NHS Blood and Transplant

Board Meeting in Public

Monday, 18 May 2026

Title of Paper	Clinical Governance Committee - Board Assurance Report	Agenda No.	5.2.2
Nature of Paper	☒ Official	☐ Official Sensitive	
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Presenter(s) at Meeting	Lorna Marson, Non Executive Director (Committee Chair)		
Presented for	☐ Approval ☒ Assurance	☐ Information ☐ Update	
Is there a plan to communicate this to the organisation?	☒ Yes	☐ No	☐ Yet to be determined

Executive Summary

The purpose of this report is to summarise the Clinical Governance Committee's activity across the 2025/26 financial year and demonstrate that it has effectively discharged its delegated responsibilities, as set out within its terms of reference. The report will also inform the Accountable Officer's Annual Governance Statement 2025/26.

During this year, there have been some leadership changes and a directorate realignment following the departure of the Chief Nursing Officer. The Director of OTDT becomes the representative for Nursing on the Board and the Director of Quality and Governance becomes the Care Quality Commission (CQC) Lead Executive and Executive Lead for the Clinical Governance Committee. These are very recent structural changes and are still embedding.

The Committee expects that, once the revised governance structures and reporting lines are fully established, the overall effectiveness and assurance provided by the Committee will be enhanced. Additionally, a wider review of Clinical Governance has commenced, the outputs of which will inform ongoing assurance reporting and may require amendments to the Committee terms of reference.

The Committee identified the following gaps in assurance during the reporting period:

- The CQSGG has been operational for a full year, an annual assurance report for 2025/26 has not yet been presented to the CGC. An annual assurance report is required to support the Committee's oversight and is included on the Committee forward plan for July 2026 subject to the scope of the report being agreed.
- The PSIRF Policy has not been reviewed since its implementation in March 2024. It is overdue a review.
- Terms of Reference: The Committee's Terms of Reference (ToR) will be updated in July to reflect any changes to membership, to reflect the merger of Principal Risks 01 and 06 and to provide clarity on the Committee's role in gaining assurance from the clinical audit programme approved by CQSGG. Outputs from the current clinical governance review may also lead to proposed changes to the Terms of Reference.
- Two clinical audits from the 2024/25 programme remain outstanding. Of the eight audits in the 2025/26 programme, six are delayed or have been rescheduled.
- The CQSGG Integrated Safety and Experience Report has not included reports on clinical workforce and mandatory training of clinical workforce.

Previously Considered by

Clinical Governance Committee – 20 April 2026

Recommendation

The Board is asked to note the Clinical Governance Committee Board Assurance Report for assurance.

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

NA

Strategic Objective(s) this paper relates to:

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

Appendices:	Appendix 1 - Gap analysis against Clinical Governance Committee delegations can be found in review room.

NHS BLOOD AND TRANSPLANT CLINICAL GOVERNANCE COMMITTEE

COMMITTEE BOARD ASSURANCE REPORT 2025-26

Status: Official

Introduction

The Clinical Governance Committee is established by the Board of NHSBT as a joint non-executive/executive committee of the Board with powers and responsibilities delegated to it within the NHSBT Standing Orders, Schedule of Delegations and these Terms of Reference.
The purpose of this Board Assurance report is to summarise the Clinical Governance Committee's activity during 2025-26 and demonstrate that it has effectively discharged its delegated responsibilities, as set out in its terms of reference. The report will also inform the Accountable Officers Annual Governance Statement 2025-26.

Purpose of the Clinical Governance Committee

The purpose of the Committee is to provide assurance to the Board that NHSBT has a robust framework for the management of all critical clinical systems and processes and in delivering patient/donor safety. This is a framework through which NHSBT is accountable for continuously improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish and innovation is supported. It includes systems for, but not limited to:

a) Clinical Incident and complaints management and reporting information
b) Clinical quality improvement
c) Clinical Audit
d) Maintaining clinical competence
e) Compliance with the Care Quality Commission (CQC) essential standards of quality and safety
f) Clinical effectiveness, including Research and Development
g) Medical and Nursing revalidations
h) Patient and public involvement.

