

**Minutes of the meeting: Quality and Risk Committee**  
**PART ONE**  
**Thursday 26<sup>th</sup> February 2026 – 14:00-16:00**  
**Chair: Graham Martin**  
**(Quarter 4, Month 2)**  
**Microsoft Teams**

<b>Present</b>	<b>Role</b>	<b>Initials</b>
Martin, Graham (Chair)	Non - Executive Director	GM
Wilkinson, Ian	Non - Executive Director	IW
Fadero, Amanda	Non - Executive Director	AF
Midlane, Eilish	Chief Executive Officer	EM
Screaton, Maura	Chief Nurse	MS
Monkhouse, Oonagh (attended in part)	Director of Workforce & Organisational Development	OM
Glenn, Tim	Deputy Chief Executive Officer & Executive Director of Commercial Development, Strategy and Innovation	TG
Meek, David	Consultant Physician in Oncology	DM
Howard-Jones Lorraine	Deputy Director of Workforce & Organisational Development	LHJ
Vaithamanithi, Raj	Deputy Director of Digital	RV
Palmer, Louise	Deputy Director for Quality & Risk	LP
Elwood, Jonthan	Associate Director of Corporate Governance	JE
Platten, Lynsey (Minutes)	Executive Assistant to Chief Nurse and Deputy Chief Nurse	LPL
<b>In Attendance</b>		
Whisken, Jennifer	Deputy Chief Nurse	JW
Hotchkiss, Marlene	Public Governor	MK
Pai, Sumita	Consultant - Microbiology	SP
Cooper, Deborah	Governor (Observing)	DC
<b>Apologies</b>		
Raynes, Andrew	Chief Information Officer	AR
Hurst, Rhys	Staff Governor (Observing)	RH

<b>Item</b>		<b>Action by whom</b>
<b>1</b>	<b>Welcome &amp; Apologies</b>	
	The Chair welcomed Committee members and attendees to the meeting; introductions were made, and those present confirmed receipt of meeting papers. Apologies were noted as above	

<b>2</b>	<b>Declarations of Interest</b>	
	There were no further declarations of interest raised	
<b>3.</b>	<b>Committee Member Priorities</b>	
	Not discussed	
<b>4</b>	<b>Ratification of Previous Minutes Part 1</b>	
	The minutes of the meeting dated 29 <sup>th</sup> January 2026 were <b>AGREED</b> to be a true and accurate record of the meeting, subject to the following amendments: Page 7 of the combined papers should be patient safety incident response framework not patient safety event response plan. Sarah Powell's initials to be changed to SJP for clarity.	
<b>5</b>	<b>Matters Arising – Part 1 Action Checklist</b>	
	<p>The Committee <b>NOTED</b> the Action Log from the meeting held on 29<sup>th</sup> January 2026.</p> <p>Discussion regarding action 136 - IS presented data on TAVI mortality outcomes, focusing on whether there were differences between patients transferred urgently as inpatients and those coming from the elective waiting list. This was explored due to concerns that outcomes for inpatient transfers might be less favourable, given that existing evidence for TAVI is largely based on elective cases.</p> <p>Discussion took place between the committee regarding the data, Tavi capacity and quality of life impact.</p> <p>The committee agreed that there was a need for a further deep dive and data collection required of sources external to the Trust, to explore further justification regarding the distribution of benefits from TAVI (in terms of added life years or QALYs) given the wider characteristics of the population, including ethnicity. Further resourcing maybe required such as a clinical fellow to complete the ask. Action 136 is now closed and a new action 136c has been listed on the action log.</p> <p><b>Action:</b> <b>A proposed plan is presented to the committee that outlines how a further analysis of the TAVI service will be undertaken.</b></p>	<b>IS</b>
<b>6</b>	<b>Quality and Safety</b>	
<b>6.1</b>	<p><b>Quality and Risk Management Group (QRMG) and Safety Incident Executive Review Panel (SIERP) Highlight and Exception Paper</b></p> <p>The paper was taken as READ</p> <p>LP provided an overview of the key highlights:</p> <ul style="list-style-type: none"> <li>• There are no escalations from SIERP</li> <li>• It was escalated to QRMG, that there is ongoing work required into the processes of the Post Falls Trauma pathway.</li> <li>• There were three harm events reported in January 2026</li> <li>• There were no escalations from the Harm Free Care Panel</li> <li>• Overdue incidents have reduced to their lowest level in six months, supported by the introduction of the Divisional Governance Facilitator role in December. This work is strengthening the incident-management</li> </ul>	

