:
The Committee received the update

12.0 Reflection on Patient story

Reflection discussed under agenda item 5.0.

13.0 Response to Quality & Safety Committee Challenge

Members discussed whether MACIC needs to report to the Quality and Safety Committee or should it report straight to the Board.

Action: Sue Cousland will feedback post Trust Board and will discuss again at the November meeting.

Sue Cousland invited any further comments or questions and none were received.

14.0 Communications/media issues

No representative present or update received.

14.1 SHMI release

15.0 Priorities/Actions by exception for Mortality Lead

Post meeting note from Bryony Simpson;

Bryony Simpson's proposals on the issues for priority were;

- Secure commitment from Operations to report of the repatriation of stroke patients at the next meeting.
- Report back to MACIC Chair following attendance at cardiology M&M meeting on Friday 20th October
- E mail Dr Menon regarding Robin Howes presenting CARS to A&E consultants and CC outreach teams
- Discuss with Jeremy/Dr Menon the possibility of establishing Ward based Mortality reviews
- Discuss with Jeremy Daws and Kate Wood (Interim MD) the issues raised by Dr Mysore of surgical patient deaths being attributed to Medical specialties e.g. Gastro

- Contact Claire Phillips regarding the PAS recording of Consultant transfers including the issue of those on AL.
- E mail Dr Ali re John Berry's feedback that E. Linsey CCG are not aware of any problems with stroke patients being discharged from DPoW back to their area.
- Circulate revised MMR to Chair and present at next MACIC
- Reformat the Delivery plan Log into key areas for action and send to Chair and Medical Director for discussion at Executive Team
- Get an update from the General surgery Group
- Ensure that Cardiology/Sepsis, General Surgery are scheduled to report to the next MACIC

16.0 Board Highlight report

At Sue Cousland's request, members agreed the key issues to be included in the Committees highlight report to the Board as follows;

- Patient story
- Issues relating to Gastro
- Elements of the mortality report – SHMI, Dr Foster letter, lack of attendance from Cardiology
- Recommendation that we do reinforce all deaths should be reviewed
- Sepsis
- Computer aided risk score and what decision has come to today
- Dr Menon appointed for Mortality

17.0 Items for information

See appendix A for items for information

Action: Laura Coo to ask Wendy Booth if the Clinical Harm process minutes can be shared with MACIC.

18.0 Any Other Business

The meeting closed at 16.10hrs

19.0 Date and Time of Next Meeting

Tuesday 21 November 2017
14.00hrs – 17.00hrs
Main Boardroom, DPoW vtc to Boardroom, SGH