Royal Papworth Hospital
NHS Foundation Trust

Minutes of the Quality and Risk Committee, Part 1
Thursday 27th February 2025 – 14:00-16:00
Chair: Michael Blastland
(Quarter 4, Month 2) – via Microsoft Teams

PART ONE

Present	**Role**	**Initials**
Blastland, Michael (Chair)	Non-Executive Director	MB
Fadero, Amanda	Non-Executive Director	AF
Glenn, Tim	Deputy Chief Executive Officer & Executive Director of Commercial Development, Strategy and Innovation	TG
Midlane, Eilish	Chief Executive	EM
Palmer, Louise	Deputy Director for Quality & Risk	LP
Powell, Sarah	Clinical Governance Manager	SP
Raynes, Andrew	Director of Digital & Chief Information Officer	AR
Screaton, Maura	Chief Nurse	MS
Smith, Ian	Medical Director	IS
In attendance		
Cooper, Deborah	Trust Governor	DC
Halstead, Abi	Lead Governor	AH
Hurst, Rhys	Staff Governor	RH
McCorquodale, Chris (item 12.2 – from 14:52-15:23 hrs)	Chief Pharmacist	CMc
Martin, Graham	Non-Executive Director (newly appointed)	GM
Meek, David	Consultant Respiratory Physician in Thoracic Oncology/ Associate Medical Director – Clinical Governance	DM
Mensa-Bonsu, Kwame	Associate Director of Corporate Governance	KMB
Monkhouse, Oonagh	Director of Workforce & Organisational Development	OM
Moorjani, Narain (item 6.2 – from 14:29-15:02 hrs)	Cardiac Surgeon and President of the Society of Cardio-Thoracic Surgery in Great Britain and Ireland	NM
Pai, Sumita (item 6.4 – from 14:57-15:16 hrs)	Microbiology Consultant	SP
Watson, Alice	Executive Assistant	AW
Apologies		
Wilkinson, Ian	Non-Executive Director	IW

Discussion did not follow the order of the agenda, however, for ease of recording these have been noted in the order they appeared on the agenda.

Item		Action by whom	Date
1.	**Welcome & Apologies** The Chair opened the meeting, and apologies were noted as above. Attendees were noted to be Narain Moorjani, Sumita Pai and Chris McCorquodale. Graham Martin was introduced as a newly appointed Non-Executive Director (NED), commencing in post in October 2025, and would succeed the interim Chair of Q&R, from January 2026.		
2.	**Declarations of Interest** No declarations of conflict of interest were raised.		
3.	**Committee Member Priorities** There was nothing to note.		
4.	**Ratification of Previous Minutes Part 1 (30.01.25)** The minutes of the 30 January 2025 Quality & Risk Committee (Q&R) (Part 1) meeting were agreed to be a true and accurate record of the meeting and would be signed as such.		
5.	**Matters Arising – Part 1 Action Checklist (30.01.25)** MS highlighted that actions **086** and **089** were identical and had been duplicated on the log. **Action:** AW to remove one entry, as necessary. ***076 – National cardiac audit programme data.*** Narain Moorjani (NM) to be invited to the February Q&R meeting to provide an example of the National Cardiac Audit Programme and its use. Alternatively, a member of the audit team would be invited. NM would present at today's meeting. To be **CLOSED**. ***081 – Produce a report on the QUACS study findings.*** The decision had been taken by the Board to invite Sam Nashef to a Board workshop to discuss this issue (date TBC). To be **CLOSED.** ***083 – Gemma Bibby to be invited to attend an upcoming Q&R meeting for a focused session on mouth care, work undertaken and areas of progress.*** A date in April was being secured with Dietitian Assistant, Gemma Bibby, to attend for a focused session on the work undertaken and progress made in relation to mouth care. To remain **OPEN**. **085 –** Clarity and assurance to be provided at the March Q&R meeting to understand how well RPH was performing compared to other centres. To remain **OPEN**. ***086 – M.abscessus Dashboard: A briefing to be provided at the end of March 2025 to review progress.*** This item would be heard at the March meeting. To remain **OPEN**.		