	<p>processes. As of 26.02.2026, there are ninety-nine overdue incidents for 2025, nine relate to outstanding learning responses, which are not yet due for response.</p> <ul style="list-style-type: none"> <li>• There were eight complaints received in January, which aligns within the usual range. Cumulative complaints for the year remain elevated and will continue to be monitored.</li> <li>• There were two Clostridioides difficile (C-diff) cases in the month of January 2026.</li> </ul> <p>EM requested further detail into pressure ulcers and the change in nature from medical related ulcers to moisture related ulcers.  LP advised that this was part of the Harm Free Care Panels focus and further educational sessions are being put in place.  MS advised that the Trust are good at reporting ulcers so that this can be monitored and in turn acted upon, but also recognised that moisture associated ulcers can be a sensitive indicator of quality of care. As a result MS has been in discussion with the Nurse Consultant for tissue viability. It has also been a focus on the Chief Nurse Visibility rounds. It has been noted that all except one case reported were patients in critical care. It is believed that this is due to the nature of the patients being extremely sick. MS has requested that it is a focus for the Tissue Viability team, who will support in finding other strategies to prevent moisture related pressure ulcers. This has also been addressed at divisional performance meetings. AF welcomes MS review and recognises that there should be a better strategy for controlling moisture related ulcers.</p> <p>AF requested a position update regarding post fall procedures for patients requiring radiological investigation for Trauma and the Cambridgeshire University Hospital (CUH) pathway. IS advised that it is being reviewed and areas that are being addressed are; the training gap in immobilising patients to be safely moved and the equipment required, discussions with radiologist and radiographers on scanning patients and how CUH will assist with complex trauma cases. The policy and governance processes now require finalising. MS advised that the falls policy would also require changing, which means that Q &amp; R would have oversight as it will require ratification. MS suggested a two-month timeline for completion.</p> <p>AF asked if four incidents reported to the National Health Service Blood and Transplant (NHSBT) within a quarter is an “normal” number. MS advised that the number reported in the quarter would be acceptable, but the concern would be more, if harm was reported and the level of harm. MS confirmed that there was no harm in these cases.  AF recognised that the Recommend Summary Plan for Emergency Care and Treatment (ReSPECT) form has been built into the Transplant pathway.</p>	
6.2	<p><b>Safety Incident Executive Review Panel (SIERP) minutes (30.12.26, 06.01.26, 13.01.26, 20.01.26 &amp; 27.1.26)</b></p>	
	<p>The minutes were taken as READ.</p>	
6.3	<p><b>Q3 Falls Report and Improvement Plan</b></p>	

	<p>The paper was taken as READ  LP advised that the paper was a quarter three update which shows continued focus on falls following the recent cluster of harm events. December saw a small peak in repeat falls, and further work is underway to understand supervision decisions, particularly where 1:1 support was declined. The Falls Group and ward teams are reviewing these cases to strengthen assessments and prevent recurrence. The Falls Improvement Plan is progressing, with an updated summary included in the appendix; one post-trauma-falls action remains overdue and is being addressed. The falls action plan produced is in progress, and along with sustained work by the Falls Group, and there is oversight by the Harm-Free Care Panel.</p> <p>The committee agreed that as the Falls group reports to the Harm Free Care Panel that their quarterly report should be included in the reference pack for future Q &amp; R committees.</p>	
<p><b>6.4</b></p>	<p><b>Surgical Site Infection (SSI) Quality Monitoring Dashboard</b></p> <p>Dashboard taken as READ</p> <p>MS provided an overview of the key highlights:</p> <ul style="list-style-type: none"> <li>• Quarter three SSI rate is currently recorded at 4.2%, however this has yet to be validated due to the often late presentation of infections.</li> <li>• A majority of SSI's being reported are superficial, and they are a combination of leg and sternal infection.</li> <li>• Environmental dashboard shows good compliance with key standards, there are some amber areas such as level 5 and CCA in particular cleaning and decontamination.</li> <li>• The decontamination of surgical instruments - there were two unknown plastic type debris of unknown origin found in the instrument packs. All packs undergo extensive scrutiny by staff, which is the reason why the debris was found. Any issues are reported to the supplier by the decontamination lead through their weekly meeting.</li> </ul> <p>GM questioned the ongoing outstanding amber actions in the environmental audits, questioning whether this reflects resourcing issues, specific area-based challenges or the need for additional targeted support beyond current activity.</p> <p>MS advised that she had spent time with the matron on level 5 and it was identified that the ward had no Patient Environment Assistants in post, impacting equipment cleanliness and bed-space management. Recruitment is underway, but to maintain standards in the interim, the matron has implemented a plan to utilise Healthcare Support Workers to provide essential support. Early signs already indicate improvement as a result of this approach. A further review is required in critical care, where clutter in long-stay patient areas continues to present challenges.</p>	
<p><b>6.5</b></p>	<p><b>Mycobacterium Abscessus (M Abscessus) Dashboard</b></p>	

