Northern Ireland Blood Transfusion Service

Board Assurance Framework
February 2015

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Change History

Version	Section	Change
05	9	Amendment to the number of Board meetings in 2015/16
	Appendix 2	Addition of revised TOR for Health and Safety Committee.
	Appendix 3	Update to schedule of key meetings.
04	4	Update to reflect vision and mission as in business plan for 2013/14
	8	Update to table of committees
	Appendix 2	Addition of revised TOR for Health and Safety Committee
03		Addition of Change History table
	1 Introduction	Update to reflect established and current Board Assurance Framework
	All sections	Revised to reflect current structures including removal of references to the Learning and Development and Clinical Audit Group. Specific comments regarding Clinical Audit and delivery of a Learning and Development Strategy are included on Page 14 (f) and (g)
	Appendix 2	Addition of TOR for Serology, Medical Devices and Equipment Group, Incident Management Group and ICT Steering Committee

Content

1 Introduction

HSC organisations and other Arm's Length Bodies of the Department of Health Social Services and Public Safety (DHSSPS) must be able to demonstrate effective systems of internal control. It is essential that such systems facilitate assurance throughout the organisation to Board level. This document has been drafted in keeping with guidance issued by DHSSPS March 2009. This guidance on assurance frameworks has been commended for use within Arm's Length Bodies. NIBTS are committed to adopting principles set out within this guidance in the development of the assurance framework within the Service. In developing the assurance framework within NIBTS it is important to note that it is a relatively small organisation with a Board of limited size. The key objective in developing this assurance framework is to ensure that there are systems and controls, put in place to manage NIBTS, which are comprehensive. This assurance framework will not impose any new requirements on staff within NIBTS but will in fact provide the Agency Board with an instrument for making full use of the existing governance capacity:

- In terms of how the various aspects of governance relate to organisational responsibilities and accountability to each other.
- In relation to the information they need to discharge their responsibilities and accountability.
- To know how the different facets of governance are working.
- To ensure effective management of risk.

It should be noted that the NIBTS Board have completed the Board Governance Self Assessment Tool and recommendations have been made.

It is the responsibility of NIBTS to protect donors, patients, staff and others in the employment and delivery of services. Reducing risk is not just about financial management aspects; it is in fact about improving safety and quality of the user's experience of the Service. For this reason the assurance framework will reinforce governance across all aspects of the organisation. Key to this is the application of an organisation wide risk management scheme. Within the HSCB the Regulation Quality and Improvement Authority (RQIA) have a role in ensuring that integrated governance processes are in operation. NIBTS will fully co-operate with any monitoring or inspection undertaken by the RQIA.

2 Governance

The NIBTS Board need to be confident the arrangements are managed effectively. They must be assured that they will be able to identify and manage risks inherent in the provision of services by the organisation.

The Chief Executive, NIBTS, as accountable officer, must sign a "Governance Statement" as part of the statutory accounts and annual report process. A further mid-year assurance statement to attest to the maintenance and improvement of control systems is required. This assurance framework aims to harness the existing risk management activity to resolve uncertainties and deepen NIBTS understandings of these aspects of governance. The NIBTS Board must determine the level of assurance required to manage their principle risks and to take stock of the various forums of assurance available to them. This is set out in this document. The assurance framework will provide a tool by which the Board can monitor the effectiveness of internal control and hence commit to a statement of internal control as required.

3 Accountability

NIBTS recognizes that accountability can be defined in four domains - Corporate Control, Safety and Quality, Finance and Operational Performance and Service Improvement. In developing this assurance framework NIBTS have considered the four domains and its operational objectives. These are translated into five themes/objectives.

1 **Donor/Customer** – Improving the Donor/Customer experience

2 **People** – Engage, Empower and Encourage learning and development

3 **Improvement** – Embedding a Culture of continuous improvement

4 **Quality** – Ensuring governance and compliance

5 **Resources** – Improving performance and achieving excellent results

4 Objectives

This assurance framework is dependent on identification of key objectives for the NIBTS; looking at the principle risks to those objectives and what controls can be applied. Independent assurance and controls, and co-ordination are also important to allow for Board reports and further development of Board action plans to improve control and ensure delivery of principle objectives and gain assurance.

Figure 1 – the Key Stages

NIBTS CORPORATE OBJECTIVES

Principle Objectives

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Principle Risks

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Key Controls

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Sources of Independent Assurance on Controls and their co-ordination

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Board Reports positive assurances gaps in control gaps in assurance

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Board Action Plan

Management checks, Quality Management System, Internal Audits, BSO Internal Audit, Clinical and Multi-professional Audit, , DHSSPS Quality and Service Standards, Controls Assurance Standards, Circulars and Guidance, RQIA, Professional and Staff Regulatory Bodies, External Audit, Medicines Healthcare products Regulatory Agency, Human Tissue Authority, Clinical Pathology Accreditation (UK) Ltd, Counter Fraud Unit etc.

To improve control, ensure delivery of principle objectives and gain assurance

NIBTS sets out its objectives taking into account the mission, vision and core values for the organisation. These are:

Mission

"NIBTS aspires to be the best Transfusion Service that it can:

- The best care for our donors
- The best service for our patients
- The best development for our staff"

-

Vision

The following statements set out the NIBTS vision and strategic direction for the next 3 years 2013/14 – 2015/16.

Five corporate themes are captured. These feed into individual staff development reviews; team development plans; DHSSPS objectives and corporate goals. These are:

1 **Donor/Customer** – Improving the Donor/Customer experience
2 **People** – Engage, Empower and Encourage learning and development
3 **Improvement** – Embedding a Culture of continuous improvement
4 **Quality** – Ensuring governance and compliance
5 **Resources** – Improving performance and achieving excellent results

4.1 Donor/Customer – Improving the Donor/Customer experience

NIBTS has two obvious sets of customers – the donors whom we collect blood from and the patients and clinical teams whom we serve in NI hospitals.

Donors

The key issues here relate to blood stocks and involve recovering an adequate amount of blood to meet patient demand; maintaining an active donor list and replacing retiring and resigning donors with new donor recruits.

We are also focusing on better donor information which will include revising/updating the 'frequently asked questions' on our website; piloting 'registration clinics' in respect of new donors by giving them better information so that they can self-exclude and also know what to expect during their donating career. This is also important for Club 96. This is an initiative to target recruitment of donors born after 01 January 1996. These donors have not been exposed to prion contamination in their diet. The proposal is to link or pair these donations with recipients who are also born after 01 January 1996 so that the risk of transfusion transmitted variant CJD is mitigated.

Customers

NIBTS interacts daily with hospital blood bank colleagues and medical staff. NIBTS works closely with the NI Transfusion Committee (NITC) to promote excellent clinical transfusion practice. NIBTS performance is assessed annually through customer satisfaction surveys.

4.2 People – Engage, Empower and Encourage learning and development

NIBTS was successful in achieving Investors in People accreditation award 06 April 2012. The IiP framework has been used to imbed people centred practices in the organisation. The list includes individual staff development reviews; team development plans; consultation around the business planning process and inclusion of staff ideas in the final business plan document. A Corporate IiP Action Plan has been developed and is monitored by the Board.

4.3 Improvement – Embedding a culture of continuous improvement

Each departmental section and team is required to produce and deliver a quality improvement objective each year.

4.4 Quality – Ensuring governance and compliance

NIBTS statutory duties are set out in The Northern Ireland Blood Transfusion Service (Special Agency) (Establishment and Constitution) Order (Northern Ireland) 1994 and also in subsequent Northern Ireland Blood Transfusion Service (Special Agency) Accounts and Financial Provision Direction (NI) 1995. NIBTS complies with its statutory duties.

What is more visible to NIBTS staff and colleagues is licensing regulations which relate to our Blood Establishment Authorisation from the Medicines and Healthcare product Regulatory Agency (MHRA) and our cord blood authorisation provided by the Human Tissue Authority (HTA). We also participate in the Clinical Pathology Accreditation (CPA) scheme for our diagnostic laboratories. We have achieved excellent results across these three standards in the past year. NIBTS Agency Board governance is supported by a Board Assurance Framework which is consistent with current DHSSPS Guidance. The same applies to Controls Assurance Standards, three of which are mandated and are subject to external verification each year with the other Controls Assurance Standards being self-assessed.

NIBTS will continue to adhere to all statutory objectives with regard to Section 75 of the Northern Ireland Act (1998).