	087 – Scan4safety initiative: Executives to raise the issue of compatibility applications such as Scan4safety in relation to the new EPR. MS advised that GS1 standards would form part of the EPR procurement and suggested the matter could therefore be closed. The Chair added that contact had been made with the Chair of SPC to advise of recent discussions around the subject, and assurance had been received that it would continue to be on the radar of the SPC. AF sought clarity as to when and how the work on waiting list and harm reviews would appear. MS responded that a relevant report had been brought back previously; a process was in place but required embedding. As part of quality priorities 2025/26 this had been identified as a priority to take forward, with a focus on reducing the time to treat, to ensure harm did not arise, and to assess any harm on this part of the pathway. LP advised that a more comprehensive version of the quality account priorities would be presented to Q&R in April 2025. The Chair highlighted the significant safety risk of patients on the waiting list, for which proportionate attention was required, and questioned whether the harm-free work being undertaken to assess the situation was sufficient to provide the reassurance. MS responded that there may be a need to reconsider the approach and the process, but an opportunity may lie in work currently underway on RTT recovery. In addition, a session for the Executives to look at the BAF on Monday (03 March), may be an appropriate forum at which to consider the issue. EM noted the 7,500 patients on the RTT waiting list, which was an increase of 3,500 from the pre-pandemic position. However, the largest cohort of patients were not on RTT pathways, but rather on open pathways for continued care; a figure of 4000-4500 individuals. A meaningful review would therefore be a significant undertaking. What had been and remained in place, was a prompt response to an escalation of care, relying on the patient's local physician to escalate, should any deterioration be observed. The patient was also in a position to make contact, should they feel they were deteriorating. AF appreciated the clarity provided but stressed the need for a robust approach to those on the waiting list, for which assurance was required. DM confirmed the undertaking of risk assessments of patients reaching pathways, which was conducted after the pathway had finished and treatment had been provided to ensure full assessment of harm, which was dependent on the metric used. Clinicians had been empowered to make those assessments when seeing patients, rather than conducting these by telephone, to establish a genuine assessment of harm. When a cluster of patients passed away on the emergency TAVI waiting list, a PSII had been initiated and had been reviewed, thus reaction was appropriate when such clusters emerged. DM added that the time required to undertake the reviews was significant.		

	LP clarified the changes to the harm review process and highlighted the capacity issues around undertaking waiting list harm reviews. AR referred to automation tools which may assist in this regard, as part of digital and data strategy, moving forward. DM responded that cancer pathways were operated through a different digital system (Somerset) which identified where delays and other relevant timeline data featured. IS considered that within the whole spectrum of work, a decision should be taken as to which pathways should be under special scrutiny, as there were certain areas where there was no capacity and nothing which could be done for the patient in terms of wait-time. Adopting this position would narrow the number of cases to be addressed and enable focus where it was possible to achieve an outcome. LP concurred that further work was required and highlighted the extent of the January data needing review; both waiting list and harm reviews were required. The Chair noted the scoping work and considered the reviews to have a dual purpose; to identify those for whom intervention could prevent further harm, and to understand the burden of waiting, in order to balance Trust priorities. EM alluded to previous Executive Director (ED) conversation where it was noted that intervention would feature at the front end of the pathway, so patients did not wait for a long time. The harm review was retrospective, at the end of the pathway, to ascertain where excessive wait times had arisen. EM clarified that there was no in-waiting time deployment of clinical staff to be reaching out at intervals to support an assessment whilst patients were waiting. IS added that for the individual patients it would not alter the escalation but may change the escalation for a category of patients if a number of harm reviews were flagged in one area. Item to be **CLOSED**. **088 – PSII-WEB52388 – Organisational – Cardiology TAVI pathway.** Progress with this action as identified from the PSII WEB52388 in relation to the TAVI pathway to be brought back to Q&R in July 2025 for update. To remain **OPEN**. **090 – Annual Quality and Risk Committee Self-Assessment.** The Board was active in its consideration of the Committee composition; a uniform and not entirely supportive response had been received through self-assessment across a number of committees. As participants undertaking self-assessment did not attend Board, consideration was to be given as to how this should be addressed in the assessment, to ensure accuracy of response. Escalation to Board for consideration. To remain **OPEN**.		