<p>6.6</p>	<p>Dashboard taken as READ MS advised that there was one new case of M.abscessus reported in January 2026, however the result has been received for UKHSA, who confirm that they are not related to the outbreak strain. MS advised that results are being returned efficiently, which is helpful for patient care and treatment.</p> <p>LP advised that there have been two clinical claims received in January 2026, which are now with the Trust's legal team. (See report for further details)</p> <p><b>Antimicrobial Stewardship (AMS) Quarterly Report (inc. regional assurance on AMS Gap Analysis)</b></p> <p>Paper taken as READ</p> <p>LP responded to GM pre meet question regarding the interpretation of data and the paragraph above which requires further clarification. LP to discuss with SP outside of meeting.</p> <ul style="list-style-type: none"> <li>• The Trust have met the target of reducing antibiotic use by 5% below the 2019 baseline. The Trust achieved the greatest reduction in the East of England.</li> <li>• World Antimicrobial Resistance Awareness Week (WAAW) was a great success. The Trust collaborated locally and with Health Innovation England to produce a digital AMS Escape Room-like game.</li> <li>• An Antimicrobial Stewardship Education Module has been created and is now available on LearnZone®</li> <li>• The Trust received a letter from the Department of Health outlining assurance requirements for AMS standards across all Trusts. A subsequent gap analysis has identified three priority areas for improvement next year. IS has agreed to act as Executive Lead, as the Trust aims to demonstrate clear progress in these areas by April 2027.</li> </ul> <p>GM thanked SP for a clear report and gap analysis, and congratulated SP for achieving the national target. GM felt that there are a couple of areas which would benefit from clearer timelines and defined deadlines, particularly the item relating to increasing appropriate antibiotic prescribing. SM advised that a timeline was initially omitted from the action due to capacity constraints within a small team; however, a timeline has now been added, setting April 2027 as the completion date and providing a one-year implementation plan. GM recognised that April 2027 deadline was an ambitious but feasible goal and identified the proposal for additional staffing within the report.</p> <p>MS advised that the letter received for the department of Health required that the Gap analysis was signed off at Board level. AF thanked SP for a very good report and noted as a point of interest was the expectation for more detailed information to be escalated to the Board,</p>	
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	<p>reflecting a broader emerging national trend toward greater scrutiny and depth in Board-level reporting. MS stated that antimicrobial stewardship is a top national priority which is why there is a sustained national focus from NHSE.</p> <p>The committee agreed that the gap analysis is included within the reference pack, and noted within the chair's report for Board.</p>	
<b>7.</b>	<b>Patient Experience</b>	
<b>7.1</b>	Nothing to report	
<b>8</b>	<b>Performance</b>	
<b>8.1</b>	<p><b>Performance Reporting: PIPR M10</b></p> <p>Paper taken as READ</p> <p>MS provided an overview of the key highlights:</p> <ul style="list-style-type: none"> <li>• The PIPR Safe domain is rated as Amber this month.</li> <li>• The completion of VTE risk assessments require continued monitoring, which the VTE group have oversight of. There was no harm events associated with omissions of VTE risk assessment completion</li> <li>• Supervisory Sister time is being monitored on a weekly basis. The performance is linked closely to the reduction of temporary staffing usage. MS recognises the importance of supervisory sister time and the key to a well-run ward.</li> <li>• Level 3 Safeguarding Compliance, there has been a significant reduction due to a change in denominator following the updated Intercollegiate Guidelines. Staff that are band 5 and above are now required to complete Level 3 safeguarding training. The training availability has been mapped out and at the current trajectory is an estimated 18–24 months to restore compliance levels. This trajectory is under review to identify opportunities for acceleration and focus on identifying priority areas and key staff groups to ensure appropriate coverage across all shifts.</li> </ul> <p>Appreciation was expressed for the safeguarding plan, with acknowledgment that the 18–24-month trajectory is lengthy; however, efforts to accelerate progress and prioritise key staff groups were welcomed.</p> <p>GM queried the significance of reporting two c-diff cases in one month, noting that this would equate to more than 18 cases if annualised, and sought clarification on the level of concern, and how this compares with the longer-term trend</p> <p>MS advised that both cases have been investigated and there was no evidence that either case had been acquired in the hospital, and no evidence of deficiencies in transmission prevention. The Trust remains below the annual threshold set at 18 by UKHSA. The Trust is monitoring C-</p>	