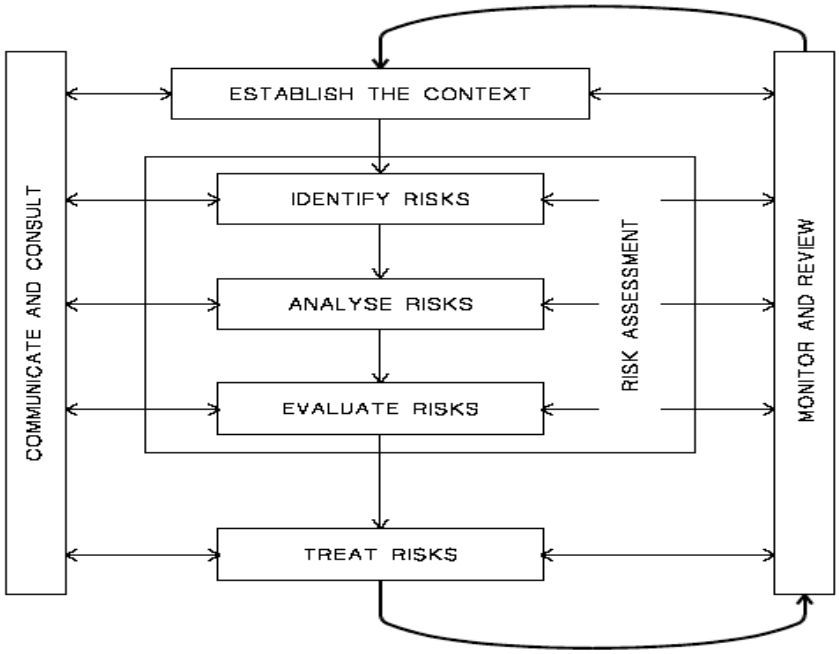
4.5 Resources – Improving performance and achieving excellent results

NIBTS has seen successful reductions in its annual budget line. These relate to annual European procurements for key reagents and consumables; specific projects within laboratories in relation to lean methodology working and benchmarking productivity measures across blood collection which compare well with other UK and Ireland Blood Transfusion Services.

5 Risk Management

NIBTS have developed a comprehensive risk management process in compliance with the Controls Assurance Standard for risk management AS/NZS 4360

Figure 2 – The AS/NZS 4360:2004 Model[1] – Risk Management Process – An Overview



The NIBTS risk management system seeks to ensure:

- Board and senior management are committed to risk management and that there is a clear sense that risk management is integral to all planning and achieving objectives and to being accountable.
- An understanding that risk taking can bring both rewards and penalties and that certain risks are not to be accepted
- A common framework for the analysis of risk
- A single point of coordination for the process

The NIBTS approach to risk management is detailed in the following documents:

- STG:RMS:001 Risk Management Strategy
- POL:RP:001 Risk Management Policy

[1] Based on material originally developed by SAI Global

- SOP:RM:001 Risk Register Process
- SOP:RM:002 Operational Risk Assessment Procedure
- SOP:HS:011 Health and Safety Risk Assessment Procedure

These processes and others embedded in NIBTS processes such as incident reporting and change control, allow an effective risk management systems to apply both from the top down and from the bottom up.

6 Performance Management Framework

Key objectives are set out in the annual business plan which is approved by the Agency Board. Performance management involves a range of external bodies and internal groups. General oversight is by the DHSSPS and NIBTS Agency Board. The roles and reporting relationships of the various bodies and groups are summarised below:

6.1 General Oversight

(a) Agency Board

- Assures corporate governance, approves business plan and monitors performance.
- Audit Committee – assures internal governance, receives reports from external and internal auditors and other reports which it considers appropriate.
- Governance and Risk Management Committee – assures governance and risk management systems and processes including governance, risk assessment and management, Controls Assurance Standards, quality development, clinical standards and audit, learning and development, business continuity planning and how compliance is managed and reported.

(b) DHSSPS

- Regular reports on progress with governance and implementation of policies.
- Biannual Accountability Review meetings
- Annual Performance Review meeting.
- Northern Ireland Blood Safety Committee (chaired by Chief Medical Officer).

6.2 External Assessment and assurance is provided by:

- Medicines and Healthcare products Regulatory Agency (MHRA). Responsible for inspection in respect of compliance with the Blood Safety & Quality Regulations and the requirements relating to Wholesale Distributors Licensing.
- Clinical Pathology Accreditation Ltd. (UK) – Diagnostic Laboratory Services.

- Human Tissue Authority
    - Licensing of Cord Blood Bank.
    - Responsible for ensuring compliance with the Human Tissue Act.
- External financial audit – NI Audit Office.
- Compliance with DHSSPS ‘Codes of Conduct and Accountability’.
- Equality Commission NI.
- Information Commission (Freedom of Information and Data Protection Acts).
- Regulation & Quality Improvement Authority.
- Investors in People.
- Health and Safety Executive NI.
- National Health Service Blood and Tissues (for Bone Marrow Donor Registry).
- Health & Social Services Boards (service monitoring and complaints referral).
- BSO Internal Audit – NIBTS Processes and Compliance with Controls Assurance Standards.

6.3 Internal Arrangements

A range of operational teams and processes are involved in the monitoring and management of governance and performance. These include:

(a) General

- Senior Management Team.
- Quality Improvement Review Committee - Quality Management Programme – quality monitoring reports (blood component testing etc), incident management programme, change control, internal quality audit programme (all departments), document control (policies, procedures). The Quality Management System is described in the NIBTS Quality Manual (MAN:10:QD:001).
- ICT Steering Committee.
- Health and Safety Committee – Health and Safety, Fire safety and Security management, Environmental and Waste Management
- Equality and Human Rights Committee – Equality, Human Rights and Good relations, and general Section 75 responsibilities.
- Estates Management Group.

(b) Finance

- Audit Committee meetings and assurance systems.
- External audit (financial accounts)
- Internal audit programme (Business Services Organisation)
- Monthly reports to Agency Board and to DHSSPS
- Budgetary control systems
- Customer contracts: monitors performance against Service Level Agreements with Hospital and HSCT Boards

(c) HR & Corporate Services Department

- Internal: Human resources: recruitment, retention, turnover, employee relations, absence monitoring, workforce planning, employment law, policy and strategy development, training and development and best practice HR.
- Coordination, development and performance monitoring of corporate service level agreements.

- Equality and Human Rights and Section 75 obligations.

(d) Blood Collection Programme

- External input: Blood Transfusion Service Communities Partnership.
- Internal: Blood Donation Co-ordinating Group (co-ordinating, planning and general oversight).
- Quarterly and monthly performance management reports, donor satisfaction and complaints, waiting times, blood donation/collection data and quality incidents.

(e) Laboratory Departments

- External: User Group Meetings (hospital blood bank, immunohaematology and antenatal departments) - monitor service provided to customers.
- Internal: Laboratory Management Team and Departmental meetings (blood bank, serology, microbiology, cord blood) – role in performance monitoring in addition to planning and general oversight.