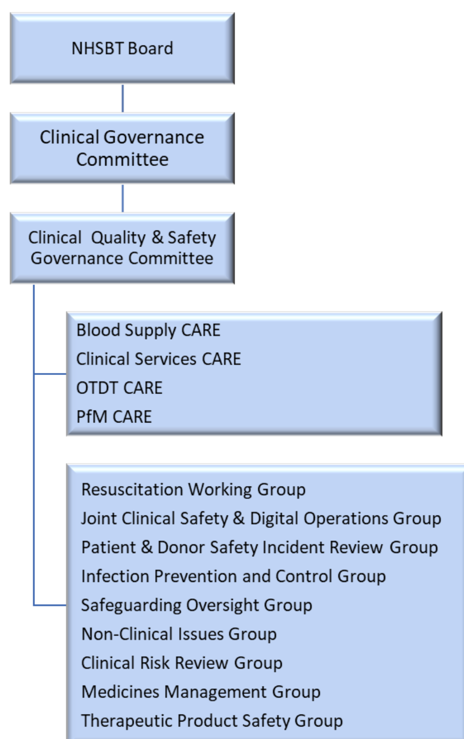
The Clinical Governance Committee (CGC or the Committee) sets the tone and direction for patient/donor safety, clinical effectiveness, patient outcomes and patient/donor experience. It supports the operating directorates in the development, implementation and monitoring of a robust framework for clinical governance, meeting donors' and patients' needs.

Reporting structure

The Clinical Governance Committee is a Committee of the NHSBT Board and reports its activities to the Board, escalating concerns via quarterly reports.

Following the establishment of the Executive Clinical Quality and Safety Governance Group (CQSGG) in 2024–25 to strengthen the organisation's internal governance framework, the Group has continued to provide a structured and comprehensive internal review of all clinical quality and safety reports. This process ensures that any significant matters are scrutinised and assessed prior to escalation to the Clinical Governance Committee (CGC). The enhanced governance tier has improved the efficiency and consistency of reporting pathways and reinforces the CGC's ability to deliver effective oversight and assurance across all aspects of clinical quality and safety.

Directorate-level Clinical Audit, Risk and Effectiveness (CARE) Groups, along with nine additional governance groups, now report into the CGSGG, which in turn provides consolidated and exception-based assurance to the CGC.



Committee membership and attendance 2025-26

During 2025-26, the Committee met four times. Meetings have been well attended and quoracy achieved on all occasions. The annual attendance of voting (V) and non-voting (NV) members is shown below:

Members	10.04.2025	10.07.2025	20.10.2025	15.01.2026	**Total**
Lorna Marson, Non-Executive Director (V)	√	√	√	√	**4**
Charlie Craddock, Non-Executive Director (V)	√	√	√	√	**4**
Dee Thiruchelvam, Chief Nursing Officer (V)	√	√	√	√	**4**
Gail Miflin, Chief Medical Officer/Director of Clinical Services (V)	√	√	√	√	**4**
Helen Gillan, Director of Quality (NV)	√	√	√	√	**4**
Anthony Clarkson, Director of Organ & Tissue Donation & Transplantation (OTDT) (NV)	√	√	√	√	**4**
Gerry Gogarty, Director of Blood Supply (NV)	x	√	√	√	**3**

NHSBT has arrangements in place regarding the identification and management of any conflicts of interest. Members' interests are included on the agenda for visibility. During the year, no conflicts of interest requiring management were raised.

Summary of Activity

In 2025–26, significant progress has been made in establishing and embedding the Clinical Quality and Safety Governance Group (CQSGG) as a core component of the organisation's internal governance framework. The CQSGG functions as the primary reporting body for the Clinical Audit, Risk and Effectiveness (CARE) groups and other clinical governance groups, providing a structured forum for detailed review and challenge of reports prior to the escalation of any significant issues to the Clinical Governance Committee (CGC). This allows the Committee to have the time to fully debate significant matters. Throughout the reporting period the CQSGG has continued to provide an integrated assurance report to the CGC, summarising key activities and highlighting matters requiring scrutiny by exception. This additional layer of oversight ensures that the CGC receives sufficient, timely, and well-synthesised information to support informed assurance decisions. While the integrated report is now established, its format and content continue to mature, with ongoing development aimed at offering a more comprehensive view of both qualitative and quantitative clinical risk and assurance information from across the organisation.