	<p>diff rates closely as nationally there has been an increase. The Trust is actively contributing to the ICB-wide quality improvement focus, which includes a monthly ICB-level action on infection prevention. The Trust has taken a leading role in supporting other organisations, and the ICB infection control nurse reported that the initiative has had a positive impact across the system. Although overall ICB rates remain higher than desired, the programme is showing beneficial results</p> <p>AF questioned the number of patient safety incident investigations (PSII) commissioned being two in month, and the target for the year is zero, which as a result makes the PIPR report show as red.</p> <p>MS confirmed that they were the two PSII reported on at committee in January. MS provided a brief overview of each PSII. MS advised that indicators for PIPR Safe and Caring is going to be reviewed and rationalised with GM.</p> <p>MS advised that notification has been received that Trusts need to start reporting on numbers of Candida Auris within the PIPR slides, as it is now becoming a nationally reported alert organism.</p>	
<b>9</b>	<b>Risk</b>	
<b>9.1</b>	<p><b>Cover: Board Assurance Framework (BAF)</b></p> <p><b>Appendix 1: BAF Report</b></p> <p>The BAF report was taken as READ</p> <p><b>Appendix 2: BAF Tracker</b></p> <p>The tracker was taken as READ</p> <p>MS advised that the current BAF risks are up to date and there are no changes to the two BAF risks associated with the committee.</p>	
<b>10</b>	<b>Governance and Compliance</b>	
<b>10.1</b>	<p><b>Internal Audits/Assessment</b></p> <p><b>BDO Benchmarking Health Inequalities</b></p> <p>Audit taken as READ</p> <p>IS reported that the committee has now passed its first year and has made steady progress, with further developments since the audit was written in October. Initial work focused on tobacco-dependency treatment, with this year's priorities expanding to obesity and diabetes in key subpopulations. The report also recommends additional staff training on health inequalities, which IS suggested may require further discussion with MS for clarity or its origin. It was noted that internal hospital processes appear to function equitably once patients are referred, with no evidence of differential treatment based on acuity. However, a significant concern remains around patients not being referred into the Trust, indicating that the principal inequalities issue lies outside the hospital rather than within it. Further work is needed to understand and address barriers to referral.</p>	