	091 – Committee priorities: to be placed on agenda for formal discussion, with a view to including a Quality Improvement item on the agenda going forward. MS had addressed with programme of improvements. To be **CLOSED**. The Committee **reviewed** and **noted** the Matters Arising – Part 1 Action Checklist.		
6.	**Quality & Safety**		
6.1	QRMG and SIERP Highlight and Exception Paper LP presented the QRMG and SIERP Highlight and Exception paper, which was taken as read. The below was of note: • There had been no formal escalations from either QRMG in February or SIERP meetings held in January. • Patient safety incidents were being reported at similar levels to last year, however medication incident numbers had increased in number slightly, overall. However, the Medicines Safety Group had no concerns about the increased reporting rate, or the types of incidents being reported. • Controlled drug (CD) errors remained at a higher-than-average proportion of all medication errors. There were two high-profile controlled drug incidents around June/July 2023 which the Chief Pharmacist considered may correspond to the change in reporting. At the time of the CD drug events, a campaign had been rolled out, to encourage staff to report all controlled drug-related incidents (including storage and security of medications) and the CD incidents continued to be mostly low harm/no harm. • Attention was drawn to the extent of the work that had been undertaken relating to quality and risk, as detailed in the Q3 report data. • In January 2025 there were 271 safety events involving patients reported on Datix incident reporting system. 239 were attributable to RPH, and 32 occurred outside RPH. • There was one incident graded as moderate harm or above discussed at SIERP in January 2025, within Cardiology. • During January 2025 there were two RIDDOR reportable incidents, all others were Near Miss (4), Low (49) or No Harm (69). The two reportable staff injuries were WEB54942 mild concussion following head injury and WEB55018 needlestick injury from Hep C+ patient. These were reported to the Health & Safety Executive (HSE) within the deadline. **Discussion:** The Chair referred to medicine safety, being of the view that the trend did appear to relate to issues around controlled drugs. LP concurred, noting the factors within the reporting to support this theory; areas for improvement in the reporting were noted, that would assist in providing further clarity in the Q4 report, and going forward. MS advised of the appointment of a Medicines Safety Governance Pharmacist which had improved oversight reporting of medicine incidents and raised awareness generally.		

	AF referred to the CD incidents and requested that there be clarity on their detail in future reports, sentiments echoed by DM; LP confirmed that further drilling-down of the data would be evident in the next report. The Chair expressed confidence that the matter related to reporting culture rather than any prominent issue and suggested a "good" assurance level be relayed to the Board, which was agreed by those present. AF referred to the coroner's reports and sought clarity on the phrase "Not an Interested Person (IP)" on page 10 of the report. LP explained that as a Trust, if invited to Court to represent a death review, one was either the Trust of an interested person, or not. If not an interested person (non-IP), there were no concerns about the Trust, but it was noted as having been part of the care pathway. The Chair referred to the table demonstrating the extreme risks category and questioned whether this should have more detailed tabulation to display the date first identified, current status and expected resolution. LP confirmed this was already received by Q&R, within the quarterly Corporate Risk Register. AF noted that 'projects' contained four extreme risks. LP clarified that these related to Nexus project risks. LP suggested that, going forward, this particular table was removed from the monthly report, but received greater focus within the quarterly report. The Committee **reviewed** the QRMG and SIERP Highlight and Exception Paper.		
6.1.1	Serious Incident Executive Review Panel (SIERP) minutes (07/01/25, 14/01/25, 21/01/25, 28/01/25). The Committee **noted** the SIERP minutes.		
6.1.2	Harm Free Care Report, Q3 LP highlighted that this was in the reference pack for noting quality improvement work. The Chair noted an improved position in many areas and extended thanks to LP for the work involved. The Committee **noted** the Harm Free Care Report, Q3.		
6.2	NICOR Presentation SP introduced the NICOR presentation. It was noted that the paper had not been included in the pack. SP provided relevant context to the committee and introduced NM. NM explained his role as Cardiac Surgeon at RPH, and nationally as President of the Society of Cardio-Thoracic Surgery in Great Britain and Ireland. Relevant data relating to NICOR outcome reporting was explained to the committee, demonstrating what had transpired in the last 12 months. Different outcomes, process measures and mortality/morbidity were also noted to be included within the report.		