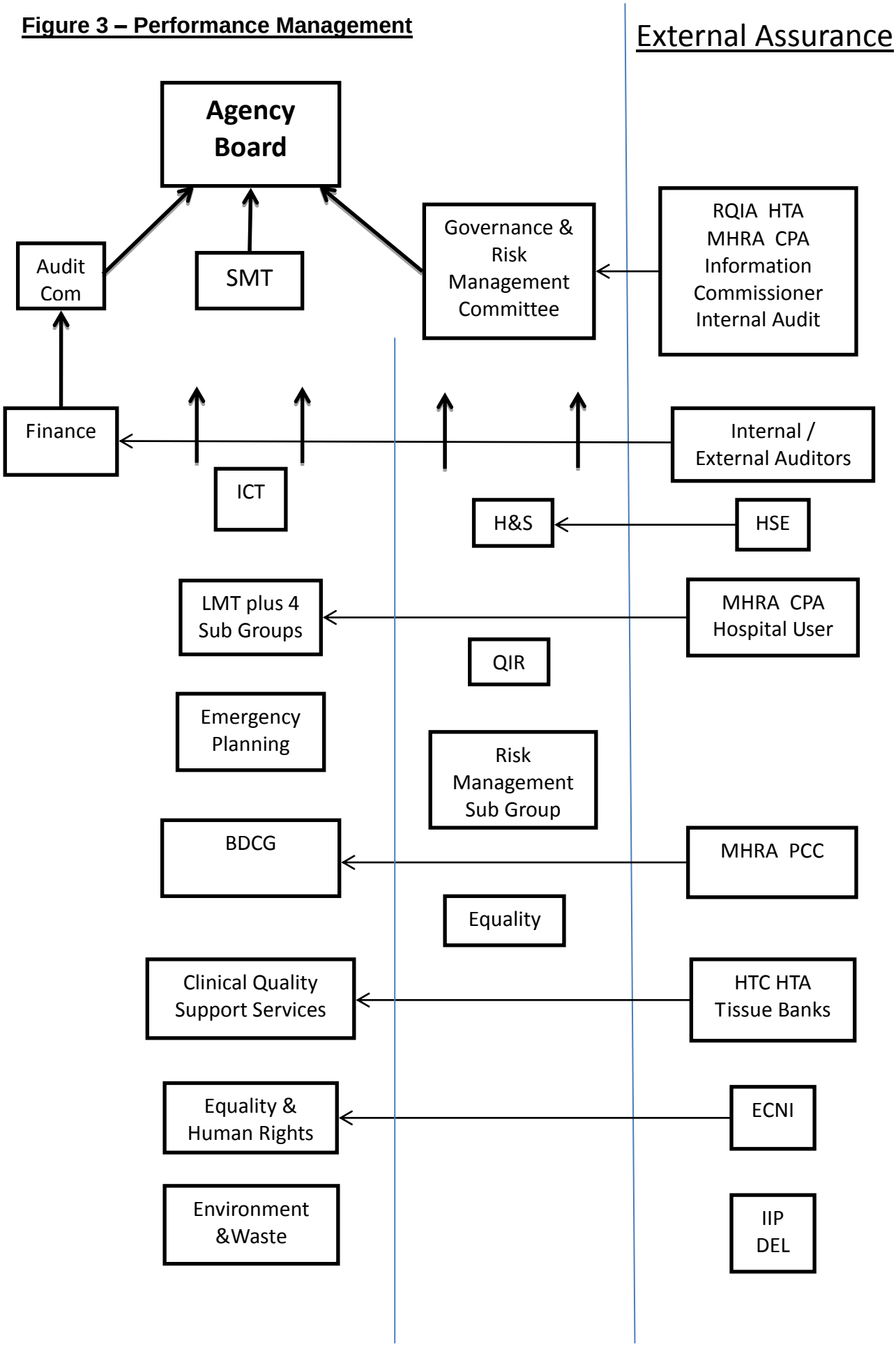
(f) Clinical Audit

- NIBTS are committed to on-going clinical audit and will identify clinical audits for completion. Results of such audits will be incorporated into training and development for relevant clinical/medical staff

(g) Learning and Development

- External: Requirements for training and development as determined by relevant professional bodies – medical, biomedical scientists, nurses and managers.
- Internal: As set out in the annual training plan.
- Individual appraisal and performance development systems for all staff.
- Delivery of a Learning and Development Strategy

Figure 3 – Performance Management



7 Independent Assurance

All core services provided by NIBTS are subject to Regulatory Inspection and /or Accreditation. NIBTS Board fully acknowledges that it is appropriate to obtain independent assurance that good governance systems are in place and working effectively. Bodies from which the NIBTS will seek independent assurance include: Regulatory and Improvement Authority (RQIA); Business Services Organisation (internal audit), NI Audit Office (external audit), Medicines and Healthcare products Regulatory Agency, Human Tissue Authority, Clinical Pathology Accreditation Ltd (UK). Independent assurance is applied against a wide range of standards which include relevant Controls Assurance Standards, Blood Safety and Quality Regulations 2005, Human Tissue Quality and Safety Regulations 2007; CPA standards. An overview of such external assessments is provided by the application of SOP:QA:096 i.e. Procedure for the management of assessments of NIBTS by external bodies. The management of compliance with controls assurance standards is in keeping with departmental guidance and forms an integral part of the organisation assurance framework. This is described in an NIBTS procedure SOP:QA:106

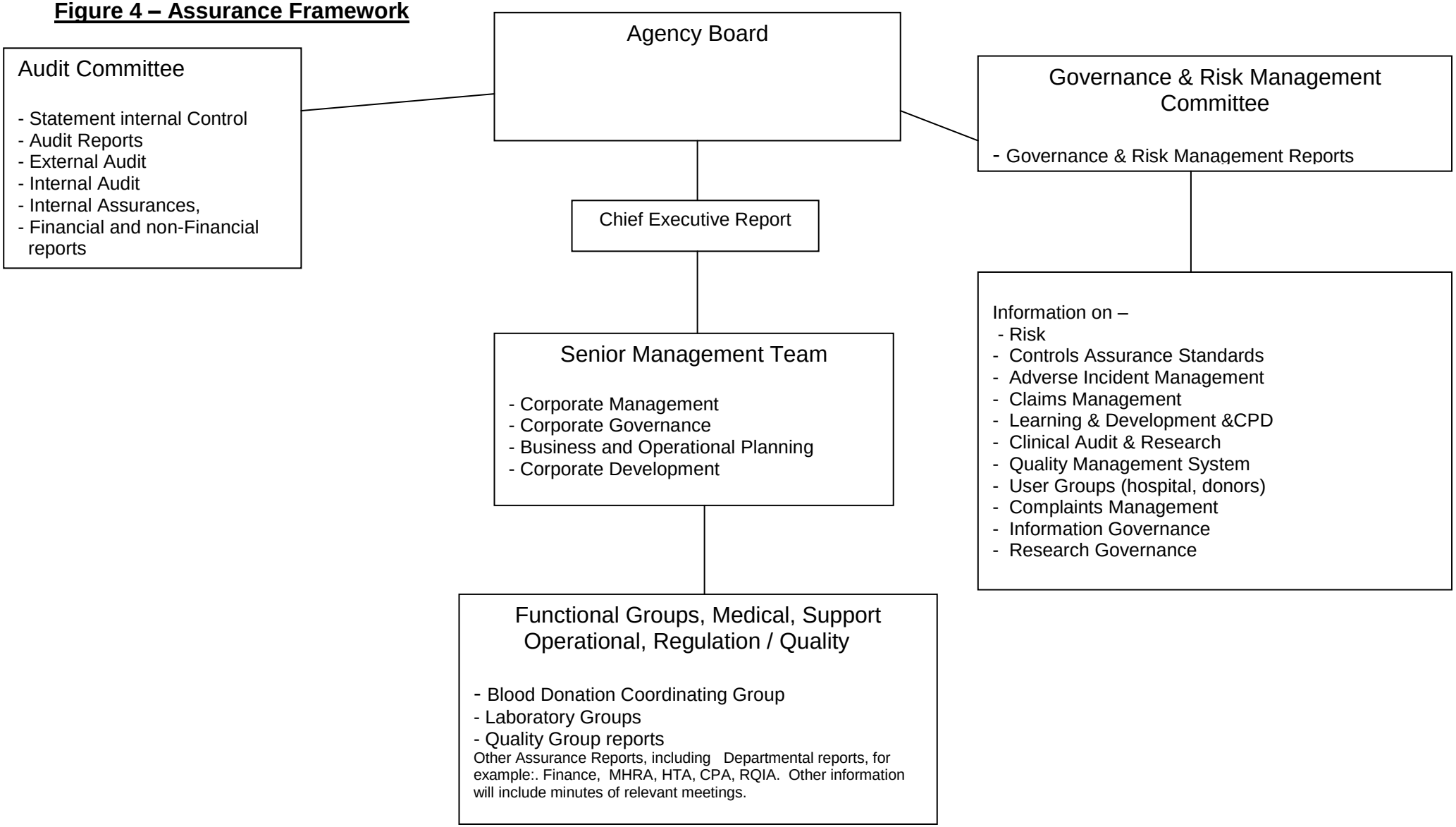
8 Co-ordination

NIBTS have a range of committees and groups which meet periodically. This is set out in Table 1. A schematic diagram is included at Figure 3.

Table 1

NIBTS Agency Board
NIBTS Agency Board – Audit Committee
NIBTS Agency Board - Governance and Risk Management (GRM)
Senior Management Team
Risk Management (GRM Sub-committee)
Quality Improvement Review Group
Incident Management Group
Health and Safety Committee incorporating Environmental and Waste Management, Fire Safety and Security
Estates Management Group
Blood Donation Co-ordinating Group
Donor Services Team
Laboratory Management Team
Hospital Services Committee
Serology Committee
Microbiology Committee
Cord Blood Bank Committee
Medical Devices and Equipment Group
ICT Steering Committee
Equality and Human Rights Committee

Figure 4 – Assurance Framework



The Board Terms of Reference are included in the NIBTS Standing Orders and Terms of Reference have been developed for all Committees (Appendix 2) to facilitate coordination and management of progress with objectives and management of risks.

Where appropriate key agenda items include:

- Performance management
- Risk Assessments and management plans
- Corporate issues
- Learning and development issues
- Service developments
- Quality issues including incidents, complaints.

Meetings are scheduled to facilitate effective management, assurance, communication and development. An annual schedule of key meetings is included at Appendix 3. It should be noted that Terms of Reference for each committee are regularly reviewed. The Audit Committees TORs are reviewed annually and have been reviewed in approving this document.

9 Reporting

NIBTS Board is scheduled to meet six times during 2015/16. A number of reporting mechanisms to assure governance have been put in place to provide appropriate reports to the Board.