<p>10.1.2</p>	<p>MS explained that the training recommendation arose from work led by the health inequalities lead, specifically in relation to treating tobacco dependency. It was identified that all staff should feel confident in discussing and referring patients for smoking-cessation support, as some medical staff were not consistently doing so. This insight fed into the audit findings and resulted in the training action. MS acknowledged the wider point that the main inequalities challenge lies outside the hospital, but noted that this issue is being addressed</p> <p>GM noted the need for the committee to discuss the recommendations regarding the reporting structure for the Health Inequalities Panel. Reference was made to page 99, where the external recommendation suggested the panel report directly into Q&amp;R, which was felt to be inappropriate. GM confirmed that the response provided, which clarified the correct reporting flow via QRMG before escalation, was appropriate.</p> <p>IS agreed with MS response in the audit regarding the reporting structure and highlighted that repeated suggestions to report all matters directly to the Board are impractical. The comment reinforced the need to maintain the established escalation pathway through the committee structure.</p> <p>AF questioned how the EDS 2 self-assessment and Health Inequalities links together, and if the EDS 2 has been completed.</p> <p>IS noted that the EDS2 work spans both staff and patient-related elements, requiring alignment between Workforce, this committee, and related governance groups. It was confirmed that these strands will come together in the final report, which is still in progress, with clarification sought on its current status</p> <p>OM advised that the EDS 2 submission is due shortly.</p> <p>The audit was agreed and noted by the committee</p> <p><b>BDO Benchmarking – Quality Improvement and Innovation</b></p> <p>Taken as READ</p> <p>LP advised that much of the report’s content reflects work already recognised within the Trust, referencing the earlier Board paper on quality improvement and previous discussions around NHS Impact and continuous improvement and innovation.</p> <p>The staff survey findings provided some assurance that staff feel empowered to undertake quality improvement. However, the survey also highlighted the need for greater knowledge and resources. Actions taken are underway to identify who leads on QI and continuous improvement across the organisation and to consolidate knowledge in one place.</p> <p>LP noted that formal training programmes had been explored previously but were challenging to sustain due to staff turnover, emphasising instead a model where QI is embedded as everyone’s responsibility. Divisional quarterly reports increasingly reference QI activity, which is positive.</p> <p>An initial meeting has been held with the Strategic Projects Team to explore how existing tools can support this. The next steps include aligning this work with the developing Quality Strategy and the Innovation Strategy. LP highlighted that staff survey findings reinforce that the workforce is</p>	
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	<p>motivated to engage in QI and is seeking the very resources the Trust is now working to put in place. GM advised the report was overall very useful and agreed with the decision not to focus at this time on trying to come up with a single unified methodology.</p> <p>MS agrees that there should be a consistent model for how improvements take place. TG provided examples from around the Trust where very good improvements have been made, but the documentation used differs. TG recognises the different approaches can lead to confusion when the same sort of consistent standardised approach and response is needed around the improvement of services. LP discussed the role of the Head of Quality Improvement and Transformation and it being a clinical nurse who can act as that resource to help individual clinicians, services change, transformation change and carrying out continuous improvement cycles of the self-assessments.</p> <p>The report was agreed and noted by the committee</p>	
<p><b>10.2</b></p>	<p><b>External Audits/Assessment</b> Nothing to report</p>	
<p><b>10.3</b></p>	<p><b>Cover Paper for the Quality and Risk Self-Assessment</b></p> <p>The cover paper was taken as READ</p>	
<p><b>10.3.1</b></p>	<p><b>Quality and Risk Self-Assessment</b></p> <p>GM thanked IW for his chairing of the committee, which is reflected in the results of the self-assessment. GM discussed a possible anomalous result for Question 11, where most respondents strongly disagreed that there is appropriate consideration of assurance reports. It's believed this may be due to a change in the order of response options that respondents didn't notice. Since there were no accompanying comments that would normally highlight a genuine concern, the committee agreed not to explore the point any further.</p> <p>JE advised that across all committee self-assessments, several issues have been identified with how data is collected, interpreted, and presented. These will be addressed for future cycles, and question 11 has been highlighted as one of the items requiring correction.</p> <p>GM noted strong overall endorsement of the committee's performance and expressed a desire to maintain this going forward. The free-text comments on the self assessment highlighted areas for development, including service-user involvement and clarifying priorities such as SSI improvements and addressing health inequalities. Drawing on practice from other committees, GM suggested setting one or two key objectives to review periodically—particularly around health inequalities. GM invited the committee to consider whether to establish explicit objectives to monitor progress over the coming year.</p>	