	It was noted that an interactive tool was now available which enabled scrutiny of different outcomes, as data was uploaded every three months; an example was shared on screen for the benefit of the committee, as well as slides relating to breakdowns in mortality and morbidity data. This information enabled comparison with national averages and identified any areas for improvement. LP advised that she had circulated the paper which contained the necessary link to NM's presentations. TG considered that the data analysed how well patients were being treated at RPH and also the challenges of the waiting list but questioned whether consideration had been given to impact on the population rather than the individuals who had been able to reach the Trust. NM advised that at the East of England Network, how patients were served in areas of social deprivation had been a topic of conversation. In addition, this work would happen at national level, via the Cardiology Societies. AF referred to NM's observation that RPH had been a top performer in respect of volume of procedures, but was now third in the table, for multiple reasons. AF questioned these reasons and whether it was important to be at the top of the list. NM responded that this related to activity, but more importantly, to outcomes, which remained of a high standard. In respect of activity, one reason was the fact that one of the centres in London had merged, with numbers predicted for the new establishment having not yet manifested. It was felt there were opportunities at RPH to increase activity, such as the ERU which had allowed for a greater grasp on facilities and infrastructure, green lists and virtual ward. NN explained that the numbers did identify recruitment and retention issues nationally, both nursing and medical. Initiatives were being developed at RPH to make the most of a challenging situation and to try to ensure as many patients as possible were put through the infrastructure, as possible. The Chair had scrutinised the NICOR data and queried for whom the presentations had been prepared. NM explained that NICOR produced the presentations, being mandated by the Department of Health to monitor cardio-vascular outcomes. This was produced for both public and professionals. NM had been through three areas where data was monitored and could be cross-referenced, namely NICOR (which detailed every hospital), the Society of Cardio-Thoracic Surgery in Great Britain and Ireland (from which RPH data had been extracted) and RPH waiting list and morbidity/mortality outcome data. The Chair questioned the statement that NICOR data was 18 months old. NM confirmed this to be the case but advised that information was produced on three different levels, to ensure an adequate level of responsiveness to any issues arising. The Chair further queried whether a tracking exercise had been undertaken regarding outcomes compared to other organisations. NM advised that there had always been room for improvement and the point of monitoring was to identify those areas. The concept that delivery of care was by teams,		

	rather than one surgeon as reported historically, and the associated dynamics of that group of individuals, was key. Infection was noted to be an area requiring improvement at RPH and much work had been undertaken to improve the position in this regard. The Chair questioned the appropriate level of detail that should be received by Q&R committee and suggested this formed part of a conversation at a future meeting. The Committee **noted** the NICOR presentation.		
6.3	SIRO Report 2024/25 AR presented the SIRO Report 2024/25, which was taken as read. The following key points were noted: • Work on the Trust's 2025 Toolkit submission was underway and the audit scheduled to start in April. This year's toolkit had been redesigned to align with the Cyber Assurance Framework, and the audit had also changed; in addition to the mandatory items, the Trust was to pick four additional items, each of which were noted within the report. • It was clarified that the action plan for cyber-security was monitored through the Performance Committee; this was brought through Q&R as the SIRO report. • Document compliance was improving, standing at 84%. • There were 28 information governance related issues recorded on Datix for Q3, of which 4 were actual incidents, with the remainder classed as 'near misses'. Those related to wrong-patient details were highlighted. • Zivver statistics for Q3 revealed prevention of 959 potential data leaks. • Freedom of information requests continued to be received, with over 2000 being addressed in the last quarter. • Privacy impact assessments were noted to be pivotal. **Discussion:** The Chair referred to Zivver, which AR confirmed acted as a prompt for staff and was noted to be a useful tool. For training purposes, its use was monitored in those areas of higher risk. **Action -** the Chair requested that a trend be included in the report, in respect of the percentages, as for other areas, to demonstrate practice being spread across the organisation. AF expressed concern regarding document compliance figures and specific compliance areas and sought explanation in respect of the 'IGSG Attendance Grid'. AR shared AF's concern regarding document control figures, but necessary escalations were going to leaders in the organisation for support with teams, and this had made a difference. With regard to the IGSG, this table was used to raise awareness and as a prompt to departments and divisions to ensure their attendance. MS noted further queries would be raised offline regarding inaccuracies in the IGSG table in terms of attendees. DM also raised that he had not been	**AR**	