The Governance Statement and "mid-year assurance statement" will be provided to assure the Agency Board, HSC Board, DHSSPS, Minister and the public that the operations within NIBTS are of a high standard and quality. The collation of these statements is based on robust information and involves the collation, sharing and agreement on a range of information generated internally and from internal and external audit. This Assurance framework is key to the development of robust Governance/Internal Control Statements.

10 Assessment and Review

- This framework document will be reviewed in conjunction with the Annual Business Planning process and any improvements will be applied.

Author: C Boyd, Business Continuity and Risk Manager

Signature: _____ **Date:** _____

Approved By: M Barkley, Chief Executive

Signature: _____ **Date:** _____

Approved By: NIBTS Agency Board **Date:** _____

Appendix 1

Assurance Framework

Theme 1 Donor Customer – Improving the Donor Customer experience – Risk: Failure to/delay in implementing improvements

	Area	Existing Controls	Assurances Internal (I) External(E)	Gaps in Controls and Assurance	Action	Reporting arrangements
1.1	Blood Safety Initiates Comply with mandatory national developments on blood safety. This will ensure appropriate planning (financial & operational) pending Government decisions on implementation	Corporate Plan, Business Plan, Performance Management Processes, Quality Management Systems	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA (E) MHRA (E) HTA (E)			Department Operational meetings. Reports to Governance and Risk Management Committee, Performance Management reports against Corporate Plan and Business Plan to Board,
1.2	Support hospital transfusion practice • Clinical advice and support • Support HPA initiative relating to improved clinical transfusion practice	Commitment to Transfusion Committees including, ,NI Regional Transfusion Committee, Regional Pathology Network	Clinical audit outcomes. Feedback measures from hospitals. User Surveys, Incident Reporting procedures			Department Operational meetings. Reports to Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board,
1.3	• Reference testing service	Corporate Plan, Business Plan, Performance Management Processes, Quality Management Systems	Clinical audit outcomes. Feedback measures from hospitals. User Surveys, Incident Reporting procedures MHRA (E) CPA (E)			Department Operational meetings. Incident Management and Quality Improvement Review meetings. Reports to Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board

Theme 2 Donor related improvements Risk: Reduction in donor numbers and inability to supply

	Area	Existing Controls	Assurances Internal (I) External(E)	Gaps in Controls and Assurance	Action	Reporting arrangements
2.1	Blood Collection	Blood Collection Strategy, Corporate Plan, Business Plan, Performance Management Processes, Quality Management Systems	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA (E) MHRA IA (E)			Department Operational meetings. Incident Management and Quality Improvement Review meetings. Reports to Governance and Risk Management Committee, Performance Management reports against Corporate Plan and Business Plan to Board

Theme 3 Regulatory compliance – Risk: Failure to maintain licensing/accreditation

	Area	Existing Controls	Assurances Internal (I) External(E)	Gaps in Controls and Assurance	Action	Reporting arrangements
3.1	Blood establishment authorisation. Blood Bank Compliance	Corporate Plan, Business Plan, Performance Management Processes, Quality Management Systems	Corporate Plan, Business Plan, Performance Management Reporting(I) NIBTS Internal Quality Audit Programme (I) MHRA (E)			Department Operational meetings. Incident Management and Quality Improvement Review meetings. Reports to Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board Specific Reports to the Board on this subject
3.2	CPA accreditation of laboratory diagnostic service.	Corporate Plan, Business Plan, Performance Management Processes, Quality Management Systems	Corporate Plan, Business Plan, Performance Management Reporting(I) NIBTS Internal Audit Programme (I) CPA (E)			Department Operational meetings. Incident Management and Quality Improvement Review meetings. Reports to Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board, Specific Reports to the Board
3.3	HTA licensing (cord blood)	Corporate Plan, Business Plan, Performance Management Processes, Quality Management Systems	Corporate Plan, Business Plan, Performance Management Reporting(I) NIBTS Internal Audit Programme (I) Use of third party audits by other tissue banks(E) HTA inspections(E)			Department Operational meetings. Incident Management and Quality Improvement Review meetings. Reports to Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board Specific Reports to the Board
3.4	DHSSPS requirements • Controls Assurance Standards	Corporate Plan, Business Plan, Performance Management Processes, Quality Management Systems Specific Controls Assurance procedures and Action Plans	Corporate Plan, Business Plan, Performance Management Reporting, Self Assessments(I) BSO IA(E)			Department Operational meetings, Specific Committees, Reports to Governance and Risk Management Committee as per SOP QA:106, Performance Management reports against Corporate Plan and Business Plan to Board

Theme 4 Staff related improvements – Risk: Failure to meet Departmental Targets

	Area	Existing Controls	Assurances Internal (I) External(E)	Gaps in Controls and Assurance	Action	Reporting arrangements
4.1	HR Strategy	Corporate Plan, Business Plan, Performance Management Processes	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E)			Department Operational meetings. Performance Management reports against Corporate Plan and Business Plan to Board Specific Reports to the Board or. Governance and Risk Management Committee on this and Relevant Action Plans
4.2	KSF	Corporate Plan, Business Plan, Performance Management Processes,	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E) IIP(UK)			Department Operational meetings. Performance Management reports against Corporate Plan and Business Plan to Board Specific Reports to the Board or. Governance and Risk Management Committee on this and Relevant Action Plans
4.3	Service modernisation	Corporate Plan, Business Plan, Performance Management Processes	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E)			Department Operational meetings. Performance Management reports against Corporate Plan and Business Plan to Board
4.4	IiP	Corporate Plan, Business Plan, Performance Management Processes	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E)			Department Operational meetings. Performance Management reports against Corporate Plan and Business Plan to Board Specific Reports to the Board or Governance and Risk Management Committee on this and Relevant Action Plans

Theme 5 Improvement in business processes – Risk: adverse outcomes relating to patient/donor safety or inspection/accreditation

	Area	Existing Controls	Assurances Internal (I) External(E)	Gaps in Controls and Assurance	Action	Reporting arrangements
5.1	Governance arrangements	Board Assurance Framework. Risk Management Strategy Quality Manual, Corporate Plan, Business Plan, Performance Management Processes	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E)			Operational meetings. , Incident Management and Quality Improvement Review meetings, Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board
5.2	Information governance •Records management •Data Protection •Freedom of Information regulation • ICT Security(see 5.6)	Corporate Plan, Business Plan, Performance Management Processes	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E)			Operational meetings. Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board, Specific Reports to the Board on Relevant Action Plans
5.3	Quality Management Systems	Corporate Plan, Business Plan, Performance Management Processes	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E) MHRA (E) CPA (E) HTA (E)			Operational meetings. Incident Management and Quality Improvement Review meetings. Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board, Specific Reports to the Board on Relevant Action Plans

	Area	Existing Controls	Assurances Internal (I) External(E)	Gaps in Controls and Assurance	Action	Reporting arrangements
5.4	Risk management/Business Continuity Planning Risk registers – regularly reviewed and updated. Business Continuity Plans are in place	Corporate Plan, Business Plan, Performance Management Processes Risk Management Processes Business Continuity Plans	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E)			Operational meetings. Incident Management meetings. Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board, Specific Reports to the Board on Relevant Action Plans
5.5	Emergency planning	Corporate Plan, Business Plan, Performance Management Processes	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E)			Operational meetings, Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board Specific Reports to the Board on this Relevant Action Plans
5.6	IM&T(including ICT Security)	Corporate Plan, Business Plan, Performance Management Processes	Corporate Plan, Business Plan, Performance Management reporting(I) BSO IA(E) MHRA (E) CPA (E), HTA (E)			Operational meetings, ICT Steering Group, Software management Boards, Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board, and Specific Reports to the Board on this Relevant Action Plans
5.7	Procurement. Major tenders. Progress opportunities for joint (national approaches) • Blood packs including platelet pooling packs • Plateletpheresis systems • Microbiology tests (core donor testing)	Corporate Plan, Business Plan, Performance Management Processes	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E)			Operational meetings, PaLs Meetings, Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board
5.8	Estates	Corporate Plan, Business Plan, Performance Management Processes,	Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E) MHRA (E) CPA (E) HTA (E)			Operational meetings, Estates Meetings, Governance and Risk Management Committee Performance Management reports against Corporate Plan and Business Plan to Board

	Area	Existing Controls	Assurances Internal (I) External(E)	Gaps in Controls and Assurance	Action	Reporting arrangements
5.9	Performance management	Improved effectiveness and efficiency. Improved communication with key stakeholders.	Corporate KPIs Corporate Plan, Business Plan, Performance Management Reporting(I) BSO IA(E)			Reports to SMT and Board
5.10	Finance • Achieve mandatory targets (will involve meeting the required HSC efficiency gains)	Meet statutory requirements	Breakeven - revenue - capital			Reports to SMT Board and DHSSPS

Appendix 2

NI BLOOD TRANSFUSION SERVICE AGENCY

AUDIT COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (The Committee). The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2 MEMBERSHIP OF THE COMMITTEE

The committee shall be appointed by the Board from amongst the Non-Executive Directors of the Board and shall consist of not less than 3 members. A quorum shall be 2 members. One of the members will be appointed as Chair of the Committee by the Chairman of the Board.