Key areas of focus for the Committee in 2025-26 have included:

a) Infected Blood Inquiry (IBI) update reports which provided assurance. The current Spending Review monies have not provided funding for many of the recommendations. The recommendations most relevant to NHSBT are those in R7. These have been incorporated into the Transfusion Transformation strategy that has been written by NHSBT, the National Blood Transfusion Committee and NHSE and presented to the DHSC. Conversations are ongoing to agree what can be delivered within the current funding envelope and what would need further funding to bid for in the future. It is not anticipated by the Executive Team that further funding could be made available by NHSBT, however the committee noted that were this to be the case, the opportunity costs linked to internal reprioritisation and the potential impact on NHSBT's wider operational capacity should be considered.

b) Reports on implementation and progress with the Patient Safety Incident Response Framework (PSIRF). The update in July 2025 provided assurance that the transition continues to advance in line with national expectations, with stakeholder feedback and an assessment of progress against the previous plan informing development of the next phase of the transition programme.

c) In July and October 2025, two principal risks, P-01 (harm to donors or patients) and relevant elements of P-06 (failure to monitor clinical outcomes) were merged to create a more comprehensive and integrated risk profile encompassing Patient and donor safety.

d) A deep dive review of the consolidated P-01 Donor and Patient Safety risk was presented to the Committee in January 2026, providing assurance on the effectiveness of controls, monitoring arrangements and planned improvements.

e) PSII Annual deep dive was completed with further recommendation that a multidisciplinary team should be engaged in the review.

f) Patient and Donor Safety Incident Investigation Closure Reports were received at the July and October 2025 meeting, providing ongoing assurance regarding the robustness of incident investigation processes. These reports offered the Committee clear visibility of outcomes, identified learning, and any associated improvement actions. Their routine presentation supports organisational learning, strengthens the safety culture, and enables the Committee to monitor the timely and effective closure of investigations.

g) An update on HHV-8 testing was considered in July 2025, following advice from the Therapeutic Product Safety Group regarding the potential introduction of pre-transplant testing. The working group's recommendation to be presented to the OTDT Senior Management Team for endorsement.

h) The Committee reviewed the management and delivery of the 2024/25 Winter Wellbeing Flu Vaccination Campaign and highlighted the opportunity to simplify vaccination forms to support improved engagement and uptake.

i) The Committee received in July an independent research study completed in March by the Head of Clinical Research, titled*, Exploring challenges and opportunities for successfully establishing an integrated clinical governance strategy within NHSBT*. The study provided assurance through an assessment of existing clinical governance arrangements and examined opportunities to strengthen a more integrated, consistent, and effective framework across NHSBT's diverse clinical services. The report identified key enablers and challenges and set out five strategic recommendations designed to support the development and maturity of clinical governance, with a focus on enhancing patient safety, organisational learning, and consistency of practice.

j) The Committee reviewed the CQC Self-assessment process against CGC Quality Statements and Standards in July 2025.

k) Annual reports on the following subjects were received by the Committee: Management Quality Review, Safeguarding, Information Governance, Clinical Claims, Non-clinical issues, Clinical Audit, Medical Revalidations, Nursing Revalidations, Complaints, Serious Hazard of Transfusion (SHOT), Joint NHSBT/PHE Epidemiology, Infection Prevention and Control and Donor Derived Transmissions.

l) The Committee received regular updates on the Clinical Audit Programme, including progress against the annual plan and the status of actions arising from completed audits. Of the eight audits scheduled within the 2025/26 programme, two have been completed and six are outstanding. Two audits from the 2024/25 programme also remain outstanding. The Committee noted that eight audit-related actions are currently overdue, all of which are subject to active monitoring and management.