	invited to these meetings as Clinical Governance Lead, and this would also require amendment. The Committee **noted** the SIRO Report 2024/25		
6.4	AMS (Antimicrobial Stewardship) Trust Board Report SP presented the AMS Trust Board Report. The following was noted: • RPH was meeting the national 10% reduction target in Watch and Reserve DDDs/1000 admissions (vs 2017 baseline). Latest data produced revealed a 21% reduction. Currently only 33 Trusts in England were reaching this target and RPH was sitting 12th out of the 33 Trusts. • RPH was meeting the England-wide non-mandatory IV antibiotic switch to ORAL antibiotic (IVOS) CQUIN whereby inappropriate IV antibiotic use should be less than 15%. Q1 = 10%, Q2 =14%, Q3 =9%. • AMS Guidelines were now hosted on RPH intranet and the Eolas app. Microsoft had been unable to support the MicroGuide platform from September 2024. All guidelines had been successfully migrated across to new Eolas platform, Eolas Medical. • Trust Fungal Guidelines (DN816) had been updated. • A poster had been accepted for presentation as FIS2024. • The AMS Team pharmacists had provided clinical support to the Critical Care Team, Surgical and Cardiology pharmacy teams (due to pharmacist shortages) and to the pharmacy dispensary team. **Discussion:** MS referred to the review of antibiotic resistance data of sputum samples under 'Service Review', highlighting a current improvement project around the post-operative pathway in preventing hospital-acquired pneumonia. MS questioned how much of this data was related to those patients and the trend. SP advised that there had been a significant rise in hospital-acquired pneumonia over a period; this was not post-surgical and spanned the Trust. Work was underway to investigate further, from which issues around patient behaviours and reduced standards in mouth-hygiene had been identified and were being addressed. In addition, work was underway with OTs, physiotherapists and the pain team, with ward nurses, to encourage patient confidence in moving, post-operatively. In respect of antimicrobial resistance, establishing whether patients had a true chest infection was a challenge, and enhanced education for registrars and junior doctors, in the form of a video, had been created, to reiterate good practice. **Action:** MS requested that a presentation regarding this quality improvement work be brought back to Q&R in six months' time, to assess progress. The national concern of antimicrobial resistance was highlighted as extensive and required addressing for RPH patients but also for the wider health economy. AR referred to the Eolas app and questioned if this had been through a privacy impact assessment. SP confirmed that this had previously been	**SP**	

	named MicroGuide; there had been liaison with IT and it was thought that the necessary assessment had been undertaken. **Action:** AR requested that SP speak with Cath Wilcox, to confirm. The Chair concurred with MS that it would be helpful to see the quality improvement work relating to hospital acquired pneumonia going forward. It was also requested that the data be provided, across as long a period as possible, to establish the trends over time. SP confirmed that this could be produced from April 2017. The most significant impact was thought to be CFTR modulators in cystic fibrosis patients, and levels of activity on wards, particularly for surgical and cardiology patients, in changing patients from IVs to orals. The Chair suggested that this type of explanation would be helpful to receive in future reports. The Committee **noted** the AMS (Antimicrobial Stewardship) Trust Board Report.	SP	
6.5	Health and Safety Highlight Report MS introduced the Health and Safety Highlight Report, which was taken as read. The following was highlighted: • A site-wide fire risk assessment had been completed, with a report awaited. • Test training sessions had been delivered to specific groups and had been well evaluated. • Fire safety training analysis had been conducted by an authorised engineer. Work was underway to facilitate more widespread training provision and engagement, with additional fire modules identified to be required. There had been a request by the committee to understand the timeframe by which the Trust was likely to meet an acceptable compliance level of fire safety training. • The committee received and approved a proposal to aid improvement of department representatives' education and training. It was expected this would show an improvement throughout Q4 and Q1 (2025/26). **Discussion:** OM highlighted the omission of violence and aggression against staff within the report and advised of revised NHSE guidance on the subject. A number of departments were working together to address the issue, and there was a plan in place to undertake a risk assessment using the new assurance toolkit, over the coming months. Updates would be provided in future reports. The Committee **noted** the Health and Safety Highlight Report.		
6.6	SSI Quality Monitoring Dashboard MS presented the SSI Quality Monitoring Dashboard, which was taken as read. • Q3 2024 consolidated data had recorded 3.9%, being the best position achieved since 2017. • Quality metrics required ongoing monitoring. **Discussion:**		