3 ATTENDANCE

The Finance Manager and appropriate Internal and External Audit representatives shall normally attend meetings. However at least once a year the Committee should meet privately with the External and Internal Auditors.

The Chief Executive should be invited to attend at least annually, to discuss with the Audit Committee the process for assurance that supports the Statement on Internal Control.

The Board Secretary shall be Secretary to the Committee and shall attend to take minutes of the meeting and provide appropriate support to the Chairman and committee members.

4 FREQUENCY OF MEETINGS

The Audit Committee will meet four times per year. The External Auditor or Head of Internal Audit may request a meeting if they consider that one is necessary. The Chair of the Audit Committee may convene additional meetings, as they deem necessary.

A minimum of two members of the Audit Committee will be present for the meeting to be deemed quorate.

The Audit Committee may ask any other officials of the organisation to attend to assist with its discussions on any particular matter.

The Audit Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters.

The Agency Board may ask the Audit Committee to convene further meetings to discuss particular issues on which they require the Committee's advice.

5 AUTHORITY

The Committee is authorised by the Agency Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Agency Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders

6 DUTIES & RESPONSIBILITIES

The Audit Committee will advise the Agency Board on:

- the strategic processes for internal control, controls assurance and the Statement on Internal Control in conjunction with the Governance and Risk Committee.

- the accounting policies, the accounts, and the annual report of the organisation, including the process for the review of the accounts prior to submission for audit, levels of error identified and management's letter of representation to the external auditors

- the adequacy of the policies for ensuring compliance with relevant regularity, legal and code of conduct requirements, including the Agency's Standing Orders and Standing Financial Instructions

- the planned activity and results of both internal and external audit

- the adequacy of management's response to issues identified by audit activity including external audits management letter

- assurance relating to the corporate governance requirements for the organisation

- anti fraud policies, whistle- blowing processes and arrangements for special investigations

- the Audit Committee will also periodically review its own effectiveness and report the results of that review to the Agency Board.

In carrying out its work, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these functions. It will also seek reports and assurances from other Agency Committees, Heads of Service and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

Internal Audit

The Committee shall ensure that there is an effective internal audit function established by management that meets the DHPSSPS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Agency Board. This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework
- consideration of the Chief Internal Auditor's annual report, major findings of internal audit work (and management's response), and ensure co-ordination between the Internal and External Auditors to optimise audit resources
- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation
- annual review of the effectiveness of internal audit.

The Head of Internal Audit and representatives of External Audit will have free and confidential access to the Chair of the Audit Committee.

External Audit

The Committee shall review the work and findings of the External Auditor appointed by the NI Audit Office and consider the implications of, and management's responses to, their work. This will be achieved by:

- consideration of the performance of the External Auditor
- discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the Trust
- review of all External Audit reports, including consideration of the annual Management Letter before submission to the Board and any work carried out outside the annual audit plan, together with the appropriateness of management responses.

Financial Reporting

The Audit Committee shall review the financial extract of the Trust's Annual Report and the Financial Statements before submission to the Board, focussing particularly on:

- the wording in the Statement on Internal Control and other disclosures relevant to the terms of Reference of the Committee
- changes in, and compliance with, accounting policies and practices

- unadjusted mis-statements in the financial statements
- major judgemental areas
- significant adjustments resulting from the audit

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

Value For Money

The Audit Committee shall oversee the adequacy of the Trust's arrangements for ensuring that value for money is obtained in the expenditure of all public funds entrusted to its care. This will include a review of the findings from, and management's response to, all value for money audit reports issued to the Agency as part of the regional VFM programme sponsored by DHSS&PS.

7 REPORTING

The minutes of Audit Committee meetings shall be formally recorded by the Board Secretary and submitted to the Agency Board. The Chair of the Committee shall draw to the attention of the Agency Board any issues that require disclosure to the full Agency Board, or require executive action.

The Audit Committee will provide the Agency Board with a written Annual Report, timed to support finalisation of the accounts and the Statement of Internal Control, summarising its conclusions from the work it had done during the year.

Other Matters

The Committee shall be supported administratively by the Board Secretary, whose duties in this respect will include:

- Agreement of agenda with the Chairman and attendees

- Collation and distribution of papers sufficiently in advance of each meeting to facilitate their full consideration and discussion at the meeting

- Taking the minutes and keeping a record of matters arising and issues to be carried forward and advising the Committee on pertinent areas.

Information Requirements

For each meeting the Audit Committee will be provided with:

A progress report from the Head of Internal Audit summarising:

- Work undertaken
- Keys issues emerging from Internal Audit work
- Management response to audit recommendations
- Action plans and changes to periodic plan
- Any resourcing issues affecting the delivery of Internal Audit objectives

A progress report from the External Audit representative will also be provided summarising work done and emerging findings

As and when appropriate the Committee will also be provided with:

- Proposals for Terms of Reference for Internal Audit
- The Internal Audit Strategy
- The Controller Internal Audit's Annual Opinion and Report
- Quality assurance reports on the Internal Audit function
- The draft accounts of NIBTS
- The draft statement of Internal Control
- A report on any changes to accounting policies
- External audit's management letter
- A report on co operation between Internal and External Audit

NORTHERN IRELAND BLOOD TRANSFUSION AGENCY

GOVERNANCE AND RISK MANAGEMENT COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION

The Board hereby resolves to establish a Committee of the Board to be known as the Governance and Risk Management Committee (The Committee). The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

2 MEMBERSHIP OF THE COMMITTEE

The committee shall be appointed by the Board from amongst the Non-Executive Directors of the Board and shall consist of not less than 2 members. A quorum shall be 2 members. One of the members will be appointed the Chair of the Committee by the Board.

3 ATTENDANCE

The following senior staff shall be invited to attend meetings:

- Chief Executive
- Medical Director
- Finance Manager
- Head of Human Resources /Corporate Services Manager
- Donor Services General Manager
- Laboratory Manager
- Regulatory Affairs and Compliance Manager
- Quality Manager
- Business Continuity and Risk Manager

Other members of Trust staff may be required to attend meetings as the committee considers necessary.

The Board Secretary shall be secretary to the committee, shall attend the meetings and provide appropriate support to the Chairman and committee members.

4 FREQUENCY OF MEETINGS

Meetings shall be held not less than four times a year.

5 AUTHORITY

The committee is authorised to investigate any activity within its terms of reference

6 REMIT

This committee is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee, and will be given the resources necessary to carry out its role. The committee will be given full access to any information within the NIBTS Agency that it requires to fulfil its function. The committee is authorised by the Board to obtain external professional advice and to invite outsiders with relevant experience to attend if it considers this necessary.

The remit of the committee is to ensure that:

There are robust and regularly reviewed systems and structures in place to support the effective implementation and development of integrated governance and risk management across the organisation.

Risk management is a planned and systematic approach to identifying, evaluating and responding to risks and providing assurance that responses are effective.

Effective systems are in place to ensure and manage effective staff practice

Principal risks and significant gaps in controls and assurances are considered by the Board of Directors.

Timely reports are made to the Board of Directors, including recommendations and remedial action proposed or taken if there is an internal failing in systems or services.

There is sufficient independent and objective assurance as to the robustness of key processes across all areas of governance and risk management.

In carrying out its work, the committee will utilise information from:

- Licensing and Regulation
- Controls Assurance standards
- Risk assessment and risk management
- Health & Safety
- Adverse Incident Management
- Clinical Audit
- Complaints management & Personal and Public Involvement
- Learning and Development and Continuing Professional Development
- Evidence based practice
- Litigation
- Quality and Professional standards
- Research and education
- External assessments and inspections

7 REPORTING

Any business conducted in a confidential session by the Governance and Risk Management Committee will be reported to a confidential session of the Board of Directors.

8 OTHER MATTERS

The minutes of the Governance Committee shall by formally recorded by the Board Secretary and submitted to the Board. The Board secretary duties in this respect will include:

- Agreement of agenda with the chairman and attendees.
- Collation and distribution of papers 3-working days in advance of the meeting.
- Producing the minutes of the meeting and taking forward matters arising and issues to be carried forward.
- Advising the committee on pertinent issues.