m) The GIAA audit of the Clinical Audit Process (published January 2023) delivered a limited assurance opinion and raised 14 recommendations with 17 actions, all of which have been completed. In addition, the GIAA audit of Joint United Kingdom (UK) Blood Transfusion and Tissue Transplantation Services Professional Advisory Committee (JPAC's) emerging infections and horizon-scanning process provided moderate assurance, concluding that arrangements are generally effective, underpinned by robust surveillance, governance, stakeholder engagement, and risk escalation processes. Three actions were identified, all of which have been closed.

n) Assurance reports related to, Blood Supply Safety and Experience Assurance, Infection Prevention and Control (IPC) Board Assurance Framework External Assurance and the Scientific Advisory Committee (SAC) have been received.

o) The Committee endorsed the Safeguarding Policy review at its April 2025 meeting, and the Board subsequently approved the policy in May 2025.

p) A review of Board skills and capabilities, specific to the Clinical Governance Committee (CGC), was undertaken. Members noted the current skills profile against the Committee's required capabilities and agreed the identified skills gaps. The need for representation from the DDTS team on the CGC was considered and has subsequently been addressed.

q) Received the CQSGG Terms of Reference and revised the CGC Terms of Reference (July 2025), which were subsequently approved by the Board in July 2025.

r) Directorate CARE reports for Clinical Services, OTDT, Blood Supply, and Plasma for Medicines were received by the Committee via the quarterly Safety and Experience Integrated Report. In addition, the Regulatory Radar and the quarterly Management Quality Review (MQR) were received as part of the regular quarterly reporting cycle.

Committee Effectiveness Review

An internal effectiveness review of the Board and its Committees was carried out in December 2025 by the Company Secretary, using a questionnaire-based survey to gather the views of Board members. The findings from the NHSBT Board effectiveness review were formally reported to the Board at its meeting on 3 February 2026. The Committee is seen to be evolving into its new format and whilst generally effective in its role improvements can be made. Scores ranged from 50% to 100% in agreement for the questions asked. The main areas of improvement highlighted related to ensuring the right items for agendas with the right standard of papers to allow review and challenge. It was felt that there was room for improvement in the level of detail and quality of papers and their presentation and in ensuring appropriate challenge and support in a respectful manner. Comments related to the Committee bedding into its new format and a need to align to clinical risks, incidents and learning. There was a desire for greater understanding of the timeframe and plan for the clinical governance review with a view to how this may impact the information and data that the Committee sees.

The graphs below show a summary of the results for the period to February - December 2025.

The Committee wishes to record its appreciation for the significant contribution of all those who have dedicated time and expertise to its work to date; their continued commitment has been highly valued.

Assurance and Statement to the Board

The opinion of the CGC is that the organisation's current risk management, control and governance arrangements are adequate, effective, and can be relied upon by the Board. The Committee notes, however, that it is operating during a period of transition as the new Executive Leadership arrangements embed and a review of Clinical Governance arrangements takes place. The Committee anticipates that, once the leadership arrangements embed and the Clinical Governance review reports, there will be an opportunity to revise and update the Committee terms of reference to ensure the overall efficiency and effectiveness of its operations will be enhanced.

The Committee identified the following gaps in assurance during the reporting period:

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- Terms of Reference: Terms of Reference: The Committee's Terms of Reference (ToR) will be updated in July to reflect any changes to membership, to reflect the merger of Principal Risks 01 and 06 and to provide clarity on the Committee's role in gaining assurance from the clinical audit programme approved by CQSGG. Outputs from the current clinical governance review may also lead to proposed changes to the Terms of Reference.
- Two clinical audits from the 2024/25 programme remain outstanding. Of the eight audits in the 2025/26 programme, six are delayed or have been rescheduled.
- The CQSGG Integrated Safety and Experience Report has not included reports on Clinical workforce and Mandatory Training of Clinical Workforce.

A full gap analysis against the Clinical Governance Committee delegations set out in the Terms of Reference has been completed and can be found in the review room for the meeting.