	The Chair expressed concern that identification of a trend of consistent improvement within the environmental dashboard was unclear. The Committee **noted** the SSI Quality Monitoring Dashboard.		
6.7	M.abscessus Dashboard (Jan 2024 data) MS presented the M.abscessus Dashboard (Jan 2024 data), which was taken as read. A more detailed report would follow at the March Q&R meeting. The following was of note: • One new patient WEB55250 (7) under the care of the transplant team had received a positive result for M. abscessus in January 2025; relatedness results had been requested. • Work was being undertaken with the microbiologists regarding processes with UK HSA/Great Ormond Street (GOS) and where RPH was positioned between the two. MS noted that companies were not finding M.abscessus within environment samples, but this was being identified by the refence lab. Commercial labs were therefore not being used for this purpose. • Water safety work fed into the above in terms of the measures being taken and treatments being adopted. The Water Safety Group would attend the IPCC meeting with a plan to describe these measures, to ensure there was adherence to a water safety plan in its totality. • A thorough risk assessment was being undertaken around M.abscessus. • A new Authorised Engineer for Water post was in place, which had proved insightful. • Retaining the confidence of staff and patients was considered key. The Committee **noted** the M.abscessus Dashboard (Jan 2024 data).		
6.8	Safeguarding Quarterly Report MS advised that the quarterly report was in the pack for information. AF referred to the previous case of a patient who had disconnected themselves from a cardiac monitor, walked to the bathroom and had subsequently fallen; the patient had capacity, but struggled to take medical advice from staff. AF wished to know if this was considered a safeguarding matter and how was this balanced. MS responded that this case was not obviously a safeguarding issue, but there were other conversations to have with staff at different levels, to support with identification of such vulnerable individuals. Supervisory Sister roles would assist in this regard and in helping patients to understand risk. The Committee **noted** the Safeguarding Quarterly Report.		
7.	**Patient Experience**		
8.	**Performance: Performance Reporting: PIPR M10** MS introduced the PIPR M10, which was taken as read. Questions were invited. **Discussion:** The Chair considered there to be nothing of particular concern within the report.		

	The rate of improvement in Matron performance was noted to be outstanding, which it was expected would yield positive outcomes going forward. One complaint had changed the rating in relation to 'caring' and the importance of getting complaint responses correct for patients was noted to be pivotal, even if this took time and resulted in missing targets. Consideration was being given as to how the PIPR metrics were serving the Trust and whether it was possible to be more proportionate with the data. The Committee **noted** the PIPR M10.		
9	**Risk**		
9.1	Board Assurance Framework (BAF)		
9.1.1	Appendix 1: BAF Report KMB advised that this represented the update on SSI risks for the quarter. The document was taken as read. The Committee **reviewed** the Board Assurance Framework (BAF).		
9.1.2	Appendix 2: BAF Tracker The document was taken as read. The Committee **reviewed** the BAF Tracker.		
10.	**Governance & Compliance**		
10.1	Review of Terms of Reference (ToR). The ToR were taken as read. LP was of the view that there was terminology included which required updating and wished to amend this further. In addition, some reporting-in committees did not feature. **Action:** LP would liaise further with KMB to make the necessary amendments, and the ToR would come back to Q&R. The Committee **noted** the Review of the Terms of Reference (ToR).	**KMB/LP**	
10.2	Internal Audits: There were none to review.		
10.3	External Audits/Assessment There were none to review.		
11.	**Quality Accounts** There were none to review.		
12.	**Policies & Procedures**		
12.1	DN931 New Delivering Same Sex Accommodation Policy The DN931 New Delivering Same Sex Accommodation Policy was taken as read. MS advised that this was a new policy based on the NHSE framework for mixed sex accommodation, which would provide assurance and assist in raising awareness. The Committee **ratified** and **approved** the DN931 New Delivering Same Sex Accommodation Policy.		