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	SENIOR MANAGEMENT TEAM
CHAIRED BY:	Chief Executive
MEMBERSHIP:	Medical Director Donor Services General Manager Finance Manager HR/Corporate Services Manager Laboratory Manager Quality Manager Regulatory Affairs and Compliance Manager Secretary: PA to Chief Executive
SUMMARY OF ROLE:	This team includes the most senior managers of each department in NIBTS and it has wide ranging roles. These include the following: • Has a key co-ordinating role in relation to: - All corporate and interdepartmental issues - The provision of support functions within the Service • Supports the Chief Executive by determining and agreeing: - Strategic and Business Plans for the Service - In-year priorities and adjustment of plans - Relevant policies prior to going to the Agency Board for approval - Performance targets - Allocation of capital expenditure
REPORTS TO:	Agency Board through Chief Executive
RESPONSIBLE FOR (SUB-GROUPS):	None
MEETING FREQUENCY:	Monthly
QUORUM	Chief Executive plus 3 other members
SECRETARIAT:	The Chief Executive shall provide secretariat facilities
DOCUMENTATION REQUIRED:	Minutes, reports including KPIs
REMIT:	As above
COMMUNICATION LINKS WITH VARIOUS GROUPS:	Minutes are sent to Agency Board members and made available to all staff

TERMS OF REFERENCE

NAME OF COMMITTEE/SUB-GROUP	RISK MANAGEMENT SUB-GROUP
SUMMARY OF ROLE:	The Risk Management Sub-Group is a sub-group of the NIBTS Governance and Risk Management Committee, responsible for supporting development and implementation of business resilience and risk management solutions. • Development, implementation and review of policies and procedures to minimise business risk in compliance with relevant Northern Ireland/ UK Risk Management standards. • Development, implementation and maintenance of business continuity plans.
REPORTS TO:	Governance and Risk Management Committee
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Quality Manager/Risk and Business Continuity Manager
MEMBERSHIP:	Representatives from Donor Services, Laboratory Services, Corporate Services (including Health and Safety), and Finance/IM&T and Quality Departments.
QUORUM:	Four members
MEETING FREQUENCY:	3 monthly
SECRETARIAT:	Secretariat facilities will be provided by the Quality Manager
DOCUMENTATION REQUIRED:	Minutes, Risk Registers, Risk Assessments, Business Continuity Plans
REMIT:	Specific activities of the Sub-group will include overseeing: • Promotion of good risk management practice throughout NIBTS. Implementation of risk reduction policies and measures to respond effectively to incidents, which may otherwise prevent normal activity. • Development of departmental and organisation-wide risk registers. • Development and implementation of business continuity plans throughout the organisation. • Implementation and maintenance of processes for audit and testing of the policies and measures relating to business continuity and risk reduction, including relevant Controls Assurance Standards on Risk Management and Emergency Planning. • Development of a coordinated approach across the NIBTS to business risk and business continuity matters. • Planning of the testing of the business continuity plans to ensure the plans remain effective. • Identification of training and education requirements of NIBTS managers and staff in business risk assessment and business risk reduction. • Identification of risk management performance indicators. • Monitoring and reporting of risk management performance within NIBTS and to the Clinical Governance and Risk Management Committee. • Initial prioritisation of risks within NIBTS for presentation to SMT and NIBTS Board
COMMUNICATION LINKS WITH OTHER GROUPS	Governance & Risk Management Committee and other functional groups as required

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP	QUALITY IMPROVEMENT REVIEW GROUP
SUMMARY OF ROLE:	To plan, review and monitor the effectiveness of all aspects of the Quality Management System within NIBTS.
REPORTS TO:	Reports from the Group will be presented regularly to the Agency Board.
RESPONSIBLE FOR (SUB-GROUPS)	Incident Management Group and Change Control Group who report regularly to this Group
CHAIRED BY:	Regulatory Affairs and Compliance Manager
MEMBERSHIP:	Senior Management Team
QUORUM:	Chair plus three members
MEETING FREQUENCY:	Monthly
SECRETARIAT:	The Chief Executive shall provide secretariat facilities
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers The Regulatory Affairs and Compliance Manager will be responsible for the provision of general reports and analysis for the meeting but each member will be responsible for reporting on performance within their respective departments
REMIT:	• To plan, review and monitor the effectiveness of all aspects of the Quality Management System (QMS) within NIBTS. • To ensure compliance with the relevant legislation and accreditation standards, specifically the Blood Safety and Quality Regulations 2005, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and Clinical Pathology Accreditation Standards • To develop and review relevant key performance indicators by which performance in relation to quality can be monitored and continuously improved. • To agree/approve action plans developed to address areas of the QMS where KPI's indicate poor performance. • To plan, review, and monitor a quality audit programme within NIBTS. • To review serious incidents referred from the Incident Review Group.
Communication links with other groups:	Governance & Risk Management Committee, SMT, NIBTS Board

TERMS OF REFERENCE

NAME OF COMMITTEE/SUB-GROUP	INCIDENT MANAGEMENT GROUP
SUMMARY OF ROLE:	The Incident Management Group is a sub-group of the Quality Improvement Review Group. The group is responsible for • Supporting the on-going maintenance and development of Quality Incident Management systems in NIBTS • Providing an organisation wide review of incidents reported through the incident management system.
REPORTS TO:	Quality Improvement Review Group
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Regulatory Affairs and Compliance Manager
MEMBERSHIP:	The Business Continuity and Risk Manager, Representatives from Donor Services, Laboratory Services, Corporate Services (including Health and Safety), and Finance/IM&T, Quality and Regulatory Affairs and Compliance Departments.
QUORUM:	Four members
MEETING FREQUENCY:	Monthly
SECRETARIAT:	Secretariat facilities will be provided by the RAC Manager
DOCUMENTATION REQUIRED:	Minutes, Incident Management Performance Data, Specific Incident details as required.
REMIT:	Specific activities of the Sub-group will include:: • Review of incident management performance against agreed KPIs related to investigation and closure of incidents. This includes specifically the submission of completed investigations within 30 days and closure within 90 days. • Consideration of onward reporting • Consideration of potential wider effects of individual incidents • Identification and consideration of trends in incidents • Identification and consideration of any specific risks associated with incidents • Providing consolidated reports on incident management across the NIBTS to SMT
COMMUNICATION LINKS WITH OTHER GROUPS	Quality Improvement Review Group, Risk Management Sub-Group through the BC&RM, other operational meetings.

TERMS OF REFERENCE

Name of committee/group:	Health and Safety Committee
SUMMARY OF ROLE:	The Health and Safety Committee is responsible for the implementation of all aspects of health and safety including Fire Safety Management and Security Management
REPORTS TO:	Governance and Risk Management Committee
Responsible for (sub-groups):	None
Chaired by:	Facilities Manager or Head of HR & Corporate Services
MEMBERSHIP:	Representatives from each section within the Agency; union representatives; member of the Regional Tissue Typing staff.
Meeting frequency:	At least 8 times per year.
Quorum:	Four, and at least three departments represented
Secretariat:	Administration Officer, in Facilities
Documentation required:	Agenda, minutes, supporting papers
Remit:	Specific activities of the Sub-group will include: • Developing an action plan for the year ahead • Ensure health and safety arrangements are in place in each department and corporately and that there is a consistent approach to health and safety management throughout the organisation • Reviewing and developing policies and procedures for NIBTS on health and safety to ensure consistency/coherence across all departments and compliance with current legislation. • Assist Department Managers with risk assessments within their departments, ensuring that these are reviewed as required. This will include but are not limited to COSHH, DSE, Lone worker, New & Expectant Mothers, etc. • Maintain Centralised Record for Risk Assessment • Co-ordination and maintenance of a Health and Safety Audit Programme • Review health and safety incident statistics and agree actions to be taken as a result • Ensuring staff are appropriately trained in health and safety • Produce 6-monthly reports on health and safety matters within the organisation for presentation to the Governance and Risk Management Committee and Agency Board
Communication links with other groups:	Governance & Risk Management Committee, SMT, NIBTS Board

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP	Estates Management Group
SUMMARY OF ROLE:	To plan, review and monitor the effectiveness of all aspects of the Estates Management Systems within NIBTS and ensure compliance with relevant standards including GMP and Controls Assurance Standard.
REPORTS TO:	Reports from the Group will be presented regularly SMT and QIR Group.
RESPONSIBLE FOR (SUB-GROUPS)	No sub-groups are defined at present
CHAIRED BY:	Quality Manager
MEMBERSHIP:	Facilities Manager and Department representatives
QUORUM:	-
MEETING FREQUENCY:	Monthly
SECRETARIAT:	HR and Corporate Services provide the secretariat for this group
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers, minutes of meetings held with Belfast Trust Estates.
REMIT:	• To plan, review and monitor the effectiveness of all aspects of the Estates Management System within NIBTS. • To ensure compliance with the relevant legislation and standards, notably the Blood Safety and Quality Regulations 2005, the Human Tissue (Quality and Safety for Human Application) Regulations 2007 and the Controls Assurance Standards for Building and Plant Management. • To develop and review relevant key performance indicators by which performance in relation to estates management can be monitored and continuously improved. • To assist in the development of action plans developed to address areas of Estates Management where KPI's indicate poor performance. • To assist in the identification and management of risks associated with Estates • To review serious incidents involving estates issues.

