NHS
Blood and Transplant

Board Meeting in Public
Tuesday, 26 March 2024

Title of Report	Clinical Governance Committee Effectiveness Review Report	**Agenda No.**	5.4.3
Nature of Report (tick one)	☒ Official	☐ Official Sensitive	
Author(s)	Tapiwa Songore, Interim Corporate Governance Manager Samaher Sweity, Head of Clinical Governance, Clinical Services		
Lead Executive	Helen Gillan, Director of Quality		
Non-Executive Director Sponsor (if applicable)	Charlie Craddock, Chair of Clinical Governance Committee		
Presented for (tick all that applies)	☐ Approval ☒ Assurance	☐ Information ☐ Update	☒ Discussion

Purpose of the report and key issues

This report presents the findings of the internal effectiveness review of the Clinical Governance Committee (CGC). The report also includes a review of the committee's performance against its delegations as per its terms of reference.

The Committee at its meeting on 8 March 2024 was presented with the report to review the outcomes of its effectiveness review, together with its delegations as per its terms of reference and collectively agree what actions should be taken, including areas of prioritisation and timescales for delivery.

Previously Considered by

The Clinical Governance Committee was presented with the report at its meeting on 8 March 2024.

Recommendation	The Board is asked to note the outcomes of the CGC effectiveness review.

Risk(s) identified (Link to Board Assurance Framework Risks)

Linked to Regulatory Compliance risk (BAF-09).

Strategic Objective(s) this paper relates to: [Click on all that applies]

☒ Collaborate with partners ☒ Invest in people and culture ☒ Drive innovation
☒ Modernise our operations ☒ Grow and diversify our donor base

Appendices:	Appendix 1 – CGC Delegations review Appendix 2 – Analyses of the CGC's effectiveness review by section

NHS
Blood and Transplant

1. Background

It is good practice for Committees of the board to undertake a yearly review of their own effectiveness. The Clinical Governance Committee should regularly assess its own performance – and the adequacy of its terms of reference, work plans, forums of discussion and communication, with a view to highlighting skills and/or knowledge gaps and identifying areas in which the Committee and its processes might be more effective.

2. Review Process

A self-assessment questionnaire was reviewed at the CGC meeting on 17 November 2023, and circulated to members and regular attendees for completion, together with guidance notes. Nine completed questionnaires were received back. For the purpose of this report, members refer to all individuals who completed the questionnaire.

The questionnaire examined six parts, with sub-sections for each part as follows:

1. **Part One**: Membership, independence, objectivity and understanding
   1.1 Membership, independence and objectivity
   1.2 Making the most of your time
2. **Part Two**: Skills and experience
   2.1 Range of skills
   2.2 Training and development
3. **Part Three:** Roles and responsibilities
   3.1 Governance
   3.2 Risk Management
4. **Part Four:** Scope
   4.1 Terms of reference
5. **Part Five**: Communication and reporting
6. **Part Six:** Continual Improvement

Members were asked to select from four ratings with the representative scores in bracket:

1. **Neutral** - Since this is the first effectiveness review of the committee, members / attendees may not have a definite position on some of the questions.
2. **Room for improvement** - The committee is falling short of requirements and should consider how it can work towards becoming more effective in this area.
3. **Meeting standards** - The committee is performing to the required standard in this area. There may be room for improvement, but the CGC can be seen to be discharging its responsibilities effectively.
4. **Excelling** - This is an area where the CGC is performing beyond the standard expectations and is a real area of strength when it comes to exercising its responsibilities.

Each area of the effectiveness tool allowed space for comments and members were encouraged to provide greater insight rather than simply pointing out what could be improved. This provides an important opportunity to expand on any considerations relating to that section of the effectiveness tool and to highlight any concerns about the CGC's performance.

3. Summary of Analysis

The completed questionnaires submitted have been analysed to draw conclusions and propose recommendations. An in-depth analysis of each section with comments made for each sub-section is presented in Appendix 2. All comments have been anonymised.

4. Delegations review

A review of the Committee's delegations as detailed in its terms of reference was undertaken to determine whether the committee discharged its duties as delegated by the board, and as recorded in its terms of reference. The review has been RAG rated with gaps identified.

This review is separate from the annual update of the Committee's terms of reference which is a separate item on the agenda.

The results of the review are in Appendix 1.

Appendix 1 – Review of Delegations

CGC Delegations review					
Delegation	**How's was this discharged**	**Gaps**	**Action**	**Owner**	**Status / Date**
Support and oversee the work of the operating directorates' CARE (Clinical, Audit, Risk and Effectiveness) groups and monitor their effectiveness and performance in achieving clinical effectiveness, including approval of the Terms of Reference and membership of Directorate CARE sub-groups.	The CARE Groups present a report to every Committee meeting and the ToRs were approved during the year.				
Develop overarching clinical governance policies and procedures and ensure reviews are in line with their set review dates.	Overseen PSIRF, Clinical audit and safety policies.	The role should be changed from develop to seek assurance or oversee	ToR has been changed to: Seek assurance that overarching clinical governance policies and procedures are developed and reviewed on a timely manner.		
Ensure effective mechanisms are in place to review and monitor the effectiveness and quality of clinical care and services across NHSBT, including ensuring actions are taken to address issues of poor clinical performance.	Serious Incident summary report SI/Never Events Annual Report Audit reports CARE reports TPSG reports Annual reports				
Ensure that lessons are identified for improvement and ensures these are implemented in relevant areas.	Report on Serious Incidents Shared Learnings and SI Closure Report are presented to Committee meeting. SI deep dives. Shared learning from CARE groups. Assurance of implementation of shared learning through CARE				