12.2	DN932 Pharmacy Vision CMc presented the DN932 Pharmacy Vision, which was taken as read. It was noted that the document had been presented one year previously as a strategy and had been reformulated. **Discussion:** The Chair questioned whether CMc was of the view that the vision would evolve into a strategy. CMc suggested that the document would serve as a 'compass'; those elements of the vision which could be, were being delivered already. Detailed timelines and Gantt chart-type project documents had been produced, to depict to how elements of the vision might be delivered, which were noted to be resource-dependent. The Chair considered it would be useful to view this information to establish how aspirations might evolve into practical action and questioned whether there was an associated schedule of reporting, which MS confirmed to be the case and had received recent revision, to include the Pharmacy vision. AF commended the ambition and aspiration behind the document. How this linked to the strategy refresh and business priorities, and the business plan for the year, was key. OM questioned the section relating to workforce, noting targeted action in this regard, and queried whether there was opportunity to include the inclusive leadership vision and developing skills for leadership teams. CMc acknowledged that this level of detail in terms of skills had not been included, although the document had been written prior to production of the leadership framework. Moving forward, this, and the strategy work, could all be pulled together. The Committee **ratified** and **approved** the Pharmacy Vision.		
12.3	DN168 Chaperone Policy The DN168 Chaperone Policy was taken as read. MS advised that this had been included in other safeguarding policies, but it had been felt required to be a stand-alone policy. It was noted to have received sufficient scrutiny over the period of a year. The Committee **ratified** and **approved** the DN168 Chaperone Policy.		
12.4	DN307 Safeguarding Adults Policy The DN307 Safeguarding Adults Policy was taken as read. MS noted that this had been updated with changes to legislation and policy and had been reworked to be more readable and user-friendly. It had been through various iterations over the past few months. The Committee **ratified and approved** the DN307 Safeguarding Adults Policy.		
13.	**Research and Development**		
13.1	Minutes of the Research & Development Directorate meeting (No December Meeting, 10/01/25 minutes to come to March Q&R).		

	The Committee **noted** the Minutes of the Research & Development Directorate meeting.		
14.	**Other Reporting Committees**		
14.1	Escalation from Clinical Professional Advisory Committee (CPAC) There were no escalations from the Clinical Professional Advisory Committee (CPAC).		
14.2	Minutes from Clinical Professional Advisory Committee (18/12/24) The Committee **noted** the minutes from CPAC.		
15.	**Areas of Escalation and Emerging Risk**		
15.1	Audit Committee There was nothing to report.		
15.2	Board of Directors There was nothing to report.		
15.3	Emerging Risks There was nothing to report.		
16. 16.1	**Any Other Business** The committee did not consider that any areas of assurance had been lacking within the items delivered at the meeting. However, TG contended that harm on the waiting list required escalation due to a lack of assurance on the issue. The Chair concurred that whilst this had been moved into longer-term review via the Quality Accounts, the scope of what was trying to be achieved was unclear. AF echoed TG's sentiments and was of the view that the matter should be tracked via Board and Committee. LP noted that this issue had not come through any Medical Examiner review, which was now statutory. Should there be a death on the waiting list, the Trust would be notified, but no such notification had been received. As such, there was a need for triangulation of data.		
17.	Date and time of next meeting Thursday 27th March 2025, 14:00-16:00 - Microsoft Teams		