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	BLOOD DONATION CO-ORDINATING GROUP
SUMMARY OF ROLE:	To oversee the blood collection programme with particular emphasis on coordination of the operational, clinical, quality/regulatory and marketing aspects
REPORTS TO:	Chief Executive
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Donor Services General Manager
MEMBERSHIP:	Donor Services General Manager, Chief Executive, Medical Director, senior nursing representatives, Regulatory Affairs and Compliance Manager, Laboratory Manager(if necessary)
MEETING FREQUENCY:	Two monthly
QUORUM:	3 members
SECRETARIAT	Donor Services General Manager
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers
REMIT:	Specific activities of the Committee will include overseeing: • Arrangements for the recruitment and selection of donors (whole blood, platelets, bone marrow) and collection of blood • Clinical care of donors • Procurement of session equipment and supplies • Compliance with BSQR, national policies and quality standards • Training of blood donation session staff • Arrangements for meeting the needs of internal as well as external customers • Review quality incidents and risk management issues • Encourage innovation and development
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of meeting are discussed at Donor Services Team meetings • Other team meetings Within NIBTS – Donor Services Team meeting (as appropriate); Clinical Team Group; Update meetings (RGNs/MOs); Training and Communication meetings (session staff). - External groups of particular relevance are: 1 Local - Blood Transfusion Communities Partnership 2 National - JPAC (SAC on Care and Selection of Donors); MSBTO, NBS (BTSAG)

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	DONOR SERVICES TEAM
SUMMARY OF ROLE:	To oversee matters concerning the blood collection programme and associated corporate issues
REPORTS TO:	Donor Services General Manager
RESPONSIBLE FOR (SUB-GROUPS):	Donor Recruitment and Organisation, Donor Administration, Headquarters and Omagh-based Units
CHAIRED BY:	Donor Services General Manager
MEMBERSHIP:	Donor Recruitment & Session Organisation Manager, Donor Administration Manager, Senior Nurse/Unit Manager (2)
MEETING FREQUENCY:	Every 4-6 weeks
QUORUM:	Three members
SECRETARIAT:	DS Hub staff
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers
REMIT:	• To oversee the implementation of the Donor Strategy and Donor Programme. • Takes action on relevant matters from SMT, GRM Committee, BDCG etc. • Considers issues arising from UK Blood Services (normally via BDCG) and HPSS/HSC NI.
COMMUNICATION LINKS WITH VARIOUS GROUPS:	Minutes of meeting are shared with the Chief Executive and Medical Director and relevant aspects communicated to appropriate SN/ULs and other Donor Services section staff

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	LABORATORY MANAGEMENT TEAM
SUMMARY OF ROLE:	To oversee the operational performance of the four laboratory departments. To provide a forum for communication and discussion of matters arising both within and external to the laboratories.
REPORTS TO:	- Senior Management Team through the Laboratory Manager
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Laboratory Manager
MEMBERSHIP:	Laboratory Manager, Heads and Deputy Heads of the four Laboratory Departments
QUORUM:	Laboratory Manager and representatives from at least three Departments
MEETING FREQUENCY:	Monthly
SECRETARIAT	Laboratory Secretary
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers including risk register, quality metrics form and planned quality objectives
REMIT:	• To ensure compliance with national policies, regulations and quality standards, including BSQR, Human Tissue (Quality and Safety for Human Application) Regulation 2007, Human Tissue Act and CPA standards • To agree allocation of staff and facilitate training • To oversee procurement and evaluation of equipment, reagents etc. • To review current laboratory procedures and facilitate change, if required • To review quality incidents, quality monitoring reports and risk management issues, internal/external audit and Quality Assessment Scheme results • To determine and agree priorities for the department • To encourage innovation and development • To oversee planned quality improvements
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of meetings will be made available to all Laboratory Staff, via Sharepoint and Hard copy will be posted on Laboratory Notice Boards • Intradepartmental meetings are held in all laboratory departments where the focus is on operational, quality regulatory and staff/training issues. • Other NIBTS groups with links to Laboratory Management activities include: Serology committee, Microbiology committee, Hospital Services committee, H& S committee, Medical Devices and Equipment Group, Blood Donation Coordinating Group and Apheresis groups, Governance and Risk Management Committee (and its sub-groups), Pulse Expert Group, Environmental and Waste Management committee and Investors in People team. • External groups and committees of particular relevance are: Hospital Users Meeting, Antenatal User Meeting, JPAC (SACBC), JPAC (SAC Immunohaematology), JPAC (SACTTI), MSBTO, UK NEQAS; DHSSPS Advisory Committee on Antenatal Screening, BCSH, Microbiology Test Evaluation Group

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	HOSPITAL SERVICES COMMITTEE
SUMMARY OF ROLE:	To oversee the work of the Hospital Services Department with a particular emphasis on the coordination of operational, clinical and quality/regulatory aspects
REPORTS TO:	Chief Executive and Medical Director
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Hospital Services Manager
MEMBERSHIP:	Head/deputy of hospital services department, Chief Executive, Medical Director, Laboratory manager, Quality Manager, Regulatory Affairs and Compliance Manager,
QUORUM:	3
MEETING FREQUENCY:	Two monthly
SECRETARIAT	Secretariat facilities provided by Hospital Services Department
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers, monthly Blood Components Monitoring report
REMIT:	Specific activities of the Committee will include overseeing: • Arrangements for preparation and supply of blood components • Procurement and supply of plasma products • Procurement and evaluation of equipment, including blood packs • Compliance with BSQR, national policies and quality standards • Arrangements for meeting the needs of clinical users and hospital blood banks (in keeping with evidence based, best practice) • Review quality incidents, quality monitoring reports and risk management issues • Determine and agree priorities for the department • Encourage innovation and development
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of meetings will be made available to all staff in Hospital Services Department and Quality Control Laboratory • Other team meetings • Within Hospital Services two separate groups meet regularly, involving respectively, BMS staff and MLA staff. Here the focus is on detailed operational, quality/regulatory compliance and staff/training issues. • Other NIBTS groups with links to Hospital Services' activities include: Laboratory Management Team meeting, Blood Donation Coordinating Group and apheresis groups, Clinical Governance and Risk Management Committee (and its sub-groups), Pulse team and Investors in People team. • External groups and committees of particular relevance are: Hospital Users Meeting (annual), JPAC (SACBC).

TERMS OF REFERENCE

Name of committee/group:	Serology Committee
Summary of role:	To oversee the work of the Automated Serology and Blood Group Reference Laboratory Departments with a particular emphasis on coordination of the operational, clinical and quality/regulatory aspects
Reports to:	- Chief Executive and Medical Director
Responsible for (sub-groups):	None
Chaired by:	Chief Executive/Consultant in Transfusion Medicine
Membership:	Head of automated serology laboratory; deputy head of automated serology laboratory; head of blood group reference laboratory; deputy head blood group reference laboratory; quality assurance manager; laboratory manager
Quorum:	Three members
Meeting frequency:	Two monthly
Secretariat:	Secretariat facilities provided by Chief Executive's office
Documentation required:	Agenda, minutes, supporting papers, NEQAS reports
Remit:	Specific activities of the Committee will include overseeing: - Arrangements for screening/testing of blood donors for ABO group, Rh type and antibody screen - Arrangements for the screening/testing of antenatal patients for blood group and red cell antibodies, includes referral of samples to SNBTS for quantitation anti D and anti c - Procurement and evaluation of equipment - Regulatory compliance: - Donors – BSQR, national policies and quality standards - Antenatal testing – CPA standards, national policies etc • Review of quality metrics for incidents, change control documents, validation projects and internal audit • Review of External Quality Assessment Scheme results • Agree quality objectives and service improvement plans for each year • Encourage innovation in the development of this service in collaboration with the requirements of users
Communication links with various groups:	• Minutes of the meetings will be made posted on the Staff Intranet • Minutes of meetings will be available to all staff within automated serology and blood group reference laboratory departments • Other team meetings and committees: - Intradepartmental meetings are held in automated serology laboratory department and blood group reference laboratory department where the focus is on operational, quality regulatory and staff/training issues - Other NIBTS groups with links to serology include: Laboratory Management Team meetings, Pulse team, Clinical Governance and Risk Management Committee (and its sub-groups), Investors in People team - External groups of particular relevance are: UK NEQAS; DHSSPS Advisory Committee on Antenatal Screening, Antenatal User Meeting; JPAC (SAC Immunohaematology); BCSH

