NHS
Blood and Transplant

# Board Meeting in Public
# Tuesday, 26 November 2024

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| **Title of Report** | Clinical Governance Committee Report | **Agenda No.** | 5.2.2 |
| **Nature of Report** (tick one) | ☒ Official | ☐ Official Sensitive | |
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| **Lead Executive** | Dee Thiruchelvam, Chief Nursing Officer | | |
| **Non-Executive Director Sponsor** | Charles Craddock, Clincial Governance Committee Chair | | |
| **Presented for** (tick all that applies) | ☐ Approval<br>☒ Assurance | ☒ Information<br>☐ Update | |

| **Purpose of the report and key issues** |
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| This report is submitted to the Board to draw attention to the main items discussed at the Clinical Governance Committee (CGC) held on Thursday 7 November 2024. |
| **Previously Considered by** |
| N/A |

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| Recommendation | The Board is asked to note the report for assurance. |

| **Risk(s) identified (Link to Board Assurance Framework Risks)** |
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| The Clinical Governance Committee is a key aspect in the governance and oversight of risks to Donor and Patient Safety (P-01). |

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

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

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| **Appendices:** | None |

**1. Background**

This report is submitted to the Board to draw attention to the main items discussed at Clinical Governance Committee (CGC) held on 7 November 2024.

**2. Infected Blood Inquiry (IBI)**

It was noted that November 2024 marked six months since publication of the IBI final report. The Committee received an update in relation to the NHS Blood and Transplant (NHSBT) programme of work following the Infected Blood Inquiry (IBI) Report (final report published in May 2024). Progress with actions related to recommendation seven of the report (Patient Safety Blood Transfusion) was provided as this was the recommendation most pertinent to NHSBT.

It was noted that the IBI recommendations would require significant investment in digital, capital and capability. NHSBT were currently quantifying its financial requirements whilst continuing work to explore opportunities for delivery via existing programmes.

**3. Delivering Digital Solutions to address Patient and Donor Safety Incident Learning and Manual Processes Update**

The Committee received an update on the work to assess the risks associated with the lack of digital and integrated systems. This initiative stemmed from a series of incidents and risks related to patient and donor safety, which were traced back to manual, paper-based processes and gaps in digitisation. It was agreed that it would be beneficial to have a high level view of requirements for digitisation of records and interfacing of systems across the organisation, however seeking to address requirement across the whole of NHSBT in one phase was not feasible and a multi-year programme of activity would be required.

It was noted that another project within Clinical Services had been identified that overlapped with this work. As a result, a recommendation was made to consolidate this work into a unified project and to use Clinical Services as a discovery phase to thoroughly investigate and document the scope and scale of the issues, identify their root causes, and identify recommendations, seeking to test solutions that might be rolled out to other areas of the organisation. CGC will receive regular updates with consideration of how the risk profile changes over time.

**4. Five-year NHSBT Research and Development Activities Review**

The Committee received a review of NHSBT Research activities over the last five years. The review had been undertaken by an international expert panel with the aim of assessing and evaluating the quality of recent and current research, assessing the relevance of research to the core purpose of NHSBT and to donor and patient care, and to identify recommendations to inform future research.

The outcome of the review was very positive, with NHSBT commended for its exceptional research. Several recommendations to further strengthen and align research activity to NHSBTs priorities were highlighted and work was underway to address those recommendations, including a review of research priorities.

**5. Patient Safety Incident Response Framework (PSIRF) Programme Update**

The Committee received an update report following the implementation of the first phase of PSIRF in June 2024. The report highlighted actions taken, observations and learning since implementation. Observations included the need to focus on continued proportionate improvement in the management of safety incidents and the importance of collaboration and clearly defined roles across the Clinical Governance and Quality Directorates.

Work is taking place to improve reporting, recording and monitoring incidents to enable better data analysis and a greater understanding of NHSBTs Patient Safety Incident profile. A full stock take following phase one activities would take place before phase two was commenced with consideration of financial and people resources. CGC will receive regular updates on this work as the programme proceeds.

**6. CQSGG (Clinical Quality and Safety Governance Group) Integrated Report**

The Committee received its first Integrated Report since changes to enhance clinical governance arrangements within NHSBT had been implemented. Those changes included the establishment of a Clinical Quality and Safety Governance Group (CQSGG). The CQSGG has a role in ensuring thorough internal review of reports before they reached the CGC, to optimise efficiency and strengthen the effectiveness of the CGC's role in oversight and assurance.

The Integrated report summarised the work of the CQSGG and highlighted matters for committee oversight and scrutiny by exception, including those raised in CARE Group reports, clinical audit and data security, privacy and records management reports and updates, incident investigations in progress, regulatory developments and quality audits. Members were advised that development of the report would be iterative over the coming months. The CGC determined that they should continue to review the findings of clinical audits and Patient Safety Incident Investigations upon their closure.

**7. PSII (Patient Safety Incident Investigation) Closure report**

The Committee reviewed the details of PSII QI40259 noting the identified opportunities for learning and improvement. The Committee considered how systems and processes contributed to the patient safety incident. Five areas for improvement/safety actions had been identified.

Updates in relation to progress in implementing agreed actions and their effectiveness will be reported to the Committee in the future.

**8. BAF (Board Assurance Framework) P-06 Fail to Monitor Clinical Outcomes Risk Review**

The risk review was presented as part of the annual deep dive schedule agreed with the Audit, Risk and Assurance Committee. The purpose of the deep dive was to provide information and assurance regarding the status of the risk, and to enhance wider understanding and awareness of the risk.

P06, Clinical Outcome of Patients was the risk that NHSBT fails to deliver continuous improvements to its service provision, caused by a lack of comprehensive information about the clinical outcomes of patients, resulting in a failure to achieve the strategic ambition of reducing health inequalities and providing every patient with the treatment or donation they need. The risk had an ‘open risk appetite’ as per NHSBT’s agreed risk tolerance range.

The Committee discussed elements of the risk that were manageable and within the control of NHSBT, and recognition that NHSBT had an influencing role in respect of wider elements of the risk. It was agreed that the risk be further discussed at the Board's Risk Workshop on 25 November 2024.

**9. Clinical Governance Committee Skills, Capability and Diversity**

The Board received an analysis of Board members skills and capabilities in September 2024. This report focused on the outcome of the exercise specific to the Clinical Governance Committee. Members noted the analysis and considered that there were no significant gaps to be addressed in terms of Committee membership. In respect of training, there was agreement that Board level PSIRF training would be beneficial.

**10. Serious Hazard of Transfusion (SHOT) Annual report**

The Committee received the Serious Hazard of Transfusion (SHOT) annual report for information. Committee members welcomed the report and its findings, particularly noting its relationship to the IBI report and recommendations.

**11. Items for escalation to the Board**

The following items were escalated:

a) The Board risk workshop scheduled for 25 November 2024 will include discussion on the risk related to delivering digital solutions to address patient and donor safety incident learning, and the approach to including external challenges beyond the ability of NHSBT to directly mitigate within the risk register as discussed in relation to P-06.

b) The five-year NHSBT research and development activities review to be presented to the Board in November 2024.