	<p>LP noted the importance of strengthening patient experience and engagement, highlighting that this aligns well with the priorities set out in the Quality Account for the coming year. LP emphasised the need to progress from the current focus on experience and engagement towards a more robust model of co-production.</p> <p>LP suggested inviting one of the Patient Safety partners (PSP) to future Q &amp; R committee's. The PSP are very much the voice of patient and carers, LP felt that their attendance would be beneficial to the committee.</p> <p>MS advised of her agreement with LP's comments on patient engagement and co-production. MS is supportive of the Patient Safety Partner joining the committee but recommended that the specific scope and responsibilities of the role within the committee be clearly defined before extending the invitation.</p> <p>GM agreed it should be a longer-term option to include the PSP and suggested starting with a presentation to understand their role, with any future involvement needing proper governance.</p> <p>AF agreed with the suggestion of extending the planner and felt it would be useful to incorporate it into the committee's technical planner—covering not only required reports but also the important discussions that need to take place.</p> <p><b>Action:</b>  <b>Review the committee action tracker, to include addition discussion items</b></p>	GM/MS
<b>11</b>	<b>Quality Accounts</b>	
<b>11.1</b>	<b>Cover Paper for Quality Accounts - revised timetable.</b>	
	Paper taken as READ	
<b>11.1.2</b>	<b>Quality Accounts - revised timetable</b>	
	<p>JE advised that the quality accounts timetable has been updated to align with deadlines across the various organisations. There are no new national guidelines on Quality accounts for 2026.</p> <p>LP advised that a similar format has been followed so the committee receive an advanced draft of the quality accounts.</p>	
<b>12</b>	<b>Policies &amp; Procedures</b>	
<b>12.1</b>	<b>Cover Paper for all Documents</b>	
	Paper taken as READ	
	LP provided an overview of the key changes for both policies.	
<b>12.2</b>	<b>DN091 Medicines Management Policy DN091 v8.1</b>	
	The committee <b>RATIFIED</b> the <b>DN091 Medicines Management Policy DN091 v8.1</b>	

12.3	<p><b>DN180 Sharps injury and splash incident involving blood or bodily fluids V11</b></p> <p>EM advised that the policy was fine, however the Quality Impact Assessment (QIA) discussed the potential risk groups to staff instead of a QIA in relation to the use of the policy by Trust staff.</p> <p>The committee <b>RATIFIED</b> the <b>DN180 Sharps injury and splash incident involving blood or bodily fluids V11</b> subject to the adjustment listed above.</p> <p><b>Action:</b></p> <ul style="list-style-type: none"> <li>• <b>LP to report back to the document owner of the policy the amendment required</b></li> </ul>	LP
13	<b>Research and Development</b>	
13.1	<p><b>Minutes of Research and Development Meeting</b> The minutes were taken as READ.</p>	
14	<b>Other Reporting Committees</b>	
14.1	<p><b>Escalation from Clinical Professional Advisory Committee</b> No escalations reported</p>	
14.1	<p><b>Minutes from Clinical Professional Advisory Committee</b> Minutes were taken as READ</p>	
14.2	<p><b>Minutes from Safeguarding Committee</b> Minutes were taken as READ</p>	
14.3	<p><b>Minutes from End-of-Life Steering Group</b> Minutes were taken as READ</p>	
14.4	<p><b>Minutes from Patient and Public Involvement Committee</b> Minutes were taken as READ</p>	
14.5	<p><b>Minutes from Fundamentals of Care Board</b> Minutes were taken as READ</p>	
14.6	<p><b>Minutes from Health and Safety Committee</b> Minutes were taken as READ</p>	
15	<b>Annual Reports</b>	
15.1	No annual reports presented	
16	<b>Areas of Escalation and Emerging Risk</b>	
16.1	<p><b>Audit Committee</b> No escalation required.</p>	
16.2	<p><b>Board of Directors</b> No escalation required.</p>	

16.3	<b>Emerging Risks</b> No escalation required.	
16	<b>Any Other Business</b>	
	GM noted that this was OM last meeting and thanked OM for her valuable contribution to the committee.	
	<b>Date and time of next meeting:</b> Thursday 26 <sup>th</sup> March 2026, 14:00-16:00 – In person HLRI 88 & 89 Thursday 30 <sup>th</sup> April 2026, 14:00-16:00 - Microsoft Teams Thursday 28 <sup>th</sup> May 2026, 14:00-16:00 - Microsoft Teams Thursday 25 <sup>th</sup> June 2026, 14:00-16:00 - Microsoft Teams Thursday 30 <sup>th</sup> July 2026, 14:00-16:00 - Microsoft Teams Thursday 27 <sup>th</sup> August 2026, 14:00-16:00 - Microsoft Teams Thursday 24 <sup>th</sup> September 2026, 14:00-16:00 - Microsoft Teams Thursday 29 <sup>th</sup> October 2026, 14:00-16:00 - Microsoft Teams Thursday 26 <sup>th</sup> November 2026, 14:00-16:00 - Microsoft Teams Thursday 17 <sup>th</sup> December 14.00 – 16.00 – in person HLRI	