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	MICROBIOLOGY COMMITTEE
SUMMARY OF ROLE:	To oversee the work of the Microbiology Department with a particular emphasis on coordination of the operational, clinical and quality/regulatory aspects
REPORTS TO:	- Chief Executive and Medical Director
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Head of Microbiology
MEMBERSHIP:	Head of microbiology department/deputy, Chief Executive, Medical Director, Laboratory manager, Quality Manager
QUORUM:	3 members
MEETING FREQUENCY:	Two monthly
SECRETARIAT:	Secretariat facilities provided by Microbiology Department
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers, NEQAS reports
REMIT:	Specific activities of the Committee will include overseeing: • Arrangements for screening/testing donors (blood, bone, bone marrow, cord blood) and for meeting the needs of internal users • Arrangements for screening/testing of antenatal patients and for meeting the needs for clinical users (in keeping with evidence based practice) • Arrangements for outsourced/reference testing • Procurement and evaluation of equipment • Regulatory compliance: donors – BSQR, national policies and quality standards antenatal testing – CPA standards, national policies etc • Review quality incidents and risk management issues • Review of External Quality Assessment Scheme results • Determine and agree priorities for the department • Encourage innovation in the development of this service
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of the meeting will be made available to all staff within the microbiology department • Other team meetings and committees • Intradepartmental meetings involving all staff in microbiology are held regularly. Here the focus is on detailed operational, quality/regulatory and staff/training issues. • Other NIBTS groups with links to microbiology include: Laboratory Management Team meetings, Pulse team, Clinical Governance and Risk Management Committee (and its sub-groups) and Investors in People team. • External groups of particular relevance are: DHSSPS Advisory Committee on Antenatal Screening, Hospital Users Meeting (annual), Microbiology Test Evaluation Group (SNBTS/NIBTS), JPAC (SACTTI), MSBTO.

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	CORD BLOOD BANK COMMITTEE
SUMMARY OF ROLE:	To oversee the work of the Cord Blood Department with a particular emphasis on coordination of operational, clinical and quality/regulatory aspects
REPORTS TO:	Chief Executive
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Medical Director/Designated Individual for Cord Blood Bank
MEMBERSHIP:	Laboratory Manager, representatives from cord blood laboratory, Cord Blood Coordinator (nursing), Quality Manager
MEETING FREQUENCY:	Two monthly
QUORUM:	Chair plus 3 members
SECRETARIAT:	Secretariat facilities are provided by the Cord Blood Bank
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers, Component Production Quality Monitoring Report
REMIT:	Specific activities of the Committee will include overseeing: • Arrangements for the recruitment and selection of donors and collection of cord blood. • Processing, testing, storage and distribution of cord blood units • Procurement and evaluation of equipment • Compliance with national policies and regulations including Human Tissue (Quality and Safety for Human Application) Regulation 2007 and Human Tissue Act • Links with key stakeholders in hospital maternity units, H&I Laboratory, British Bone Marrow Registry • Review quality incidents and risk management issues • Determine and agree priorities for the department • Encourage innovation and development
COMMUNICATION LINKS WITH VARIOUS GROUPS:	• Minutes of meetings will be made available to all staff in cord blood department and quality control laboratory • Other team meetings • Within NIBTS – Other relevant groups include Microbiology Committee, Update and Training meetings for RGNs, Pulse Team, Laboratory Management Team meeting, Clinical Governance and Risk Management Committee • National – British Bone Marrow Registry, JPAC (and SACs for Tissue and Cells, Donors and TTI), MSBTO

TERMS OF REFERENCE

Name of committee/group:	Medical Devices and Equipment Group
Summary of role:	In keeping with Guidance for healthcare and social services organisations, DB2006(05), November 2006 healthcare organisations should establish a medical devices management group to develop and implement policies across the organisation. This group should review the policies at least once a year and submit regular audit reports to the board. It will also: • improve communication about medical devices within the organisation • gain the agreement of clinicians, technical staff and users in relation to any proposed changes • reduce confusion about who is responsible for device management tasks, training and safe device operation.
Reports to:	Governance and Risk Management Committee
Responsible for (sub-groups):	These will be defined as required
Chaired by:	Quality Manager
Membership:	Representatives from each department within the Agency who have a knowledge of medical devices and equipment within their department. Business Continuity and Risk Manager and Facilities Manager
Meeting frequency:	Quarterly
Quorum:	Four, and at least three departments represented
Secretariat:	Quality department admin staff
Documentation required:	Agenda, minutes, QIR reports, Incident Data, other supporting papers
Remit:	Specific activities of the group will include: The remit of such a group(s) should also encompass providing advice on: • Medical device and equipment purchasing/acquisition issues and comparisons of alternative medical devices or equipment. • Technical specifications, regulatory compliance information and related issues • Financial data, including consideration of full on-costs, i.e. running, maintenance and consumables costs, when preparing a medical device or equipment purchase bid, including disposable and replacement costs at the appropriate time • Standardisation to single models where possible • Risk management considerations • Device/equipment evaluation reports, including user experience and preferences • Drawing up guidelines for medical device and equipment decontamination • Co-ordinating a medical device and equipment inventory • Monitoring of manufacturer's instructions and training
Communication links with other groups:	Governance & Risk Management Committee

TERMS OF REFERENCE

Name of committee/group:	ICT Steering Committee
Summary of role:	To oversee planning, management and decisions for all matters in relation to ICT.
Reports to:	Agency Board
Responsible for (sub groups):	-
Chaired by:	Finance Manager
Membership:	Senior Management Team, IM&T Manager
Quorum:	Chair plus 3 members
Meeting frequency:	Four monthly
Secretariat:	Provided by Finance Department
Documentation required:	Minutes
Remit:	Annual update of ICT Strategy taking account of key factors included in NIBTS Business Plan and regional ICT Strategy Establish IM&T plans and priorities for the year Agree IM&T expenditure plan for the year Mid-year review of progress against priorities and re profile of priorities as required Annual review and assessment of progress against plans and priorities
Communication links with various groups:	PULSE Expert Users Group

TERMS OF REFERENCE

NAME OF COMMITTEE/GROUP:	Equality and Human Rights Committee (EHRC)
SUMMARY OF ROLE:	The EHRC is responsible for the strategic implementation and monitoring of progress against corporate objectives for all aspects of the Agency's Section 75 and Human Rights responsibilities and ensuring that departments apply any necessary actions to comply with legislation and corporate objectives
REPORTS TO:	SMT and Agency Board. Where necessary issues requiring action by departments will be presented to SMT.
RESPONSIBLE FOR (SUB-GROUPS):	None
CHAIRED BY:	Head of HR & Corporate Services
MEMBERSHIP:	Quorum: Medical Consultant, Donor Services General Manager, Head of HR & Corporate Services, HR Representative. As available a representative from BSO Equality Unit will also attend.
MEETING FREQUENCY:	3-4 times a year.
QUORUM:	Four with at least two departments represented – see above
SECRETARIAT:	Provided by the HR & CS Department
DOCUMENTATION REQUIRED:	Agenda, minutes, supporting papers
REMIT:	Specific activities of the Sub-group will include: • Developing an action plan for the year ahead. • Reviewing ongoing screening within departments is taking place • Developing policies and procedures in relation to Equality. • Advising SMT, Board and other forums of issues of note that require corporate and/or departmental action. • Ensuring all staff are appropriately trained in all matters concerning equality and human rights • Produce periodic reports on Equality and Human Rights issues to the Agency Board. • Ensure completion of Annual Review of Progress, Disability Action Plan and Equality Scheme.
COMMUNICATION LINKS WITH OTHER GROUPS:	Primarily SMT and Agency Board.

Appendix 3

Table 1– Schedule of key meetings 2015-16

Year 2011/12	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.
NIBTS Agency Board		X		X		X	X		X			X
NIBTS Agency Board – Audit Committee		X		X		X						
Governance and Risk Management (GRM)			X			X		X			X	
Senior Management Team	X	X	X	X	X	X	X	X	X	X	X	X
Risk Management (GRM Sub-committee)		X			X			X			X	
Quality Improvement Review	X	X	X	X	X	X	X	X	X	X	X	X
Incident Management	X	X	X	X	X	X	X	X	X	X	X	X
Health and Safety Committee												
Equality and Human Rights Committee		X			X			X			X	
Estates Management Group	X	X	X	X	X	X	X	X	X	X	X	X
Blood Donation Co-ordinating Group		X		X		X		X		X		X
Donor Services Team	X	X	X	X	X	X	X	X	X	X	X	X
Hospital Services	X		X		X		X		X		X	
Serology	X		X		X		X		X		X	
Microbiology	X		X		X		X		X		X	
Cord Blood		X			X			X			X	
Medical Devices and Equipment Group	X			X			X			X		
ICT Steering Group		X			X			X			X	