Encourage a continuous improvement culture and gain assurance that systems are in place to deliver it.	Through reviewing and scrutinising reports and work, creating actions and monitoring completion.				
Provide assurance to the Board that clinical complaints and incidents are managed in accordance with NHSBT procedures. This ensures that there is a robust process for serious incidents and near miss reporting, investigation and organisational learning through ensuring trends are identified, learning is shared and appropriate actions are taken.	SI/NE annual report SI deep dives. Shared learning from CARE groups.	Complaints is partially reported			
Conduct a serious incident deep dive annually, in order to assure processes.	A serious incident deep dive is done annually				
Gain assurance that clinical risks are managed as set out in the NHSBT Risk Management policies.	The Committee undertakes a deep dive into the Principal Risks assigned to it	Operational risks that linked to pt/donor safety are not discussed			
Have oversight of all corporate and business unit level risks with a clinical risk impact, review and challenge the actions and controls for those risks, ensure appropriate escalation of any areas of concern to the Board and highlight areas of good practice and shared learning.		All other corporate and business unit level risks will need to be reviewed by the Committee			
Provide scrutiny and seek assurance from the management of the clinical claims process.	The Clinical Claims Report is discussed at the Committee meeting				
Promote positive complaints handling, advocacy and feedback including learning from adverse events	Some complaints when become major are discussed at CARE groups where CARE provide assurance to CGC	Oversight is not sufficient – need complaints reports			
Ensure that the views of patient, donors, service users and carers are systematically and effectively engaged in clinical governance activities.		No patient/donor representative in the CGC membership			

Ensure that systems are in place for review of external national guidance (e.g., NICE) and for ensuring compliance with relevant recommendations made.	Regular report is provided. Same as the below				
Monitor alerts received via the Central Alerting System and review any actions taken in response to any relevant alerts.	A report on alerts received via the Central Alerting System is presented to each meeting				
Monitor compliance with all relevant Care Quality Commission (CQC) outcomes and the organisation's overall preparedness for CQC inspection.	Some aspects are reported through Regulatory Radar	Not fully /systematically done			
Have oversight of and approve any significant changes to Organ Allocation policies	Not yet requested				
Receive reports seeking clinical advice and audit-related to the Caldicott principles and Information Governance (IG) standards from the Information Governance Committee.	A regular report is provided and annual report	Need further info about IG breaches?			
Review reports relating to children and adult safeguarding and gain assurance that effective management and process are in place.	Annual report is provided. Report by exception	A more detailed and frequent reporting is required.			
Link into the Management Quality Review (MQR) process and have oversight of the MQR quarterly and annual reports.	The Management Quality Review report is presented every quarter.				
Review and approve research proposals that relate to more than one operating directorate for which the relevant operating directorate CARE group (with expert input from the Scientific Advisory Group) have been unable to reach a decision.	Reported by exception	The process require improvement			
Disseminate learning from research findings reported to relevant groups.	In place				
Ensure that clinical governance decision making is informed by evidence-based information and research contributions from the Scientific Advisory Committee (SAC) overseeing the NHSBT Research and Development programme and partnerships.	SAC has not yet established.				

Seek assurance from the Directorate CARE groups that practice is evidence-based and supported by a robust process of clinical audit.	CARE reports Clinical Audits reports				
Oversee and prioritise the clinical audit work plan and ensure that the schedule is aligned with internal audits and that it triangulates themes from risks, incidents, complaints, clinical claims and patient/donor feedback.	The annual plan is approved by the Committee and a report is presented on completion of each audit.				
Review summaries of clinical audit findings and gain assurance that the recommendations and their implementation by operational directorate CARE groups will focus on identifying any concerns or significant issues and/or where no improvements have been made since the last audit; and gain assurance that the action plan in response to the audit is implemented without undue delay, especially where limited assurance is given.	The reports from the Audit findings are discussed after every audit has been completed				
Ensure that best clinical practice is provided by appropriately trained and skilled professionals with the competencies required for service delivery.	Mandatory training and risks are reported regularly Workforce updates	Professional registration and competencies report is required			
Monitor the education and development system for the clinical workforce that supports performance improvement within their scope of practice.	Mandatory training and PDPR is monitored.	Maintaining professional registration monitoring			
Ensure adequate resources are allocated to support the provision of safe and responsive care and services.	Workforce issues/risks are reported through CARE groups, and people updates. Key concerns are reported to the Board through the Clinical governance report.				
Provide the Board with regular clinical effectiveness updates and exception reports.	A clinical governance report is provided after each meeting.				
Provide the Board with an annual report of work undertaken, providing positive assurance that	Annual report to be provided to the May Board				

clinical governance mechanisms are in place and effective and highlighting key concerns, meeting the terms of reference for the committee and supporting the annual Governance Statement. This annual report should cover key findings from the programme of audits and the proposed plan for the subsequent year. This report should also be shared with the ARG Committee for information.					
To note safety policies affecting NHSBT and review of internal safety policy decision making and framework (i.e., through Therapeutic Product Safety Group (TPSG). Any changes to the organ allocation policies in OTDT, the policies that should come to CGC for oversight.	The Therapeutic Products Safety Group (TPSG) provide a report at each meeting				